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Evaluation of the 'Mental Health First Aid in the Armed Forces Community' Project - Final Report

mhfa
for the Armed Forces Community

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Mental Health First Aid for the Armed Forces Community (MHFA AF) Evaluation Team

The MHFA AF evaluation was conducted by a multidisciplinary team; personnel, their affiliations and roles are detailed below:

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- Professor Diane Crone (project lead, project development, qualitative data collection and analysis, report writing)
- Dr Elizabeth Loughren (project development, operational lead [2015-2016], qualitative and quantitative data collection and analysis, report writing)
- Dr Colin Baker (project development, survey design, qualitative and quantitative data collection and analysis, report writing)
- Dr Tabitha Dickson (qualitative and quantitative data collection and analysis, proof report)
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The following three members of the evaluation team are now working in other universities.

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- MHFA AF trainers and trainees who assisted with the evaluation and in the collection of data,
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- All members of the MHFA AF Project Steering group.
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Outputs to date from this project

Crone et al., (2015). Evaluation of the MHFA Armed Forces project. British Psychological Society 4th Military Psychology Conference, Milton Keynes, November 26th, 2015.

Crone et al., (2015). Preliminary results from the MHFA Armed Forces evaluation. House of Lords, November 9th, 2015.

Executive summary

There has been growing evidence in the UK that Armed Forces community members are less likely to engage with mental health support than the general population (1-3). This lack of engagement has been attributed to mental health stigma and the lack of trust in care providers (4). However, in the Ministry of Defence's (MOD) latest annual report on mental health in the UK Armed Forces (5), it was concluded that there were changes in rates of assessments for mental disorders at MOD Specialist Mental Health Services, seeing a steady increase from 1.8% of UK Armed Forces personnel in 2007/08 to 2.9% in 2014/15. A useful avenue for supporting the well-being and improving the mental health of military personnel can be achieved through education that seeks to improve mental health knowledge and attitudes (often called mental health literacy) among veterans, serving personnel and their families. Funding from the Libor Fund allowed the development of a specific MHFA Armed Forces programme which involved training trainers to deliver a MHFA Armed Forces course and the subsequent delivery of that training course to trainees. The aim of the programme was to train 180 trainers and 6642 trainees across the Armed Forces community. This Executive Summary presents a summary of findings from an evaluation of the MHFA intervention to support mental health literacy among members of the Armed Forces community in the UK. The intervention was a specifically designed Mental Health Frist Aid programme for the Armed Forces community. Funding was secured for the programme which included the development of the course, the training of MHFA Armed Forces trainers to deliver courses within the Armed Forces community.

A mixed method evaluation included both quantitative (surveys) and qualitative (observations, interviews, and focus groups) elements. The quantitative aspect of the evaluation involved the development of a pre- and post-training survey which assessed shifts in trainee (*n*=602) knowledge, attitudes, and confidence around mental health issues from pre-training to post-training. This survey was followed up 10 months after the course to establish whether the course had a sustainable impact. Of the 602 trainees who completed the initial survey, *n*=120 completed the follow-up survey. The qualitative aspect of the evaluation comprised of course

observations (*n*= 13 courses observed), semi-structured telephone interviews with trainees post-training (*n*=13 trainees), focus groups with trainers (*n* =14 trainers) and a focus group with an expert reference group, the Steering Group, who oversaw the project (*n*=4 participants). For the purposes of this Executive Summary, the term 'trainers' refers to the individuals who were trained by MHFA England to deliver the Armed Forces courses to the 'trainees'. Trainees were the people who attended the courses provided by the trainers, and included veterans, serving personnel and their families.

Quantitative findings revealed that:

- immediately following training, from pre- to post-intervention (the training course) trainees showed a significant increase in knowledge, attitudes, and confidence. Importantly, this effect was sustained at the 10 month follow-up.
- there was a small but significant decrease in knowledge which occurred from post training to follow-up. Despite the decrease from post training to follow-up, overall, knowledge, attitudes, and confidence were all significantly higher than at baseline.

Qualitative findings reported that trainees:

- increased their knowledge, understanding and confidence in talking about and communicating with people who have mental health issues;
- had improved listening skills, advice giving, and confidence in asking difficult questions regarding mental health issues.

Trainers reported:

- increased learning and confidence in understanding and managing mental health through the training experience;
- shared feeling with other trainers and trainees of wanting to support and help the promotion of mental health and its awareness in the Armed Forces community; and the need to manage military and civilian dynamics within the courses.

Trainers made a number of recommendations including:

- embedding MHFA into the Armed Forces formal training schedule to ensure the sustainability of the programme;
- the development of central coordination and communication including a networking facility between MHFA trainers;
- the targeting of specific population groups for the promotion of MHFA Armed Forces, for example, service personnel, ex-service, and the families of veterans.

The Expert Steering Group concluded that the programme had been accepted within the military environment and that this was due to the professionalism of MHFA England; the quality product provided; and the persistence of partners to overcome initial scepticism. They were of the opinion that the programme had helped to address scepticism, stigma, and misunderstanding of mental health issues within the military environment. They further suggested that the experience of different organisations working and learning together had resulted in a collaborative relationship thought to be useful for future sustainability of the programme. There was evidence of sustainability of the project through commissioning of programmes, and via the 'champions' now in the community, highlighting awareness of the mental health agenda in the military from various organisations and at different levels. In terms of the future, there was a desire for the continuation of the project, but also an awareness, due to funding constraints, of the potential need to move from a funded model of delivery to a non-funded model. There was also recognition of the importance of continuing to work together as a multiagency group to promote mental health literacy within the wider Armed Forces community, veterans, and their families.

The findings support previous research which has investigated the impact of MHFA on specific communities (6, 7) but this is the first evaluation to date that has investigated the effect of MHFA in the Armed Forces community in the UK. These findings provide evidence that the MHFA Armed Forces programme has helped to improve mental health literacy, and reduce stigma and misunderstandings surrounding mental health in the UK Armed Forces community. Such an intervention

holds the potential to provide longer term support to personnel, veterans, and their families' by identifying mental health problems and enabling those in need to access the necessary support services.

There is evidence to suggest that MHFA Armed Forces may be a useful mental health education programme within the Armed Forces community for all serving personnel, veterans, and their families to increase mental health literacy within the community. This evaluation therefore concludes that a targeted programme, such as MHFA Armed Forces, can positively influence mental health literacy among members of the Armed Forces community in the UK.

The following recommendations for future practice are made:

- Recommendation 1: To modify and update the MHFA course materials to include relevant and contemporary media clips, and to include up-to-date statistics.
- Recommendation 2: To consider MHFA England to have a clearly defined role in the coordination and networking of the MHFA Armed Forces trainers.
- Recommendation 3: To develop a specific support and information system for the MHFA Armed Forces civilian trainers to enable them to network with, and deliver to, a military environment.
- Recommendation 4: To consider the development of a networking forum for MHFA Armed Forces trainers to communicate and to provide ongoing support, information and guidance for trainers.
- Recommendation 5: To seek further commissioning of MHFA Armed Forces training to enable the initiative to be made available to all service personnel, veterans, and their families, through the most appropriate channels.
- Recommendation 6: To consider the development of a non-funded model of delivery by embedding the product into the working practices of all organisations (statutory and third sector) involved in the coordination and management of the programme.
- Recommendation 7: Consider embedding MHFA into the Armed Forces formal training schedule (particularly for senior personnel).
- Recommendation 8: To consider the future coordination of MHFA Armed

Forces training to be undertaken by a multi-agency group which includes representatives from all key statutory and third sector organisations which support service personnel, veterans, and their families.

- Recommendation 9: To explore accreditation pathways for the MHFA Armed Forces course to enhance its profile amongst trainers, trainees, and within the Armed Forces community more generally.

1. Introduction

Within the UK there is growing evidence that Armed Forces community members are less likely to engage with mental health support than the general population (1, 2, 8). This dearth of engagement has been linked to mental health stigma and the lack of trust in care providers (4). However, in their latest annual report on mental health in the UK Armed Forces, the Ministry of Defence (5) concluded that there were changes in rates of assessments for mental disorders at MOD Specialist Mental Health Services which had seen a steady increase from 1.8% of UK Armed Forces personnel in 2007/08 to 2.9% in 2014/15. A useful avenue for supporting the well-being and improving the mental health of military personnel is through bespoke training that seeks to improve mental health knowledge and attitudes (often referred to as 'mental health literacy') among veterans, serving personnel and their families. This improved mental health literacy may, in turn, prove to promote an increase in the seeking of mental health support amongst those who have served. Recognising this, the MOD pledged to improve mental health care services for its personnel by developing and implementing a comprehensive Mental Health First Aid (MHFA) training programme designed to increase mental health literacy among military personal, veterans, and their families (MOD, 2011). More specifically, in 2013, the Soldiers, Sailors, Airmen and Families Association (SSAFA), MHFA England, Combat Stress, and the Royal British Legion formed a collaboration to deliver MHFA specifically for the Armed Forces Community. MHFA seeks to improve mental health literacy, identification of, and access to support, and to reduce the stigma of mental health (7). This collaboration secured funding from the Libor Fund to develop a specific MHFA Armed Forces programme which involved training trainers to deliver a MHFA Armed Forces course and the subsequent delivery of that training course to trainees. The programme included the development of the MHFA Armed Forces course, the training of MHFA trainers to deliver courses within the Armed Forces community and the subsequent delivery of courses. The aim of the programme was to train 180 MHFA trainers to deliver courses to over 6000 trainees (i.e. members of the Armed Forces community).The programme was overseen by a Steering Group which comprised representatives from the above organisations and the Department

of Health. Such an initiative supports current priorities in the Armed Forces (5) and this evaluation report presents the findings from this collaborative project.

1.1 Review of evidence for MHFA training in the Armed Forces

People with mental health problems in the UK often avoid seeking professional help from GPs, psychologists, and/or counselling services (9). Armed Forces personnel may be particularly vulnerable and often choose not to utilise services due to concerns of career development and stigma associated with mental health issues, such as being seen as weak or unable to cope (1, 2, 8). Given the number of Armed Forces personnel undertaking major deployments (e.g., Iraq and Afghanistan), the need to support people facing poor mental health is paramount. Recent estimates suggest that around 20% of service men and women have mental health problems upon completing their deployment (4). In recognition of this high incidence of mental illness, proposals have been put forward by the MOD to improve mental health care provision for its personnel (5). Yet, the extent to which these improvements have increased the knowledge, attitudes, and confidence of service men and women in identifying, and acting upon, mental health problems to date, remains unknown.

In the UK, the use of mental health services by Armed Forces personnel is rising (5). However, this data does not reflect how many personnel actually experience problems yet do not seek help (10), as only a minority actively seek medical care for mental health problems (1, 11, 12). To help illustrate this, a sample of UK service personnel (13) found that only 23% of those with common mental disorders (e.g., depression) who were still serving in the Armed Forces were receiving any form of professional help from a General Practitioner (GP) or medical officer. Instead, service personnel indicated a clear preference to consult peers, friends, and non-medical sources of help. One way in which barriers to care can be broken down is via encouragement from family and friends to actively and openly discuss mental health issues (14). Developing interventions among the Armed Forces community that seek to improve mental health knowledge and attitudes which incorporate veterans, serving personnel, and their families may help to promote an increase in the levels/numbers of service men and women seeking medical support and options for coping outlets amongst those who have served, and their families. This MHFA

Armed Forces project supports other projects available which have been developed to prevent post-deployment mental health problems, such as TRiM (a Trauma Risk Management a system to identify service personnel at risk after traumatic events) (15).

While within the context of military personnel, the gap between mental health literacy and improved mental health is nothing new, there is a need to evaluate interventions committed to reducing that gap. Providing information on mental illness and its treatment has been shown to increase readiness to seek help in the general population (16, 17) (18). In terms of MHFA specifically, Hadlaczky et al. (2014) synthesized published evaluations of the MHFA programme in a meta-analysis to estimate its effects and potential as a public mental health awareness-increasing strategy. Fifteen relevant papers were identified through a systematic literature search. The results of this meta-analysis suggest that MHFA increases knowledge, attitudes, and behaviour and therefore the mental health literacy of the general population. However, this review only included evaluation studies of the standard MHFA or youth programmes. Indeed little is known about the effect of such a programme in an Armed Forces community. The present evaluation of the MHFA Armed Forces programme attempts to understand this, and investigates how a bespoke Armed Forces MHFA programme impacts mental health literacy in the Armed Forces community. There is an increasing need to develop and evaluate appropriate health literacy training among the Armed Forces community to identify whether it is effective amongst this population, to determine whether the effects endure over time and to examine the potential for population level impact. This report therefore presents evidence from a mixed method evaluation of an intervention to support mental health literacy amongst members of the Armed Forces community in the UK.

2. Evaluation strategy, aims and objectives and method

2.1 Evaluation strategy and design

The evaluation strategy utilised a mixed methods approach combining observations, surveys, interviews, and focus groups to investigate MHFA training for the Armed Forces community. MHFA for the Armed Forces community is a specifically designed training programme for veterans, serving personnel, and their families aiming to improve mental health knowledge, their confidence to address such issues, and their ability to address attitudes and behaviours towards mental health issues. For the purposes of this report 'trainers' refers to the individuals who were trained by MHFA England to deliver the Armed Forces courses to the 'trainees'; 'trainees' were the people who attended the courses, provided by the trainers, and included veterans, serving personnel and their families, and civilian and medical staff whose job roles deal with Armed Forces personnel. The 'Expert reference group' refers to members of the MHFA Armed Forces steering group.

A mixed method evaluation included both quantitative (surveys) and qualitative (observations, interviews, and focus groups) elements. The quantitative aspect of the evaluation involved the development of a pre- and post-training survey which assessed changes in trainee knowledge, attitudes, and confidence around mental health issues from pre-training to post-training. Following the pre- and post-training evaluation, at 10-months into the evaluation, a similar pre- and post-training survey was developed to see if the training had created a sustainable impact. The qualitative aspect of the evaluation comprised of course observations (1-month into evaluation), semi-structured telephone interviews with trainees post-training (7-months into evaluation), focus groups with trainers (8-months into evaluation) and a focus group with an expert reference group, the steering group who oversaw the whole project (13-months into evaluation).

2.2 Aims

The evaluation had two specific aims, which included:

Aim 1: To explore the extent to which MHFA training served to:

- Improve knowledge of mental health issues.
- Improve attitudes toward mental health.
- Improve confidence to help, advise, and recommend support services to people who have mental health problems.
- Improve long-term, sustainable, changes in knowledge, attitudes, and confidence.

Aim 2: To evaluate the overall programme, specifically to:

- Better understand the experience of trainees taking part in MHFA training.
- Identify how MHFA training affects mental health literacy.
- Understand areas of strength and weakness in the MHFA initiative and how training might be improved.
- Assess overall delivery, programme process, and recommendations for the future of MHFA training in the Armed Forces community.

2.21 Specific Objectives

From these aims, there were a number of evaluation objectives:

2. To develop a pre-post and follow-up survey package that assessed:
    - Trainees' knowledge of mental health issues.
    - Attitudes toward mental health.
    - Confidence to help, advise and recommend support services to people who have mental health problems.
    - End-user satisfaction/areas for training improvement.

3. To recruit MHFA Armed Forces trainees (i.e. veterans, serving personnel and their family members, and civilian and medical staff who had undertaken the course) to participate in a semi-structured telephone interview to generate information about the experience of taking part in the MHFA training, how it affected their mental health literacy, and how the delivery might be improved.
4. To recruit MHFA Armed Forces trainers to participate in a focus group to generate information about the experience of being involved in MHFA delivery, their assessment of programme process, and how the training might be improved.
5. To recruit an expert reference group (i.e., relevant stakeholders) to participate in a focus group to establish areas of strength and weakness in the MHFA initiative, and generate ideas about the future of MHFA Armed Forces and ways forward.
6. Using the survey package to collect and analyse the quantitative responses from trainees at pre-, post- and follow-up MHFA training, to address the questions of:
    - To what extent (if at all) does MHFA Armed Forces training improve trainee knowledge, attitudes, and confidence in dealing with mental health problems?
    - To what extent (if at all) do changes in these outcomes persist over time?
    - How useful did trainees find the training and what improvements would they recommend?
7. Using the interviews and focus groups to collect and analyse the qualitative responses from trainees, trainers, and steering group of the project, to address the questions of:
    - To what extent (if at all) did MHFA Armed Forces training meet/not meet trainee expectations?
    - What (if anything) did trainees learn about dealing with and responding to mental health issues?
    - To what extent (if at all) did trainees use the skills they were taught on the course?

- How useful did trainers find the training and what improvements would they recommend?
- What were the positive and negative aspects of the programme process for trainers?
- To what extent (if at all) did trainers feel supported by MHFA England during programme delivery?
- According to stakeholder perception, how effectively is the MHFA Armed Forces initiative being implemented?
- According to stakeholder perception, what is the future of the MHFA Armed Forces initiative?

8. To triangulate the different aspects of the evaluation and draw together the quantitative and qualitative data, with a view to addressing the overall evaluation aims.

3. Method

The evaluation adopted a mixed method approach and was undertaken over an 18 month period between November 2014 and April 2016. Primary data, incorporating both quantitative and qualitative methods, was collected from MHFA Armed Forces trainees, trainers, and an expert reference group (the MHFA Armed Forces Project Steering Group).

Methods of data collection included:

- Quantitative:
    - Questionnaire survey of trainees' knowledge, attitudes, and confidence in dealing with mental health problems administered at training and 10 months follow up.
    - Questionnaire survey of trainees' satisfaction with the delivery of the MHFA training, and areas for improvement administered at training.
    - Questionnaire survey of trainees' views on the usefulness of MHFA training and usage of knowledge and skills administered 10 months after training.

- Qualitative:
    - Course observations to gather information about how MHFA training is delivered in practice (1-month into evaluation).
    - Semi-structured telephone interviews with trainees to gather information about the experience of taking part in MHFA training, how it affected their mental health literacy, and how the delivery might be improved (7-months into evaluation).
    - Focus groups with MHFA Armed Forces trainers to gather information about the experience of being involved in MHFA delivery, their assessment of programme process, and how the training might be improved (8-months into evaluation).
    - Focus group with an expert reference group (i.e., MHFA Armed Forces Steering Group and relevant stakeholders) to establish areas of strength and weakness in the MHFA initiative and generate ideas

about the future of MHFA Armed Forces and ways forward (13-months into evaluation).

4. Quantitative data collection methods and procedures

4.1 Method

Participants were members of the Armed Forces community who enrolled on an MHFA accredited training course. They were provided with a multi-section questionnaire at the end of their MHFA training in a classroom setting by either a trained researcher or the MHFA accredited Instructor. This questionnaire (Appendix 1) measured participants' quantitative satisfaction with the MHFA training, as well as their perceptions of its usefulness in their working and overall life. The questionnaire also quantitatively tapped participants' knowledge (viz. "how would you rate your knowledge of mental health issues"), attitudes (viz. "how would you rate your attitudes toward mental health?") and confidence (viz. "how would you rate your confidence to help, advise and recommend support services to people who have mental health problems") around mental health issues at pre-training and post-training. Responses to the knowledge, attitudes, and confidence items were responded to on a 5-point Likert scale (1 = *very low/not at all useful*; 5 = *very high/very useful*). It also included demographic information (e.g., age, gender) and space for contact information and consent for follow-up.

Six-months later the same questionnaire was sent electronically to participants who had consented to being contacted for follow-up data collection. The follow-up questionnaire was open for three months.

4.2 Procedures

During August 2014 the evaluation team developed the questionnaire and subjected it to in-house piloting among two other colleagues. Following minor iterations, the agreed set of quantitative items for the training evaluation were placed in a survey pro-forma word document and printed for distribution.

Paper distribution of training session questionnaires began in December 2014. After each MHFA training session, the questionnaires were collected or mailed back to the evaluation team for data entry. This process continued for seven months until a sufficient number had been collected to allow for the analyses. In September 2015,

the paper questionnaire was converted into an online questionnaire hosted by Bristol Online Survey, and this online questionnaire was sent to all participants who had consented to be contacted for follow-up data. As an incentive to participate, three £25 Amazon vouchers were offered in a prize draw to those who completed the survey. The online questionnaire was live for three months with a reminder sent at two months. The data entry for the online questionnaire was completed by the survey host.

Following all data entry, the data were matched by email address for comparative analysis, pre and post survey. The evaluation team undertook pre, post, and follow-up data analysis using repeated measures Multivariate Analyses of Variance (MANVA), which is suited to quantifying the statistical significance of mean-level, within-person change across three time points. The more descriptive data associated with levels of satisfaction were simply reported as percentage of sample indicating their satisfaction with the training. The outcomes of the analyses can be found in Results Part 2.

5. Qualitative data analysis methods and procedures

5.1 Methods

5.11 Observation of courses

Observation has been used in a variety of disciplines as a tool for collecting data about people, processes, and cultures in qualitative research and is used to observe activity in its natural setting (19). In the context of the present evaluation, course observations were organized to gather information about how the MHFA training was delivered in practice. To facilitate systematic observation and to enable consistency between the various observers, an observation guide was developed by the evaluation team (see Appendix 2). This directed the evaluation team to observe various aspects of the courses such as the physical environment, participants, trainers, course content, ambience and interactions. Importantly, this was meant as an observation *guide* with aspects to consider and not as a definitive list. As such the observers were encouraged to add other observations and impressions that were considered significant or relevant in addition to the aspects presented in the guide.

5.12 Interviews with MHFA trainees

Interview techniques were deemed the most appropriate method for collecting data from trainees because detailed information of “rich” quality was required to fully investigate and understand the trainee experience of MHFA training (20). In order to facilitate the interview process an interview guide was developed by the evaluation team (see Appendix 3). The guide consisted of four main sections: background, general mental health knowledge and awareness, MHFA training and evaluation of the training. This guide acted as flexible set of questions aimed at generating information about the experience of participants taking part in the MHFA training, how it affected their mental health literacy, and how the delivery might be improved.

5.13 Focus groups

Trainers and Steering Group

Focus groups were deemed the most appropriate method for collecting data from trainers and the steering group because participants knew each other, and thus were sufficiently confident to share their opinions. Focus groups allow for discussion between participants which can often elicit a broader range of views with depth (21). In order to facilitate the focus groups an interview guide was developed by the evaluation team (see Appendix 4). As in the development of the interview schedule for the trainees these schedules were designed to guide the conversation but remain sufficiently flexible to enable debate and exploration of issues. For the trainers, the questions aimed to generate information concerning their experience of being involved in MHFA delivery, their assessment of programme processes, and how the training might be improved. For the steering group the focus was to identify areas of strength and weakness in the MHFA initiative and generate ideas about the future of MHFA Armed Forces programme, and future development.

5.2 Procedures

5.21 Observation of courses

Following ethical approval (received in December 2014), the evaluation team contacted trainers delivering the course requesting permission to observe. Some hesitation from trainers was experienced, due to negative perceptions of the observer being an 'evaluator', but once the role and purpose had been explained most were happy to accommodate the evaluation team member.

During the MHFA training, the observers took notes relating to the various aspects of the course. These were written up, in line with the observation guide template document (see Appendix 2). Subsequently, the observational notes were analysed for patterns or recurrent themes across the different courses. In total, 13 MHFA Armed Forces courses were observed between December 2014 and April 2015. These included:

1. London Stoll (2nd and 3rd December 2014)
2. Tipton (8th and 15th December 2014)
3. Salisbury (11th December 2014)
4. Nuneaton (27th and 28th January 2015)
5. Amport (3rd and 4th February 2015)
6. Cosford (4th and 5th February 2015)
7. Amport (26th and 27th February 2015)
8. Southampton (2nd and 3rd March 2015)
9. Tidworth (19th and 20th March 2015)
10. Bristol (25th and 26th March 2015)
11. London Wellington Barracks (8th and 9th April 2015)
12. Amport (17th April 2015)
13. London Wellington Barracks (22nd and 23rd April 2015)

5.22 Interviews with trainees

On the initial pre-post quantitative survey distributed during the course, participants

were asked if they would be willing to take part in a telephone interview to discuss the training, and related topics. Of those that agreed (n=61), in May 2015, a random sample were contacted by email directly by the evaluation team and invited to take part in a telephone interview. The email explained the purpose of the interview, what to expect, and an invitation to participate in the telephone interview. Participants were sent two follow-up emails if no response had been received within 7 days. Those who responded positively to the invitation (n=13; 21% conversion rate) were emailed again to arrange a mutually convenient date and time to speak on the telephone. In total,13 trainees were interviewed by the evaluation team between June and July 2015.

Individual telephone interviews were conducted with 13 MHFA AF trainees (females n = 7, 54%). A diverse range of organisations was represented including Ministry of Defence, British Army, Royal Air Force, Royal Navy, Royal British Legion, and private healthcare, and had participated in 13 different MHFA Armed Forces courses.

The interviews, which ranged in duration from 20 to 60 minutes, were digitally recorded verbatim. Transcripts were analysed using inductive thematic analysis techniques (22). These included the following steps:

1. Familiarisation with the data - transcripts were read and re-read, with brief notes recorded to create preliminary ideas for the next phase of the analysis.
2. Codes of interest were generated by extracting and collating pertinent excerpts of the data.
3. Emerging codes were organized into broad themes that reflected the content and meaning of the data, and reflected the evaluation aims and objectives.
4. Themes were reviewed and refined in relation to the generated codes and the entire data set.
5. Themes were labelled and defined, attempting to capture the essence of the data it contained.
6. Quotations were used in each theme to enable the voices of participants to be represented in the findings.

5.23 Focus groups

Trainers

The focus groups with trainers took place at a refresher day for trainers, organised by MHFA England. Trainers were invited to the day which also included time set aside for the focus groups. Participants were verbally invited to attend on the day, and they had been made aware that the focus groups would be taking place and that involvement was entirely voluntary. Two focus groups were undertaken with members of the evaluation team. It was decided two would be more efficient due to the high numbers of trainers attending the session. In total there were n = 14 trainers, in the two focus groups (n=7 in each focus group). The 14 consisted of four independent trainers, seven who worked in the armed forces or the NHS, and three employed in the charitable sector. The focus groups lasted approximately one hour and were recorded and transcribed verbatim. Transcripts were analysed using the inductive thematic analysis procedures outlined above.

Steering group

The focus group with the steering group took place at one of the quarterly meetings in December 2015. Steering group members had been sent an email invitation to take part, prior to the steering group meeting. Four members of the steering group agreed to participate. The focus group lasted approximately one hour and was recorded and transcribed verbatim. The transcript was analysed using the inductive thematic analysis procedures outlined above.

6. Results

6.1 Part 1: Observation of courses

Observations of the course resulted in summary findings listed below; further detail can be found in Appendix 5.

- Physical environment – overall the settings for the courses were deemed appropriate and sessions within the course were undertaken with an amiable atmosphere, positive attitude, and were interactive.
- Participants – there was a mix of both military and civilian participants, mostly they were motivated and interested. Participants were either attending voluntarily or had been instructed to attend.
- Trainers – knowledgeable, with an interactive style and good organisation.
- Course content – targeted to the specific Armed Forces community but there were some dated videos and statistics.
- Ambience and interactions – a good rapport was observed between the participants and trainers.

6.2 Part 2: Survey: Knowledge, attitudes and confidence

6.21 Participants

Participants at pre- and post-training were 602 trainees (Mean age = 40.81; SD = 11.10; female % = 45.50) enrolled on an MHFA Armed Forces course. They consented to answering a questionnaire, which, alongside demographic items, required participants to indicate their overall satisfaction with the course, in addition to number of items concerning changes in their knowledge, attitudes and confidence around mental health issues from pre-training to post-training. Of the 602 participants at pre- and post-training, 120 completed a six-month follow-up

questionnaire (Mean age = 42.66; SD = 11.26; female % = 53.30) containing the same knowledge, attitudes, and confidence items to test for changes from post to follow-up. All items were responded on a 5-point Likert scale.

6.22 Statistical analysis

Descriptive statistics are provided to detail the overall satisfaction of the course across the sample, as well as to describe the usefulness of the training to participants at 6-months follow-up. To test for differences in knowledge, attitudes and confidence around mental health issues, from pre-training to post-training and from post-training to six months follow-up, a repeated measures ANOVA was performed. The SPSS Statistics 22 package (IBM) was used for statistical analyses. A P-value of <0.05 was considered as statistically significant. This is because, if the probability of obtaining a difference falls below this cut-point, chance is rejected as a possibility for the results on the grounds that the finding are so unlikely (only five percent of the time or less, through repeated sampling) that a zero difference cannot be supported.

Findings

The majority of our sample, 69.56%, indicated that their satisfaction with the MHFA Armed Forces course was ‘very high’ (5 on the 5 point Likert scale). In addition, a further 27.82% reported ‘high’ satisfaction (4 on the 5 point Likert scale). A small proportion of participants indicated their satisfaction with the course as either ‘neutral’ (3 on the 5 point Likert scale; 2.45%) or ‘low’ (2 on the Likert scale; 0.16%). None of the participations reported ‘very low’ satisfaction with the course (1 on the 5 point Likert scale). The results for levels of overall course satisfaction are reported in Figure 1.

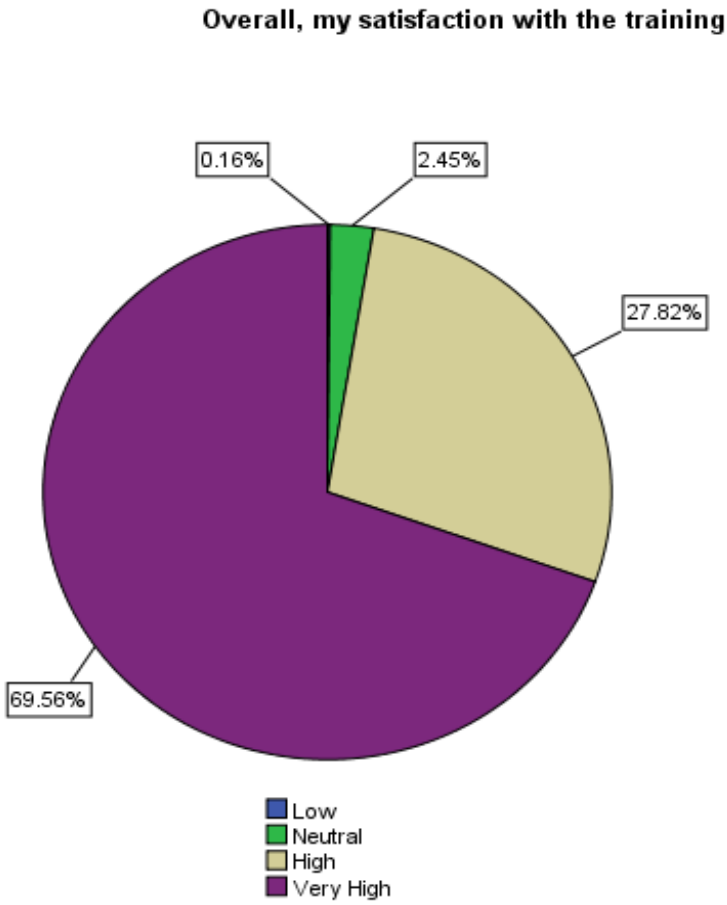

Figure 1: *Levels of overall satisfaction with the course*

At follow-up, the majority of our sample (51.72%) indicated that they found the MHFA course to be ‘very useful’ (5 on the 5 point Likert scale) to their working life. A further 44.59% found the course to be at least ‘somewhat useful’ to their working life (3 and 4 on the 5 point Likert scale). Only 3.69% of the follow-up sample found the training to be ‘not useful’ to their working life (1 or 2 on the 5 point Likert scale). The results for course level of usefulness to work are reported in Figure 2.

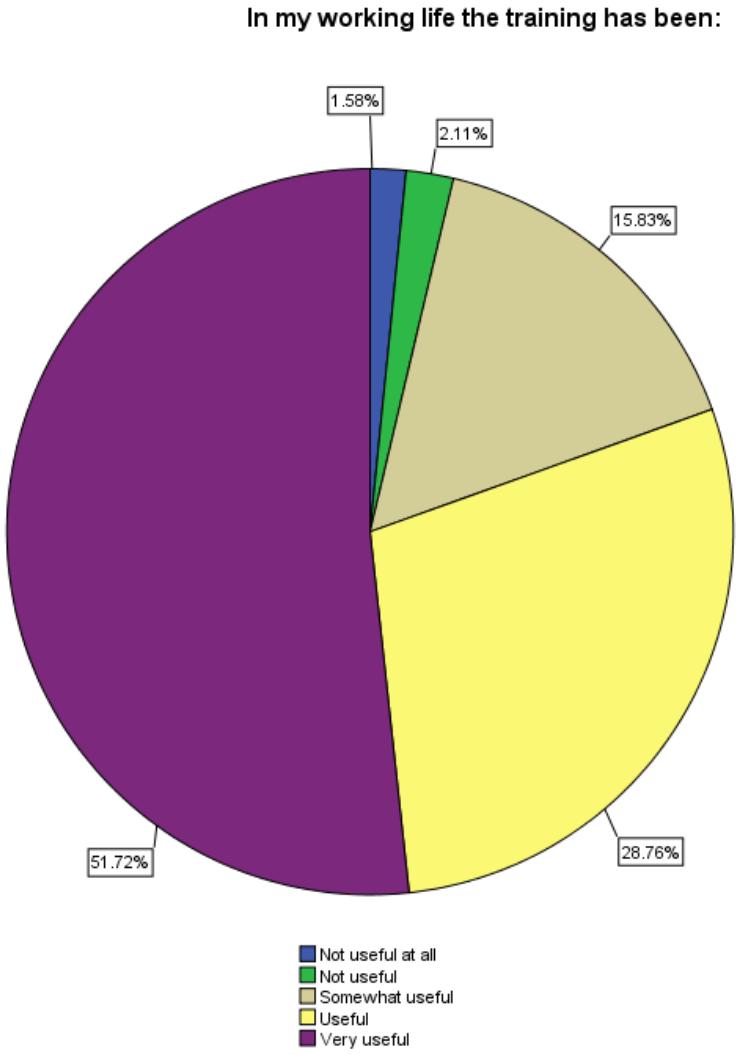

Figure 2. *Levels of training usefulness to work*

Also at follow-up, participants were asked to report the extent to which they believed the MHFA training had been useful to their everyday life. The largest proportion of our sample (39.58%) indicated that they found the MHFA course to be 'very useful' (5 on the 5 point Likert scale) to their everyday life. A further 56.77% found the course to be at least 'somewhat useful' to their everyday life (3 and 4 on the 5 point Likert scale). Only 3.64% of the follow-up sample found the training to be 'not useful' to their everyday life (1 or 2 on the 5 point Likert scale). The results for levels of course everyday life usefulness are reported in Figure 3.

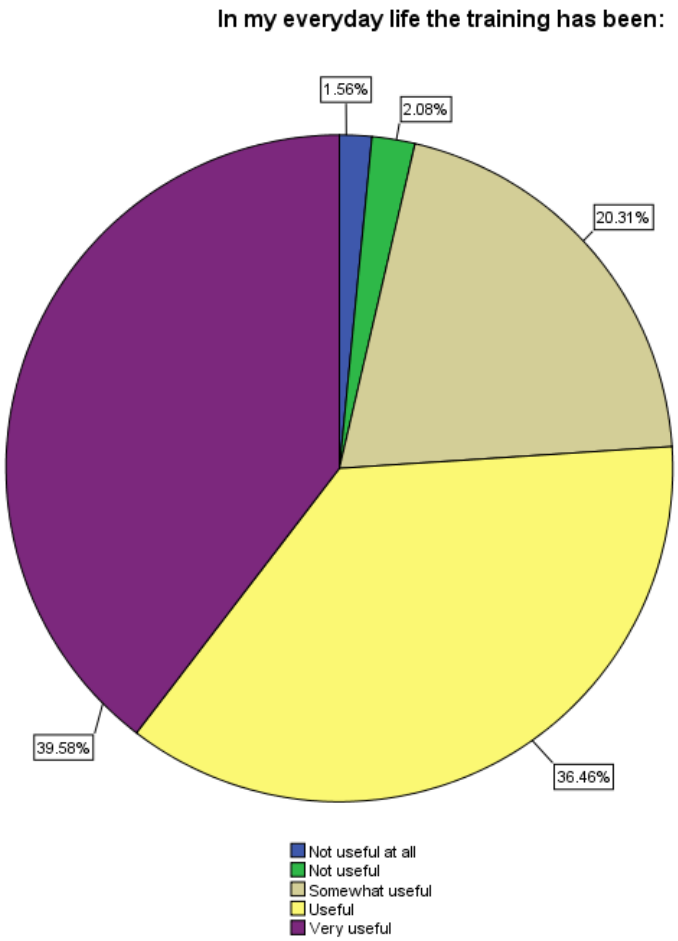

Figure 3. *Levels of training usefulness to everyday life*

With regard to the pre-, post-, and follow-up training findings repeated measures ANOVAs were performed to examine mean differences in knowledge, attitudes and confidence. A summary of these findings is presented, with further detail provided in Appendix 6.

Knowledge: results show that there was a significant main effect of the training on knowledge of mental health issues F (1.73, .51) = 247.17, p = .00. Further analysis reveal that immediately following training, from pre- to post-intervention, participants showed a significant increase in their knowledge of mental health issues ($M^{difference\ pre.post}$ = 1.68, 95% CI = [1.48, 1.87]). This was found to be sustained at follow-up ($M^{difference\ pre.follow}$ = 1.62, 95% CI = [1.37, 1.86]). A small but significant decrease in knowledge occurred from post training to follow-up ($M^{difference\ post.follow}$ = -.55, BCa

95% CI = [-.71, -.39]).

Attitudes: results show that there was a significant main effect of the training on attitudes toward mental health issues *F* (1.52, .66) = 60.93, *p* = .00. Further analysis reveal that immediately following training, from pre- to post-intervention, participants showed a significant increase in their attitudes toward mental health issues ($M^{difference\ pre.post}$ = .98, 95% CI = [.75, 1.21]). This was sustained at follow-up ($M^{difference\ pre.follow}$ = .68, 95% CI = [.42, .95]). A small but significant decrease in attitudes toward mental health occurred from post training to follow-up ($M^{difference\ post.follow}$ = -.30, BCa 95% CI = [-.45, -.15]).

Confidence: results show that there was a significant main effect of the training on confidence in supporting those displaying mental health issues *F* (1.69, .59) = 159.38, *p* = .00. Further analysis reveal that immediately following training, from pre- to post-intervention, participants showed a significant increase in their confidence in supporting those displaying mental health issues ($M^{difference\ pre.post}$ = 1.52, 95% CI = [1.29, 1.75]). This was sustained at follow-up ($M^{difference\ pre.follow}$ = 1.26, 95% CI = [1.00, 1.51]). A small but significant decrease in confidence occurred from post training to follow-up ($M^{difference\ post.follow}$ = -.26, BCa 95% CI = [-.43, -.09]). These findings are reported in Table 1 and Figure 4.

Table 1. Results of the repeated measures ANOVA

	Pre		Post		Follow-up	
	M	SE	M	SE	M	SE
Knowledge	2.87[b,c]	.08	4.54[a,c]	.05	3.99[a,b]	.06
Attitudes	3.80[b,c]	.10	4.78[a,c]	.04	4.48[a,b]	.06
Confidence	2.96[b,c]	.10	4.48[a,c]	.05	4.22[a,b]	.06

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

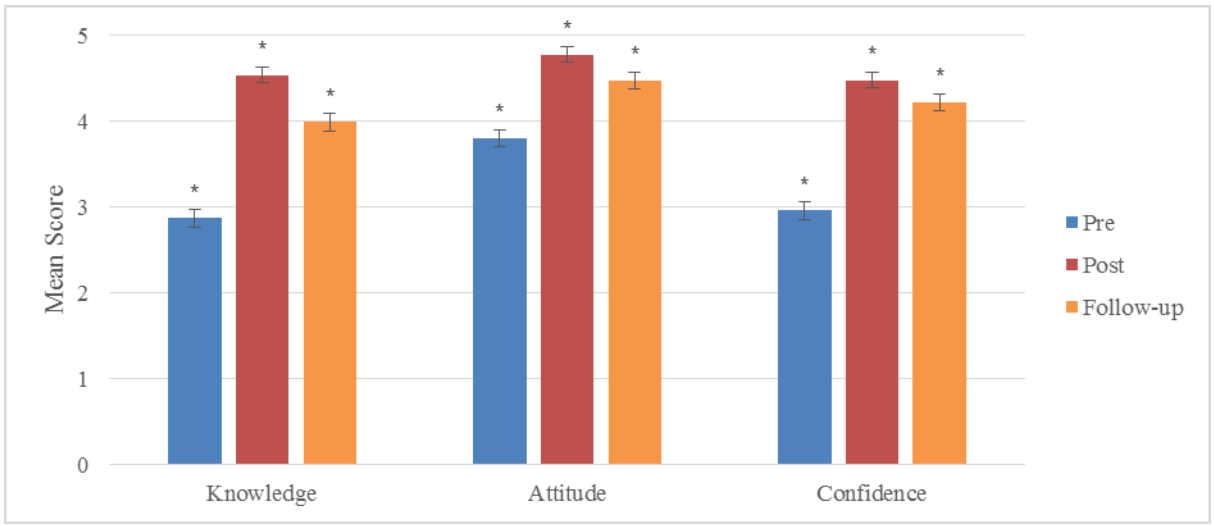

Figure 4. *Mean differences in knowledge, attitudes and confidence*

6.3 Part 3: Qualitative component: Trainers, Trainees and Stakeholders

6.31 MHFA Armed Forces trainees

Findings from data collection with trainees focus on their experiences and opinions of the programme and its impact on their understanding of mental health issues and their confidence to respond. These include general perceptions of the training and the processes involved, expectations concerning the programme and its impact on knowledge, skills and confidence, and potential areas for improvement. Following brief background information on participants themselves, findings are presented in accordance with five key themes; (i) Prior experiences of mental health; (ii) Delivery style; (iii) Education; (iv) Outcomes; and (v) Recommendations.

Background information

Participants (13 MHFA AF trainees) came from varying backgrounds and brought with them expertise from such diverse areas as education, selection and training, policy development, welfare of veterans (including recovery and medical assistance), and logistics. Operationally, participants fulfilled a number of roles including: administration to support training, welfare and staffing, working with amputees, and volunteering with veteran charities. Varying degrees of seniority and experience were evident within the participant cohort, with roles including departmental head, Petty Officer, Flight Lieutenant. Participants had worked in organisations for between 4 and 21 years. In turn, participants had experience and expertise in a range of occupational areas including: communications, accounting and administration, welfare support for veterans (or those in transition), Military Police, logistics, Special Forces, intelligence, and training.

Prior experiences of mental health

Some participants had professional experience with respect to dealing with people with mental health problems. They also had an awareness of the stigma surrounding mental health which, within the context of the armed forces, was perceived to be different than in civilian world: '…*I think there's a bit more of a stigma within our working environment than perhaps in the general population*'.

Those that had experience also had a degree of confidence and practical ability with respect to dealing with, and responding to, people with a mental health issue. It was acknowledged however, that this understanding of mental health tended to be superficial in the sense that it was based on a specific instance or event (i.e. crime or attempted suicide), rather than a deeper understanding of mental health overall. One respondent noted that the MHFA Armed Forces programme itself had challenged their perceptions concerning what might be normally expected in training of this type:

> '*…it wasn't so much about fixing problems, it was all about recognising them. But I went into the course very much thinking, because this is the way the military do things when we talk about first aid, I went into the course thinking "I'm going to be told here how to fix someone with a problem." But having done it and realise what it's about and go through it, actually the instructions we received, the teachings we got from it are really good, and will be helpful going forward*.'

Participants who were more experienced in terms of exposure to mental health issues were fairly confident in dealing with such occurrences: '[*I help] either manage it themselves, or get the right services in place to help them manage it … if it meant that a community psychiatric nurse would be visiting twice a week or …presenting at the local mental health team to get an injection*'. However, this support was not necessarily based upon a sound understanding of the issues at hand, or their effects: '*I would have been quite practical about it. Almost dismissive and dealing with things in a very black and white basis. Not necessarily trying to diagnose or help people along with it but just dealing with them in a practical manner*'.

Some respondents indicated that they themselves had, or were, experiencing challenges which had provided insight into what it was like to experience mental health issues with respect to service in the armed forces. Furthermore, a number of participants highlighted that they had personally experienced mental health issues in the past or knew of friends or family members that had experience of mental health issues. These personal histories provided a level of empathy and understanding with respect to the experiences of veterans, and of people more generally, and the potential effects of poor mental health.

However, within the sample of trainees interviewed, other participants highlighted a historically limited knowledge of, or contact with, people experiencing issues either within the Armed Forces or in civilian life: '*I didn't really know any in-depth information about things such as post-traumatic stress disorder. I'd heard about it, I knew people had it but it didn't really have any real knowledge of how to maybe identify or how to spot the signs.'* As a consequence, while not intentionally seeking to avoid dealing with people with mental health issues, some participants indicated that they had, prior to the MHFA programme, not necessarily been very confident in supporting people in such circumstances should the need arise. Although this did not necessarily imply that they were not prepared to support people if called upon.

Delivery style

This theme related to perceptions concerning the way in which the programme was delivered. Overall, the quality of the resources, coupled with the enthusiasm and expertise of the instructors, provided the foundation for successful programme delivery as typified by the following comment: '*It was good that the training was reasonably participative, allowing everybody to contribute something. The scope of the material was quite broad, thus providing a good overview. The facilitators were excellent, the booklet is excellent*'. The Delivery style theme includes four subthemes: (i) Instructors, (ii) Interaction, (iii) Content and (iv) Resources.

Instructors

Generally speaking, the instructors were praised with respect to their enthusiasm, knowledge and expertise in delivering the programme sessions. This established a learning environment in which participants felt comfortable in asking questions and exploring mental health issues: '…*even if they didn't know the answers…they went away and found it for us. Even now, we can contact them for questions and support if we need anything*…'

Participants were not necessarily confident with respect to their own personal knowledge and experiences, and there was an onus on the instructors to ensure that an inclusive and 'safe' environment was established in which participants felt freely

able to explore issues concerning mental health. As such, the credibility of instructors was highlighted: '…*they also work in the types of areas … they have the right level of compassion and understanding and experience to be able to deliver these courses*'. Credibility was also enhanced when instructors possessed military experience, as this helped participants feel more connected to the programme, for example: '*One of the instructors was a mental health professional and ex-military which added real value to the material he was teaching*…'

Given the subject matter, it was also important that courses were delivered in such a way as to blend serious aspects of mental health with more light-hearted perspectives. The instructors actively sought this approach which helped foster learning and enjoyment.

Interaction

Active engagement between participants was encouraged by the instructors and provided a means of exploring personal experiences and learning. This helped to challenge participants to explore multiple viewpoints of mental health: '*You got a lot of interaction and sort of views from different angles of perspectives. The course certainly taught you a lot about the different illnesses and how to identify some of the conditions that people may or may not have*.' Interaction appeared to help participants develop increased confidence in talking about mental health issues, being less concerned with the stigma or social taboos that were perceived to surround the topic: '…*one of the most useful things was talking to other people in the room and hearing kind of…experiences that people have had or shared or heard of…the more you talk about it the more common it becomes and the more normal it becomes*.'

Underpinning this interaction was the diversity of programme participants, which was generally seen as a positive feature: '…*it was a really good mix…that brought a massively different dimension to it…I think it was really important to have them [civilians] in there…a lot of civvies face the same problems and we seem to have claimed them just for our own. I think it was quite important to have the mix'*. This was important for helping participants learn about other lines of work and for sharing

experiences and issues that participants had in common: '*These experiences gave me a better understanding on how to deal with different situations regarding mental health issues*…' It also gave civilian participants insight into the actual experiences and mental health issues faced by some armed forces veterans. In this respect, group interaction provided a powerful means of allowing participants to formulate a deeper understanding of issues discussed during the programme: '*Being able to talk to my peer group who were on the training with me and coming to conclusions which were the right conclusions, having examined all the various possibilities, that discussion element was very good and a really positive thing.'*

Content

There was broad agreement that the content offered in the programme was of a high quality and instilled a much greater level of understanding of mental health. The breadth and depth of information provided participants with an appreciation of the diverse conditions within the mental health spectrum and a deeper understanding of how these were experienced by people: '…*we all understood what suicide and depression was, and how those things could be expressed by people, as in self-harm and anxiety disorders. So we got a lot of information on a, sort of, more clinical front*.' Although there was criticism that some of the statistics were out of date, the blend of presentations, group work, videos and opportunities for discussion were seen as positive aspects:

> '…*the videos in particular, that were shown during the course kind of highlight people who have mental health issues, or who have had them, and are talking about their experiences, were very good, very useful. They give an insight into how that person might have thought at the time they were having their problems. That really helped I think to kind of crystallise the thoughts for me*…'

Resources

Participants repeatedly cited the course booklet as a very useful resource both as a learning tool during the programme and in practice following completion of the MHFA training:

'*…the book that we were given was very useful, did give some really good descriptions of things in there, what you can do to help people in terms of their wellbeing, and guiding in the right direction to get help or help themselves…it's a very good reference piece that you can go back to as and when you need to'*.

This appeared to complement the other resources used in the programme, providing a sound base from which to take the learning into practice: '*I think overall as a package everything worked really well together. The only thing I think stands out on its own is the book because it's such a useful piece of reference, but as a package of instruction all the elements seem to work very well together*.'

Education

This theme related to the impact of the programme on participants' knowledge and understanding of mental health and how it had helped them have a better understanding of mental health and how to deal with it. Three sub-themes emerged through the data analysis namely: (i) knowledge and awareness (ii) skills and conduct, and (iii) usefulness of ALGEE (ALGEE is an acronym used in the MHFA course section on Action Planning which stands for A - Assess for risk of suicide or harm, L - Listen nonjudgmentally, G - Give reassurance and Information, E - Encourage appropriate professional help and E - Encourage self-help and other support strategies).

Knowledge and awareness

Although some participants were more informed about mental health than others based on their roles (both professional and personal) and experiences, the programme was found to have had an impact on knowledge and understanding: '*The main aspect for me was the varied types of mental health there is. Many types with many different types of symptoms, but now I have a better understanding of the subject'*. This enabled them to provide a number of emotional and practical skills:

'*[It's about] helping people to develop knowledge and compassion about mental health. Helping people to understand what they can do to decrease*

their stress and anxiety. Helping people to understand what it may be like to live with a mental health problem.'

The course also helped to clarify misconceptions and for some, it led to a revised attitude toward mental health than that held prior to participation in the MHFA programme: '… *in some of the particular types of mental health issues either bipolar, psychosis, those kinds of things, the extra understanding that it gives you, it's a lot easier to be a lot more empathetic towards people in those situations and not treat them like they're making it up or exaggerating these things*'.

The programme also increased awareness of the support structures designed to assist people experiencing mental health issues: '*I didn't realise how many agencies and people who were out there and the organisations that can help and support people and that, for me, was probably the biggest and positive thing for going forward*'. As such, even though participants might not necessarily have had a keen interest in mental health as a subject area, the programme provided an opportunity to become more aware of mental health issues:

'*I don't mean to sound horrible, not 'not' interested, but it didn't affect me. After the course I thought that it does, 'cause it affects everyone in different ways. And for me I just thought, "Yeah, it's good to listen to people and know where to go and get the right advice*.'

The clarification of mental health issues and understanding behaviours, illnesses and strategies, provided participants with a greater appreciation of the types of conditions affecting people and the impact of these for individuals and their families.

Skills and conduct

Closely connected to the theme of knowledge and awareness, skills and conduct related to the specific abilities that participants learnt from the course. These included listening in a non-judgmental manner, offering reassurance and advice, and confidence in asking pertinent and sometimes difficult questions for example, concerning suicide. Participants recognised that the programme provided a

framework within which a structured and purposeful response to those displaying signs and symptoms of mental health issues could be made. The simplicity of the approach was especially relevant in this sense, providing participants with an effective means of supporting people, particularly those suffering acute symptoms:

> '*…how you actually deal with an issue…that's probably my main take away from it, it still sits in my head. And because it's sufficiently short and to the point, how to go and practically deal with one of these situations it's very much at the forefront of my memory*.'

These skills provided participants with a means of recognising signs and symptoms, and responding effectively to situations: '*I'm certainly not gonna feel worried about saying the wrong thing anymore. I certainly was before...So I certainly know, you know, a slight turn of voice, the right things to say, and I feel much more comfortable in being able to do that*'. Here, talking in a sensitive manner was perceived as a key strategy:

> '*…take time to really understand my client's journey, just take the time. I may not have an answer immediately but if I just allow them that respect to talk about it, talk about their experience and share with me, the fact that I'm listening will help build up trust and we can work on an action plan*...'

Usefulness of ALGEE

ALGEE was particularly beneficial in providing a systematic approach that could be applied simply and quickly in a range of situations. It helped to cement the learning taken from the programme, providing a means of drawing on the knowledge and awareness obtained, and putting it into practice:

> *…it's revised my awareness [of] how to react and identify a possible mental health situation. It has equipped me with appropriate tools to deal without over reaction to future situations, given me confidence in the use of ALGEE and the importance of not telling casually, what they should do*.'

Outcomes

A number of outcomes arose from participation in the programme for different participants. These are summarised in the following three subthemes: (i) confidence, (ii) skills, and (iii) mental health ambassadors.

Confidence

The programme provided participants with a sense of confidence in respect of talking about, understanding, and responding to people with mental health issues:

> '*I didn't expect to get so much personally out of it that I got. And I have met one or two people since that I have been able to, sort of, say things to I wouldn't have dreamed of saying to them otherwise. So it's improved my confidence, and I've perhaps realised that we can all be in a bad place at a certain time, and it might just be a bad place at a certain time, but if it's not addressed, discussed and, you know, sign-posted, then it can turn into something worse…*'

Participants highlighted that this had a number of impacts. For example, some divulged that they had supported friends and family by applying the ALGEE system as a direct means of supporting people experiencing mental health issues. For others, the confidence to support people was more subtle. For example, one participant discussed how he shared his knowledge with colleagues and also identified instances where suggesting a short time away from work (an hour, for example) had helped staff to feel less stressed. One participant noted that, such was the impact of the course, they had initially felt less confident:

> '*…now that I have done the course, it is almost like a little bit of a back step, in a way, because now that I have done the course and I have a much better understanding, I now actually realise how little I knew about it and how I wouldn't really be the right person to help somebody*.'

However, generally respondents had developed a better understanding of their role in supporting people in relation to the wider range of services available: '*[now] I can help somebody… now know that they'd definitely need proper agencies and more*

people involved, if they were having a mental health struggle, apart from just a minor one.'

Skills

Participants identified a number of skills, principally the ability to recognise and deal with situations in which mental health issues were important. For example, the programme helped participants to assess a situation and understand what was going on before responding appropriately: '*I have learnt to step back from the first response from the individual and listen to what is going on and evaluated the whole situation before advancing with their care*'. Equally, some participants highlighted how they felt better able to communicate with individuals experiencing mental health issues, for example:

> '*I actually felt more confident to address and more confident to speak openly about it and actually it's not going to offend people if you speak about it. Sometimes actually you might ease the situation for that person just to know that yeah you are aware of it and that it's not kind of a taboo*.'

Another participant alluded to the fact that the programme was about providing skills to deal with issues in the first instance, rather than being concerned with solving these in the long term:

> '*We're not trying to diagnose what the mental health issue might be, we're just trying to stop them from doing anything catastrophic and then signpost them and deliver them to the next point in the process. So I was completely reassured by that and felt well enough equipped to go on and deal better than I had before taking up the training*'.

These skills were important in respect of meeting the needs of individuals in the first instance, but also in addressing the broader subject of mental health: '*I actually felt more confident to address and more confident to speak openly about it and actually it's not going to offend people if you speak about it. Sometimes actually you might ease the situation for that person just to know that yeah you are aware of it and that*

it's not kind of a taboo.'

It was apparent that these skills were also useful in respect of helping others: '… *[there was] an ex-forces male suffering PTSD and having financial issues. I visited and assessed both his mental health issues and other matters. He repeatedly stated how important his family were and they were providing his support and reason to get himself sorted…I provided some info I felt relevant and provided reassurance, signposting him towards various professional bodies*…', and also from a personal perspective: '*I used the skills to access my own status when I recognised I was being seriously overcome by grief. I recognised I needed help and sought it out. I am [also] much more aware of the nuances of colleague's behaviour and have developed a level of trust with a vulnerable colleague who will now approach me to talk*'.

Mental health ambassadors

This describes the effect of the programme in terms of a broader understanding which helped participants recognise and interpret mental health issues more deliberately: '*I found the training informative and helpful and, unlike some training I have undertaken, not at all dull! I think many more people should be trained, particularly in the Armed Forces, to raise awareness and remove the stigma attached to mental health issues.'*

In this sense, participants were promoters of mental health who were alert to the need to identify and address issues as and when it was relevant to do so:

> '*I think I am more aware of my own mental health and that of others. I am more prepared to talk about mental health issues and dispel stigma surrounding it. For those who have suffered mental health issues or are still recovering I have been able to talk about how it affected their lives and how they overcame, in particular what was helpful to them*.'

As a consequence, people perceived that they were more able to play a role in supporting mental health in the armed forces community: '*[I'm] more understanding*

and I hope more approachable if someone needs advice or just someone to chat to. …I'm now in a management role and as such would be sought out for advice or guidance.'

In this sense, such participants could be described as resources in themselves, both at home and work, as a means of supporting the mental health of those around them: '*I am now more confident in looking out for people. Due to my role I am frequently approached outside of my working role for advice and guidance. I am better prepared to give proper guidance and signpost individuals or give advice to relatives*.'

Recommendations

This theme includes recommendations for improvement to future courses. Two areas of recommendations were identified: (i) Delivery style and course participants, and (ii) Content.

Delivery style and course participants

The dynamics of the group, and the engaging and sometimes emotive nature of the subject matter occasionally created situations in which not all participants were comfortable:

> '…*quite a few of our colleagues on that course used it as a self-help group and, now I don't mind people sharing, but there was a lot of over-sharing and that's why I thought the instructors were very patient because they let the people over-share, but it didn't make a very comfortable working environment*.'

Such instances showed the importance of the high degree of skill demonstrated by the course instructors to ensure that group sessions remained focused. In addition, some participants were more sensitive to the distinction between military and civilian personnel. Here, it was perceived that civilians were not necessarily in a position to understand very well the experiences of armed forces personnel which made some, albeit a very few people, uncomfortable: '…*no disrespect to civilians, I was one and*

in theory I am a civilian now, only in theory though, once a squaddie always a squaddie, so to speak…I do believe that people who actually attend the course should have some sort of link with military, whether it be family or marriage or whatever...'

In contrast, other participants enjoyed the mix of civilian and armed forces personnel, perceiving this as something which brought greater interest and balance to the programme:

> '*Obviously everybody's got their own experiences, we were lucky enough to have both in a military sense, but then the civilian has what he sees, you know…the civilian world, it was a great balance to be fair. I think if we knew we had [just forces] maybe not civilian, you probably wouldn't have got the same, nowhere near*.'

Others suggested that there was a need for a greater mix of age and experiences within the groups. This demonstrated the need to strike a balance between types of participants attending the course with respect to their own experiences and preferences in order that all were able to benefit equally from participation.

Content

In addition, there were some minor concerns about programme content, specifically the outdated nature of some of the data and potential inaccuracies:

> '*The slides should show a balanced view, regarding statistics, between military and civilians to provide audience with a comparison…the slides should show percentage figures against population rather than just occurrences, otherwise it makes the army look bad against other services*.'

Furthermore there was some concern about the heavy use of presentation slides. At worst, the slides were perceived as *'dry'* and *'dull',* with instructors occasionally relying too much on their content rather than seeking to present 'real world' examples. While these issues were not perceived by all participants, there was

sufficient feedback to suggest that these were key areas in which improvements could be made for future programmes.

6.32 MHFA Armed Forces trainers

Themes that emerged from data collection with trainers focus on their experiences, understandings and opinions of the programme. Following a brief background information section on participants, findings are presented in line with four key themes: (i) Awareness of mental health in the armed forces and veterans community; (ii) Opinions – Programme and Processes; (iii) Opinions – Specific to the course, and (iv) Recommendations for the future.

Background information

The 14 participants comprised five independent trainers, seven who were working in the armed forces or the NHS, and three employed in the charitable sector. Independent trainers were self-employed and typically delivered a range of lifestyle/health type programmes. Trainers who worked for the armed forces were often in roles such as that of Welfare Officer, and those from the charitable sector were often employed by military related charities. Most trainers who were independent had previously worked in the area of mental health promotion / awareness and some had personal experience of mental health problems prior to their involvement in the MHFA programme. Some independent trainers had both experience of the armed forces and established networks; many however did not. Some had delivered the standard MHFA programme prior to moving into MHFA AF. Trainers from charities or the armed forces generally worked in the welfare areas of provision including with veterans, serving personnel at the stage of transition into civilian life, and also with currently serving members of the Armed Forces.

Awareness of mental health in the armed forces and veterans community

Trainers had a general opinion that the armed forces had a more accepting climate towards mental health than previously, and that more people were talking about mental health, including people who might not have done so in the past: *'people talk about stress, people talk about depression… there's a climate now to talk about it and all those… a lot of men who never had the chance to talk about these things, the young soldiers'*. However, there was also an acknowledgement that the MHFA programme had helped although more could still be done. An acknowledgement of this was made through a comparison with another public service organisation where one participant had previously worked, whereby training had been a requirement for

all: *'I've been a police officer for 18 years and we did quite an extensive training around dealing with mental health issues'.*

There was an acknowledgement of the different kinds of mental health issues that people were facing in the Armed Forces, for example: *'dealing with suicidal, vulnerable, mental health people. Post-operative stress, trauma, resettlement and adjustment of people leaving the forces.'* Despite an awareness of various campaigns to address stigma, there was a general scepticism about how much success these had had, and a feeling that the Armed Forces needed to do more in this area. The program was seen as an opportunity to continue to educate people in the area of mental health stigma within the context of the Armed Forces.

Opinions - Programme and processes

Opinions on the programme and processes of delivery can be summarised via two themes: (i) Administration, costs and charging, and (ii) Support and network.

Administration, costs and charging

Trainers perceived MHFA England to be a credible organisation and one which had developed a high-quality product: *' they're a great outfit, it's a great product, it's a great process.'* There were, however, concerns regarding administration which was deemed to be a little slow at times and it was felt that this could be more efficient. There were also opinions with respect to costs and charging, and the strategy for not charging trainees for attending the courses that the trainers were required to provide:

> *'…can I make a play for not talking about free places; could they be subsidised because it takes away the value of our professionalism and the whole thing in my view and I think that's really important. By all means talk about being subsidised because that's actually what they are'.*

The independent trainers often had costs associated with putting on 'free' courses such as travel, subsistence, postage charges etc. Not charging for courses meant that there were expenses that still needed to be covered:

'…you give the manuals for free, we can get a building for free maybe, but I can't expect somebody to drive from Nottingham to Luton for free or not eat for two days. All this freeness, it's never really free, there's always a cost, you know, it costs me a pound, not your stuff because it's freepost but it costs me a couple of quid to stick stuff in the mail to MHFA to get the signature sorted out. I have to have ink for my printer; I've got to have fuel for my car.'

Others highlighted that free places were not always valued by people and that some kind of contribution should be stipulated to ensure that they were valued: *'I found that even by charging £30, because they've handed some money over they'll turn up.'* There was also an opinion that there was a lot of responsibility and work undertaken to ensure sufficient numbers of courses ran, especially for the independent trainers who did not have such good links into the military environment.

Support and network

Dependent on the type of trainer, support and feeling part of a bigger project/network varied. Those in the Armed Forces seemed to feel more supported, for example:

'I was quite fortunate because obviously I was in the military community so I tapped straight into army welfare service, they bit my arm off, they organised the course so they carried all the risk.'

However, the independent trainers, who did not have links with the Armed Forces felt less supported and outside of the network.

Trainers expressed great passion for the programme and their role within it, but would have appreciated more concrete links to the Armed Forces community. Responsibility for this would have helped them to facilitate the planning and delivery of courses once they were trained, but trainers were not sure who this responsibility lay with:

'They're a lovely ... organisation (MHFA) and everybody individually is great and collectively they're great but that's not their job to do this (support). Their

job wasn't to be our support.... So really who should be looking after us as it were, I mean no-one owns this project and I think the danger is that it will drift…. It will just stop being that great product it is.... For me that would be a real shame, a real shame. I don't mind the warts and all the problems and the hiccups along the way if I know there's something that's maybe… a mother-ship.'

Opinions - Specific to the Course

Opinions regarding the specific course included themes in three areas relating to: (i) content, structure and delivery of the course, i.e. structure, content, delivery, plain English, opportunity for self-reflection; (ii) Developing knowledge and skills, i.e. learning from others and increased awareness of mental health issues; (iii) Military and civilian dynamic, and (iv) Areas of concern.

Content, structure and delivery of the course

This subtheme included opinions on structure, content, delivery, accessible language, and opportunity for self-reflection. Trainers appreciated the fact that the course was highly structured, and that clear guidance was available on how to deliver the group work within the course and also the skills needed in terms of managing the group work for timekeeping etc.: *'I like the fact, the teaching skills as well, so the things about time keeping, about different ways of doing ice-breakers and things like that but there again you've got 10 minutes, here's your 30 second warning and then cut away... So it wasn't just do you know what you're talking about.'* The combination of tasks on the course enabled trainers to develop their confidence: *'all these little steps just grows your confidence'*, and being with others also helped with the learning. It was also appreciated that the course allowed time to consolidate and to reflect, something that was often not available in standard Army-based courses:

'…what I liked about that was it gave you a gap to consolidate, reflect, … …in the army it's very good at sending us away, …, 'right you, you need to be an instructor of climbing. Go off for a week. You may never have climbed before, it doesn't matter, you come back a climbing instructor. It's just how the army does it, it just makes you be whatever it wants and we're very good at picking those up and doing it. Ask me to tie the ropes up six years later

and I wouldn't put myself up there because I've forgotten all of that. What I liked about this was you got that consolidation at the time, you could go back, answer questions'.

For one participant learning about how to facilitate group work was appreciated and enabled them to develop a new skill:

'you had to think about it….but it's not something the army does really because we don't care what you all think when we're teaching you. We'll tell you what you're going to learn it, we'll tell you it and then we'll ask you the questions and make sure you know it and that's it, you're away. So the facilitation thing was quite a skill..., but it's wonderful. It's a really good skill because... I let the students do it and that is a really good skill, actually.'

The content of the course was highly commended and appreciated by the trainers. Of particular note was the facilitation:

'some of the exercises are absolutely exceptional; the way the facilitation's worked into it's really brilliant so I think emphasise that as much as possible' and the peer evaluation. The peer evaluation included being asked to research an area and then present it to the group. This enabled people to come out of their comfort zone but in an environment that helped them to grow their confidence in terms of delivery.'

Trainers thought the course was good: *'overall I think it's a really good course',* and were very committed to it: *'I'm really passionate about it and I think the feedback's always positive, I get people who are just… when I put it out it goes viral, people are just always wanting to go on it and it's a really good course'.* It was also found to be challenging: *'yeah, very challenging and nerve-racking as well'* but they were pleased that they had undertaken it: *'I'm glad I did it.'*

The delivery of the course seemed to work best when trainers worked together thus allowing a pooling of knowledge and experience. This was seen as complementing the knowledge and experience of the trainers delving the course. Examples given

included combinations of trainers from mental health, and a civilian background or a military background. This was appreciated by trainers and in their opinion enabled the course to be delivered well:

> '…w*hen I first started I co-delivered with a girl that used to work at Mind, she'd been a psychological nurse so she had really good psychological background and a good armed forces background and so that first couple of courses we sort of tag teamed and I learned lots off her, she learned lots off me*.'

One participant compared shared delivery as being similar to a successful entertainment pair in terms of them complementing each other:

> *'…it does work really will with me and him, so it's X and Y as opposed to Ant and Dec, you know what I mean....but some of the comments that we've had back have said you two actually work well, really, really, really well together.'*

Trainers appreciated the fact that the course was delivered in an accessible way and that there was a limited amount of medical jargon involved, all of which helped people to better understand the complexity in play: '*I think as* [name of other participant] *said about the plain English, sometimes people who aren't from a professional background finding ways to put something across you think that is a really clever way of explaining a really complex thing really easily.'* This enabled laypeople to understand more and help to demystify these topics and this was seen as being influential to addressing stigma:

> *'…there's a limited amount of medical jargon in there so even if you have got top notch psychiatric nurses or psychiatrists or anybody on the course, this is in a language that what I call the ordinary layperson can understand. You're demystifying a lot of it and I think part of that is it helps to take the stigma away... This is nice, plain, ordinary English and let's talk about it as you will over a cup of coffee.'*

Trainers appreciated the opportunity to undertake self-reflection during their time on the course, and enjoyed the peer evaluation aspects when asked to deliver elements

of the programme: *'it was good, it gave us the opportunity to sort of self-reflect as well and like you say, sort of evaluate, peer evaluation, that was really nice that we all did that and sort of joined in'.* Peer evaluation appeared to help with confidence in delivery, especially when other trainers provided positive feedback about what had been done well:

> *'…it's natural sometimes to focus on what you didn't do so it was nice to get good feedback ... it really increases your confidence and you might know a lot of it, but I think when it comes to actually standing up that's the nerve-racking bit, it's actually hard to express yourself. It can be quite difficult so it helps you to be gain confidence to be able to do that.'*

Developing knowledge and skills

This subtheme can be characterised by two main issues: learning from others and an increase in awareness and knowledge of mental health issues.

Learning from others included learning from other trainers on the course and from the trainees themselves: *'the people on the course at the time, I learned a lot from them as well as the actual trainer, and still now when the students come on the course, every course I learn lots and not just me spouting information to them. So it's a continual learning process.'*

Trainers appreciated the mix of people within the programme and the sharing of knowledge that that it facilitated 'cross pollination': *'…you cross-pollinate, you come away and you're like, I didn't know that, I like that, I'm going to use that, I like that. So you come away with that extra little bit every time you teach with someone different'.* The mixture of people enabled learning which not only included both learning about mental health problems, but also for the civilian trainers, military life and the attitudes and behaviours within that: *'it was about the way they mixed the people that were on the course and I learned so much, I learned on that course about military life really and about the attitudes and behaviours.'* It also enabled trainers to feel comfortable in contacting other trainers afterwards to ask questions

when they arose which they did know the answer to, or were not necessarily covered in the course material.

Overall, participation in the MHFA trainer course increased trainers' awareness and knowledge of mental health conditions: *'I'd heard of bi-polar and schizophrenia, I didn't know exactly what it was and it sort of filled in those blanks. I knew that eating disorders weren't great for anybody, but understanding exactly what does it do and how it affects individuals, what can you do to help.'* It also reinforced and made trainers aware of the range of mental health conditions that are prevalent in society and in the Armed Forces: *'the different self-harming ones, things like over-work and over-exercise and things like that that I'd never considered to be self-harming and you read it in there and go, Oh God, I know loads of people that have done that kind of thing.'*

This knowledge and understanding enabled people to have the confidence to discuss these issues: *'it taught me a lot and because it's taught me a lot I now feel, yeah I do, I feel quite confident now that if something did crop up or like you said, you know, the more you get that safety net goes the more… So now when I stand up now and I'm teaching if somebody says something I like that bang, [click's fingers], bang [click's fingers], bang [click's fingers] and I'm back there with the answer straight away.'* It also appeared to produce trainers who were happy to acknowledge where they did not necessarily know the answer to something, but had the confidence and ability to identify relevant sources of information:

> *'I like the fact that the course doesn't allow you to look too stupid you can just go, 'No idea, but I'll see if I can find out in the next break what the answer is' .... Also there're a lots of other people around who can help you and it's us saying that it's a first aid thing. None of us are experts and we don't need to be. It's reassuring that they don't need to be experts and by, the very same token, nor does the instructor. It's a first aid thing so I found that quite useful.'*

Military and civilian dynamics

Trainers were aware that there were differences between the types of people both on the training course and between the people they would be training. The civilian,

military and veteran differences were acknowledged, but most felt that the training course, by mixing people together, enabled them to learn about the other worlds.

Non-military trainers were known to write down specific military sayings, so that they could remember them and potentially use them in the future: *'Well they (other people on the course) were writing, they were taking military notes down, you know, our acronyms that we use and our sayings, they were writing them down in books so that when they were teaching military they could actually use the acronyms coming back so it was quite funny.' D*espite the potential differences and barriers that these military, civilian and veteran aspects brought, one trainer acknowledged that these were not necessarily important because, through the taking part in the programme, he realised that people were all there for one purpose:

> *'I think to go back to the point (name of another trainer) made about committed people because of the time. I had the same, not apprehensions… yeah, apprehensions when I went a long and I was there, I was military, I wasn't part of a professional group and all of that. By the end of day four when you've done your bit there was a realisation that everybody in the group had that one common thing that they wanted to help other people. There was a sense of suddenly we were all kindred spirits. We might all come from different backgrounds, we might have different ways of doing things but our object is to help people and you just sort of… I can remember at what stage of the day it hit me, I was just sat there listening to somebody and suddenly thought, I am in a group of like-minded people regardless of backgrounds.'*

Areas of concern

Areas of concern included three main issues: accreditation, sustainability and militarisation of the programme.

In terms of accreditation, a number of questions arose as to why the course did not have accreditation attached to it: *'It's not accredited. All the others are accredited and this one isn't, so why isn't this accredited?'* It was not clear to the trainers why the standard mental health first aid course had accreditation, but the MHFA Armed

Forces course did not. Indeed, there was a general feeling that the course would benefit from being accredited.

Concerns around sustainability were expressed regarding the long-term strategy and potential of the MHFA AF project: *'from what I've heard is also the fact that there is so much potential in it that it's just not necessarily being fully realise.'* There was also concern that it was raising awareness of the need for a strategy, but that this need might not be met: *'we're setting up an appetite here for something that everybody's biting your hand off for that we know is needed and it could be ruined by the lack of a bit of attention or coordination or someone having a strategy.'*

Trainers appeared not to have much awareness or knowledge about any longer term strategy for the programme, but they did have a desire to know if there was one: *'it makes me wonder, was there a strategy for the rollout of the delivery and where does it go, or, I don't know?'.* This concern showed the commitment of the trainers to the programme and their desire to ensure that it was sustainable. In turn, this concern was underpinned by the importance that trainers placed on the project and their commitment to it: *'well taking it forward the four main signatories to this, SSAFA, the Legion, Combat Stress and MHFA England, I'd like to know what is the strategy, where are they taking it … when they all meet to talk about what's happening, why don't we know about that?'*

There was an acknowledgement that the programme needed to be embedded within broader military culture (see 'Recommendations' theme below) and this was coupled with a concern that it could be 'militarised'., i.e. to become standardised into military training, i.e. within other courses:

> *'…the downside is that it becomes militarised, it becomes methods of instruction and so it's delivered, and A, B, C, D, E, F, G and it's a bit like you're now a qualified Mental Health First Aider which is…. This is for everyone, not just okay we need a quota of five military mental health first aiders in the unit, which is exactly what the military… of course they'll do that, it's what they do.'*

Trainers were of the opinion that this would be detrimental to the programme and that it might change: *'but let's just say it becomes a product for the military, what are they going to do? They're going to chop and change, and do what they want.'*

Recommendations for the future

In terms of recommendations for the future of the course, trainers put forward a number of suggestions which comprised: ownership; useful things for trainers to know; strategic plan for the future; improvement to the course and processes, communication and coordination.

Ownership

There was some debate between trainers about where the programme should be situated, for example with MHFA England, or within the Armed Forces. Some trainers were aware that various branches of the Armed Forces had embedded MHFA into their wider training programmes: *'…so they all jumped on board, so now they have TRiM and they have the Mental Health First Aid'.* One respondent suggested that given that the Armed Forces were not making the course compulsory and that in his experience most of his instructors had been civilians, he did not feel that the military were interested in taking ownership: *'they're (the armed forces) not forcing people to do it, they're certainly not asking army instructors to go out and do it. I don't think… most of my instructors were civvies on my course, there was only ever three or four military… so I don't think it's going to be taken over by the military. The military is not that fussed over it.'*

There was a discussion about who had attended the course with one participant suggesting that all Welfare Officers in the British Legion should attend the course. One participant argued that there was a moral responsibility to do something about mental health awareness and that this was a responsibility that everyone had: *'…the biggest responsibility for me is that, ... there's no legal responsibility here, but moral responsibility. You walk through the door, I'm sorry, but you have a moral responsibility to do something and doing nothing's not an option.'*

Useful things for trainers to know

Trainers felt that one of the most useful things for trainers to know to help deliver

courses would be the nature of the infrastructure of the Armed Forces in the area in which they were operating. This would also enable them to identify the veteran market for the course: '*but if you understand what your infrastructure is in your region, that's where you need to tap into in terms of your marketing for veterans.'*

Strategic plan for the future

Trainers suggested that there was a need for a long-term, nationwide, strategic plan for the future that was clear and available to the instructors and the target groups: *'I think we need a strategic view of mental health first aid for the armed forces community and share that with the instructors.'*

As well as a request for similar funding opportunities across Northern Ireland, Scotland and England, there was a call for MHFA England to promote the programme on behalf of the trainers, as they would have more influence with some of the larger employers of veterans. Trainers also suggested that if there was a suitable network between them this would enable them to remain current and competent in their knowledge: '*I think as long as we all keep current and competent through networking then it works well.'*

Trainers also felt that there was a role for MHFA England to promote the programme and to be more strategic about who the programme was targeted at, and also to have a lobbying role. However, it was acknowledged that marketing would be costly, and that 'word-of-mouth' and current promotion approaches appeared to be successful:

> *'…it's kind of doing it itself. You can spend a lot of money on marketing but actually it's getting out there, and people are starting to realise that it's out there just by word of mouth, just by the fact that more and more people are doing it so I don't really think, I don't really see if there's much else to be done, just do it.'*

It was perceived that the MHFA programme had been successful in the veterans' community but that there were other organisations that could potentially benefit from

the programme which might usefully be targeted: '*but there are so many different organisations out there who could potentially use the service.'*

Improvement to the course

Trainers requested the need to keep the course up-to-date, especially in terms of mental health related statistics. Some instructors had had some embarrassing moments when people on the course had more up-to-date statistics than the course materials provided:

> *'Yes, the course needs up-to-date statistics. It's plainly embarrassing when you have a Colonel on your course and he has got all the up-to-date and he's generous enough to share them but it's not the way that I want to train, that's not quality training in my view, and some of them are really old, so I think that's important.'*

There were also some suggestions that the video clips could be improved in terms of being clearer, having subtitles, and integrating the exercises with the film clips: '*Yes, integrated exercises and film clips, process two-way information, not so one-way, mapping and delivered according to need'.* In terms of content, some trainers suggested more emphasis on prevention and recovery: *'push, emphasise prevention more, right up front, and recovery, a bit more on recovery*'.

Processes, communication and coordination

A role for MHFA England was identified whereby it could help the trainers to link up with their regional armed forces personnel. This would help to get the courses established and would save considerable wasted time spent trying to locate relevant networks. Trainers also wanted more opportunities to engage with each other through the use of a message board facility: '*…wouldn't it be good if we had some kind of message board, that if you're successful with that, you can post that up so we can approach other brigades.'* They also thought that networking events where good practice could be shared would also be useful:

'…a quarterly seminar where we all come together, share good practice, have a coffee, learn something, get updates on stats, figures, changes in legislation' and *'go back and have a refresher, even if it's top tips on how… you know if you've got to come with one way but you particularly like teaching a lesson and someone else comes with others then you can pick up again.*'

Despite the call for refresher sessions, there was some concern that unless there was support in place from a line manager it would, in practice, be difficult to attend these.

There was also some discussion regarding finding out centrally what was happening in different areas of the country and whether MHFA England could provide that role:

'…well, MHFA could be doing this to support the instructors. That's great but there are actually instructors in the military and in other organisations that are already tremendously well supported so it doesn't have to be all fed from them. It might be a case of putting one instructor in touch with another and drawing on the good experiences and the contact.'

6.33 Project Stakeholders

Themes that emerged from the analysis of the data concerning project stakeholders focus on their reflections on the project to identify strengths, weaknesses and recommendations for the future. The findings are presented in relation to four main themes: (i) Strengths, (ii) Weaknesses, (iii) Overcoming barriers, (iv) Sustainability and recommendations for the future. This begins with background information on the participants.

Background information

The 4 participants consisted of personnel who represented the various organisations on the project Steering Group. All, except one, had been involved from the start of the project.

Strengths of the project

There were five strengths identified that included MHFA England and their resilience, the product, adoption of the project 'in the wire', working partnership, and learning.

MHFA England

MHFA England were commended for their professionalism and high quality product: *'the most powerful reassurance to me and interacting with a very high quality, extremely experienced professionals that the delivery and quality assured the service, it gave me huge confidence.'* This provided positive reassurance and feedback for participating organisations: '*only positive feedback and I think really has given people confidence and help to demystify, you know it's done what it says on the tin and in a way that people have felt comfortable in engaging with it.'* They were also commended for their resilience and confidence to persevere in the development of the project: *'the fact that the organisation delivering it has been resilient enough and confident enough in itself to continue to come back to those people that have perhaps not been hugely positive the first time… Maybe even the third time.'* The product was also deemed appropriate which helped with that success: *'the concept is very clear, the training is very simple,… its pitched at a level that heartening .. and they absolutely can understand it.'*

The product

The programme was commended on a number of counts including:

- its simple public health approach with clear aims and objectives focused on knowledge, and behaviour identification of signs and stigma reduction: *'I think that the strengths of the project are, it's not complicated, its public health approach, it's got very simple aims and objectives.'*

- that the product was new and innovative: *'I think there's nothing out there like this so it's been really important it's come about.'*

It was felt that the number of people that had been through the programme was an achievement: *'I think that the sort of coverage that you had and the amount of people that have gone through it.'* This included both ex-service and serving personnel even though the programme had initially been developed specifically for ex-service personnel. This was considered a positive development.

Adoption of the project 'in the wire'

Participants felt that the project had been accepted within the military environment, and that once that happened things could become established throughout: *'there's a real understanding and a real championing of it, it's that classic thing that once something is accepted and in at one part inside the wire, and it's very quickly is accepted all the way through.'* The acceptance of it *'inside the wire'* and that the programme was for all i.e. serving, ex-serving and families, was deemed important for establishing the project: *'it's been and also very publicly at a very senior level inside the wire, within the armed forces itself and from the huge positive feedback from individuals and organisations and that has helped build confidence.'*

Working partnership

The project challenged organisations on the Steering Group about working practices, in particular the consideration of working more effectively together and how organisations fit together within the landscape of the Armed Forces community: *'it has also challenged the organisation serving part of the screening group to think about how we work together how we can add value as a team rather than as individual organisations.'* However, as a consequence of working together participants acknowledged that a positive outcome from the project had been the

collaboration that had occurred, the strength of the various organisations involved, and the working partnership it generated: *'we've worked collectively,… There's been some really strong organisations involved'*. The support they had provided collectively, to ensure the project's success was acknowledged and seen as something to be continued: *'…makes us think about where we fit in terms of our roles and the way that we see are organisations moving forward in terms of where this particular activity should be championed and moved forward.'*

Learning from the project

Learning took place between the organisations, and from the evaluation process. There was evidence of both significant learning for the organisations involved in the experience and, as a consequence of that, a commitment to ongoing support and involvement in the future: *'…would be delighted to be involved with the capacity in the future what that might be, what that might look like is all for the discussion, but I think we learnt an awful lot'.*

An emphasis on the importance of collaborative working between the different agencies was clear: *'…we'd like to see the partnership continue, it's really important that we work in this way, I think, going forward not only in them mental health space but in other spaces too.'* There was also a desire to embed it into the core curriculum of the working practices of the organisations involved, including the roles within the military charitable organisations: *'it would be great to see it are core curriculum for the different types of roles we have.'* However the model of embedding and funding was acknowledged as something partners needed to discuss and develop. It was thought that this continued partnership might include those organisations who had not yet been involved to date but had similar aims: *'I think it would be useful to see if we could involve other organisations.'*

Evaluation of the programme had not been a consideration during project development, and was introduced after the programme had begun. Its inclusion however was perceived to be a valuable way of being able to provide an independent review of the project and to provide the necessary evidence to support sustainability and learning: *'I think that an independent evaluation .. will be so critical to particular something like this, where people are going to say, well show me what it's done then? It's part of this proving thing.'* It was also noted that due to the

scepticism that had been experienced that the independent evaluation was a necessary requirement: *'given all that we talked about in terms people not understanding, not valuing perhaps of being anxious or concerned about it for a whole raft of reasons an independent credible evaluation I think is a key piece in this and I think the future projects.'*

Weakness of the project

Two weaknesses were identified in terms of project implementation these were: (i) speed of reaction to the bid, and (ii) buy-in from the military.

Speed of reaction to the bid

There was a need for a quick reaction to enable the bid and subsequent funding to be secured for the project. Due to the lack of time to do this there were some initial concerns regarding *'mental health'* and the role of the organisations in the support of that. For example there was some anxiety about the amount of knowledge that volunteers i.e. the trainees, would have and their ability to act to support mental health issues. There was however a *'healthy caution'* from organisations but some slight anxieties prior to the project starting and that this was, for most, a new venture.

In terms of learning from the implementation process and the need for a quick reaction time, there was acknowledgement that more time would have been useful to enable a suitable processes to be set up with the strategic promotion and lobbying to secure buy- in from all levels of military related environment/sector: *'it would have been really helpful to have maybe had a bit more time to set up a proper process where we start to meet and greet a lot of those key people that would have been able people to open doors.'*

Buy-in from the military

Organisations felt that there were a large number of organisations in the military arena who undertook similar work which did not always facilitate the establishment of good working relationships. Furthermore due to the nature of military culture, it had been quite difficult to infiltrate: *'I think that's where some of the challenges have been because of that very structured, rigid, not easy to crack military culture has made it difficult for this.'*

There was a feeling that the organisations included were 'on the outside' and that

there was a sense of 'organisational protectionism', perhaps in relation to funding: *'…there's lots and lots of organisations in this particular sector and there seems to be a worry at the time around people being quite competitive trying to protect their funding streams.'* Coupled with this was the initial resistance to the project experienced by some stakeholders, and scepticism displayed through various behaviours, all of which had been overcome by people's persistence and professionalism.

Participants discussed opinions on the perceptions of mental health within the military, and the problems that this had raised for the project. There was discussion around how mental health is sometimes viewed in the military, for example as a perceived myth and as something might be used negatively by serving personnel as an excuse to get out of various roles and/or responsibilities:

- *'I'm thinking particularly about serving personnel that are about to be deployed for whatever reason, you know are they pulling the mental health card because they want to get out of something.'*
- *'…there's this belief that somehow people are malingerers if they got a mental health problem'*
- *'…it seems to be that at a very senior level, people have got mental health problems either we haven't trained them properly therefore someone is to blame… Or that person wasn't appropriate to come into the Armed Forces, so do we do recruitment selection correctly?'*

This appeared contrary to the support someone would receive if they had a physical problem, which it seemed, was more readily understood. It was acknowledged that there was a different approach when the problem was a mental health related:

> *'but when it comes to mental health it's almost a different approach than a physical injury, the mental health bit, something must be wrong with either the individual or something else has gone wrong he can't just be a reaction to something or just life that's just not part of the book.'*

There was, however, an acknowledgement that attitudes towards mental health in the Armed Forces may be a result of the nature of the community itself:

'…what happens within the military environment is just really a much more heightened awareness of what happens in the general population…. That fear of mental health… That is not something people understand and know about… It's exaggerated within the military environment because it's such a closed environment.'

Over time, however, the project, had challenged the such aspects of institutional culture and factors that had helped with this included: persistence, the championing of mental health issues, confidence in the product, *'we knew the product could do it'* and experienced trainers: *'luckily some existing structures that were very experience working with the Armed Forces, so that was a good resource as within the community.'*

Overcoming barriers

Participants inferred that bringing new programmes into the military often resulted in scepticism and cynicism especially when such initiatives were hosted by non-military organisations: *'…it's been really hard work I think, trying to do that piece to reassure people, because I think there's a real reticence all sorts of reasons and I'm sure you will pick this up.'* Reticence, cynicism and scepticism had all been experienced and were deemed a result of stigma: *'…it felt like that was what was motivating a lot of scepticism, … obviously there was a high level of stigma and misunderstanding around mental health within this particular sector and there was a lot of fear about it.'*

This scepticism and cynicism was commonplace for participants and had resulted in them being challenged: *'it was probably about 200 people there, and I was almost heckled by a few people in the audience about why do we need this,… Who are you anyway, you know, the sort of types of questions .. I've never had that sort of, what could only be described I guess, is almost hostility.'* This attitude was considered to be due to inherent barriers to mental health programs that are new and because of the 'outsider' status of the organisations concerned: *'there is a real reticence and anxiety in I think around mental health so anything that comes in, not just in the format of a new service.'* This attitude however was overcome by the Steering Group organisations through realisation that they had to work hard to overcome this: *'we*

just have to really prove and believe in ourselves and believe in the product' and *'I'm really proud, I mean I just, it's been a challenge. In a way we had to really prove our worth.'*

Sustainability and recommendations for the future

Two programs have been commissioned since the project started so there was evidence of sustainability. Participants acknowledged that there were 'champions' (advocates) in a range of related communities supporting this: *'so the words out there, we got real champions into different communities both serving a neck serving personnel, different types of organisations.'* These champions were highlighting the mental health on the agenda: *'really passionate individuals championing for the discussion, whole topic area of mental health to be on the agenda.'*

There was a desire for the continuation of the project and that embedding the MHFA Armed Forces programme into the organisation's training portfolio as standard should be considered: *'and embedded properly in our training programme going forward.'* There was also a call for it to be embedded into standard officer training:

> *'I'm just thinking about wider training, officer training particularly, they could embedded into their standard training so that everybody that has got a responsibility understand some of the basics of our mental health and how that can impact.'*

It was also thought appropriate for personnel who have responsibility for the care and welfare of non-service personnel:

> *'I think anybody who's got a responsibility working with people and families, members that may or may not have experienced mental health problems just to be aware, because I think it's actually critical of any job that involves people that you understand some of the basics.'*

However there was acknowledgement that the move from a funded model to a non-funded model of delivery would need to be thought through and managed: *'the journey for a lot of these instructors that have been to a funded programme that are*

now going to have to move to a different model, in the absence of that funding so we're going to have to manage that.' The lack of continuous funding also means that there is time and space to review the evaluation report, reflect and lobby significant people and organisations to consider a new non-funded model of future delivery: *'and you don't want to have a break necessarily, but it may be that it needs to have that report to actually be able to wave under people's noses.'*

In terms of recommendations to support the sustainability there was an acknowledgement of the important need to work together as a multiagency steering group in the future in this and other programmes.

7. Summary of results

The main findings from the evaluation are summarised on the infographic below.

The evaluation utilized a mixed method approach comprising both quantitative and qualitative elements in order to address the following evaluation questions:

1. To what extent (if at all) does MHFA Armed Forces training improve trainee knowledge, attitudes, and confidence in dealing with mental health problems?
2. To what extent (if at all) do changes in these outcomes persist over time?
3. How useful did trainees find the training and what improvements would they recommend?
4. To what extent (if at all) did MHFA Armed Forces training meet/not meet trainee expectations?
5. What (if anything) did trainees learn about dealing with and responding to mental health issues?
6. To what extent (if at all) did trainees use the skills they were taught on the course?
7. How useful did trainers find the training and what improvements would they recommend?
8. What were the positive and negative aspects of the programme process for trainers?
9. To what extent (if at all) did trainers feel supported by MHFA England during programme delivery?
10. According to stakeholder perception, how effectively is the MHFA Armed Forces initiative being implemented?
11. According to stakeholder perception, what is the future of the MHFA Armed Forces initiative?

The findings of the evaluation are summarised below in relation to these specific questions.

Evaluation question	Finding	Section page no.
1. To what extent (if at all) does MHFA Armed Forces training improve trainee knowledge, attitudes, and confidence in dealing with mental health problems?	Trainee knowledge, attitudes, and confidence: quantitative findings showed that there was a significant effect of MHFA training on trainee's knowledge, attitudes, and confidence in dealing with mental health problems.	28-30
2. To what extent (if at all) do changes in these outcomes persist over time?	Trainee knowledge, attitudes, and confidence over time: quantitative findings revealed that immediately following training, from pre- to post-intervention, participants showed a significant increase in knowledge, attitudes, and confidence. Importantly, this effect was sustained at follow-up. Specifically, there was a small but significant decrease in knowledge which occurred from post training to follow-up. Despite the decrease from post training to follow-up, overall, knowledge, attitudes, and confidence were all significantly higher than at baseline.	31-32
3. How useful did trainees find the training and what improvements would they recommend?	Trainees reported the following regarding the training and improvements they would recommend: • Courses were well received and trainees enjoyed the interactive approach and opportunity to reflect on the MHFA training course. • The systematic approach that ALGEE provided was commended as a tool to help trainees to deal with various situations. • Trainees reported an increase in knowledge and awareness of mental health issues. • The course enabled some trainees to become ambassadors for mental health and play a role in supporting others in this area. Recommendation: • Improvements to course materials and delivery (e.g., up-to-date statistics and video clips, fewer slides).	28-32 and 34-47

4. To what extent did MHFA training meet/not meet trainee expectations?	In terms of expectations, from both the quantitative and qualitative findings, it can be concluded that: • Quantitative findings confirmed that trainee satisfaction from the course at completion was 'very high' (69.56% of the sample), with a further 27.82% reporting 'high' levels of satisfaction. At follow-up, 51.72% indicated that the course was 'very useful' to their working life, and a further 44.59% reported it to be at least 'somewhat useful'. • Qualitative findings suggested that trainees enjoyed the course and that it met its objectives of increasing knowledge, attitudes, and confidence in mental health literacy.	34-47
5. What (if anything) did trainees learn about dealing with and responding to mental health issues?	Based on the qualitative findings, trainees reported learning the following regarding dealing with, and responding to, mental health issues: • Increased confidence talking about, understanding, and communicating with people with mental health issues. • Improved listening skills, advice giving, and confidence in asking difficult questions.	28-32 and 34-47
6. To what extent (if at all) did trainees use the skills they were taught on the course?	Based on the qualitative findings, trainees reported using skills from the course in the following ways: • Supporting people using the ALGEE acronym. • Sharing their new knowledge with others in the workplace. • Acknowledging an increased understanding of their role in supporting others. Quantitative findings confirmed that, at follow-up, the majority of trainees indicated that the course was 'very useful' (51.72%) to their working life, and a further 44.59% reported the course to be at least 'somewhat useful'.	28-32 and 34-47
7. How useful did trainers find the training and what	Trainers reported the following regarding the training and improvements they	48-61

improvements would they recommend?	would recommend: • Increased learning and confidence in mental health through the training experience. • Shared feeling with other trainers and trainees of wanting to support and help the promotion of mental health and its awareness in the Armed Forces community. • Importance of the need to manage the challenge of military and civilian dynamics. Recommendations: • Consider embedding MHFA into the Armed Forces formal training schedule to ensure the sustainability of the programme but caution regarding ensuring maintenance of the content and course uniqueness. • The provision of information and support to the non-military based trainers to deliver training in a military environment. • Update the course material to be contemporary and more visually appealing. • Consider the development of central coordination and communication including a networking facility between trainers. • Highlight a specific target population group for the promotion of MHFA, for example, in-service, ex-service, and the families of veterans.	
8. What were the positive and negative aspects of the programme process for trainers?	Positive aspects of the programme process included: • A good organisation, product, and process. • Valued course structure and delivery model. Negative aspects of the programme process included: • A lack of support for civilian trainers to link them into their local AF community, and a lack of information to assist with the understanding of the working dynamics/structure of the Armed Forces.	48-61

	• A need to improve central management and administration, and revise the current costing model.	
9. To what extent (if at all) did trainers feel supported by MHFA England during programme delivery?	Trainers commended MHFA England for their processes and for being a good organisation. However, they felt that they could play an increased role in terms of promotion and lobbying, and a coordination role in terms of developing a networking facility for MHFA AF trainers.	48-61
10. According to stakeholder perception, how effectively is the MHFA Armed Forces initiative being implemented?	Stakeholders reported the following with respect to implementation: • The MHFA programme had been accepted within the military environment which was commended. This was thought to be due to the professionalism of MHFA England, the quality product provided, and the persistence of partners to overcome initial scepticism. • The MHFA programme had helped to address scepticism, stigma, and misunderstanding of mental health issues within the military environment. • The experience of working together and learning between the different organisations on the steering group resulted in a collaborative relationship which was thought to be useful for future sustainability of the programme. • The experience of working together resulted in a desire to embed the core curriculum into the working practices of the organisations involved. • There was evidence of sustainability of the project through commissioning of programmes, and of the 'champions' now in the community, highlighting the mental health agenda in the military from various organisations and at different levels.	62-69
11. According to stakeholder perception, what is the future of the MHFA Armed Forces initiative?	Stakeholders reported the following with respect to the future of the MHFA Armed Forces programme: • Positivity that the programme had been accepted 'in the wire' and a feeling that this would support sustainability of the project within the military in the future.	62-69

	• A desire for the programme to become embedded into standard training for serving officers. • A desire for the continuation of the project but an awareness of the potential need to move from a funded model of delivery to a non-funded model, due to funding constraints. • Recognition of the importance of continuing to work together as a multiagency group to promote mental health literacy within the Armed Forces community, veterans, and their families.	

8. Conclusions

MHFA seeks to improve mental health literacy, improve identification, improve access to mental health support, and reduce stigma association with mental health issues (23). The current programme was designed to implement the MHFA initiative into the Armed Forces community.

The findings from this evaluation support previously published evidence that MHFA is an effective programme for increasing participants' knowledge regarding mental health, and enhancing confidence and aptitudes for identifying and supporting people with mental health problems (6, 7). As with previously published research, this evaluation has also concluded that MHFA programmes can help address stigma and improve attitudes surrounding mental health issues (7). The findings from Hadlaczky et al. (2014) are also echoed in this mixed methods evaluation with all three participant groups (i.e., trainees, trainers, and stakeholders) reporting that the programme positively influenced knowledge, attitudes, and confidence with respect to mental health at various levels in the Armed Forces community and in different aspects of that community.

With respect to the trainers' findings, conclusions support previous research regarding the importance of developing skills and confidence to deliver such programmes and of using reflection to enhance course delivery (24). This aspect was acknowledged by both trainees and trainers in this evaluation. In terms of the development of a network to support MHFA Armed Forces trainers, this was also highlighted in Terry's (2010) study of MHFA (standard course) trainers as a mechanism that trainers would find useful for ongoing support and advice.

This evaluation of the MHFA Armed Forces programme has investigated how MHFA impacts mental health literacy in the Armed Forces community. Findings support previous research which has investigated the impact of MHFA on specific communities, but this is the first evaluation to date, that has investigated MHFA in the UK Armed Forces community. These findings provide evidence that the MHFA Armed Forces programme has helped to improve mental health literacy in

the UK Armed Forces community and helped to reduce stigma /and misunderstandings surrounding mental health. Such an intervention could help in the longer term provide support for personnel, veterans, and their families' in identifying mental health problems and enabling access to support services for those people.

In turn, there is evidence to suggest that MHFA Armed Forces may be a useful mental health education programme within the Armed Forces community for all serving personnel, veterans, and their families to increase mental health literacy within the community. This evaluation report concludes therefore, that a targeted programme such as MHFA Armed Forces can positively influence mental health literacy among members of the Armed Forces community in the UK.

9. Recommendations

A number of recommendations are made based on the findings of the evaluation of the MHFA Armed Forces programme. These include those related to the course and trainers, and to process and sustainability:

Recommendations related to the course and trainers:
Recommendation 1: To modify and update the course materials to include relevant and contemporary media clips, and to include up-to-date statistics.

Recommendation 2: To consider MHFA England to have a clearly defined role in the coordination and networking of the MHFA Armed Forces trainers.

Recommendation 3: To develop a specific support and information system for the MHFA Armed Forces civilian trainers to enable them to network with and deliver to, a military environment.

Recommendation 4: To consider the development of a networking forum for MHFA Armed Forces trainers to communicate and to provide ongoing support, information and guidance.

Recommendations related to programme process and sustainability:

Recommendation 5: To seek further commissioning of MHFA Armed Forces training to enable the initiative to be made available to all service personnel, veterans, and their families, through the most appropriate channels.

Recommendation 6: To consider the development of a non-funded model of delivery by embedding the product into the working practices of all organisations (statutory and third sector) involved in the coordination and management of the programme.

Recommendation 7: Consider embedding MHFA into the Armed Forces formal training schedule (particularly for senior personnel).

Recommendation 8: To consider the future coordination of MHFA Armed Forces training to be undertaken by a multiagency group which includes representatives from all key statutory and third sector organisations which support service personnel, veterans, and their families.

Recommendation 9: To explore accreditation pathways for the MHFA Armed Forces course to enhance its profile amongst both trainers and trainees and within the Armed Forces community more generally.

Appendices

1. Survey

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MHFA Armed forces Course PARTICIPANT survey

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

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

SECTION 1

Overall, how satisfied are you with the MHFA training?	**Very Low**		**Neutral**		**Very High**
Overall, my satisfaction with the training is	1	2	3	4	5

How would you rate your knowledge of mental health issues?	**Very Poor**		**Average**		**Very Good**
My knowledge of mental health issues **before** MHFA Training was	1	2	3	4	5
My knowledge of mental health issues **after** MHFA Training is	1	2	3	4	5

How would you rate your attitudes toward mental health?	**Indifferent**		**Neutral**		**Sympathetic**
My attitudes toward mental health **before** MHFA Training was	1	2	3	4	5

My attitudes toward mental health **after** MHFA Training is	1	2	3	4	5

How would you rate your confidence to help, advise and recommending services to people who have mental health problems?	**Low**		**Average**		**Very High**
My confidence to help, advise and recommend support services to people who have mental health problems **before** MHFA Training was	1	2	3	4	5
My confidence to help, advise and recommend support services to people who have mental health problems **after** MHFA Training is	1	2	3	4	5

SECTION 2

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

Outline 3 things that you will take with you/have learnt during MHFA training.

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

Do you have any other comments about the MHFA training?

Survey End

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

Please feel free to contact the research officer for this project should you have any questions:

Dr Mustafa Sarkar

Research Fellow – University of Gloucestershire

Phone: 01242 715329

Email: msarkar@glos.ac.uk

2. Observation Template

MHFA Course Observation Template

Please use this template as a guide to structure your observation of the course that you are attending. It is meant as a guide with items to consider and not as a definitive list. Please add other observations and impressions that you consider important in addition to these items.
Name of observer: _____ Date: _____ Course venue: _____
No of trainers: _____ Number of participants: _____

Items	To include:	Observation comments; please state change over the two days in these areas as well as initial observations.
Physical environment	• The setting • Actual space • Arrangement of room (conducive) • Ambience and interactions	
Participants	• Number of people • Gender/age profile • Type of stakeholder • Compliance of • Any one of special interest over the two days • Motives for attendance	
Trainers	• Delivery/style • Ability to build rapport • Knowledge •	
Course content	• Relevance • Armed Forces specific • Up-to-date stats/refs • Pitched at right level (i.e., language used)	

Ambience and interactions	• Between trainers and participants • Between participants • Between trainers • Group culture •	
Change over the two days	• Atmosphere/ambience • Behaviour of participants • Attitude of participants • Trainers approach	
Unexpected issues	• Unexpected events • Reasons for • Reaction of participants • Reaction of trainers	
Strategies used to combat any issues / challenges	• By trainers • By participants	
General concluding observations (including perceived impact)		

3. Focus group interview schedule - Semi-Structured Telephone Interview Schedule (Participants)

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

Section One: Background

1.1 Can you tell me a bit about yourself and/or your organization?
1.2 Can you tell me a bit about your role in relation to the Armed Forces community?

Section Two: General Mental Health Knowledge and Awareness

2.1 Can you tell me a bit about your experiences of mental health prior to MHFA training?
2.2 Prior to the training, what were your perceptions about mental health issues?
2.3 Prior to the training, how did you feel about dealing with and responding to mental health issues?

Section Three: Mental Health First Aid (MHFA)

3.1 Can you describe the MHFA training to me?
3.2 What did you think about the presentation/slides, booklet and associated material (e.g., videos)?
3.3 What were your expectations of the training prior to you doing it?
3.4 In your view, did the training meet/not meet your expectations?
3.5 How would you describe the MHFA trainers?
3.6 What did you think at the end of the training?
3.7 What did you learn about dealing with and responding to mental health issues?
3.8 After the training, what were your attitudes/thoughts about mental health issues?
3.9 After the training, how did you feel about dealing with and responding to mental health issues?

Section Four: Evaluation of MHFA

4.1 Could you describe the positive aspects of the training process? What did you enjoy?
4.2 Could you describe the negative aspects of the training process? What did you least enjoy?

4.3 In your opinion, would you describe the MHFA training as useful? If so, why? If not, why not?
4.4 Have you used any of the knowledge and skills that you learnt on the course?
4.5 Can you give me an example of when you did this? Feel free not to mention names of anyone but just describe the situation and what you did.
4.6 In your opinion, do you think you would have acted in the same way if you hadn't done the training? If so, how and why do you think you did something differently?
4.7 We are interested in improving the programme. In your view, is there anything that you think might improve the training days generally, content, tasks, delivery etc…?
4.8 What advice would you give to MHFA trainers to help them improve the training?
4.9 What are your thoughts about the work that SSAFA and MHFA England do?
4.10 What suggestions would you give to SSAFA and MHFA England to help them improve mental health awareness in the Armed Forces community?
4.11 What recommendations would you give to SSAFA and MHFA England to help them aid the Armed Forces community in terms of dealing with and responding to mental health issues?
4.12 Is there anything else that you'd like to share about your experience of MHFA?

4. Semi-Structured Focus Group Schedule (Trainers)

Aim: To generate information about the experience of trainers involved in MHFA delivery, their assessment of programme process, and how the training might be improved.

Section One: Background

1.1 Can you tell me a bit about yourself and/or your organization?
1.2 Can you tell me a bit about your role in relation to the Armed Forces community?

Section Two: General Mental Health Knowledge and Awareness

2.1 Can you tell me a bit about your experiences of mental health prior to delivering MHFA?
2.2 Prior to delivering MHFA, what were your perceptions about mental health issues?
2.3 Prior to delivering MHFA, how did you feel about dealing with and responding to mental health issues?

Section Three: MHFA Instructor Training

3.1 Can you describe the MHFA instructor training to me?
3.2 What were your expectations of the instructor training prior to you doing it?
3.3 In your view, did the instructor training meet/not meet your expectations?
3.4 What did you think at the end of the instructor training?
3.5 What did you learn about educating people to deal with and respond to mental health issues?
3.6 How have you felt about educating people to deal with and respond to mental health issues?
3.7 How could the instructor training be improved to help trainers deliver MHFA more effectively?

Section Four: Evaluation of Programme Process

4.1 How would you describe the MHFA Armed Forces course?
4.2 How do you feel about the Powerpoint presentation and slides?
4.3 How do you feel about the resource booklet and the associated material (e.g., videos)?
4.4 Could you describe the positive aspects of the programme process? What has gone well?
4.5 Could you describe the negative aspects of the programme process? What hasn't gone so well?
4.6 How have you found recruitment for the courses?
4.7 Have you felt supported by MHFA England during programme delivery? If so, how? If not, why not?
4.8 We are interested in improving the programme. In your view, is there anything that you think might improve the training days generally, content, tasks, delivery etc…?
4.9 What advice would you give to MHFA England to help them improve the training?
4.10 What advice would you give to MHFA England to help them improve the programme process?
4.11 What are your thoughts about the work that SSAFA and MHFA England do?
4.12 What suggestions would you give to SSAFA and MHFA England to help them improve the outreach of the programme in the Armed Forces community?
4.13 What recommendations would you give to SSAFA and MHFA England to help them aid the Armed Forces community in terms of dealing with and responding to mental health issues?
4.14 Is there anything else that you'd like to share about your experience of MHFA?

5. Semi-Structured Focus Group Schedule (Steering Group)

Aim: To consult with relevant stakeholders to establish areas of strength and weakness in the MHFA initiative and generate ideas about the future of MHFA Armed Forces and ways forward.

Section One: Background

1.1 Can you tell me a bit about yourself and/or your organization?
1.2 Can you tell me a bit about your role in relation to the Armed Forces community?

Section Two: Mental Health in the Armed Forces

2.1 What are your perceptions about mental health issues?
2.2 How do you feel about how the Armed Forces community currently deals with and responds to mental health issues?

Section Three: Evaluation of MHFA

3.1 What are your thoughts about the MHFA course in its current form?
3.2 How would you describe the MHFA trainers and the instructors training process?
3.3 Could you describe the positive aspects of the MHFA initiative?
3.4 Could you describe the negative aspects of the MHFA initiative?
3.5 In your opinion, would you describe the MHFA training as useful? If so, why? If not, why not?
3.6 How could the MHFA training be improved (e.g., content, tasks, delivery etc…)?
3.7 What advice would you give to MHFA England to help them improve the initiative?

Section Four: The Future of MHFA Armed Forces

4.1 What are your thoughts about the future of MHFA Armed Forces?
4.2 What are your thoughts about how the MHFA Armed Forces initiative can be continued and supported?
4.3 In your opinion, how do you think the course can be sustained financially?
4.4 What are your thoughts about the work that SSAFA and MHFA England do?
4.5 What suggestions would you give to SSAFA and MHFA England to help them improve mental health awareness in the Armed Forces community?
4.6 What suggestions would you give to SSAFA and MHFA England to help them

improve the outreach of the programme in the Armed Forces community?
4.7 What recommendations would you give to SSAFA and MHFA England to help them aid the Armed Forces community in terms of dealing with and responding to mental health issues?
4.8 Is there anything else that you'd like to share about your experience of MHFA?

6. Summary of findings from the Course Observation

Theme	Summary of observation findings
Physical environment	• Overall, the facilities created a welcoming and ambient environment, with sufficient space for group work. Sessions were amiable and positive with lots of interaction.
Participants	• Mix of military and non-military personnel, but some courses had more military than civilian participants, generally more females than males. • Attendees appeared were mostly self-motivated with professional and personal interests in the topics. Most were motivated to attend although a limited number were attending under instruction and were less cognizant of why they were there. • Attendees seemed keen to develop knowledge of mental health issues and how to support people.
Trainers	• Trainers exhibited excellent background knowledge, good signposting, work well with group, engaging teaching style and providing plenty of opportunity for input by all. • Trainers had clearly established rules were evident allowing for discussion and confidentiality, and a purposeful mixing of the attendees to ensure discussion within the whole cohort. • The instructors worked together for support during interactive work to ensure consistency.

Course content	• Content tailored to participants, trainers able to draw on a lot of personal knowledge when required. Excellent activities and advice following sessions i.e. do something relaxing.
	• Attendees generally receptive to the material but course books not always used to record notes.
	• Use of video clips and discussion groups used to break up the sessions.
	• Areas for improvement/modification:
	  ○ Power Point relied on heavily Slides: includes some typographical errors, few images, and lots of bullet points.
	  ○ Some of the video clips were outdated.
	  ○ Some updating required such as statistics and signposting contact information for various organisations.

Ambience and interactions	• Good rapport between trainers and attendees, well received by the group. • The atmosphere was relaxed and open with good all round discussion between attendees, although a small number of participants sometimes dominating the sessions. However, instructors identified these individuals and integrated them well into the group.
Unexpected issues	• Some technical issues with audio visual equipment. • At times, there were differences of opinion between military and non-military personnel, although these were resolved amicably and openly.
General concluding observations	• Overall the programme was very well received and seemed to have a high degree of impact on attendees. • Many were convinced they would apply the principles.

7. Statistical findings for the repeated measures ANOVAs for knowledge, attitudes and confidence.

Knowledge: For knowledge, the repeated measure ANOVA yielded a significant Mauchly's test, indicating that the assumption of sphericity had been violated, $\chi^2(2) = .842$, $p = .00$. As such, the degrees of freedom were corrected using Greenhouse-Geisser estimates of sphericity ($\varepsilon = .86$). Results show that there was a significant main effect of the training on knowledge of mental health issues F (1.73, .51) = 247.17, $p = .00$. Bonferroni pairwise comparisons reveal that immediately following training, from pre- to post-intervention, participants showed a significant increase in their knowledge of mental health issues ($M^{\text{difference pre.post}}$ = 1.68, 95% CI = [1.48, 1.87]), which endured to follow-up ($M^{\text{difference pre.follow}}$ = 1.62, 95% CI = [1.37, 1.86]). A small but significant decrease in knowledge occurred from post training to follow-up ($M^{\text{difference post.follow}}$ = -.55, BCa 95% CI = [-.71, -.39]).

For attitudes, a similar pattern of findings emerged. Here, Mauchly's test was also violated ($\chi^2[2] = .685$, $p = .00$) and so the Greenhouse-Geisser correction (ε = .76) was applied to the degrees of freedom. Results show that there was a significant main effect of the training on attitudes toward mental health issues F (1.52, .66) = 60.93, $p = .00$. Bonferroni pairwise comparisons reveal that immediately following training, from pre- to post-intervention, participants showed a significant increase in their attitudes toward mental health issues ($M^{\text{difference pre.post}}$ = .98, 95% CI = [.75, 1.21]), which endured to follow-up ($M^{\text{difference pre.follow}}$ = .68, 95% CI = [.42, .95]). A small but significant decrease in attitudes toward mental health occurred from post training to follow-up ($M^{\text{difference post.follow}}$ = -.30, BCa 95% CI = [-.45, -.15]).

Finally, for confidence, Mauchly's test was also violated ($\chi^2[2] = .82$, $p = .00$) and so the Greenhouse-Geisser correction ($\varepsilon = .85$) was applied to the degrees of freedom. Results show that there was a significant main effect of the training on confidence in supporting those displaying mental health issues F (1.69, .59) = 159.38, $p = .00$. Bonferroni pairwise comparisons reveal that immediately following training, from pre- to post-intervention, participants showed a significant increase in their confidence in supporting those displaying mental health issues ($M^{\text{difference pre.post}}$ = 1.52, 95% CI = [1.29, 1.75]), which endured to follow-up ($M^{\text{difference pre.follow}}$ = 1.26, 95% CI = [1.00, 1.51]). A small but significant decrease in confidence occurred from post training to follow-up ($M^{\text{difference post.follow}}$ = -.26, BCa 95% CI = [-.43, -.09]). These findings are reported in Table 1 and Figure 2.

Table 1. Results of the repeated measures ANOVA

	Pre		Post		Follow-up	
	M	SE	M	SE	M	SE
Knowledge	2.87[b,c]	.08	4.54[a,c]	.05	3.99[a,b]	.06
Attitudes	3.80[b,c]	.10	4.78[a,c]	.04	4.48[a,b]	.06
Confidence	2.96[b,c]	.10	4.48[a,c]	.05	4.22[a,b]	.06

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

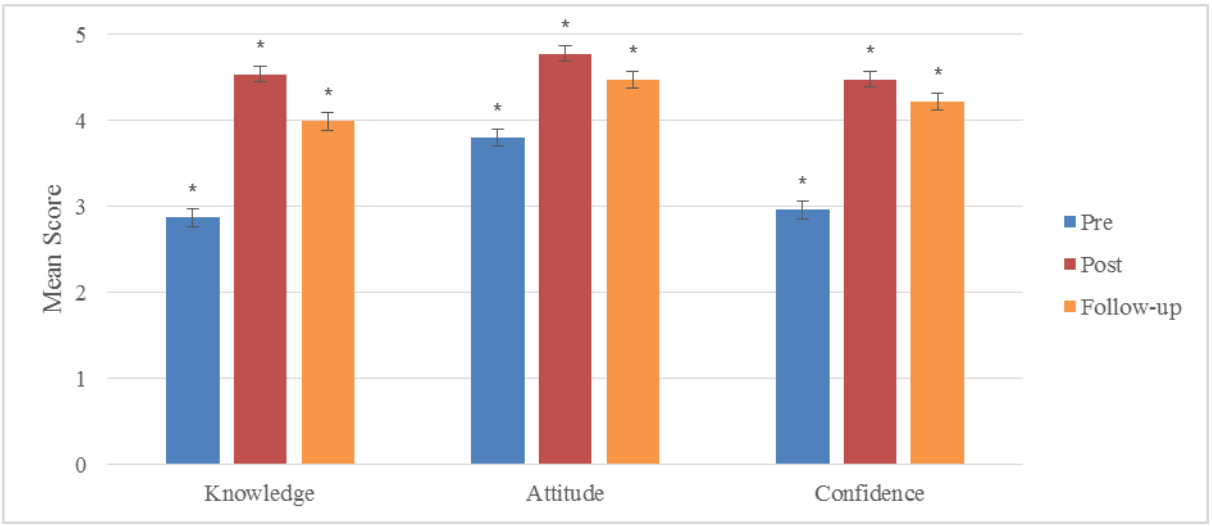


Figure 4. *Mean differences in knowledge, attitudes and confidence*

8. British Psychological Society 4th Military Psychology Conference presentation, November 2015

EVALUATION OF MENTAL HEALTH FIRST AID (MHFA) FOR THE ARMED FORCES

MILITARY PSYCHOLOGY CONFERENCE
NOVEMBER 3, 2015

TEAM: PROFESSOR D. CRONE, DR M. SARKAR, DR T. CURRAN, DR T. DICKSON, DR E. LOUGHREN, DR D. M. HILL, DR C. BAKER & PROFESSOR A. PARKER

UNIVERSITY OF GLOUCESTERSHIRE
NOTTINGHAM TRENT UNIVERSITY
UNIVERSITY OF BATH

AIM OF THE PROJECT

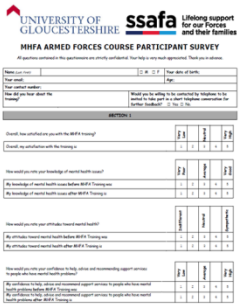
- To provide systematic evidence for the impact of a bespoke MH training programme (i.e., Mental Health First Aid; MHFA) that aims to enhance MH literacy in the Armed Forces community.

SPECIFIC AIMS OF THE PROJECT

- The specific aims of the project were to explore the extent to which MHFA training:
  - Improved knowledge of MH problems and services available to members of the Armed Forces community;
  - Improved attitudes towards, and the stigma of, MH issues;
  - Changed behaviour toward MH issues and access in receiving help for beneficiaries;
  - Improved long-term, sustainable, changes in MH literacy.

METHOD

- The development of a pre- and post-training survey that assessed shifts in trainee knowledge, attitudes, behaviour, & well-being.
- Completion of the participant survey following a two day MHFA Armed Forces training session based throughout the UK.
- Statistical analysis was completed with descriptive and matched t-tests ($p < .05$).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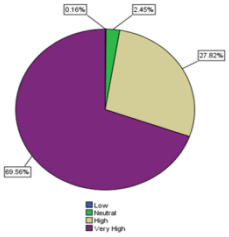
MHFA ARMED FORCES COURSE PARTICIPANT SURVEY

INITIAL RESULTS

- Surveys were collected from 13 onsite course observations (n = 145) and from courses where trainers handed out surveys on our behalf (n = 469).
- Of the total n = 614 surveys, n = 602 surveys were usable.
- Trainees mean age was 40.81 years (SD = 11.10) and 45.50% were female.

Q1: Participants were asked 'How satisfied were you with the training?'

- 69.56% indicated their satisfaction with the MHFA course was 'very high'
- 27.82% reported 'high' satisfaction
- 2.45% of responses were neutral
- 0.16% suggested their satisfaction was 'low'.



INITIAL RESULTS

Q2: How would you rate your knowledge of MH issues (pre/post)?

- Trainees showed a significant increase in their knowledge of MH issues
  - M pre = 2.80 (SD = 1.04); M post = 4.49 (SD = .53)
  - ($M^{difference}$ = −1.69, BCa 95% CI = [−1.77, −1.61], t = −43.37, p < .001).

INITIAL RESULTS

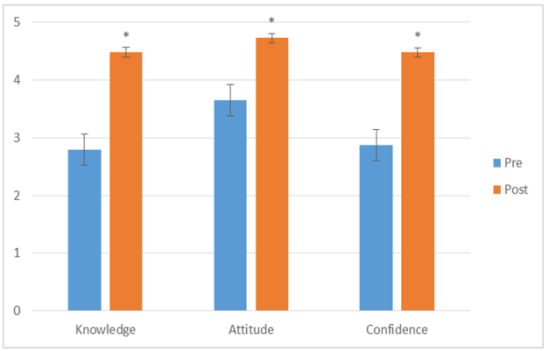
Q3: How would you rate your attitudes toward MH (pre/post)?

- Trainees attitudes toward MH issues showed a significant increase from pre-training to post-training
  - M pre = 3.64 (SD = 1.16); M post = 4.73 (SD = .50)
  - ($M^{difference}$ = −1.08, BCa 95% CI = [−1.17, −1.00], t = −23.95, p < .001).

INITIAL RESULTS

Q4: How would you rate your confidence to help, advise, and recommending support services to people who have MH problems (pre/post)?

- Trainees reported a significant increase in their confidence in supporting those displaying mental health issues from pre-training to post-training.
  - M pre = 2.87 (SD = 1.15); M post = 4.48 (SD = .59)
  - ($M^{difference}$ = −1.61, BCa 95% CI = [−1.69, −1.23], t = −37.49, p < .001).



CONCLUSIONS TO DATE

Whilst the 2nd stage of the project will explore in more detail: the experiences of trainees on the MHFA course, the strengths/limitations of the course, and identify its sustainable impact on the MH literacy of the Armed Forces community, it would appear that the MHFA programme:

- improves trainees' knowledge of MH,
- enhances their attitude towards MH issues
- Increases their confidence in supporting those with MH issues.

ACKNOWLEDGEMENTS

We would like to thank:

- SSAFA who fund the project
- MHFA England who allowed us to attend training sessions and helped to collect survey responses
- The trainers who led the courses
- The attendees who completed the surveys

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mhfa mental health first aid england

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Thanks for you time!

Any questions?

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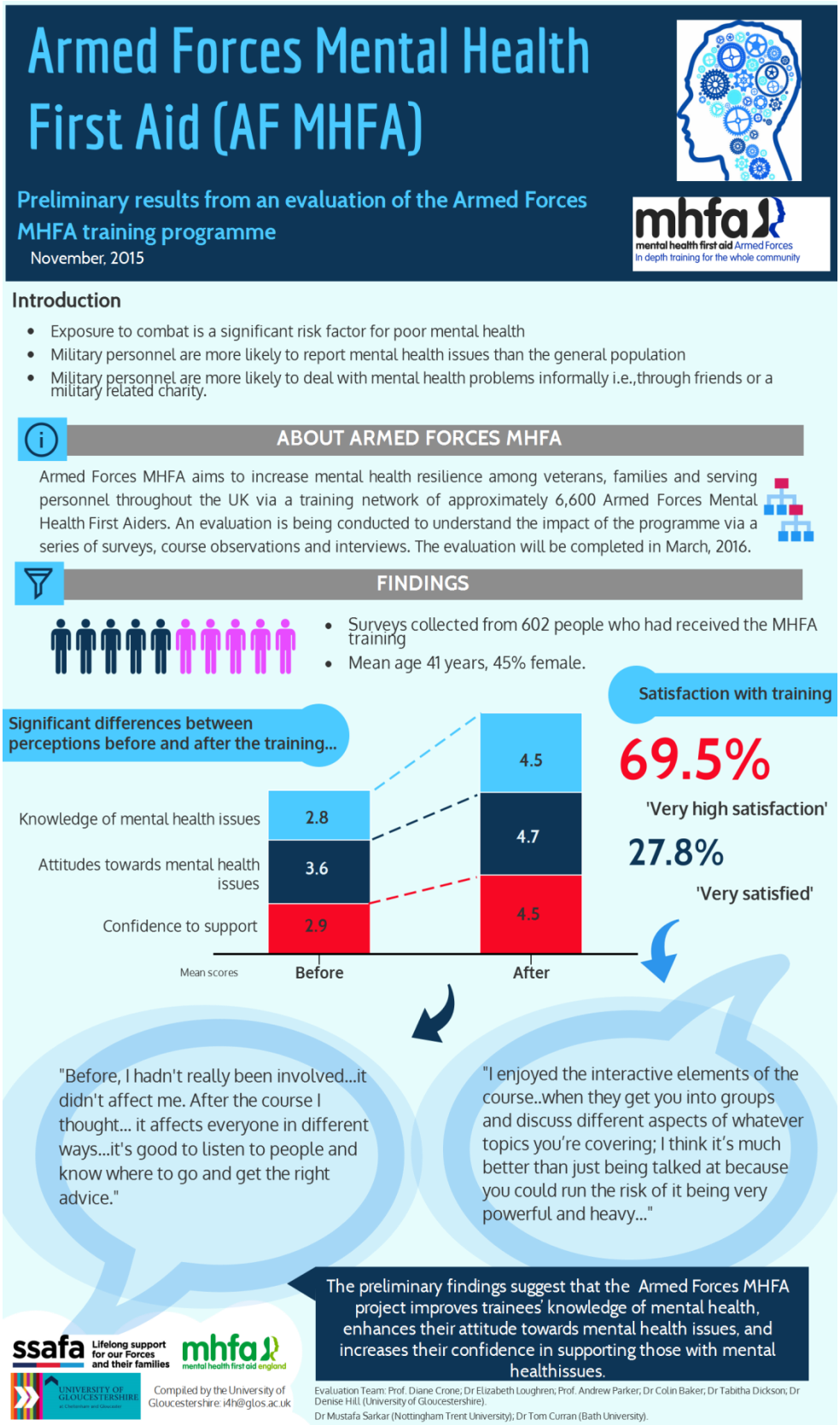
9. House of Lords poster presentation, November 2015



10.Lay Person's summary

What is the background to the project?

In the UK, members of the Armed Forces are less likely to ask for help with mental health problems than are the general population. Some researchers think that this is due to stigma and misunderstandings about mental health. Additionally there is a lack of trust in health providers.

The Ministry of Defence has committed to improving mental health care services for military personnel, by providing education and fostering helpful attitudes. Mental Health First Aid (MHFA) is a programme that promotes this type of mental health literacy.

A Mental Health First Aid programme has been developed specifically for the Armed Forces. 180 people were trained to deliver the programme. Those trainers ran courses for over 6000 members of the Armed Forces community.
This evaluation investigated the Mental Health First Aid Armed Forces programme.

What did the evaluation try to find out?

The evaluation used surveys (quantitative methods) and observation and interviews (qualitative methods) to find out the following:

- to understand whether MHFA training:
- improved knowledge and attitudes toward mental health;
- improved confidence to help, advise and recommend seeking help from support services to those with mental health problems;
- achieved long-term changes in knowledge, attitudes, and confidence.
- to evaluate the overall programme, specifically:

- to understand the experience of trainers and trainees taking part in MHFA training;
- to identify how MHFA training affects mental health literacy in the Armed Forces;
- to understand areas of strength and weakness in the MHFA initiative and how training might be improved; to assess overall delivery, programme process, and to make recommendations for the future of MHFA training in the Armed Forces community.

What happened?

Three groups of people were involved as participants in the evaluation: the trainers who delivered the Mental Health First Aid courses, the trainees who attended the courses and the Steering Group which oversaw the whole programme.

602 trainees completed a survey assessing knowledge, attitudes and confidence around mental health at the start and at the end of the course. Of these 602 trainees, 120 also completed a follow-up survey ten months after they had completed the initial course. Thirteen of these trainees also took part in a telephone interview.

The fourteen trainers and the four Steering Group members took part in focus group interviews. There were three focus groups, two with trainers and one with the Steering Group members.

What did the evaluation find?

From the surveys, we found that, immediately following taking part in the course, trainees showed a significant increase in knowledge, attitudes and confidence. With the follow-up survey (ten months after the course), although there was a slight decrease, overall knowledge, attitudes and confidence were still

significantly higher than before the course had been started**.** This suggests that the training had a lasting impact.

In the interviews, the trainees reported an increased knowledge and understanding of mental health problems. They also said their confidence in talking about them had improved, as had their ability to listen and give advice to difficult questions.

The people in the focus groups with the trainers found that, as a result of the training programme, they had increased their knowledge of mental health and their confidence in talking about it. They felt they had a shared commitment with trainees to help the promotion of mental health and its awareness in the Armed Forces community.

The focus group with the Steering Group members concluded that the programme had been accepted within the Armed Forces environment. They suggested that the professionalism of Mental Health First Aid England (who developed the course), the quality of the course itself and the persistence of the partner organisations were instrumental in this acceptance and the success of the project overall. They reported that the programme had helped to address stigma about**,** and misunderstandings of, mental health within the Armed Forces.

Finally they suggested that the experience of working and learning between the different organisations had produced an enjoyable, collaborative relationship. It was thought that this would prove beneficial for collaboration in the future.

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