Northumberland Pilot Study

Evaluation of Mental Health First Aid Training for Flood Recovery Workers

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Contents

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Summary

In September 2008, areas of Northumberland were severely affected by floods. This pilot programme aims to evaluate the effectiveness of training flood recovery workers in Mental Health First Aid England. Research suggests that following flooding communities show an increase in mental health problems such as anxiety and depression (Reacher, McKenzie, Lanes, Nichols, Kedge, Iversen, Hepple, Walter, Laxton & Simpson, 2004). Mental Health First Aid is an intensive training programme for the public, aiming to improve awareness of, and willingness to support, people with mental health problems. Versions of Mental Health First Aid have been evaluated across the world and found to have positive impacts such as improving attitudes towards people with mental health problems, and improving trainees' confidence and willingness to help people in distress.

In this pilot study, eighteen flood recovery workers were trained in Mental Health First Aid England. They completed questionnaires at pre group, post group and three month follow up. Ten participants were interviewed about their experiences of the course, between two and four weeks after training.

Whilst the results need to be viewed with caution, given the small number of participants and the lack of control group, initial signs are promising. In the post group questionnaires and interviews the flood recovery workers showed improved attitudes and feelings towards people with mental health problems, describing that they were more able to "put themselves in the shoes" of people with mental health problems. The post group questionnaires also suggested the recovery workers were more confident in their knowledge and ability of how to help someone suffering from distress and more likely to support to a friend, colleague or family member with a mental health problem.

Introduction

In September 2008, areas of Northumberland were severely affected by floods. The floods had a particularly devastating impact in Morpeth, with over 1,000 homes being affected (Channel 4 news report, 7th September 2008). Hundreds of families were left homeless and needed to camp, stay in hotels or with friends and family for several months following the disaster (Chronicle 9th January, 2009).

The training programme Mental Health First Aid was delivered to eighteen flood recovery workers in Morpeth, Northumberland. The objective of this study is to review the effectiveness of the Mental Health First Aid England training for flood recovery workers.

This introduction will outline the need for mental health intervention following a flood and give an overview of the current research on Mental Health First Aid.

Mental health needs in flooded areas

The health effects of being flooded in the UK have been documented previously, when Lewes in East Sussex was flooded in 2000 (Reacher, McKenzie, Lanes, Nichols, Kedge, Iversen, Hepple, Walter, Laxton & Simpson, 2004). Reacher *et al* conducted a large-scale study comparing 103 flooded households and to 104 non-flooded households in the same postal area. Interviewees were contacted 2-4 weeks following the flooding. The interviewers administered the General Health Questionnaire (GHQ, Goldberg 1978), a well-validated measure of psychological distress. A GHQ score of over four strongly predicts anxiety and depression. 48% of participants in flood related areas scored over four, compared to 12% in the non-flooded areas. Reacher et al also found that whilst there was also increased risk of physical health problems. This diminished when psychological distress was accounted for. Conversely Psychological distress was still significantly higher in the flooded households than the non-flooded households even when physical health problems were accounted for. Reacher *et al* note that displacement from housing and financial strain were likely Psychological stressors after flooding. They suggest that flood victims often wait months to be for compensation or for insurance to be repaid, may not be fully insured, or may have no insurance at all, resulting in a high likelihood of financial strain. Self-reported financial strain has been shown to be a powerful predictor of the onset and duration of mental health problems (Fitch, Simpson, Collard and Teasdale, 2007).

As Reacher *et al* note, their study could be criticised for only contacting those houses who have access to telephones, however, this is likely to be an underestimate of the effects of flooding as those without working telephones are likely to have been severely affected.

Werrity, Houston, Ball, Tavendale and Black (2007) investigated the social impacts of flooding in Scotland. They conducted interviews and focus groups with 257 people who had been affected by flooding. They found, in

the short-term, things that had the most detrimental effects on mental health were the anxiety associated with being flooded, people having to move out of their own homes and the stress of having to deal with builders and insurance companies. Participants said that, in the longer term, worries about potential future flooding, strained family relationships and loss of irreplaceable items caused the most problems. Werrity *et al* describe how the flooding had a significant impact on the mental health of those affected. One focus group participant was reported as saying:

*"*It was really stressful. I mean, I seen people maybe … the first day or so, they were alright and then all of a sudden you see them sitting there crying. They just crack up".

Werrity *et al* note these observations are supported by research such as that of the International Red Cross in 1998, who investigated a river flooding in Poland. These researchers found evidence to suggest that flooding, via increased depression, leads to greater suicide risk.

In a review of the effects of flooding in 2007 Pitt (2007) described:

"Some individuals have likened their flooding experience to bereavement, going through similar emotions such as shock and disbelief, anger, blame and finally acceptance".

This is supported by evidence such as the Farm Crisis Network (a telephone help line providing support to farmers going through stress and anxiety) reporting a 5-fold increase in calls following flooding (Pitt, 2007). Further, 48 interviews were conducted after the flooding in Hull, where participants reported increased levels of stress and anxiety, loss of interest in daily activities, increased alcohol consumption, decreased healthy eating and exercise and strained family relationships. In a flood recovery questionnaire, given to 869 respondents who had been flooded, the most commonly reported health problems were stress, anxiety, and depression. In addition, Pitt described research that showed (after interviews with 647 households affected by the floods) 67% of people interviewed stated flooding had an effect on their or their partner's emotional health and 22% of those married or living with partner indicated that the flooding had an impact on their relationship.

The Department of Health (2008) and the World Health Organisation (WHO, 2004) also note that flooding has important consequences for long-term mental health problems. The WHO (2004) and Pitt (2007) both recommend improved mental health support for those affected by floods.

Mental Health First Aid

Mental Health First Aid (MHFA) is a 12 hour training programme designed to inform members of the public about the signs and symptoms of mental health problems and ways of supporting someone who is experiencing mental health difficulties. The aims of MHFA are:

1. “To preserve life where a person may be a danger to themselves or others.
2. To provide help to prevent the mental health problem developing into a more serious state.
3. To promote the recovery of good mental health.
4. To provide comfort to a person experiencing a mental health problem.
5. To raise awareness of mental health issues in the community.
6. To reduce stigma and discrimination.”

(MHFA England Manual, 2008, p.15)

MHFA looks at the most common mental health problems (anxiety and depression) and one of the more misunderstood mental health problems — psychosis. It covers what to do if when coming across someone in crisis (e.g. having a panic attack, experiencing a delusion) and what to do if a colleague/friend were showing signs of a mental health problem. It discusses what treatments are available, where people can access help and the kinds of self-help available.

Betty Kitchener and Anthony Jorm originally developed MHFA in Australia in 2000. It was designed to improve mental health literacy in Australia (Kitchener and Jorm, 2005). Kitchener and Jorm (2005) describe studies designed to assess the effectiveness of MHFA with three groups: the public, the public in a rural area and those in a workplace setting. The last two studies involved random allocation to a waiting list control group and the three studies contained 1,264 participants in total, suggesting high reliability in the research findings. All studies showed statistically significant improvements post training in a range of areas including increased reported willingness to help others, more confidence in providing support and assistance to others and increased agreement with mental health professionals about effective treatments. One trial also found improved self-reported mental well-being among training participants.

These findings are supported by qualitative data from interviews with 191 training participants, 19-21 months following training. Most of the participants had been in contact with someone experiencing mental health problems within that time and were able to use the skills learnt on the course. Most said they felt more able to handle crises and were more understanding of the experiences of people in distress (Jorm, Kitchener and Mugford, 2005).

Since that time MHFA has been adopted and adapted by a wide variety of countries including Canada, Finland, Hong Kong, Singapore, Ireland, Scotland, Wales and England (Kitchener and Jorm, 2008). Each country has made some modifications to the original programme. England’s MHFA training is very much based on the Scottish programme. The Scottish MHFA adapted the Australian content by changing some of the language, covering additional topics such as self-harm and recovery and the development of a DVD that includes testimonies from people who have experienced mental health problems.

The Scottish MHFA programme has been well evaluated (York Consulting, 2004). The researchers conducted pre and post questionnaire analysis, used participant and trainer diaries and interviewed 8 managers of participants who had attended the course. The pre and post questionnaire returns were relatively low, with 61 people returning pre (41%), and 75 returning post (50%), however, 292 completed course evaluation forms. The results should be viewed with caution because of the lack of comparison group, making it more likely factors like wanting to please the researchers and changes in participants' lives other than the training could have had an effect. Nevertheless, the range of research techniques used in this study increases the validity of the results. York Consulting found significant increases in perceived levels of competence pre and post training and positive impacts on training participant's knowledge and learning about mental health. The results indicated a reduction in fear and increase in empathy towards people who experience mental health problems.

Method

Participants

The MHFA course was advertised within the local council and care trust. The advertisement stated that the training was aimed at flood recovery workers. The course was funded by Northumberland Care Trust and was provided free for all the training participants. The job roles of participants included: council workers dealing with flood victims, flood recovery and flood trauma manager, flood warden, red cross flood recovery workers, flood support group leaders homelessness officer for the council, mental health charity support worker, care manager/social worker for people with physical health problems, admin worker for the community mental health team and a community development worker. The stated reasons for attending were most commonly to assist in flood recovery work.

Pre and Post Questionnaires

All participants were asked to complete a questionnaire before the course began, immediately after the course and at three month follow up (please see Appendix 2 for details). The standardised instructions, consent forms and pre and post questionnaires were given at the training venue, immediately before and immediately after the training. An administrator in Northumberland Tyne and Wear NHS Trust emailed the three-month follow up questionnaires to participants. The participants were given 2 weeks to complete the follow up questionnaires and were sent a reminder before that deadline. Participants were also told that one participant who completed all three questionnaires would be selected at random to receive a £10 shopping voucher. Whilst is was necessary to allocate numbers to the participants to their pre, post and follow-up questionnaires could be matched up, participants were assured that their questionnaires would be made anonymous in the write-up and their responses kept confidential.

The questionnaires incorporated the following measures:

1. Perceived confidence in ability to manage own and others stress, willingness to help a family member or friend with mental health problems.

As no brief validated measures could be found, this was measured by asking: “How confident are you in managing your own stress?” and “How confident are you in managing others stress?”. Participants were also given a description of someone experiencing mental health problems and were asked “How likely would you be to offer this person help if they were a family member?” “If they were a colleague?”. These questions and the description were taken from the national MHFA evaluation. It should be noted the psychometric properties of these questions has yet to be evaluated, which could undermine the reliability of the results.

2. Social Distance

Link, Yang, Phelan and Collins (2004) define social distance as “a respondent’s willingness to interact with a target person in different types of relationships”. It is one of the more commonly used measures of stigma. Link *et al* note that the measure tends to show good internal consistency reliability (participants tend to score similar scores on each of the questions relating to social distance) and good construct validity (the questionnaire relates well to other measures of stigma). For example, people who perceive people with mental health problems as dangerous are more likely to desire increased social distance.

3. Feelings towards people with mental health problems

This measure is based on asking people’s reaction to a description of someone with mental health problems and was developed by Angermeyer and Matschinger (2004). Link, Yang, Phelan and Collins (2004) heavily endorse the use of this measure, given the apparent lack of research focussing on emotions and stigma. Link *et al* report the measure has good reliability and validity relating to other measures of stigma, however the vignettes used in the original experiment were not available, therefore, a description of a person with mental health problems used in the MHFA England national evaluation was used. Only items with the highest factor scores from Angermeyer and Matschinger (1996) were used – anger, irritation, sympathy, desire to help, anxiety and feelings of unease.

4. Negative beliefs towards people with mental health problems

The researchers were unable to find a validated measure of stigmatising attitudes towards people with mental health problems in the workplace. Therefore, these questions were based on workplace research that investigated employer views towards mental health and public attitude questionnaires about views of mental health. The rationale for each of the questions relating to stigma is outlined below:

- “People with mental health problems struggle with them all their lives”. This is based on research that suggests a strong belief in recovery is associated with reduced negative beliefs and

behaviours towards people with mental health problems (Sayce, 2003, Luty, Umho, Sessay, and Sarkhel 2007, Mann and Himelein 2004, Robson and Bostock, in preparation).

- "People should be better protected from people with mental health problems". This is linked to research suggesting beliefs about dangerousness are linked to fear and negative behaviours towards people with mental health problems (Robson and Bostock, in preparation, Sayce, 2003, Corrigan, Rowan, Green, Lundin, River, Wasowski, White, Kubiak, 2002).
- "People with mental health problems are fundamentally different to other people". This is based on research suggesting that the stigma of mental illness relates to seeing people with mental health problems as "others"; an "us and them" mentality (Robson and Bostock, in preparation, Link, Yang, Phelan, and Collins, 2004).
- "People with mental health problems can't take on new challenges" . This is based on workplace opinions research which suggests that this is a commonly held view on workplaces (Working Minds, 2001, Shift, 2008, Thornicroft, 2006).
- "People with mental health problems are likely to be unreliable at work" and "If an employee is experiencing stress at work it is the individual's responsibility to manage it, not the employers". This is based on research suggesting employers underestimate the impact of work on their employees, the responsibility for mental health tends to be put on the individual (Sainsbury, Irvine, Aston, Wilson, Williams and Sinclair, 2008, Working Minds, 2001).
- "People with mental health problems are incapable of making simple decisions about their own lives". This question is based on the Attitudes to Mental Illness Research Report (Prior and Carman, 2008).

Whilst there is research support for including these questions, the psychometric properties have yet to be established.

5. Knowledge of mental health problems

This is based on the MHFA England national evaluation and consists of 3 self-rated items: knowledge of mental health problems in general, different types of mental health problems and the signs that indicate a mental health problem. Again, there is no information on the psychometric properties of these items.

6. The causes of mental health problems.

Research suggests that increased belief in the social causes of mental health problems and decreased belief in biological causes of mental health problems results in a reduction in stigma (Read, Haslam, Sayce & Davies 2006, Walker and Read, 2000, Robson and Bostock, in preparation). Therefore, two items from Sholl, Korkie and Harper (2009) relating to belief in social or biological causes were included in the questionnaire.

7. Days absent and job satisfaction

These questions were taken from the World Health Organisation Work Performance Questionnaire (WHOWPQ) (Short Form) Kessler, Barber, Beck, Berglund, Cleary, McKenas, Pronk, Simon, Stang, Üstün, T.B. and Wang, P.S. (2003). The full version of the WHOWPQ has been validated with a range of occupational groups such as airline pilots, automobile company workers and train engineers (Kessler et al, 2003) who found that scores on the full version of the questionnaire matched accurately to objective records of job absenteeism and presenteeism. Kessler, Ames , Hymel , Loeppke , McKenas , Richling , Stang , Ustun (2004) found the full version of the WHOWPQ to have good validity and reliability and to be sensitive to change. However in our analysis we used some items from the short form questionnaire, as the short form was felt to be too lengthy to include in its full form. As Kessler, Petukhova, McInnes and Üstün (2007) note, not using the full version of the questionnaire can reduce the validity of the scores because consistency checks cannot be made, this will have to be taken into account when interpreting the results from our pre and post questionnaire.

8. Warwick-Edinburgh Mental Well-Being Scale (WEMWBS).

This is a 14-item scale designed to measure positive mental well-being. The scale has been tested on student populations and in Scottish national mental health surveys (Tennant, Hiller, Fishwick, Platt, Joseph, Weich, Parkinson, Secker, and Steart-Brown, 2007). The measure has shown good content validity (the items that are included are useful) good construct validity (all the items are measuring just one concept), good criterion validity (the questionnaire related well to other measures of mental health and well-being, such as the GHQ). It also shows good test-retest reliability. The WEMWBS was also tested against the Balanced Inventory for Desirable Responding (BIDR) designed to measure tendency to give the perceived “desired response” to a questionnaire. The correlations with this measure were low, suggesting the WEMWBS is not overly susceptible to desirable responding. Tennant et al conclude that the measure is a good assessment of mental well-being at the population level, however, they note that the scales sensitivity to change has not been measured, suggesting that our pre and post results should be interpreted with caution.

9. MHFA England questionnaire
This is a general evaluation that asks the participant to rate the quality of the course content, materials and facilitation.

Interviews

During the training, all participants were invited to volunteer to be selected for interview. All those who volunteered were given a chance of winning a

£10 shopping voucher. The group were informed that the interviews would be carried out by a person outside the training team and the identity of the interviewees would be anonymous, the trainers would not know who had been selected.

Two Psychology Assistants at Northumberland Tyne and Wear NHS Trust, with previous experience of qualitative interviewing, carried out the interviews and analysis. The interviewers were instructed to use the topic guide to conduct interviews (see Appendix 3). The interviewers were asked to complete their write-ups as soon as possible following the interview and to use the interviewee's own words as much as possible. It is acknowledged that whilst these interviews will add value, they will not lend themselves to through qualitative analysis because they were not recorded using an audio recording device.

All interviews were carried out between 2 and 4 weeks after the training. 5 volunteers were selected at random for interview. If the selected interviewee was unreachable on more than two occasions, a new interviewee was selected from the volunteers.

Results

Pre and post questionnaires

The small number of participants means that the quantitative results should be viewed with caution; they should be seen as suggestive, rather than definitive. The results are designed to help give some indication of attitude change and provide suggestions for the direction of change.

Because of the low number of participants, statistical analysis would not be meaningful. Therefore, average group scores were used to look for a group trend at pre, post and 3 month follow-up. The questionnaires that were only completed at pre test and follow up (The job satisfaction scores and well-being scale) only included those participants who had completed both the pre and 3 month follow-up questionnaires to obtain more accurate results of change.

Response rates

17 participants completed the pre and post questionnaires, these were completed on site, immediately before and immediately after the training. The 3 month follow-up questionnaire was sent out by email, which reduced the response rate. 9 participants completed the 3 month follow-up questionnaires (a response rate of 53%). The response rate for our 3 month follow up questionnaires was higher than average for postal questionnaires (Edwards, Roberts, Clarke, DiGuideppi, Pratab, Wentz and Kwan, 2002) suggesting the monetary incentive and email delivery are an effective method of increasing follow-up questionnaire returns.

Participant characteristics

There were more women than men in the sample (12:5) and the most common age range was 27-37 (n = 6). However, there was a good range of ages . At pre-test, many of the participants had received mental health training previously (n = 7), had been close to someone with a mental health problem (N = 6), had experienced a mental health problem themselves (N = 7), or had been in contact with someone with a mental health problem within the last 6 months (N = 14). These high levels of contact are unsurprising given the jobs of the training participants (noted in "participants" section of the method). However, this does make it more likely that the training participants would have a lower levels of pre-group negative beliefs towards people with mental health problems than average — contact with someone with mental health problems has consistently been associated with lower levels of stigmatising attitudes (Thornicroft, 2006, Sayce, 2003, Robson and Bostock in preparation).

Questionnaire results

Please see Appendix 1 for a detailed graphical breakdown of the results. Please note th three month follow-up data should be viewed with caution because of the small numbers of people who completed the questionnaires.

1. Perceived confidence in ability to manage own and others stress, willingness to help a family member or friend with mental health problems.

There was a slight increase in the group's average perceived ability to managing their own stress at post test and a slight further increase at 3 month follow up. There was also increases in participants average scores in confidence in managing own stress, willingness to help a family member and willingness to help a friend with mental health problems. These improvements declined somewhat at 3 month follow up, but were still higher than pre-group levels.

2. Social Distance

The average group social distance increased at post test and 3 month follow up. It should be noted that the pre-test scores of the group were already quite high.

3. Feelings towards people with mental health problems

The average group feelings towards people with mental health problems improved at post test and follow up. It should also be noted that the pre-test score of the group were already quite high.

4. Negative beliefs towards people with mental health problems

The results the group were more likely to reject negative beliefs about people with mental health problems at post test and follow up.

5. Knowledge of mental health problems

Self rated knowledge of mental health problems increased at post test. This declined somewhat at the 3 month stage, but was still higher than pre-group levels.

6. The causes of mental health problems.

On average, the group were slightly more likely to reject biological factors as the main cause of mental health problems at post test and follow up. However, there was no increase in participant's agreement that mental health problems are mainly cause by stressful events in people's lives.

7. Days absent and job satisfaction

Graph 11 showed that for the participants who completed the 3 month follow-up (8 participants), their average ratings of their job satisfaction and their current job performance (compared to their usual job performance) decreased. Graph 12 shows that for those participants who completed pre and 3 month follow-up questionnaires, the number of days they were off work due to illness and number of times they stayed at work late decreased from pre group to 3 month follow-up.

8. Warwick-Edinburgh Mental Well-Being Scale (WEMWBS).

Graph 13 shows that for the 8 participants who completed pre and follow-up questionnaires, the average (group) wellbeing score improved.

9. MHFA England questionnaire

Table 1 shows that the participants rated all aspects of the programme from good to excellent.

Area:	Presenters	Slides	Video Clips	Manual	Learning Exercises	Structure	Content
Group Average Score:	4.2	3.9	3.6	4.3	4	3.9	4.2

Table 1. This was measured by asking participants "How would you rate the…" Participants are asked to circle words- Excellent (5), Very Good (4) Good (3) Fair (2) Poor (1). Minimum score = 1, Maximum = 5.

Interviews

The interviews were transcribed by two Psychology Assistants, with experience of conducting qualitative interviews. The author then reviewed these transcripts to identify common themes in participant's responses, which are summarised below. Please note these themes just contain a flavour of the responses given by the interviewees, the full transcripts are available on request.

Q1 What was the most useful/effective part of the training?

Theme: Increased ability to notice when people are having problems:

- What personally appealed to me most was the information on suicide and depression and the ongoing influences on these, as the people I work with are most likely to manifest these problems.
- The consolidation of the information into a presentation helped me make sense of how everything linked together, which I hadn't been able to do before.

Theme: Increased confidence and knowledge in how to help people who are experiencing problems:

- Overall it gave a boost in confidence in recognising what might be happening and knowing what to do from there.
- It gave the confidence to follow through with a feeling, acting on something.
- It really made me think about how I had dealt with people in the past
- Being given a practical model - ALGEE model gave us something that could be applied in different situations.
- Generally: learning that it is more important to listen to someone than to give advice.

Theme: Increased empathy, getting a better understanding of what experience of mental health problems is like:

- Whispering in the ear was a good experience that allowed you to find out what it is like to hear voices.
- Case studies – interviews with professionals and patients. Discovering that the image most people have of mental illness is one that they get from the media/films which is far from the truth. Very eye opening.

Theme: Running of the group and materials given:

- The balance between practical and theory was spot on, the relevance to my work was excellent.
- The group discussions were very useful because other people brought experience to the group.
- I loved the focus, (one of the facilitators) was particularly good at allowing people to have their say but then bringing them back and getting them focused.

Q2- What was the least useful/effective thing on the training

Theme: Nothing not useful, very enjoyable/nothing in particular

- The work in groups was fantastic and well designed.
- I came back inspired, told my manager it was excellent!

Theme: A lot to take in, too much powerpoint

- '….only thing was that a lot of it was on PowerPoint which got a bit boring'.
- Nothing specific but it was a bit heavy going. (asked for clarification and they meant it was a lot to take in as well as being highly emotive).

Q3 How relevant was the training to your job? And Q4 Have you had the opportunity to use the training?

Theme: More confidence and knowledge that helps with daily work

- Everyday, about 20 times a day!
- It gave me awareness of the signs and symptoms I can now identify as serious or not so serious, I wish Id had this knowledge before.
- It was pitched at the right level so I have been able to use the information and it has certainly enhanced the skills I am able to bring to my job.
- I work with physical disabilities but mental health problems do happen alongside and I definitely have more confidence about what stages. people need to be referred to mental health services and what to do.

Theme: Helping when supporting flood victims

- I work with flood victims all over the country, particularly working with the emotional trauma it causes – so consequently the relevance was massive.
- Very relevant. I'm currently working with flood victims and homelessness at the moment. Good to be able to recognise the signs and to know what to do initially.

Theme: Haven't been using it yet but expect to in future

- I meet people from all walks of life such as refugees and asylum seekers, so it will come in useful. Its difficult to say today as I think its something that will become apparent in the future.
- Its given me awareness, when talking to people, about picking up on signals, perhaps earlier on, or noticing things I maybe wouldn't have before.

Q6 and 7 Have you learnt anything new? Have your attitudes changed?

Theme: Consolidated previous knowledge and attitudes

- It consolidated a lot of what I know.
- It made the knowledge more accessible.
- Put the ideas together.

Theme: Challenged assumptions participants had made about mental health

- Yes, I definitely learnt something about Depression. I realised I had maybe made a lot of assumptions and it dispelled some of these for me, put them to one side.
- It confirmed what I already knew – realised I was wrong on some things.
- It changed my attitudes towards it (mental health).
- Yes! Completely different subject than they have every dealt with before. The course took away their pre-conceptions about mental health.
- A little knowledge is dangerous and I think this was me before the training, it's blown away the assumptions I had made.
- Before the training had the attitude that people with mental health problems should just 'deal with it' but afterwards understood the difficulties they face.

Theme: Increased empathy and understanding towards people with mental health problems:

- It helped me see it from someone else's perspective, particularly the example with the mobile phone and someone talking to themselves and also the exercise where someone was whispering in your ear as you talked.
- This really raised awareness again of the particular things people may be experiencing and the impact.
- More understanding of what people may be experiencing.
  Fear factor taken away.
- Learned a different way of looking at things and am now able to better put myself in the shoes of someone who has mental health problems.

Theme: Increased general knowledge about mental health

- Absolutely – particularly the whole area of suicide.
- I think my general day to day knowledge of mental health issues has improved, it has definitely raised my awareness.
- Its also helped to update my knowledge, since I was trained techniques and thinking has changed but I've never had this update – the training definitely helped with this.
- Around particular illnesses – I feel now I have a lot more knowledge.

Discussion

The MHFA training was well received by the flood recovery workers, they rated all aspects of the programme from good to excellent. The themes from the interviews included: participants reported: they knew more about mental health, their previous knowledge had been consolidated, they were more able to recognise when people are in distress and they believed they were likely to use the training in the future, if they had not already by the time of interview.

This discussion will mainly focus on the results of the pre and post questionnaires and qualitative interviews, as the low response rate to the 3 month follow-up questionnaires makes it difficult to draw reliable conclusions. The 3 month follow up results do look largely promising and suggest that the post training effects may last longer term, but further research will need to be conducted to confirm this.

It is important to acknowledge that it is difficult to say whether the pre and post changes that have occurred did so because of the MHFA England training or as a result of external factors or multiple testing, due to the lack of an adequate comparison group. The results will be discussed with this in mind and any tentative conclusions drawn will be supported by the qualitative interviews and existing research.

1. Improved knowledge, attitudes and feelings towards people with mental health problems post training.

The groups showed relatively positive attitudes, feelings and some knowledge of mental health problems at pre test. This lis likely to be due to the job roles of the individuals who attended and the fact that many of them knew someone who had experienced a mental health problems. Nevertheless, the group showed less negative attitudes, emotions and desired social distance towards people with mental health problems following training. They also perceived themselves as more knowledgeable about mental health following training. This is particularly interesting as participants showed quite positive beliefs in the pre test and some perceived them selves as knowing quite a bit about mental health before the training.

The qualitative interviews suggest that the positive change was due to people's previous attitudes and assumptions towards people with mental health problems being challenged. One participant noted that the course took away his pre-conceptions about mental health. This is supported by research in that beliefs about people with mental health problems being dangerous (Corrigan, Rowan, Green, Lundin, River, Wasowski, White, Kubiak, 2002) or unlikely to recover (Luty, Umho, Sessay, and Sarkhel, 2007) are seen as common and likely to lead to increased negative behaviour and beliefs about people with mental health problems. The MHFA England course provides both factual information about dangerousness and promotes a strong recovery message.

Further, the interviews suggest that MHFA increased participant's empathy for people experiencing mental health problems; one participant mentioned feeling more able to "put myself in the shoes of someone who has mental health problems". This is also supported by research, Friedli (2007) argues that creating an emotional connection with the stigmatised group is an important part of selling the need for change to a group. It is likely that the personal stories included in the MHFA DVD and in the examples given by the facilitators help to create this emotional connection. Gale, Seymour, Crepaz-Keay, Gibbons, Farmer and Pinfold (2004) note:

"featuring real stories prompts emotional responses which are known to facilitate learning and change" p.12

2. Improved confidence and willingness to help others post training.

The pre and post questionnaires show that the group (on average) reported themselves to be more confident in their ability to manage others stress and more willing to help a friend, colleague or family member with mental health problems. The qualitative interviews suggest that this could be due to feeling more knowledgeable (as described above) and because they were given practical steps to take if they encountered someone in difficulty. One participant mentioned "Being given a practical model – ALGEE gave us something that could be applied in different situations". Others talked about being able to recognise if something was wrong and "knowing what to do from there".

This is supported by research that suggests that showing people what to do; giving them the role of "helper" (or mental health first aider) is likely to increase helping behaviour. The concept of bystander apathy is well known and studied within Social Psychology. It relates to the human tendency to avoid intervening when someone is in distress. This phenomenon becomes more apparent the more people that are around. It is theorised that there is a "diffusion of responsibility" where people in a crisis situation believe that someone else will manage the situation and so do nothing. Myers (1999) describes experiments designed to increase helping, which suggest increasing people's responsibility and reducing ambiguity will increase altruism. MHFA increases participant's responsibility (they are now in the position of having been trained to respond to someone in distress) and decreases ambiguity (outlines clear ways to respond).

This finding is particularly relevant in relation to the current training group who were flood recovery workers. Given the high incidence of mental health problems in flood affected areas, these results imply that the MHFA participants are more likely to recognise and support people who are in distress. One participant noted "I'm currently working with flood victims and the homeless at the moment. Good to be able to recognise the signs and know what to do…". Those who had not been using the training at the time of interviews thought it would come in useful in the future, especially in flood recovery situations.

3. Increased confidence in ability to manage their own stress

The results suggest that the training participants were more confident in their ability to manage their own stress post training. This is potentially supported by the results of the wellbeing scale, which suggests that the 8 people who completed the 3 month follow up questionnaire showed improved wellbeing on average. Further, these 8 people were less likely to have days of due to health problems or stay late at work. This wellbeing score and job score could be attributed to many things other than the MHFA training (not least the length of time since flooding occurred which is likely to impact on work tasks). Nevertheless, these results do support earlier findings from the Australian MHFA (Kitchner and Jorm, 2005) where participants also showed improved wellbeing scores post training.

The interviews did not suggest a theme as to why wellbeing may have improved. MHFA England does look at recommended self-help strategies (such as being active and keeping in touch with friends). Further, it covers the kind of treatments are available to people with mental health problems and the different ways in which people recover. It could be that exposure to this information meant that participants had a wider range of coping strategies when they felt stressed, or felt more aware of the treatments available, should they experience symptoms of a mental health problem.

It is unclear as to whether the MHFA training has an effect on job satisfaction or job performance. The interviews suggest that participants felt they would use the training in their workplace. However, the few participants that did respond to the 3 month follow-up had lower job satisfaction and performance scores. This will need investigating in further research to establish a relationship.

4. Beliefs about the causes of mental health problems.

The results here are mixed, they suggest that whilst participants show decreased belief in “biological problems in the brain” as the cause of mental health problems post-test, they show also decrease in belief that mental health problems occur in reaction to stressful events. As mentioned earlier, promoting mental health problems as “an illness like any other” or as mainly caused by biological factors, is likely to lead to increased fear and negative beliefs. Research suggests that this is because “illness” is related to unpredictability and a belief that the behaviour of people with mental health problems is out of control (Read, Haslam, Sayce & Davies 2006, Walker and Read, 2000, Robson and Bostock, in preparation).

The MHFA England course does discuss the biological differences in people with mental health problems, such as the difference in serotonin levels (MHFA England Manual, 2008). Read, Haslam, Sayce & Davies (2006) suggest that these biological differences could be promoted within their social context, such as explaining how stress can produce a chemical response and that “every single thought we have involves chemical changes in the brain” (British Psychological Society, 2000). This has the potential to increase MHFA participants’ belief in the social context of

mental distress, so reducing fear and negative beliefs towards people with mental health problems.

Conclusions and implications for further research

The limitations of the study methodology and questionnaire materials have been noted throughout the paper. The authors intend to conduct further research into the effectiveness of MHFA England within Northumberland, the data from this pilot study will help inform the development of this project. For example, this pilot study has highlighted the need for validated outcome measures relating to attitudes towards mental health in the workplace. The results will also provide us with data that we can use to gain more information of the psychometric properties of the questionnaire items used here. It is also hoped that future study will incorporate more objective measures of behavioural changes, such as organisation level sickness absence figures.

Whilst the results need to be supported by further research, the initial signs are promising. They suggest that participants, who already had a positive view of people with mental health problems, still benefit from the MHFA England course. The results imply key changes in attitudes, emotions and willingness to support people with mental health problems. This has significant implications for flood affected regions, where it is likely that residents will show an increase in emotional distress and mental health problems. MHFA England provides a potential solution for ensuring these needs are met.

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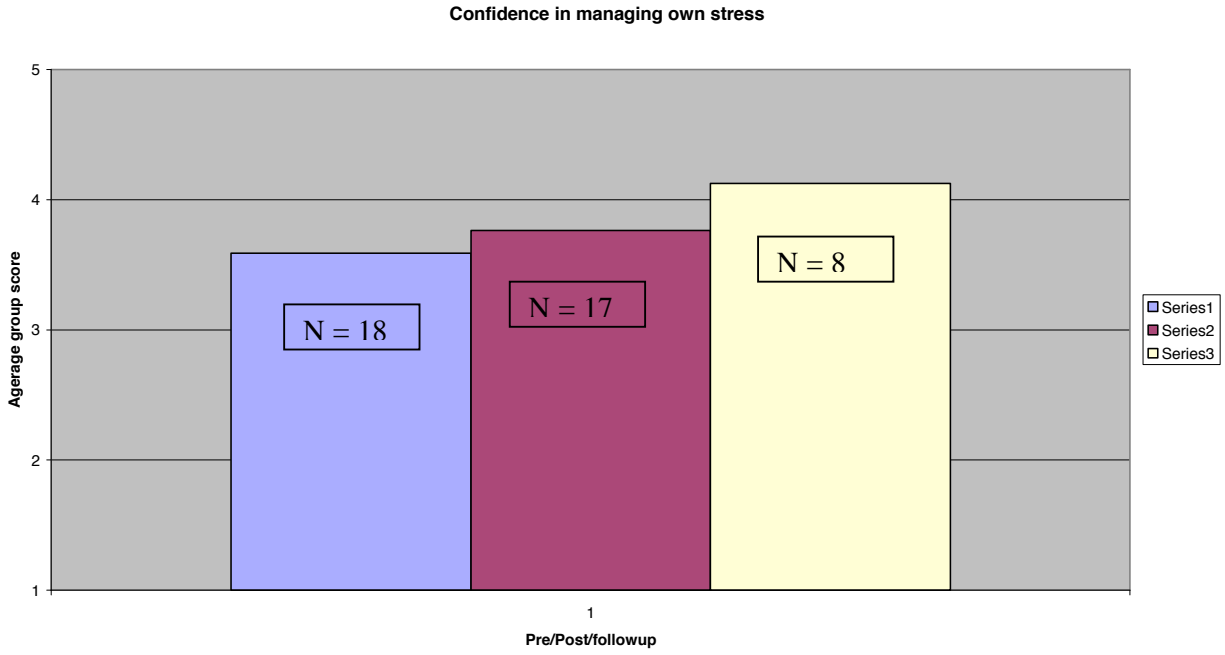
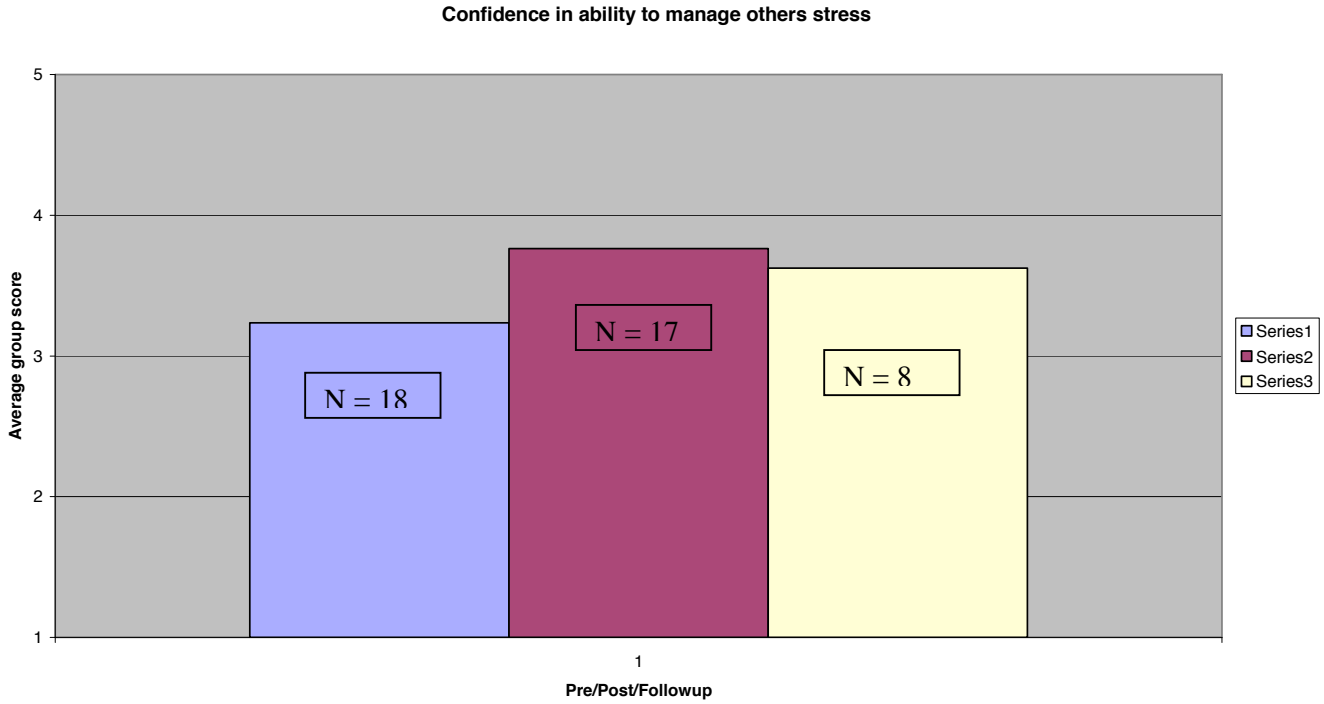
Appendix 1 — Graphical Breakdown of Results

1. Perceived confidence in ability to manage own and others stress, willingness to help others with mental health problems.

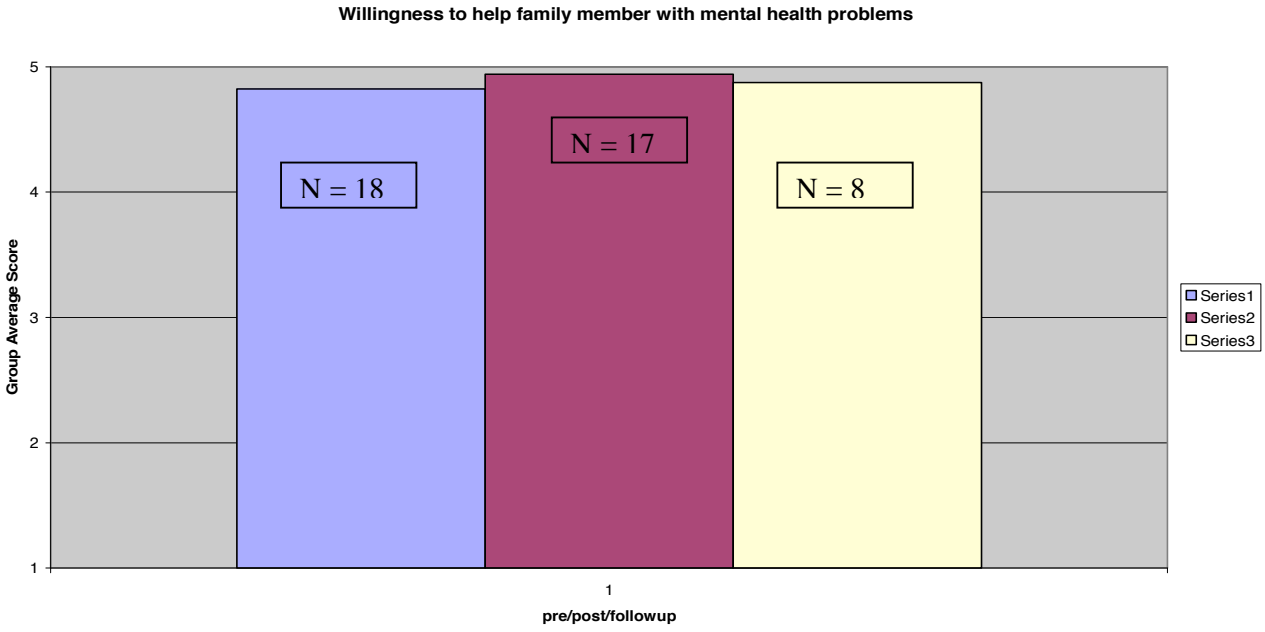
Graph 1 shows that the average group confidence in participant's ability to manage their own stress increased at post-test and 3 month follow up. Graph 2 shows an increase in the group's ability to manage other people's stress. There is a slight decrease in confidence from post test, to 3 month follow-up, but 3 month follow up scores are still higher than pre-test scores. Graph 3 shows that the group on average are more likely to report willingness to help a family member at post-test and follow-up. Graph 4 shows the group are more likely, on average, to report willingness to help a friend/colleague post-test, but this returns to pre-group levels at 3 month follow-up.



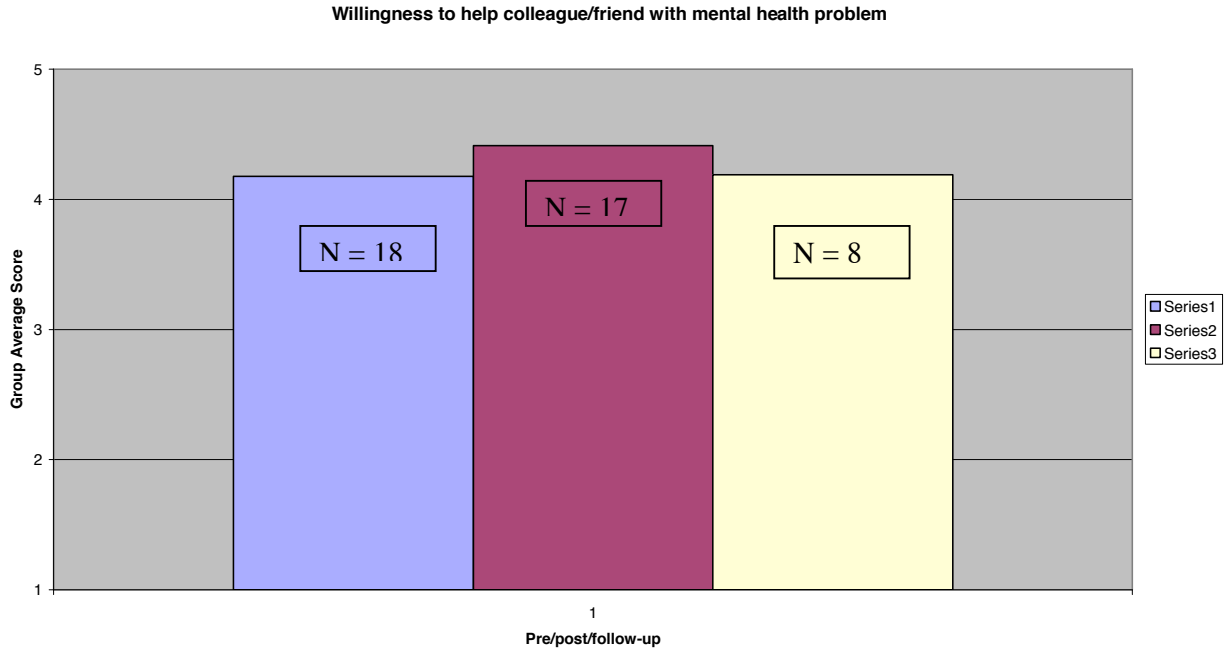
Graph 1, showing average (group) confidence in ability to manage own stress, measured by asking "How confident are you in your ability to manage your own stress? (Responses measured on a Likert scale, Minimum score 1, maximum 5).



Graph 2, showing average (group) confidence in ability to manage others stress, measured by asking "How confident are you in your ability to manage others stress? (Responses measured on a Likert scale, Minimum score 1, maximum 5).



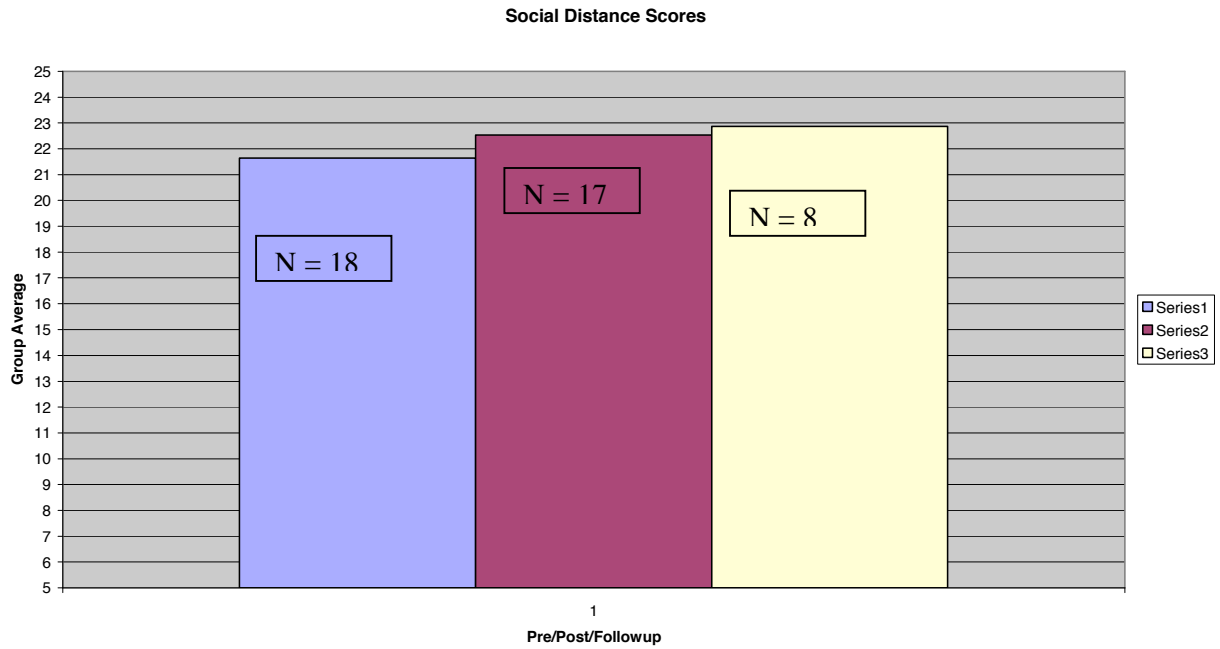
Graph 3, showing average (group) willingness to help a person with mental health problems who was a family member. Measured by giving participants a description of a person with mental health problems, then asking, how likely would you be to offer help if (person in description) was a member of your family? Low score unlikely, high score likely. Minimum score 1, maximum 5.



Graph 4, showing average (group) willingness to help a person with mental health problems who is a friend or colleague. Measured by giving participants a description of a person with mental health problems, then asking, how likely would you be to offer help if (person in description) was a friend/colleague? Low score unlikely, high score likely. Minimum score 1,

2. Social Distance

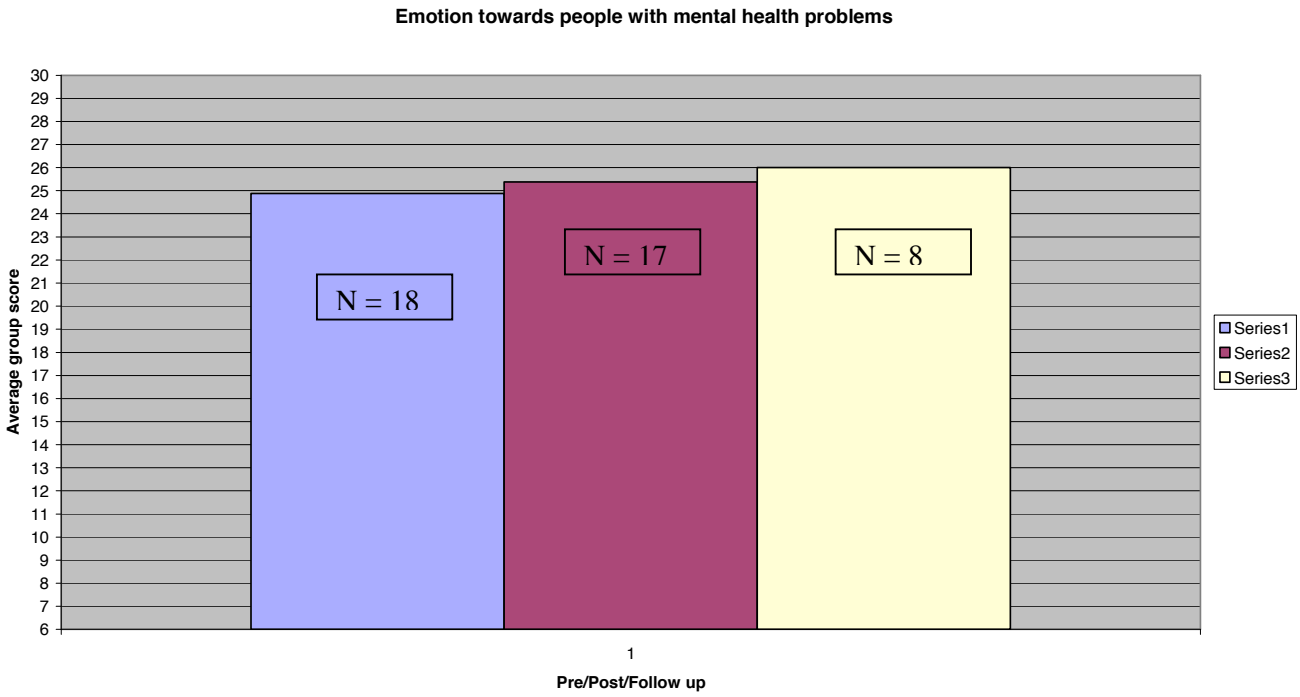
Graph 5 shows that the group average social distance improved at post-test and follow up.



Graph 5, showing average (group) social distance towards people with mental health problems. Score gained by summing responses to 5 social distance questions, each measured on a 5 point Likert scale. Low scores indicate a high desire for social distance, high scores indicate a low desire for social distance. Minimum score 5, maximum 25.

3. Feelings towards people with mental health problems

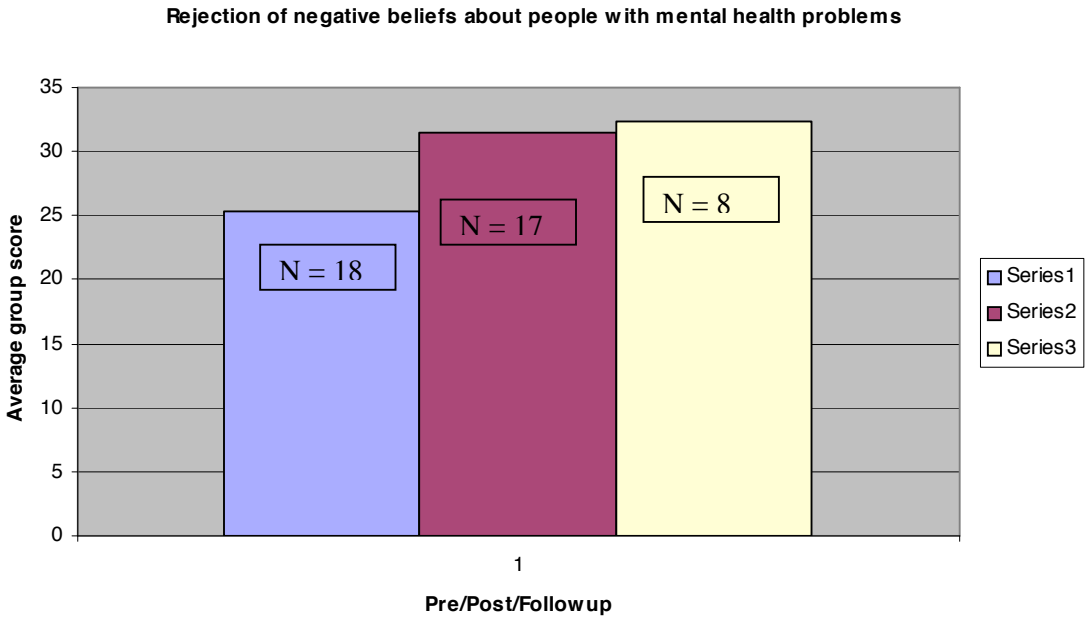
Graph 6 shows that on average, participant's emotions towards people with mental health problems improved at post-test and follow-up. Graph 7 shows group average rejection of negative belief scores improved slightly at post test and follow-up.



Graph 6, showing average group emotions towards people with mental health problems. Score gained by summing responses to 6 emotional responses to a vignette, each measured on a 5 point Likert scale. Low scores indicate high negative feelings, low positive feelings, high scores indicate a low negative feelings high positive feelings. Minimum score 6, maximum 30.

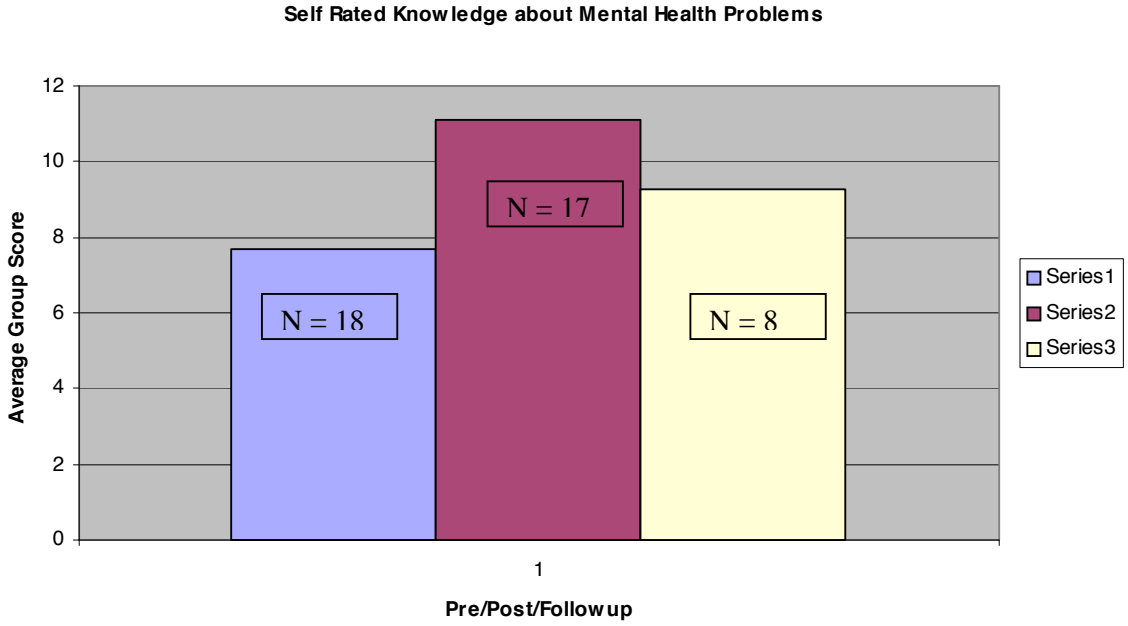
4. Negative beliefs

Graph 7 shows that on average, the groups were more likely to reject negative statements about people with mental health problems at post test and follow up.



Graph 7, Showing average group rejection of negative belief scores towards people with mental health problems. Score gained by summing responses to 7 questions associated with negative or discriminatory beliefs about people with mental health problems, each measured on a 5 point Likert scale. Low scores indicate agreement with negative statements, high scores indicate a rejection of negative statements. Minimum score 7, maximum 35.

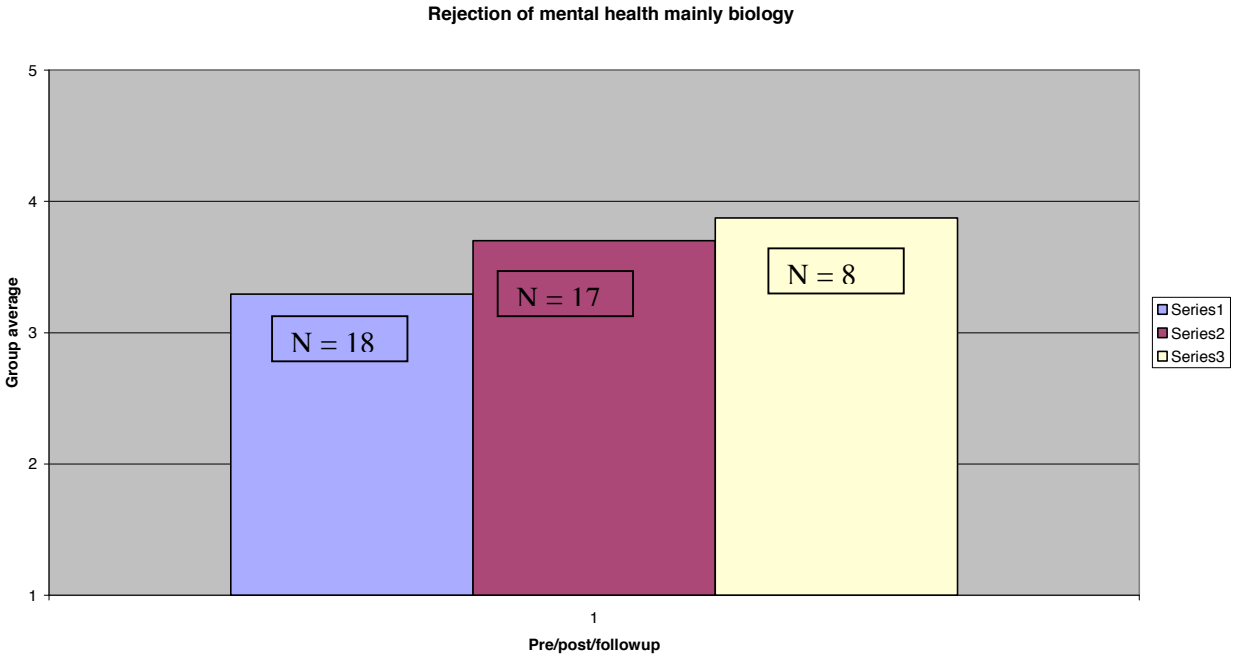
Graph 8 shows participants self-rated knowledge of mental health problems improved at post-test and 3 month follow-up. Scores decreased slightly from post-test to follow up, but follow up scores were still higher than pre-test scores.



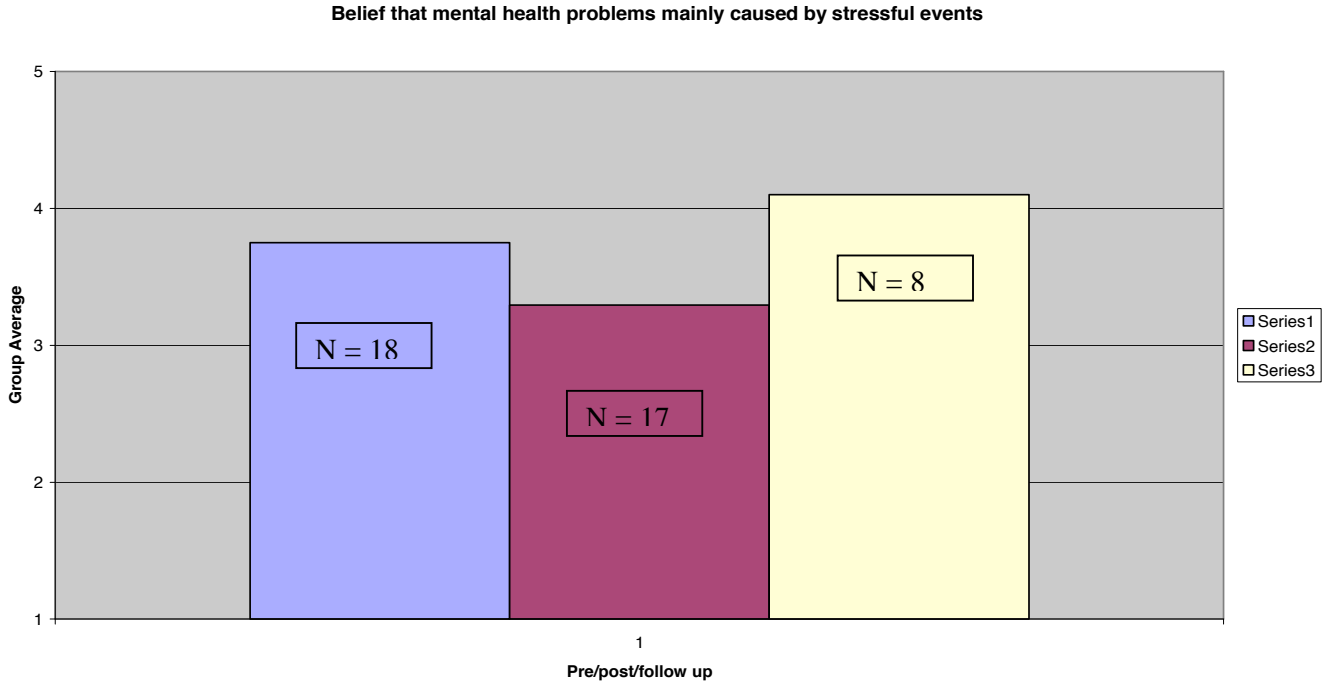
Graph 8, this is measured by summing responses on self-rated knowledge in 3 areas: knowledge of mental health problems in general, different types of mental health problems and the signs that indicate a mental health problem. All responses measured on a 5 point Likert scale. Low scores indicate a low self-perceived knowledge, high scores indicate a high self-perceived knowledge. Minimum score 3, maximum 15.

6. The causes of mental health problems.

Graph 9 shows that on average, the group were slightly more likely to reject biological factors as the main cause of mental health problems at post test and follow up. However, Graph 10 does not show an increase in participant's agreement that mental health problems are mainly cause by stressful events in people's lives.

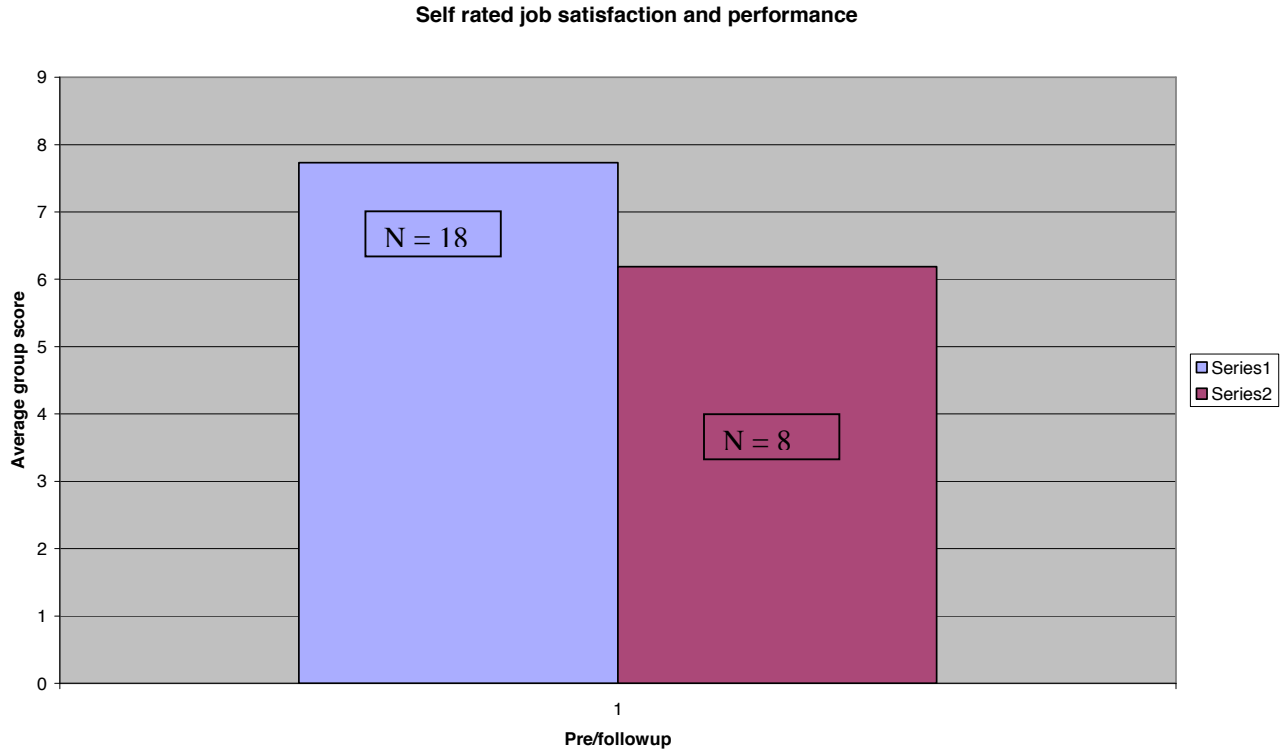


Graph 9, is measured by how often participants disagree with the statement: "mental health problems are mainly caused by biological problems in the brain" measured on a 5 point Likert scale. Low scores indicate strong agreement with the statement, high scores indicate strong disagreement with the statement. Minimum score 1, maximum 5.

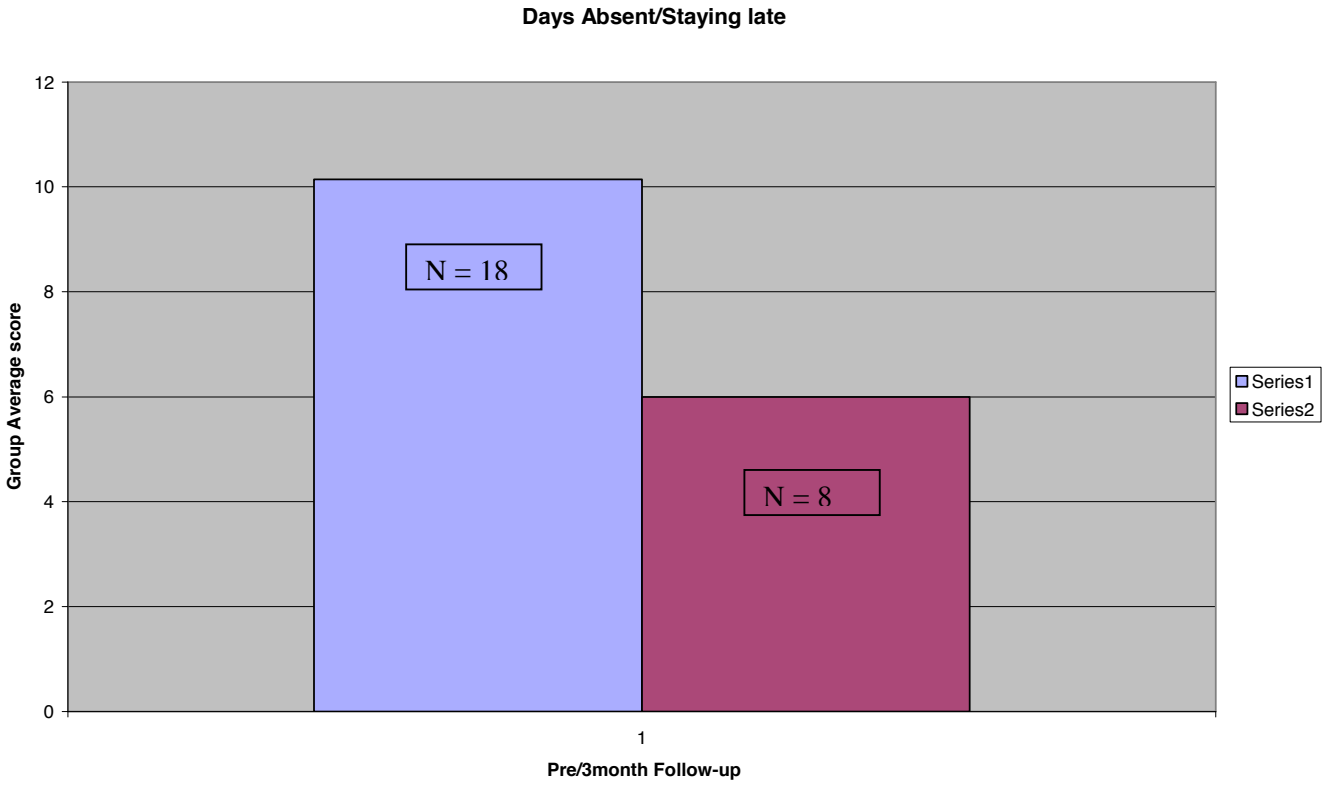


7. Days absent and job satisfaction

Graph 11 showed that for the participants who completed the 3 month follow-up (8 participants), their average ratings of their job satisfaction and their current job performance (compared to their usual job performance) decreased. Graph 12 shows that for those participants who completed pre and 3 month follow-up questionnaires, the number of days they were off work due to illness and number of times they stayed at work late decreased from pre group to 3 month follow-up.



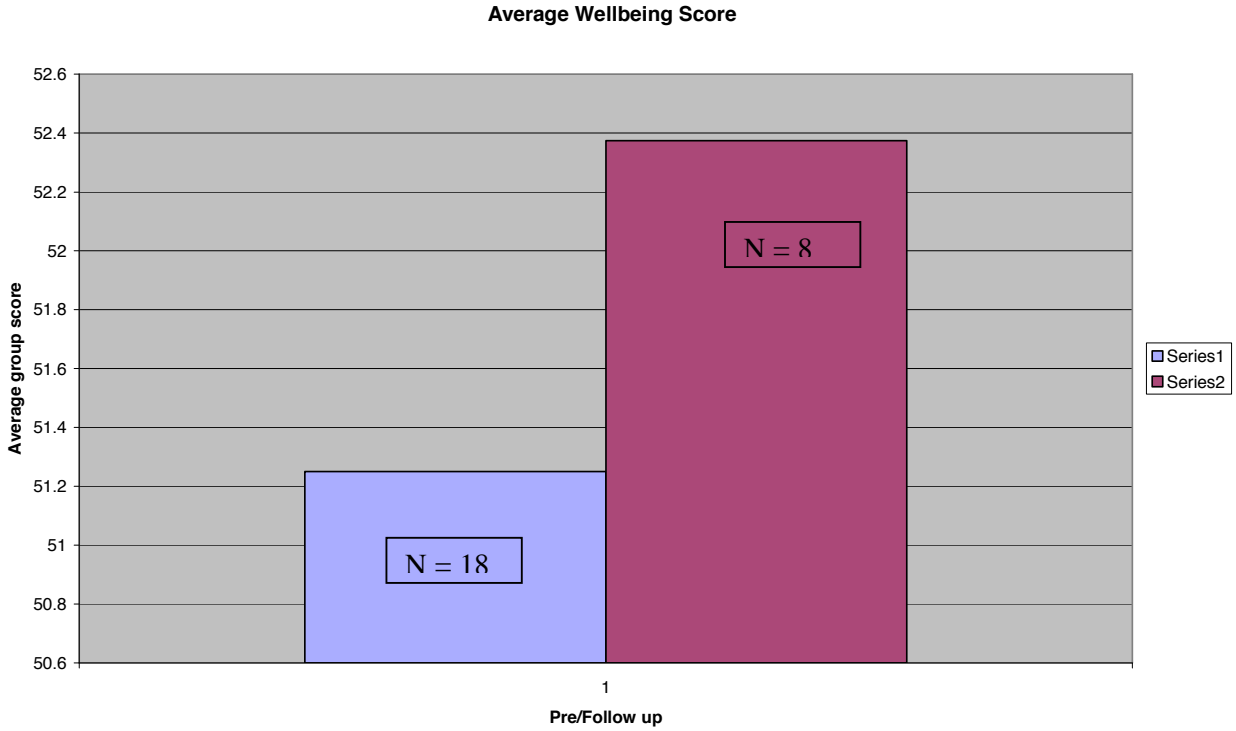
Graph 11, is measured by asking Participants "How would you rate your overall job performance over the last year or two? How would you rate your job performance over the last 4 weeks? How would you rate your job satisfaction?" All were measured on a scale of 1-10, 1 being low, 10 being high. The overall job score was subtracted from the current job score. Minimum Score = 2, Maximum = 19.



Graph 12, is measured by summing the responses to the following questions: "In the past 4 weeks (28 days), how many days did you miss an entire work day because of problems with your physical or mental health? Miss part of a work day because of problems with your physical or mental health? Come in early, go home late, or work on your day off? Minimum score = 0, Maximum = 84.

8. Warwick-Edinburgh Mental Well-Being Scale (WEMWBS).

Graph 13 shows that for the 8 participants who completed pre and follow-up questionnaires, the average (group) wellbeing score improved.



Graph 13, is measured by administering 14 items from the Warwick-Edinburgh Wellbeing Scale, each marked on a 1-5 scale, 1 being low, 5 being high. Minimum Score = 14, maximum = 70, average = 50.

Appendix 2- Pre-group Questionnaire

Pre-group Evaluation

1a Have you received any training on mental health issues before?

Yes No Not Sure

b. From what you know has anyone close to you ever experienced a mental health problem?

Yes No Not Sure Rather Not Say

c. Have you ever personally experienced a mental health problem?

Yes No Not Sure Rather Not Say

d. Have you had contact with anyone with a mental health problem in the last six months?

Yes No Not Sure Rather Not Say

e. What is your age range?

16-26 27-37 38-48 48-58 59-69 70+

f. What is your gender?

2. Please read the following statements and circle the number that most strongly represents how confident you feel:

Statement	Not at all confident	Not very confident	Moderately confident	Quite confident	Extremely confident
Manage your own stress	1	2	3	4	5
Manage a colleagues stress	1	2	3	4	5

3. Please read the following an indicate how much you agree with the following statements:

Statement	Strongly Disagree	Disagree Slightly	Neutral/D on't know	Slightly Agree	Strongly Agree
People with mental health problems will struggle with them all their lives	1	2	3	4	5
People should be better protected from people with mental health problems	1	2	3	4	5
People with mental health problems are fundamentally different to other people	1	2	3	4	5
Statement	**Strongly Disagree**	**Disagree Slightly**	**Neutral/D on't know**	**Slightly Agree**	**Strongly Agree**

I would feel embarrassed or ashamed if my friends knew that someone in my family had mental health problems	1	2	3	4	5
I would be afraid to talk to someone with mental health problems	1	2	3	4	5
I would find it difficult to work with someone with mental health problems	1	2	3	4	5
I could be friends with someone with mental health problems	1	2	3	4	5
Someone who has had mental health problems should not work in jobs that involve taking care of children or young people	1	2	3	4	5
People with mental health problems can't take on new challenges	1	2	3	4	5
People with mental health problems are likely to be unreliable at work	1	2	3	4	5
If an employee is experiencing stress at work, it is the individuals responsibility to manage it, not the employers	1	2	3	4	5
People with mental health problems are incapable of making simple decisions about their own lives	1	2	3	4	5
Mental health problems are mainly caused by biological problems in the brain	1	2	3	4	5
People develop mental health problems in reaction to stressful events	1	2	3	4	5

The mental health problems of some people are caused by child abuse or neglect in childhood	1	2	3	4	5

4. Please circle the number that represents how knowledgeable you are about the following issues

Statement	Not at all	Not very	Reasonably	Very	Extremely
Mental Health problems in general	1	2	3	4	5
Different types of mental health problems	1	2	3	4	5
The signs that indicate a mental health problems	1	2	3	4	5

Please read the following paragraph and then answer the questions that follow.
(Please note that the person described is not a real person, but there are people who are very like him. If you know of someone who is exactly like him, then this is total coincidence)

Steven has been feeling really down for the last few weeks. He wakes up every the morning with a flat heavy feeling that stays with him all day long. He doesn't enjoy things the way he normally would. In fact, nothing gives him pleasure. Even when good things happen, they don't seem to make Steven happy. He has to force himself to get through the day, and even the smallest things seem hard to do. He finds it hard to concentrate on anything and has no energy at all. Even though Steven feels tired at night, he still can't sleep, and wakes up too early in the morning. Steven feels worthless and feels like giving up. Steven's family has noticed that he hasn't been himself for about the last month. He doesn't feel like talking and isn't taking part in things like he used to.

5. Please circle the numbers below which best represent your emotions when you think about Steven

Feeling	Not at all	A little bit	Moderately	Quite intensely	Very intensely
Anxious	1	2	3	4	5
Uneasy	1	2	3	4	5
Desire to help	1	2	3	4	5
Sympathy	1	2	3	4	5
Anger	1	2	3	4	5
Irritation	1	2	3	4	5

6. Please indicate below how likely it is that you would offer Steven help

Statement	Not at all	Not very	Moderately	Quite	Extremely
If Steven was a member of your family	1	2	3	4	5

or close friend how likely is it that you would offer help?					
If Steven was a work colleague how likely is it that you would offer help?	1	2	3	4	5

7. Job related questions

a. Please think of your work experiences over the past 4 weeks (28 days). In the spaces provided below, write the number of days you spent in each of the following work situations.

In the past 4 weeks (28 days), how many days did you...	**Number of days 00-28**
. ...miss an **entire** work day because of problems with your physical or mental health? (Please include only days missed for your **own** health, not someone else's health.)	☐☐
. ...miss **part** of a work day because of problems with your physical or mental health? (Please include only days missed for your **own** health, not someone else's health.)	☐☐
...come in early, go home late, or work on your day off?	☐☐

b. Using the a 0-to-10 scale, how would you rate your usual job performance over the past year or two?

Worst Performance — *Top* Performance

1 2 3 4 5 6 7 8 9 10

c. Using a 0-to-10 scale, how would you rate your overall job performance on the days you worked during the past 4 weeks (28 days)?

Worst Performance — *Top* Performance

1 2 3 4 5 6 7 8 9 10

d. Please rate your overall job satisfaction

Not at all satisfied — Extremely Satisfied

1 2 3 4 5 6 7 8 9 10

8. Below are some statements about feelings and thoughts. Please tick the box that best describes your experience of each over the last 2 weeks

STATEMENTS	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	1	2	3	4	5
I've been feeling useful	1	2	3	4	5
I've been feeling relaxed	1	2	3	4	5
I've been feeling interested in other people	1	2	3	4	5
I've had energy to spare	1	2	3	4	5
I've been dealing with problems well	1	2	3	4	5
I've been thinking clearly	1	2	3	4	5
I've been feeling good about myself	1	2	3	4	5
I've been feeling close to other people	1	2	3	4	5
I've been feeling confident	1	2	3	4	5
I've been able to make up my own mind about things	1	2	3	4	5
I've been feeling loved	1	2	3	4	5
I've been interested in new things	1	2	3	4	5
I've been feeling cheerful	1	2	3	4	5

Thank you for taking the time to complete this questionnaire

Appendix 3 – Topic Guide for post group interviews

Qualitative evaluation

Please select 5 names from the selection of volunteers for interview. Please keep it confidential as to who you phoned for interview.

Please contact each of these volunteers, explain who you are an that you are phoning because they volunteered to give an interview on the ….. training they attended on….. The interview should take around 15-20 minutes.

Please explain that their answers will remain anonymous — the instructors will not know who has given the interview. As with the other evaluation, the intention is to use this information to evaluate the training and publish the results in a peer review journal. Their names will not be used in any future reference to the information given in the interview. The transcripts of the interview will be kept in a locked filing cabinet in the psychology department at West farm house, Cramlington. The transcripts will be kept up to 5 years and then destroyed. Participation in the interview is entirely voluntary, if you choose to participate you can withdraw at any time without giving a reason. Withdrawing from the study will not result in any penalty.

Topic guide: please ensure that you cover these questions in the interview. Try to write down the responses as they were given and try not to guide the participant towards a particular answer.

1. What aspects of the training did you find most useful/effective?
   - What stood out for you about the training
2. What aspects of the training did you find least useful/effective?
   - Can you suggest any further improvements?
3. How relevant was the training to your job?
   - How would you use it
   - Could you tell me more about that
4. Have you had opportunities to use what you learnt on the course? Please give examples
   - Can you give a specific example?
   - Can you describe what you mean by that?
   - How have your skills been improved as a result?
5. Do you think you learnt anything new? If so, what?
   - Was there any information that surprised you?
6. Do you think your attitudes or understanding of people with mental health problems changed? If so how?
   - Would you change your approach because of the training?
   - Is there any other information/resources you have access to now that you didn't have before?
     - What was it about the training that supported these changes in attitudes- what supported the change?
7. Do you think training like this would be helpful to other employers?
8. Any further comments