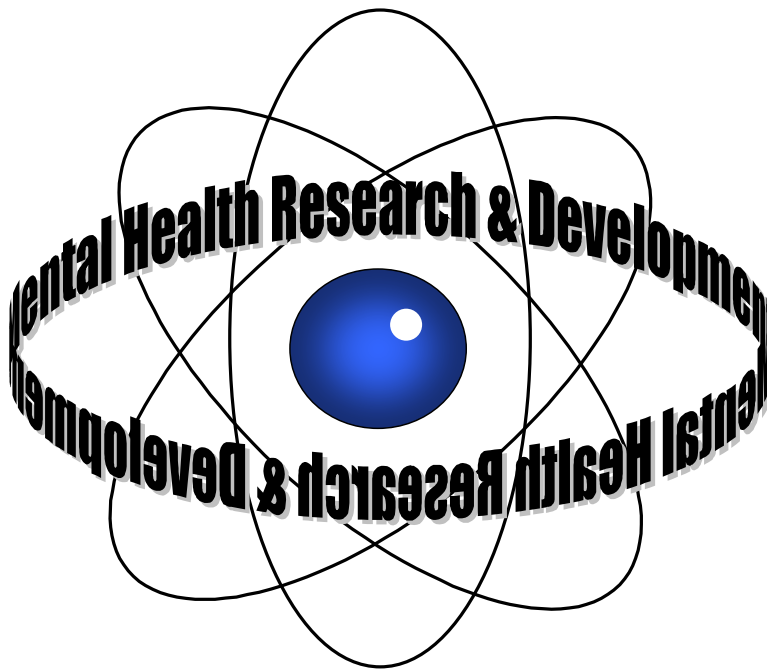


Evaluating Mental Health First Aid Training for Line Managers working in the public sector



Authors:	Janet Brandling, Researcher	Shona McKenna, Student researcher
	Mental Health Research & Development Unit	Psychology Department
	School for Health	University of Bath
	University of Bath	
	Claverton Down	
	Bath	
	BA2 7AY	
Email:	J.Brandling@bath.ac.uk	smm28@bath.ac.uk
Tel:	01225 383654	
Fax:	01225 383622	

Executive summary	4
Introduction	6
Mental health and employment	6
Mental Health First Aid (MHFA)	7
<i>Background</i>	7
<i>Course content</i>	8
<i>Previous Evaluation</i>	8
Research questions	10
Aims and objectives	10
Method	11
Population and sample.....	11
Data collection methods	11
<i>Evaluation</i>	11
<i>MHPPQ</i>	12
<i>Quiz</i>	12
<i>Interviews</i>	13
Commissioning and ethical permission.....	14
Results	15
Quantitative analysis	15
<i>MHPPQ</i>	15
<i>Evaluation</i>	15
<i>Quiz</i>	20
Qualitative Analysis	21
<i>Supporting one another</i>	21
<i>Stigma and attitude change</i>	23
<i>Increased Knowledge</i>	24
<i>Facilitation</i>	25
<i>Course applicability</i>	26
<i>Research participation</i>	27
Discussion	29
<i>Evaluation</i>	29
<i>Quiz</i>	29
<i>MHPPQ</i>	30
<i>Interviews</i>	30
Conclusion and recommendations	32
Appendix a	33
Table illustrating evaluation rating percentages for each aspect of training.....	33
Appendix bi	34
MHPPQ	34
Appendix bii	36
MHPPQ questionnaire- background and concepts.....	36
Appendix biii	38
MHPPQ raw data	38
Appendix ci	40

MHFA Quiz.....	40
Appendix cii.....	42
Quiz- perfect answers.....	42
Appendix d.	45
Interview schedule	45
Appendix e	46
Evaluation document	46
References.....	49

Executive summary

Mental health and mental ill health are prominent issues in society today; which is not surprising given that 1 in 4 people will experience some form of mental ill health (www.mentalhealth.org.uk). Specifically mental ill health can be a barrier in terms of employment; surveys have shown that less than 40% of employers would be willing to consider employing an individual that disclosed a mental health issue (www.rethink.org.uk). Working to increase mental health literacy in the workforce has been cited as a way to increase understanding of mental ill health to build a more supportive working atmosphere (Kitchener & Jorm, 2002).

Mental Health First Aid (MHFA) is a concept that was pioneered by Betty Kitchener and Anthony Jorm in 2000 with the aim of increasing mental health literacy among the Australian community. The concept of MHFA is that people should be taught how to perform basic 'first aid' for those exhibiting signs of mental health distress, just as they are commonly taught first aid for physical afflictions. Kitchener and Jorm claim that MHFA is able to increase knowledge, reduce stigma and increase supportive reactions in terms of mental health (Kitchener & Jorm, 2004). MHFA was first adapted for the UK in 2006 and the first sessions began in England in 2007, funded by the National Institute for Mental Health in England (NIMHE) as part of a national initiative to improve mental health awareness in England. The course lasts for a total of 12 hours split over two days and is led by 1 or 2 instructors. The content of the course covers a variety of mental health issues with information regarding the symptoms, treatment and ways in which first aid should be approached. The mental health issues covered include: Depression, anxiety, psychosis, self harm and suicide. The first aid principles of MHFA are based on a mnemonic, ALGEE:

- A- Assess the risk of suicide or self harm
- L- Listen non judgementally
- G- Give reassurance and information
- E- Encourage the person to seek appropriate professional help
- E- Encourage self help strategies

Through investigation of the previous evaluations of MHFA, it is clear that an independent evaluation was necessary to gain greater understanding of its value. Also, an evaluation of the course as adapted for England had not yet been completed.

The research questions related to whether training line managers in MHFA: Increased mental health literacy, improved confidence in offering MHFA and positively changed attitudes towards workers/the public with mental health issues.

The sample consisted of line managers and front line staff working for the public sector in roles where they might encounter issues relating to mental health, without this being a core part of their role. Overall the sample consisted of 55 individuals that were a combination from the three organisations: Selwood Housing, Wiltshire Council and NHS Wiltshire (See Table 1 for full breakdown of the sample).

A variety of different data collection methods, both qualitative and quantitative, were used: Course evaluation, Mental Health Problems Perceptions Questionnaire (MHPPQ), Quiz and semi structured interviews. These measures were used with the intention of evaluating whether there was a significant change in knowledge, confidence and stigma in relation to mental health between time 1 (pre-training) and time 2 (post-training).

The results were extremely positive. Significant results ($p < 0.01$) were found for all quantitative measures, showing an increase in knowledge and confidence and an improvement in the perception of mental health issues between time 1 and time 2. The semi structured interviews revealed positive reactions to and enthusiasm for the training. In particular this related to the facilitation and the course materials provided. The thematic analysis of the interviews was broken down into six themes: Supporting one another, stigma and attitude change, increased knowledge, facilitation, course applicability and research participation. The only negative views to come across in the interviews related to the venues, particularly Devizes and Chippenham. Also, one participant expressed distress at the intensity of the content and felt that more support was needed for individuals that may be affected.

The results have demonstrated answers to the research questions. Both the quantitative measures have shown that MHFA was able to increase knowledge and confidence of the participants in relation to mental health. The interviews and the MHPPQ have shown a positive change in attitude and understanding of mental health.

In light of the results the following recommendations have been made:

- Continuation and expansion of MHFA training for public sector organisations and beyond
- Long term follow up
- Integration of a quiz into requirements for certification
- Add a 'debrief' into the timetable of the training so that participants have more time to discuss the personal implications of the training

The five cohorts of MHFA training evaluated in this research project were facilitated by Bernie Graham, Director, Mental Health Support Training and Consultancy Ltd.

Email: Bernie@mhs-training.co.uk Tel: 07711 079269 / 01727 765228

Address: 16 Ramsey Lodge Court, Hillside Road, St Albans, Herts, AL1 3QY

Introduction

Mental health and employment

Mental health and ill health are important issues in society today, with statistics revealing that 1 in 4 people will experience some form of mental illness and even more will be affected by mental ill health in terms of a colleague or someone in their personal life (www.mentalhealth.org.uk).

More specifically, mental ill health can be a major barrier in terms of employment. People with mental health issues struggle as much as those with serious physical disability to gain and retain employment (Irvine, 2008). In fact statistics have shown that less than 40% of employers would be willing to consider employing someone that disclosed a mental health problem (www.rethink.org.uk). Due to the scale of this problem, it is becoming more of a focus for government policies. The 'Realising Ambitions' review (Perkins, 2009) was completed for the Department of Work and Pensions and related to achieving better employment support for those with a mental health condition. The review made three main recommendations which can be summarised as: increasing mental health service capacity and dispelling myths, more support in the workplace and effective monitoring and drivers for change. The review stressed the importance of the workplace becoming a supportive atmosphere for those suffering from a mental health condition as remaining in employment whilst struggling with a mental health condition can be an important part of rehabilitation. It has been determined through research that being in work can have a beneficial effect on mental health (Jahoda et al. 1993) and a particular survey revealed that gaining access to paid employment is a priority for mental health survey users (Secker, Grave & Seebohm, 2001).

Mental health problems can have significant costs for employers. In a report published by the Sainsbury Centre for Mental Health (2007) the annual cost of mental ill health to UK employers was cited at around £25 billion. This can be broken down to around £1000 per employee in the workforce and it is thought that mental ill health can in some way relate to 40% of all sickness absence. Obviously this cost firstly relates to the time lost at work from absenteeism; the number of days that employees take due to mental health problems they are experiencing. However, the issue is more complex and the costs may also relate to presenteeism. Presenteeism is the loss of productivity that is the result of employees coming to work when they are too ill to function at full capacity; an aspect that is not yet as widely researched as absenteeism but is becoming more of a focus (Levin-Epstein, 2005). It has been suggested (SCMH, 2007) that presenteeism is actually the larger issue and accounts for 1.5 times as much working time lost as absenteeism. In terms of monetary loss, it is estimated that the annual cost of presenteeism relating to mental ill health amounts to £605 annually per employee in the UK.

Taking the financial information discussed above into account, addressing the problems of mental ill health in the workplace has significant potential benefits not only for the individual but for the employing organisation and as a result the economy. Of course the

benefits of any action taken by employers must be weighed against the costs of such actions and there is evidence to show that programmes to address issues relating to mental ill health in the workplace have had financial benefits that outweigh the costs. An Australian programme designed to encourage early diagnosis and intervention into mental health problems in the workplace resulted in initial benefits totalling nearly five times the cost of the programme (Hilton, 2005). Similarly to MHFA this programme educated employees about mental health and how to approach intervention in others that are exhibiting signs of mental ill health. There is also the hope that with early intervention that many of the adverse effects of mental ill health in the workplace can be avoided or at least minimised.

It has been suggested that presenteeism could be the result of individuals experiencing mental distress attempting to avoid labelling and discrimination by being at work when they are not able to work at full capacity (SCMH, 2007). Research has described the effect of stigma and discrimination on an individual with mental health issues that result in damage to self esteem and social exclusion (Karidi et al. 2010). These feelings can understandably result in absenteeism, where the individual cannot face their colleagues; presenteeism where the individual feels they cannot take the time out they need without reinforcing the negative stereotypes. It has been suggested that a way of reducing these stigmatizing attitudes is to increase the mental health literacy of those in the workforce with the hope that an increase in knowledge will also lead to an increase in understanding to build a more supportive working atmosphere (Kitchener & Jorm, 2002). With an increase in mental health literacy, particularly in line managers, there is a hope that the signs of mental distress can be identified early and can be dealt with sensitively as well as effectively. Preventing costly issues such as presenteeism, absenteeism and discrimination can have benefits for individuals and employers.

Mental Health First Aid (MHFA)

Background

The Mental Health First Aid (MHFA) concept was founded by Betty Kitchener and Anthony Jorm in 2000 with the aim of increasing the mental health literacy of the Australian community (Kitchener & Jorm, 2004). The original idea behind MHFA was that if people were commonly taught first aid for physical problems then the same information should be available for mental health problems. The founders of the course claim that MHFA is able to increase knowledge, reduce stigma and increase supportive actions. However they stress that it is not teaching people how to become therapists, but providing skills to give the initial help before the individual can be directed to professional help.

MHFA was adapted for England in 2006, with the first courses being given in England in 2007. English MHFA was initially funded by the National Institute for Mental Health in England (NIMHE) as part of a national initiative to improve the awareness of mental health conditions in England (www.mhfa.org.uk) and became a Community Interest Company in 2009.

Course content

The course lasts for twelve hours and is typically taught over two days by 1 or 2 instructors. The instructors use a variety of methods including: PowerPoint presentations, case studies, video clips and role playing with the aim of encouraging learning through active participation. The course content covers issues such as depression, anxiety disorders, psychosis, self harm and suicide as well as treatment options. For each of these mental health issues the risk factors, treatments and ways in which first aid should be approached is discussed (MHFA manual). The content of the course does have minimal flexibility at the discretion of the trainer; however each course completed has standards that must be met to keep the trainer accredited on a national level. The initial first aid steps are presented using the mnemonic ALGEE:

- A- Assess the risk of suicide or self harm
- L- Listen non-judgementally
- G- Give reassurance and information
- E- Encourage the person to seek appropriate professional help
- E- Encourage self-help strategies

This mnemonic is constantly revisited during the course to give those taking the course a strong foundation for turning to these tools if they later come into contact with an individual exhibiting signs of mental health distress.

Previous Evaluation

Several evaluations of the Australian MHFA course have been conducted since it was established. The first of these by Kitchener and Jorm (2002) used questionnaires administered immediately before training commenced, immediately after it finished and a six month follow up. The questionnaires used vignettes of individuals exhibiting signs of either depression or schizophrenia and these were randomly assigned to each participant with a list of related questions. The participants were asked questions relating to what could be the problem with the individual, whether they may need help and the type of help that would be appropriate. This measure was scored using scales that rated to what extent the participants answers agreed with those of health professionals. The participants were also evaluated on a 'social distance scale' which asked questions relating to how likely they would be friends with, live with or work with the individuals described in the vignettes. This evaluation found that the course: improved the ability to recognise mental health problems, decreased social distance (stigma) and increased confidence in providing help for individuals with mental health problems. However, one problem with this evaluation was that there was no control group in order to compare the effect that was found as the researchers suggested that repeated testing alone could have an effect on attitudes.

Taking into consideration these limitations the next step of evaluation was to complete a trial involving a control group. The first randomised controlled trial completed by Kitchener and Jorm (2004) found a number of benefits of the training. This trial sample consisted of employees from Australian government departments, half assigned to receive the training in month 1 and half to receive the training in month 6; the second group being the control group. The same questionnaires used for the first evaluation were used for this trial; the only differences being the inclusion of measures relating to the participants own mental health and that half of the participants being tested had not yet received their training. This allowed for any difference found in knowledge and social reactions to be attributed to the effect of the training content. Results indicated that the training had benefits for trained participants in relation to the control group. For example: A greater confidence in helping others, increased likelihood in signposting individuals to get professional help and a decrease in negative attitudes towards mental ill health. Kitchener and Jorm concluded that MHFA was not only useful in increasing mental health literacy in the community but also in improving the participants' awareness of their own mental health.

With increased certainty of the value of the training having been established by the randomised controlled trial, research then moved on to see if individuals were able to practically apply the skills learned. Therefore another study in Australia investigated whether individuals had utilised the skills they had acquired on the course (Jorm, Kitchener & Mugford, 2005). Participants were contacted 19-21 months after the training and asked whether they had experienced a situation where they had come across an individual with a mental health problem. If this was the case they were asked to discuss their experiences of this. The questions that were asked allowed the participants to describe in detail the experiences they may have had with helping an individual in mental distress. The questions also investigated any instances where an individual felt unable to help and the reasons behind this. The analysis of the data found involved a quantitative analysis of the frequencies of particular response characteristics and a qualitative analysis identifying themes that emerged in the responses. It was found that 78% of respondents experienced a situation after the training with many positive effects. Participants reported an increased empathy and confidence, positive benefits that were experienced by a wide range of people in different situations relating to the workplace as well as problems that arose in personal situations.

Of course it must be noted that these evaluations of MHFA have been carried out at least in part by the founders of this concept. Therefore it is important for an independent evaluation of the training to be carried in order to further understand the true benefits of MHFA for how mental ill health is dealt with generally and specifically in employment. It also must be recognised that all of the previous evaluations have been carried out in relation to the original MHFA course in Australia. As previously discussed the version adapted for England does not vary greatly and so much can be learnt from the Australian evaluations. However, it is important to be aware that an evaluation specific to the course in England is necessary due to the different societal and health structures in the two countries that provide different contexts and impact on the way in which mental ill health is viewed. With this in mind the current research questions were as follows:

Research questions

Does training line managers in mental health first aid:

- Increase mental health literacy?
- Improve confidence in offering 'mental health first aid' or help to individuals they perceive to have a mental health issue?
- Positively change attitudes towards workers/the public with mental health issues?

Aims and objectives

- To measure knowledge of mental ill health before and after training.
- To measure manager perceived confidence in their ability to help and support employees/clients with mental health issues before and after training.
- To understand managers attitudes or views relating to mental ill health of employees/clients before and after training
- To assess participant satisfaction with Mental Health First Aid training

Method

Population and sample

Sixty places on the MHFA training were offered overall. This was divided into twenty places each for Wiltshire Council, NHS Wiltshire and Selwood Housing; however another place was allocated to Selwood housing due to high demand and availability (see Table 1). The individuals on the course were a mix of line managers and front line staff dealing with the public, but not necessarily in a role confronted with clients displaying mental health issues.

	Course Total	Quiz	Evaluation forms	MHPPQ	Interviews
Wiltshire council	17	8	17	8	3
NHS Wiltshire	17	9	14	5	2
Selwood Housing	21	18	21	6	5
Total	55	35	52	19	10

Table 1. Research participants

As expected, not all of the participants that took the course were willing or able to be involved in the research process. There were a few instances of participants not being able to do all or part of the course due to illness and therefore having to be excluded from the research (4). Therefore the participants were recruited using a convenience sample.

Data collection methods

There were four sources of data using a combination of quantitative and qualitative methods.

Evaluation

As a routine part of the MHFA course the trainers require an evaluation form, constructed by members of the English MHFA training team, to be completed at the end of the last session. A modified version of this was used for the purposes of the research, asking questions relating to the course to be answered using likert scales and short qualitative free text. The questions relate to:

- Personal confidence in dealing in supporting others with a mental health problem before and after training
- Level of knowledge in how to support others with a mental health problem before and after training

- Satisfaction levels with aspects of the training such as: instructor, content and environment etc.
- Open questions relating to how the knowledge gained will be used and enquiring into any change in attitudes

This evaluation was distributed by the trainer at the beginning of the first day. Attendees were asked to give a score on their personal confidence and level of knowledge before training started. At the end of the second day, attendees completed this again, reflecting upon any change. They also completed satisfaction rating for the course structure, content, facilitation, supplementary resources such as the video, slides and manual and the venue.

MHPPQ

The Mental Health Problems Perception Questionnaire (MHPPQ) used was adapted from the version by Lauder, Reynolds, Reilly & Angus (2000, 2001). Originally this questionnaire was designed to be administered to health staff (not mental health) working in the community. Language such as patient was rephrased to say 'people' instead. This was qualified by saying staff or client. Otherwise the questionnaire was unchanged. The MHPPQ questionnaire consists of 27 questions relating to the perceptions of mental ill health and the workplace to be answered on a five point Likert scale ranging from 'strongly agree' to 'strongly disagree'. These questions are broken into three concepts: Therapeutic commitment, Role Support and Role Competency. The questionnaire was administered twice:

- Time 1- The questionnaires were sent in the post along with the course information and the invitation to take part in the research. Replies were sent to the research team in freepost envelopes.
- Time 2- The questionnaires were sent again 3 weeks after completion of the training. Freepost envelopes were included for return. This interval was left so that attendees could consider the impact of the training after returning to work and the challenges this might bring.

Quiz

For the purposes of the research, a quiz was developed, with the aim of testing the ability of participants to recognise symptoms of mental health distress and to provide appropriate support. The quiz contained three vignettes of a colleague or a client exhibiting signs of mental health distress and the participant was asked to provide three steps that they would take to support the individual. The quiz was presented twice:

- Time 1- On the first day immediately before commencement of the training
- Time 2- On the last day immediately after the training has been completed

The quiz was administered at these times to gauge whether any change in knowledge between time 1 and time 2 was most likely due to the information and skills that were

provided by the training. Recommended answers were constructed by the national MHFA training committee. However, this proved difficult to use as a rating tool. Instead answers were compared to the ALGEE mnemonic, employed as a teaching tool in the training. The answers were compared to ALGEE, so gauge whether course participants could use ALGEE to respond to hypothetical scenarios. Four separate researchers rated the answers.

Interviews

Course participants were invited to take part in interviews after they had completed the training. Invitations were sent with the initial course information posted to participants before training. Responses using a tear off slip were returned in a freepost envelope along with MHPPQ returns. 10 interviews were conducted, the sample being a combination of individuals from the three different organisations. It had been intended that 15 interviews would be conducted. However, fewer participants responded but also it became clear that interview content was similar and was not providing new themes. Therefore it was considered to have reached saturation.

The interviews were conducted in a semi structured format using the aid of an interview schedule to ensure that all important information was covered. The interview questions generally covered topics such as:

- Satisfaction levels with different aspects of the training, such as the instructor, content, course materials and environment
- What each individual felt they gained from the training
- Any changes they felt attitude towards mental ill health, as well as their opinion on the stigma of mental ill health
- Any changes the training could have for interactions in the workplace

The interview schedule can be seen in appendix d. The interviews were conducted either in person or over the phone with 1 researcher and a student present; the interviews were recorded for transcription purposes. The interviews ranged from twenty to forty five minutes duration depending on how much information the participant had to share regarding the training.

The interview data was analysed using a thematic analysis. Thematic analysis is a method for identifying, analysing and reporting patterns within data (Braun & Clarke, 2006). The approach is inductive, in that themes emerge from the reports of the participants, as opposed to a pre-existing theoretical perspective. Analysis follows a step by step approach, as follows:

1. Immersion in, and familiarisation with, the breadth and depth of the data.
2. Generation of initial features or codes of potential themes.
3. Analysis of codes and consideration of how they might combine into themes.
4. Review of themes for coherence and their representation of the data set
5. Definition and refinement of themes

Commissioning and ethical permission

This research project was commissioned by Wiltshire Council and was funded by Wiltshire Council, NHS Wiltshire and Selwood Housing. The Mental Health Research and Development Unit (MHRDU) carried out this research. The MHRDU is a joint unit formed by the University of Bath and Avon and Wiltshire Mental Health Partnership NHS Trust. It is based on the University of Bath campus.

Ethical approval was sought from the NHS Wiltshire ethics committee, since some participants were NHS staff and the research lead is employed by Avon and Wiltshire Mental Health Partnership Trust. This was granted on the 9th September 2009. In addition research governance approval was sought from Avon and Wiltshire Mental Health Partnership NHS Trust and was granted on the 2nd October 2009.

Results

Quantitative analysis

MHPPQ

Nineteen respondents completed the MHPPQ at time one and time two. This sample may have been reduced from the total number of participants since it was a postal questionnaire. This is despite the inclusion of a freepost envelope. The MHPPQ produced non-parametric data. Data from time one and time two were entered into an SPSS database. Analysis was conducted using the Wilcoxon Signed Rank test for each question. These raw data can be viewed in appendix c.

The questions were also grouped into those relating to 'Therapeutic Commitment', 'Role Competency' or 'Role Support' (Lauder et al. 2000) and the difference in results according to these categories was tested.

<i>MHPPQ concept</i>	<i>Therapeutic commitment</i>	<i>Role Support</i>	<i>Role Competency</i>
<i>Score</i>	$z = -3.724$	$z = -3.493$	$z = -3.825$
<i>Significance</i>	$p < 0.01$ two tailed	$p < 0.01$ two tailed	$p < 0.01$ two tailed

Table 2 MHPPQ data analysis results

Table 2 illustrates the results of the MHPPQ, indicating significant change between scores at time one and time 2. This is positive change, as scores became smaller as they improved.

Analysis was also conducted on individual questions in the MHPPQ. The raw data can be viewed in appendix c. It is clear that in some questions there was little change in scores before and after the training. Questions with no significant change were numbers 6, 13, 16, 17, 18, 20, 21, and 22. These relate to areas that appear to have less meaning or relevance for participants. They relate to their perceived right to ask staff or clients about mental health issues, their lack of desire to work in mental health services and their caution about they can do, what they can offer, be proud of, find an important part of their role, and their satisfaction and reward from working with mental health.

Evaluation

Fifty two participants completed evaluation forms. The evaluation produced descriptive and non-parametric data. Data were entered into an SPSS database. The difference in personal confidence and knowledge before and after training was tested for significance using the Wilcoxon signed rank test.

	Level of knowledge	Level of confidence
<i>Score</i>	Z= -5.629	Z= -4.921
<i>Significance</i>	p<.01 two-tailed	p<.01 two-tailed

Table 3 Evaluation data analysis results

These results indicate that there is a significant change between time one and time two. This is a positive increase in perceived confidence and knowledge.

Further descriptive analysis of evaluation questions are illustrated below in tables 4 and figures 1-9.

Table 4 illustrates the mean score for each of the ratings. This data was collected using a 5 point Likert scale ranging from excellent (1), very good (2), good (3), fair (4) and poor (5). This illustrates high levels of satisfaction for all aspects of the training, with nearly all mean scores falling between excellent and very good. This reduces only for the training environment.

	No. respondents	Mean score
Instructor	52	1.37
Presentation slides	52	1.75
Video clips	51	1.61
Manual	51	1.71
Exercises	52	1.79
Environment	50	2.58
Session structure	51	1.84
Session content	51	1.51
Session facilitation	51	1.65

Table 4 Mean scores MHFA evaluation questions

Figures 1-9 graphically illustrate the ratings given by MHFA training participants.

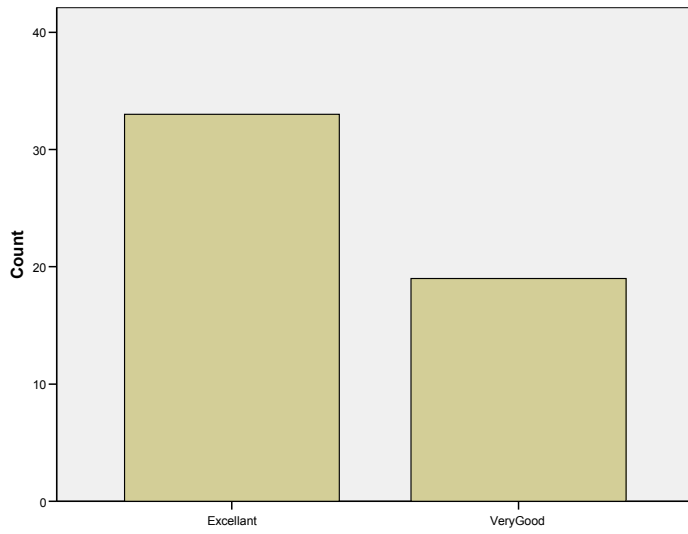


Figure 1 Instructor ratings- MHFA evaluation questions

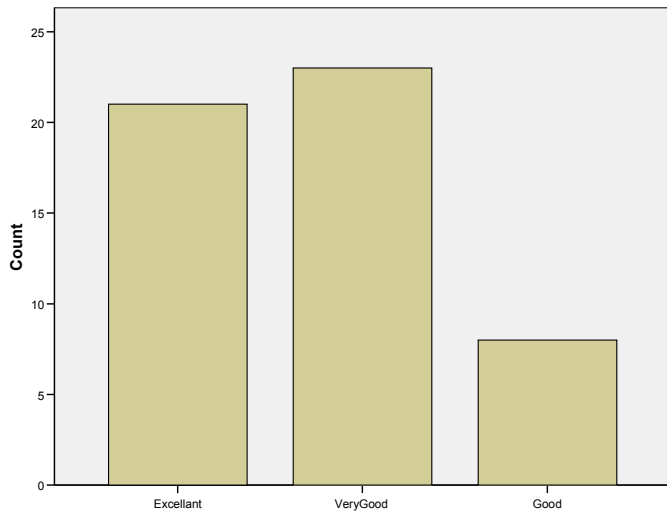


Figure 2 Presentation slide rating- MHFA evaluation questions

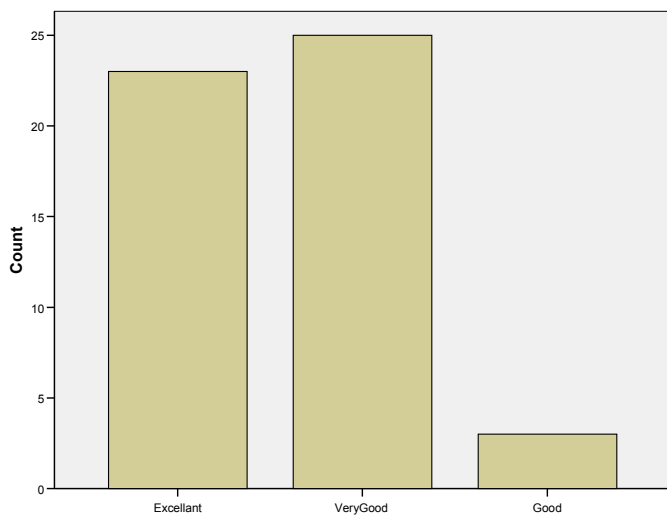


Figure 3 Video clip rating- MHFA evaluation questions

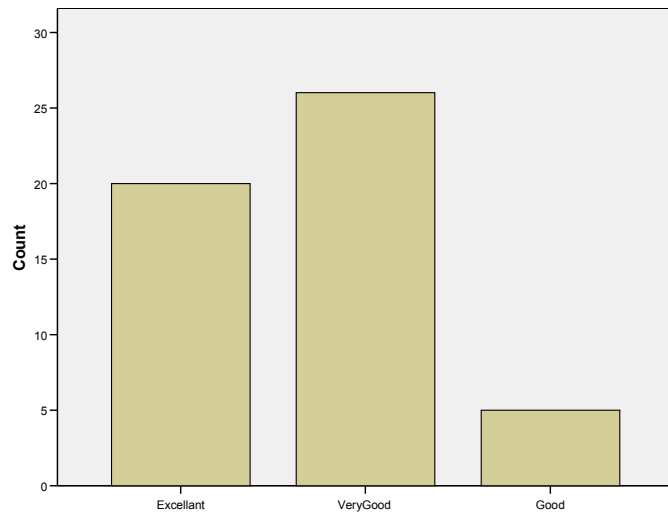


Figure 4 MHFA manual rating- evaluation questions

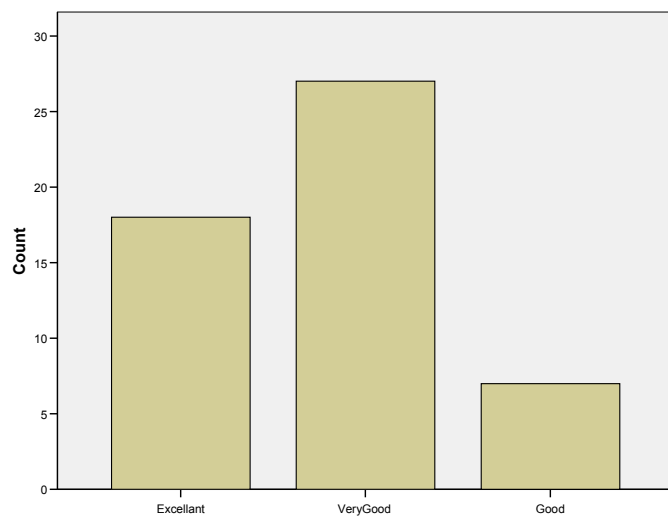


Figure 5 Training exercise rating- MHFA evaluation questions

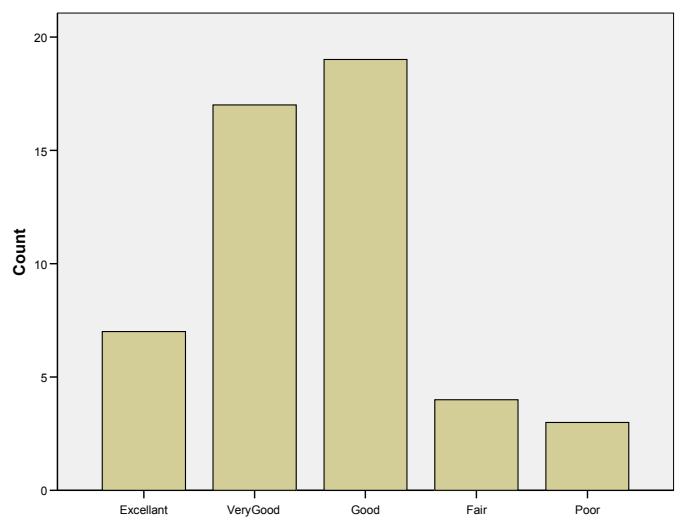


Figure 6 Session environment rating- MHFA evaluation questions

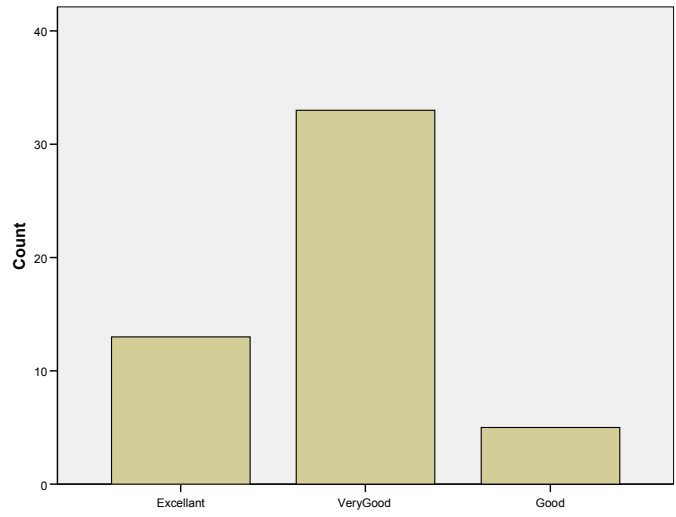


Figure 7 Session structure rating- MHFA evaluation questions

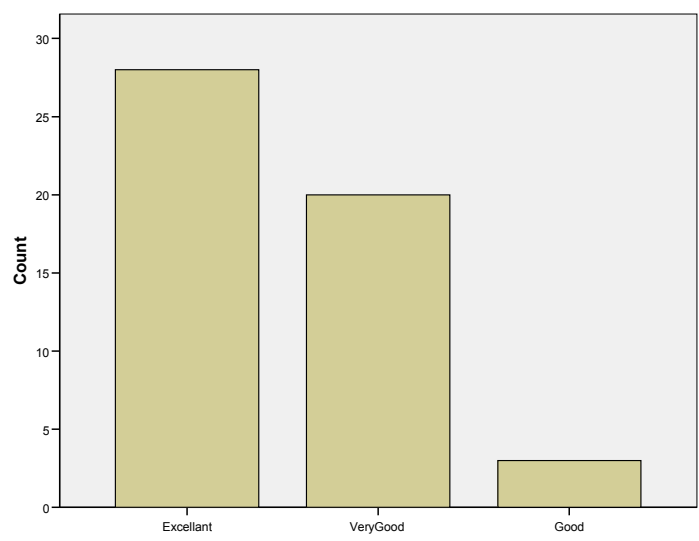


Figure 8 Session content rating- MHFA evaluation questions

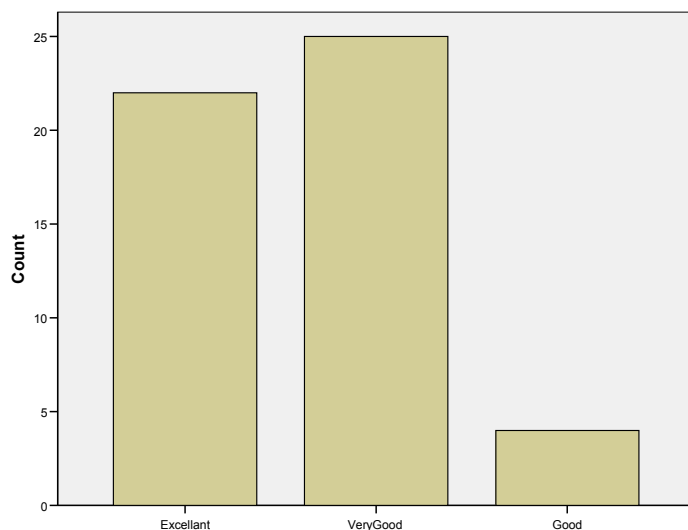


Figure 9 Session facilitation rating- MHFA evaluation questions

Quiz

Thirty five respondents gave answers to the quiz at time one and two. The answers were made anonymous and rated based on the use of the MHFA mnemonic, ALGEE. Each of the three questions had a possible score of five. The quizzes were scored by four researchers to test the reliability of the scoring technique. Significant difference in the scores for each question was tested using a Wilcoxon test.

Quiz question 1: A colleague at work seems to have lost enthusiasm for what he/ she is doing over the past couple of months. From being very punctual, he is often the last in and the first to leave. Deadlines aren't being met and this is affecting the team. Also his appearance has deteriorated and he is complaining of a lack of energy and tiredness.

Results of question 1 indicate a significant improvement in scores after training compared to answers given before training ($z = -4.201$; two tailed; $p < 0.01$).

Quiz question 2: You are just about to go into a meeting and it's quite important. Your colleague starts to become upset, agitated and sweaty. She complains of a pain in her chest and she doubles over. Her breathing is short and gasping.

Results of question 2 indicate a significant improvement in scores after training compared to answers given before training ($z = -4.342$; two tailed; $p < 0.01$).

Quiz question 3: A colleague/ client you are dealing with at work keeps missing appointments. When you do meet he seems confused and suspicious. Some things he says are nonsense. This is a change from the behaviour he showed a few months ago.

Results of question 3 indicate a significant improvement in scores after training compared to answers given before training ($z = -3.445$; two tailed; $p < 0.01$).

All ratings were compared between raters using Kappa. Unfortunately each rater did not appear to rate the answers similarly. However, each raters scores did indicate a significant change between time one and time two. This is likely to be due to the qualitative nature of the answers and their brevity. In future it would be worth planning a rating tool and pilot testing it before the evaluation begins.

Qualitative Analysis

The analysis was thematic, examining the data for common themes in the narrative accounts of MHFA training. The themes identified were:

- Supporting one another
- Stigma & attitude change
- Increased knowledge
- Facilitation
- Course applicability
- Research participation

Overall, participants who agreed to have an interview with the research team were very positive about the mental health first aid training.

Supporting one another

The way in which the members of the groups interacted with each other was an additional benefit contributing to the overall experience the course provided.

“It was good to listen to other people and to share... the environment was a result of the people in the group” (P10)

This led to a ‘support group’ effect. The group responded to the facilitator in a dynamic way. Interactions began to resemble a support group when the discussions turned to individual experiences of personal issues relating to mental ill health. The training became not just about the facts and figures of mental ill health but about how these related to the real life experiences of those in the room.

“The fact that other people were willing to share their real life experiences made you more willing to open up” (P1).

This was self-perpetuating; as one person disclosed an experience others felt comfortable to do so too. In addition the boundary of confidentiality was assured by the facilitator.

“He said ‘This is a closed environment here, its completely confidential’ and everyone sort of agreed” (P1)

In a practical sense this also reiterated the point the training is making in regards to the prevalence of mental ill health, as many were discovering people that they worked with had secretly struggled with mental health issues.

“I hadn’t realised that there would be so much in the room” (P7)

People began to feel that perhaps mental illness should not be the taboo subject that it is.

“People go, well hang on a minute you seem like a completely normal person and you’ve had issues yourself so it’s obviously not a closed door” (P1)

It is likely that this will help reduce pre-existing prejudice or stereotypes regarding mental illness, by introducing non-threatening contact with people who have had these experiences. But also a direct understanding of how this can impact on relationships in work and home life. One participant even revealed that the training reminded her of issues from her past that she could now see in a different light due to the training:

“It even dredged up some things for me that I had forgotten about in the past” (P1).

This seemed to be true of other participants, suggesting that the training can have the additional use of prompting individuals to address their own mental health history in a safe environment:

“Sometimes we have to face our own demons too” (P4).

Even those that did not have personal history relating to mental ill health appreciated the opportunity to discuss issues with a variety of people:

“It was nice to talk about it....to share experiences and expectations with different people” (P3)

The atmosphere created within the training created a forum for discussions regarding mental health; an opportunity many did not appear to have had before. At least not with the same level of freedom or with the feeling that they were in a ‘safe’ atmosphere.

"The environment was such that we all felt comfortable" (P1)

Stigma and attitude change

Many of the interview respondents reported little or no change in attitude towards mental ill health as they felt that the work they do requires them to be 'open minded'. However, despite this, all could see the benefit of the course for those that were not quite so open minded and that this could be a very useful tool for reducing the stigma relating to mental health problems in others:

"I'd like to see it rolled out to everyone. Everyone has a chance of coming across something like this; whether its with a family member or co worker etc." (P5)

"If we were all better educated maybe things would be significantly better" (P5)

This perspective can place the responsibility for prejudice and stigma with others, rather than acknowledging the responsibility themselves. One participant referred to the importance of the training being capable of "*breaking the taboo*" of mental ill health (P7). Another (P10) commented that the course is not only useful to increase knowledge but also for raising awareness and increasing sensitivity which is important for a general change in attitude towards mental health.

One interviewee commented on another member of the training group, having noticed a significant change in their attitude during the training; a person who was described as 'very closed' at the beginning of the first day.

"...by the day 2 she was a different person. She came in smiling and willing to share more. It was impressive" (P1).

This observed change in behaviour and attitude was apparently a striking turnaround, as the individual in question went from "closed" to open and comfortable.

Although participants mostly felt that they were already very 'open minded' and sensitive about mental health; there were still instances where change was recognised and appreciated. One participant felt that prior to the training she was still labelling those with a mental illness.

"I mean even given the knowledge that I had, I would still label people and think perhaps they couldn't function. But then you have to stop yourself and go no, someone with depression or schizophrenia can have medication and they can be completely functioning and you wouldn't know. So it's definitely opened my mind" (P1)

Another participant described an increased sense of empathy

“Before I would be likely to think for goodness sake pull yourself together... it has made me change” (P4)

“Before I’d have thought they’re a bit strange.. now I’d think a bit more”(P2)

Generally, in terms of stigma and how individuals thought of mental health, this was described by one participant as having:

“A lot of impact on me...how you think about mental health issues” (P7).

This participant also went on to admit that prior to the training she thought negatively about the prospect of working within mental health:

“I always said I’d never work for mental health” (P7)

She believed that clients with mental health difficulties would be too demanding and difficult to manage. Even though the training has not made her want to work in mental health necessarily it has definitely made her feel less negatively about this, should the need arise.

However, the participants often talked about other people and their views of mental health issues rather than acknowledging their own culpability in perpetuating stigma.

Increased Knowledge

Increasing knowledge about mental health issues was a major aim of the training with the effect of increasing confidence in providing mental health first aid. But also realising the boundaries of that, it is only first aid and training participants need to refer on to experts if they can. Participants reported they now knew where to go for help. They referred to the manual as a source of information beyond the life of the course. The repetition of the mnemonic ALGEE was also cited as a useful tool to be left with.

“ALGEE is embedded.....it will stay in my mind” (P10)

They also described how they could envisage this knowledge being useful beyond work situations and in their personal lives too.

“It makes me a better colleague and a better neighbour”(P1)

One participant reported that she had used the relaxation technique herself (7).

The training not only increased the knowledge of the participants, but served to make them more aware of the knowledge that they already had but perhaps were not aware of. One participant felt that the training enabled her to *“reflect on myself and my own knowledge and skills”* (P10). This suggests that the training can also be beneficial for those that may feel they already have knowledge about mental health. This is particularly relevant for some of the participants in the sample, as by working for the public sector it is logical to assume that the frontline staff would have to have a working knowledge of mental health. Due to this, participants were starting at different levels of knowledge; one participant felt that she *“started halfway up the ladder”* as being aware of mental health has been a part of her career, at least indirectly, for a long time:

“It’s my job and it has been for a while” (P3)

Despite this, similarly to a lot of the participants, she still felt she benefited from the course in terms of her knowledge base. She described the knowledge provided and the skills taught as *“recognition of what you already did”* and served to give you *“confidence that it makes sense”* (P3).

Facilitation

Positive feedback regarding the trainer of the course was a very strong theme among the participants. Mostly this was in terms of his apparent ability to make the participants feel at ease and therefore creating an atmosphere of support where people felt able to disclose personal information. In terms of the trainers delivery of the course the trainer came across as *“credible”* with suitable knowledge that was due to his vast experience within mental health (P7). In particular one participant commented that the trainer was able to tailor the delivery of the course to the knowledge base of the people in the room (P6). This meant that the trainer was able to keep the balance between providing enough complex information to make the training useful without talking over the heads of those without much prior experience.

However, several participants thought that the very intense content could have been handled better and that it would have been beneficial for the trainer to make himself more available to talk in private about issues that may arise (P2 & P9).

“Even more sensitivity to issues that might be with people in the room” (P9)

It is very important to consider the emotional impact that the intense nature of the course content can have on individuals. Especially as many could be coming to the course having had personal experience with issues relating to mental ill health, in regards to themselves or a family member. It is also important to make sure that individuals feel supported so that they do not leave the training at the end feeling that issues have arisen that they haven’t been given the support to deal with.

"I took things home that it might have been useful to get rid of before I went home"
(P9)

This participant (P9) also made a recommendation that a pre warning about the intense nature of the course content could be helpful to those that feel sensitive around these issues. However this being said, one participant felt that although in theory a pre-warning is good it would be difficult to truly prepare for the content of the course.

"I don't know if there's anyway you can prepare people for that" (P7)

The participant (P9) also felt that even though the trainer was very clear that everyone was welcome to leave whenever they felt uncomfortable, she was not able to do this. She reported a feeling of being "trapped" and needing a better "escape route" from the situation, as she felt that leaving the room during an intense moment in the course would draw attention and not feel appropriate. Unlike the majority of the participants, she did not feel the same level of comfort that enabled them to open up about personal concerns.

"I didn't feel able...I didn't want to share that with the group" (P9)

In relation to this another participant (P4) suggested that a debrief session after the course that focussed purely on how the content had made people feel would have been very useful as again much of the personal discussion had to be cut short due to time constraints. She agreed, in that it was possible to become distressed due to the content and disclosed that at the end of the first day she *"went home and cried"* (P4). She felt that it would have improved the experience if there was *"More time to go into what you were feeling"* (P4).

Course applicability

The content of the course was generally very well received with few suggestions for amendments. Several participants (P7 & P4) felt that perhaps there was emphasis on the 'higher end' mental health issues such as psychosis and suicide. This was acknowledged as useful and interesting, as well as a way of reducing stigma and prejudice. However they described a deeper interest in issues related to stress, anxiety and mild to moderate depression. This was felt to be more salient in the workplace and more likely to be encountered regularly. This was described by managers and front line workers as pertinent to their daily work. Although this is an appreciable point, care must be taken not to stratify mental health difficulties into those that are out of reach for lay persons with only MHFA training to call upon. One participant (P4) indicated that these more serious illnesses were dealt with by mental health teams and so she has less need for this knowledge. This again may be evidence of making mental ill health 'other', and the person with serious mental health difficulties needs only specialists able to cope with this illness.

One participant felt that she wishes to *"roll out a pared down version"* (P7) of the training as her colleagues had wanted to attend but had not been able to. Caution should be taken

here since this might dilute the knowledge and meaning of MHFA despite the well meaning intention.

When asked about the applicability of the training one participant said of managers it's *"more important for them than anybody"* (P1). This was so that they would be aware of their own and their staff's wellbeing in relation to their work, rather than just being for frontline staff.

Research participation

As a final question to participants they were asked about being involved in the research as well as the training. Overall, they reported it was a positive experience. They commented that they would be eager to hear about the outcome of the research and that they had been happy to be involved. One participant commented that they felt that by being involved in the research they were *"making a difference"* (P4) in terms of mental health. In practical terms, another participant (P2) commented that being involved in the research was beneficial. It helped focus attention back on the information learned during the course. This was due to the interviews being delayed until 3 weeks after the training. This had been planned to enable the participants to think about what they had learned and reflect on this.

"It's just made me think about it all again and reflect on everything I learned" (P2)

Participants suggested that the quiz questions should have been separated by facing difficulties with clients and their colleagues. This was because they felt these two groups of people would be approached in quite different ways.

"Certainly with the way I work at least; the way the two groups of people would be approached would be very different" (P3)

Another participant, (P8) commented that the completion of the quiz and the evaluation created a time pressure at the end of the training day; especially on the second day. This was confirmed by (P3) who felt that the limited time did not do their knowledge and opinions justice as it was at the end of an intense day.

"Everything had gone out the door by then (second day), we just wanted to get home by that point" (P3)

She remarked that if she had been given more time and was perhaps asked the next day, the information she would have given would be a better reflection of what she felt and what she had learned.

"I feel that if you'd asked me the next day you would have got a better idea of my feedback on the course and with those questions (quiz) you would have got a much more valid answer" (P3)

This would suggest that participant's answers could have been fuller and less flippant. However, this was balanced against the reduced likelihood of returned questionnaires once the course was complete.

Discussion

As previously discussed prior to this research an independent evaluation of the UK course had not been completed. Therefore this research was an important step in the general evaluation of the MHFA concept and its usefulness in mental health education. This research aimed to assess the ability of the MHFA course to increase knowledge of and confidence to deal with mental health issues. Also to investigate what effect if any there was on the attitudes of participants towards mental ill health and their views of the issue of mental health. There was a particular interest in these points in relation to the workplace.

This investigation used a variety of methodologies to ensure a comprehensive evaluation of the training. Four measures of data collection were used; using both quantitative and qualitative methods.

- Semi structured interviews
- Course Evaluation
- MHPPQ (adapted from Lauder et al. 2000)
- Course Quiz

Evaluation

The course evaluation results indicated a strong personal identification and satisfaction with the training. This was particularly evident in relation to the trainer and also the course materials such as the manual, where the results were overwhelmingly positive. An area that showed any signs of dissatisfaction related to the venues, namely the clinical skills lab in Chippenham and the Alzheimers centre in Devizes. Further investigation revealed that this was due the Chippenham venue not being suitable for this type of training, with computer terminals and hospital furniture; and the Devizes venue being too cramped creating a slightly claustrophobic feeling. The statistical analysis of personal confidence before and after training demonstrated that participants increased significantly in both these measures. This suggests that the participants feel that they have gained from the training in terms of their knowledge of mental health and their confidence to deal with issues pertaining to mental health.

Quiz

The analysis of the quiz demonstrated that the participants had acquired knowledge during the training in terms of initial steps to take when an individual is displaying signs of mental health distress. However due to the way the questions were formed and ultimately rated, the results of the quiz was mostly indicative of the participants' ability to recall ALGEE rather than how they would perform in a real situation. The rating of the quiz answers proved difficult due to the subjective nature of the rating; the rating was based on ALGEE and recommended answers provided by the MHFA national body which left a lot of room for interpretation. Even though analysis would be easier and clearer cut if the quiz was of a more quantitative nature, with multiple choice questions rather than qualitative free text,

this would lead to the measure losing its advantages as testing reactions to scenarios. Some of the participant's responses to the quiz were not particularly comprehensive. The interviews revealed that this was due to the last quiz being administered at the end of the training, which had been an intense and tiring experience. Participants suggested that they had not been able to do their opinions and knowledge justice as they were more focussed on being able to go home at the end an intense day. On the other hand this must be balanced with the benefits of providing and collecting data at the session in terms of response rate. One suggestion for improving participant effort is to make the quiz a part of the certification process. By informing the participants at the beginning that their certification in MHFA will be dependent on a test they will receive at the end could serve to make learning during training more goal focussed and increase consideration into answers given.

MHPPQ

The 27 questions of the MHPPQ were grouped into three main headings of: therapeutic commitment, role competency and role support. The Wilcoxon test performed showed a significant difference in all these categories between time one and time two. These results suggest that the training had a significant impact on the participant's perceptions of mental ill health. The Wilcoxon significance test does not measure ties. Therefore the significance levels do not take into account the questions where there was no change. By looking at the results in more depth, areas that did not change significantly related to issues such as: the right to ask about mental health, wanting a career in mental health, mental health being an important issue in their job, being proud of handling mental health and working in mental health being satisfying/rewarding. It is not surprising that responses did not change significantly for these questions addressed, as these issues were unlikely to be affected by training. In terms of practical issues, the response rate for the MHPPQs was lower than expected. This was due to these being distributed by post and the organisational internal postal system not being particularly reliable. Also the sample consisted of busy individuals with heavy caseloads so it is possible that some forgot, did not have time to complete and return before the deadline or did not appreciate the need to complete the questionnaire on two occasions.

Interviews

The interviews provided very positive feedback regarding the training, confirming the rest of the results. The data gathered from the semi structured interviews was analysed using a thematic analysis, under six themes:

- Supporting one another
- Stigma and attitude change
- Increased knowledge
- Facilitation
- Course applicability
- Research participation

One aspect of the training that seemed to be pivotal to the enjoyment by participants was 'Supporting one another'. The participants appreciated a forum to discuss issues relating to mental ill health, particularly those relating to personal experiences. One of the few improvements suggested in the interviews was to include more time for those taking the course to be able to discuss their personal feelings about mental health and to discuss the psychological impact of the course content. One specific idea was for there to be a 'debrief' session at the end of the training where the trainer would make themselves available to discuss any issues.

Similarly to the results from the evaluation, the 'facilitation' of the course was a common point of praise for the course. Every participant at interview commented that the trainer was vital to the positive experience of the training and that he was largely responsible for the supportive environment. However one participant had a more negative view which as an anomaly, is an important point of discussion. This participant felt that there was not enough consideration into the psychological impact of the course content, particularly for those that may have personal experience with mental health issues. To rectify this, the participant felt that the trainer should be more available for private discussion for issues that can arise and that opportunity to remove ones-self from the situation should be improved. This apparent feeling of unease in the environment did not seem to be shared by the rest of the sample; however this does not mean that this was not an issue for those not participating in the research.

More consideration could be put into the timing of the two sessions. Some participants commented that having both sessions in one week was far too intense and that they would have appreciated more of a break. On the other hand, some also felt that having the sessions too far apart meant that the information was not fresh enough in their minds to get the most out of the second session. Therefore a balance between having a comfortable gap between the two sessions and also not waiting too long would be beneficial.

The participants that agreed to be interviewed would most likely be those that were most enthusiastic about the training and wanted to share their experiences; therefore the positive feedback is not surprising. It would be helpful to be able to investigate the opinions of those that were less positive and enthusiastic however no one with these views came forward for interview.

As discussed above, the participants were generally likely to be more open minded towards mental health issues than members of the general public, not working for the public sector. Due to this there was an impression that the course was 'preaching to the converted' and that any change was merely building on what was already there. This did vary among the participants however, as despite all working for the public sector they all had different experience and knowledge levels. This difference in experience related to their public and working lives. Also, despite this sense of 'preaching to the converted' the participants commented that the course was still very beneficial even if this was mostly to reaffirm what was already known or to make them more confident in applying knowledge that was

already there. Even though the majority of the participants claimed they were already too open minded about mental ill health for there to be any change, they recognised the potential of the training to reduce stigma and increase understanding of mental health issues among the general population.

In terms of further evaluation of the MHFA training, there are a few points that could be addressed. For instance, as discussed at many points, the trainer is a vital component of the training and how it was received. The individual that facilitates the training obviously has a large impact, therefore it would be interesting and useful to do a similar evaluation with different individuals facilitating for a more comprehensive picture of MHFA. Some training sessions are facilitated by two trainers and it would be interesting to investigate if and how this affects the course dynamics and the overall experience of the training. It would be useful to perform a longitudinal investigation to study whether the impact of the training is long lasting. Participants could be tested again the future to determine whether they have retained the knowledge and the ability to use the skills imparted in the course. Of course this is dependent on financial factors and the co operation of the research participants. Also, the way in which the training would be received by those that do not work within the public sector would be an interesting progression- particularly in regards to changes in attitudes towards mental health.

Conclusion and recommendations

Due to the very positive nature of the results it is clear that MHFA training has a significant impact. Therefore, it is a strong recommendation that the training continues and expands in England; firstly on a wider scale to include more individuals within the organisations involved in the research and then to expand into more organisations in the country.

To understand the sustainability of the impact of MHFA on the mental health literacy of individuals, long term follow up would be recommended. Perhaps individuals could be tested again after six months to see if information has been retained and also how their perceptions of mental health have progressed.

It is felt that more could be gained from the quiz aspect of evaluation if it became integrated into the requirements for certification. This would make the quiz an expected aspect of the training process rather than an additional activity, meaning that participants would put more consideration into their answers and these answers would become more representative of their knowledge.

It could be beneficial to build a 'debrief' session into the timetable of the course. It was evident from the interviews that the participants would appreciate more time to discuss the personal repercussions of the information presented to them. Also, participants could benefit from a warning of what can be expected from the course prior to deciding whether to attend. Those that have personal history regarding mental health can then make an informed decision about whether to take the training.

Appendix a

Table illustrating evaluation rating percentages for each aspect of training

	Excellent	Very good	Good	Fair	Poor
Instructor	63.5	36.5	0	0	0
Presentation	40.4	44.2	15.4	0	0
Video clips	44.2	48.1	5.8	0	0
Manual	38.5	50.0	9.6	0	0
Exercises	34.6	51.9	13.5	0	0
Environment	13.5	32.7	36.5	7.7	5.8
Structure	25.0	63.5	9.6	0	0
Content	53.8	38.5	5.8	0	0
Facilitation	42.3	48.1	7.7	0	0



Appendix bi.

MHPPQ

Mental Health Problems Perception Questionnaire (MHPPQ) adapted from Lauder, Reynolds, Reilly & Angus, 2000, 2001.

Please read each question and tick ✓ your answer. Please be clear about your answers. Do not leave any questions unanswered or mark on the line between answers.

Please complete both sides of the questionnaire.

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree
1. I feel that I know enough about the factors which put people at risk of mental health problems to carry out my role at work.					
2. I feel I know how to treat people (staff or clients) with long-term mental health problems.					
3. I feel that I can appropriately advise people (staff or clients) about mental health problems.					
4. I feel that I have a clear idea of my responsibilities in helping people (staff or clients) with mental health problems.					
5. I feel that I have the right to ask people (staff or clients) about their mental health status when necessary.					
6. I feel that my staff or clients believe I have the right to ask them questions about mental health problems when necessary.					
7. I feel that I have the right to ask a people (staff or clients) for any information that is relevant to their mental health problem.					
8. If I felt the need when working with staff or clients with mental health problems I could easily find someone with whom I could discuss any difficulties I might encounter.					
9. If I felt the need when working with someone with mental health problems I could easily find somebody who would help me clarify my personal difficulties.					
10. If I felt the need I could easily find someone who would be able to help me formulate the best approach to people (staff or clients) with mental health problems.					
11. I am interested in the nature of mental health problems and the treatment of them.					
12. I feel that I am able to work with people with mental health problems as effectively as with others who do not have mental health problems.					
13. I want to work with people with mental health problems.					
14. I have the skills to work with people (staff or clients) with mental health problems					
15. I feel that I can assess and identify the work related problems of people (staff or clients) with mental health problems.					

16. I feel that there is nothing I can do to help people (staff or clients) with mental health problems.					
	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree
17. I feel that I have something to offer people (staff or clients) with mental health problems.					
18. I feel that I have much to be proud of when working with people (staff or clients) with mental health problems.					
19. I feel that I have a number of good qualities for work with people (staff or clients) with mental health problems.					
20. Caring for people (staff or clients) with mental health problems is an important part of my role.					
21. In general one can get satisfaction from working with people (staff or clients) with mental health problems.					
22. In general it is rewarding to work with people (staff or clients) with mental health problems.					
23. I often feel uncomfortable when working with people (staff or clients) with mental health problems.					
24. In general I feel that I can understand people (staff or clients) with mental health problems.					
25. On the whole I am satisfied with the way I work with people (staff or clients) with mental health problems.					
26. When working with people (staff or clients) with mental health problems I receive adequate supervision from a more experienced person.					
27. When working with people (staff or clients) with mental health problems I receive adequate ongoing support from colleagues.					

Thank you for taking the time to complete this questionnaire

Appendix bii

MHPPQ questionnaire- background and concepts

The questions of the MHPPQ can be separated into three categories relating to the handling of mental health problems in staff or clients: Therapeutic Commitment, Role Support and Role Competency.

Therapeutic Commitment

Refers to the practitioners' willingness and ability to use effective therapeutic qualities/skills. Adopting an approach which demonstrates warmth and empathy.

- 11. I am interested in the nature of mental health problems and the treatment of them
 - 12. I feel that I am able to work with people with mental health problems as effectively as with others who do not have mental health problems
 - 13. I want to work with people with mental health problems
 - 16. I feel there is nothing I can do to help people with mental health problems
 - 17. I feel that I have something to offer people with mental health problems
 - 18. I feel I have much to be proud of when working with people with mental health problems
 - 19. I feel that I have a number of good qualities for work with people with mental health problems
 - 20. Caring for people with mental health problems is an important part of my role
 - 21. In general one can get satisfaction from working with people with people with mental health problems
 - 22. In general it is rewarding to work with people with mental health problems
 - 23. I often feel uncomfortable when working with people with mental health problems
 - 24. In general I feel that I can understand people with mental health problems
 - 25. On the whole I am satisfied with the way I work with people with mental health problems
 - 27. When working with people with mental health problems I receive adequate ongoing support from colleagues
- 11-13, 16-25, 27

Role Support

The perceived level of contact/potential contact with specialist mental health workers

- 8. If I felt the need when working with staff or clients with mental health problems I could easily find someone with whom I could discuss any difficulties I might encounter
- 9. If I felt the need when working with someone with mental health problems I could easily find someone who would help me clarify my personal difficulties

10. If I felt the need I could easily find someone who would be able to help me formulate the best approach to people with mental health problems

26. When working with people (staff or clients) with mental health problems I receive adequate supervision from a more experienced person

8-10, 26

Role Competency

Refers to concepts of role adequacy Having the skills, knowledge and understanding necessary.

1. I feel that I know enough about the factors which put people at risk of mental health problems to carry out my role at work.

2. I feel I know how to treat people (staff or clients) with long term mental health problems

3. I feel that I can appropriately advise people (staff or clients) about mental health problems.

4. I feel that I have a clear idea of my responsibilities in helping people (staff or clients) with mental health problems.

5. I feel that I have the right to ask people (staff or clients) about their mental health status when necessary

6. I feel that my staff or clients believe I have the right to ask them questions about mental health problems when necessary.

7. I feel that I have the right to ask a people (staff or clients) for any information that is relevant to their mental health problem.

14. I have the skills to work with people (staff or clients) with mental health problems

15. I feel that I can assess and identify the work related problems of people (staff or clients) with mental health problems.

1-7, 14, 15

Appendix biii

MHPPQ raw data

Mental Health Problems Perception Questionnaire (MHPPQ) adapted from Lauder, Reynolds, Reilly & Angus, 2000, 2001. Number of responses per question; * **significant change**

	Pos change	Neg change	Tied/ No change
1. I feel that I know enough about the factors which put people at risk of mental health problems to carry out my role at work.	13*	0	8
2. I feel I know how to treat people (staff or clients) with long-term mental health problems.	16*	1	4
3. I feel that I can appropriately advise people (staff or clients) about mental health problems.	16*	2	3
4. I feel that I have a clear idea of my responsibilities in helping people (staff or clients) with mental health problems.	14*	0	7
5. I feel that I have the right to ask people (staff or clients) about their mental health status when necessary.	12*	3	6
6. I feel that my staff or clients believe I have the right to ask them questions about mental health problems when necessary.	8	6	7
7. I feel that I have the right to ask a people (staff or clients) for any information that is relevant to their mental health problem.	15*	2	4
8. If I felt the need when working with staff or clients with mental health problems I could easily find someone with whom I could discuss any difficulties I might encounter.	15*	0	6
9. If I felt the need when working with someone with mental health problems I could easily find somebody who would help me clarify my personal difficulties.	15*	1	5
10. If I felt the need I could easily find someone who would be able to help me formulate the best approach to people (staff or clients) with mental health problems.	13*	1	7
11. I am interested in the nature of mental health problems and the treatment of them.	1	7*	13
12. I feel that I am able to work with people with mental health problems as effectively as with others who do not have mental health problems.	12*	1	8
13. I want to work with people with mental health problems.	7	2	11
14. I have the skills to work with people (staff or clients) with mental health problems.	16*	0	5
15. I feel that I can assess and identify the work related problems of people (staff or clients) with mental health problems.	16*	0	4
16. I feel that there is nothing I can do to help people (staff or clients) with mental health problems.	5	1	14
17. I feel that I have something to offer people (staff or clients) with mental health problems.	10	3	8
18. I feel that I have much to be proud of when working with people (staff or clients) with mental health problems.	8	3	10
19. I feel that I have a number of good qualities for work with people (staff or clients) with mental health problems.	8*	1	12
20. Caring for people (staff or clients) with mental health problems is an important part of my role.	10	4	7
21. In general one can get satisfaction from working with people (staff or	5	3	13

clients) with mental health problems.			
22. In general it is rewarding to work with people (staff or clients) with mental health problems.	5	3	11
23. I often feel uncomfortable when working with people (staff or clients) with mental health problems.	10*	3	8
24. In general I feel that I can understand people (staff or clients) with mental health problems.	11*	2	8
25. On the whole I am satisfied with the way I work with people (staff or clients) with mental health problems.	11*	0	9
26. When working with people (staff or clients) with mental health problems I receive adequate supervision from a more experienced person.	10*	2	8
27. When working with people (staff or clients) with mental health problems I receive adequate ongoing support from colleagues.	13*	3	5

Mental Health First Aid

Quiz- Before & After Training

The purpose of this quiz is to test your knowledge about mental health before and after the Mental Health First Aid training.

Please read each of the examples and indicate the three ways you would respond to this in your workplace. Please add any comments you feel may be useful.`

After Training: Now you have completed the training read each of the examples again and indicate the three ways you would respond to this in your workplace. Please add any comments you feel may be useful.

1. A colleague at work seems to have lost enthusiasm for what he/she is doing over the past couple of months. From being very punctual, he is often the last in and the first to leave. Deadlines aren't being met and this is affecting the team. Also his appearance has deteriorated and he is complaining of a lack of energy and tiredness.

What are the first three things you would do?

a,

b,

c,

Comments:

2. You are just about to go into a meeting and it's quite important. Your colleague starts to become upset, agitated and sweaty. She complains of a pain in her chest and she doubles over. Her breathing is short and gasping.

What are the first three things you would do?

a,

b,

c,

Comments:

3. A colleague/client you are dealing with at work keeps missing appointments. When you do meet he seems confused and suspicious. Some things he says are nonsense. This is a change from the behaviour he showed a few months ago.

What are the first three things you would do?

a,

b,

c,

Comments:

Thank you

Mental Health First Aid

Quiz-

1. A colleague at work seems to have lost enthusiasm for what he/she is doing over the past couple of months. From being very punctual, he is often the last in and the first to leave. Deadlines aren't being met and this is affecting the team. Also his appearance has deteriorated and is complaining of a lack of energy and tiredness.

What are the first three things you would do?

a. Consider ALGEE

I would engage him in conversation, and encourage him to share how he is feeling by listening in a non judgemental way. I would explain that I was concerned for his welfare, and ask open questions, such as whether anything in particular was bothering him; whether it was work-related; whether there was anything outside work he wanted to talk about. I would offer the opportunity for him to discuss how he was feeling, or state what support he might need or want, from me or someone else.

b. I would explain some of the signs and symptoms of depression and anxiety, explaining how common they were, and how they might affect people in their work and home life. This would provide an opportunity for my colleague to share any additional information such as additional symptoms, risk taking and other harmful behaviours (the latter might include alcohol or drug misuse). I would also take this opportunity to ask clearly if they had experienced any thoughts or ideas of suicide or self harm. I would explain why I was asking this question.

c. Assuming that my colleague had no stated ideas of self harm or suicide, I would give reassurance that with support and some self help techniques he would be able to tackle his problem. I would encourage him to seek help through his GP – his lack of energy may be linked to a physical health problem, or a problem like depression. I would also ask what support he needed 'here and now' - this might include practical advice and support for him to contact his line manager and/or Occupational Health department

Comments:

2. You are just about to go into a meeting and it's quite important. Your colleague starts to become upset, agitated and sweaty. She

complains of a pain in her chest and she doubles over. Her breathing is short and gasping.

What are the first three things you would do?

a. Consider ALGEE

I would ask other people present to give her space, and ask one (preferably a female, to balance the support) to stay close by and if necessary fetch additional support such as paramedic support, or simply a glass of water. This would enable me to remain with the person experiencing the crisis. If possible I would invite her to go to a quieter room. I would explain to her that I was going to stay with her, that she was safe, and that I was going to ask several questions so I could get the right help. I would act in as calm and reassuring a way as possible.

b. I would ask the following: Whether she had had heart problems or a heart attack in the past; whether any other illness might present in the same way, such as asthma; whether she was taking any medication; and whether she had experienced panic attacks before and, if so, what had helped before.

c. If I was confident that this was a panic attack I would give reassurance and explain what was happening to her - that this was a panic attack, that it was not life threatening. I would say I would soon be helping her to reduce and control her breathing and that she would soon feel better. If she continued to complain of chest pain I would ask someone to telephone for an ambulance. I would then employ the slow breathing techniques outlined in the MHFA course.

Comments:

I would check with the person that they were OK with me, as a man (in this case), staying with them during their period of distress. There may be related psychosocial or cultural issues that would make it difficult for me to support her.

Later, I would reassure her that panic attacks are fairly common, not harmful physically in the short term, that there are good self help techniques available, and that effective treatments are available for a range of anxiety conditions. I would encourage her to visit her GP, as the first stage of getting some professional help.

3. A client you are dealing with at work keeps missing appointments. When you do meet he seems confused and suspicious. Some things he says are nonsense. This is a change from the behaviour he showed a few months ago.

What are the first three things you would do?

a. Consider ALGEE

I would explain that I was there to help and that I was concerned for his

welfare; that I could see he was upset and worried. I would then ask him to share with me what was concerning him. I would ask open questions, such as “how are you feeling?” I would listen non-judgmentally.

- b. *If the things he said were nonsensical I would not challenge this directly, but explain that I needed to get the right support for him and ask if he had experienced anything like this before and, if so, whether there was any one (professional or otherwise) who might provide help.*

- c. *If this was the first time he had experienced anything like this I would explain that I was going to remain with him until we could find someone who could help and with whom my client felt safe and comfortable. This could be his GP, or possibly a Mental Health Crisis / Early Intervention in Psychosis Team Worker. If he admitted to me that he had experienced a similar episode before, or admitted to some previous mental health care, I would encourage them to make contact again with the relevant service to get some appropriate professional support.*

Comments:

Thank you

Appendix d.

Interview schedule

Thank you for agreeing to participate in an interview regarding the Mental Health First Aid training. I would like to ask you some questions regarding the training.

- 1, Tell me about the training and what you felt it did for you.....
 - Were you satisfied with the trainers, the course materials and the venue?
 - If not, what was not satisfying?
 - What did you think of the course content and the knowledge you gained?
 - Are there any improvements you could suggest for the MHFA training?

- 2, How confident do you now feel about dealing with people in your workplace who exhibit signs of mental health problems?
 - Compare this to how you felt before the training.
 - Do you think your knowledge about signs and symptoms of mental health problems has increased?
 - Do you think you would know how to help someone with mental health problems?
 - Would you know where to signpost someone who needs help with mental health problems?

- 3, How do you think you will be able to use this training in your workplace?

- 4, Can you describe any situations that have arisen at work where you have been able to employ the skills you learned on the MHFA training course?

- 5, Do you think your attitude to people with mental health problems has changed as a result of participating in MHFA training?
 - What you think about the stigma of mental illness?
 - How would you view a person with mental health problems now compared to before training?

- 6, It is thought that MHFA training can help people cope with their own or their loved ones mental health difficulties. What do think of that idea?

- 7, Would you recommend the MHFA training to your manager, colleagues or staff?

- 8, Were there any aspects of research participation that were burdensome or unhelpful?

- 9, Are there any other areas that you wish to raise regarding MHFA training or the research?

Thank you for your participation.

Mental Health First Aid

Evaluation Form

The purpose of this evaluation form is to hear from you about your experiences of the 12 hour course, its content and usefulness and any thoughts you have on how to improve future events.

Please circle your responses and add any comments you feel may be useful.

Name of Instructor 1:		2:	
<i>I do/ do not wish this evaluation to be shared with the research team</i>			
Organisation: Wilts Council; NHS Wilts; Selwood H Assn		Course dates: ___/___/___ and ___/___/___	
Before beginning the training, please score your personal confidence in how best to support others with a mental health problem.			
<i>excellent</i>	<i>good</i>	<i>limited</i>	<i>poor</i> <i>none</i>
Before beginning the training, please score your level of knowledge in how best to support others with a mental health problem.			
<i>excellent</i>	<i>good</i>	<i>limited</i>	<i>poor</i> <i>none</i>
1. How would you rate the instructors?			
<i>excellent</i>	<i>very good</i>	<i>good</i>	<i>fair</i> <i>poor</i>
Comments:			
2. How would you rate the presentation slides?			
<i>excellent</i>	<i>very good</i>	<i>good</i>	<i>fair</i> <i>poor</i>
Comments:			

3. How would you rate the video clips?					
<i>excellent</i>	<i>very good</i>	<i>good</i>	<i>fair</i>	<i>poor</i>	
Comments:					
4. How would you rate the information in the manual?					
<i>excellent</i>	<i>very good</i>	<i>good</i>	<i>fair</i>	<i>poor</i>	
Comments:					
5. How would you rate the learning exercises?					
<i>excellent</i>	<i>very good</i>	<i>good</i>	<i>fair</i>	<i>poor</i>	
Comments:					
6. How would you rate the following overall from the sessions?					
<i>Environment?</i>	<i>excellent</i>	<i>very good</i>	<i>good</i>	<i>fair</i>	<i>poor</i>
<i>Structure?</i>	<i>excellent</i>	<i>very good</i>	<i>good</i>	<i>fair</i>	<i>poor</i>
<i>Content?</i>	<i>excellent</i>	<i>very good</i>	<i>good</i>	<i>fair</i>	<i>poor</i>
<i>Facilitation?</i>	<i>excellent</i>	<i>very good</i>	<i>good</i>	<i>fair</i>	<i>poor</i>
<i>Having completed the training, please score your personal confidence in how best to support others with a mental health problem.</i>					
<i>excellent</i>	<i>good</i>	<i>limited</i>	<i>poor</i>	<i>none</i>	
<i>Having completed the training, please score your level of knowledge in how best to support others with a mental health problem.</i>					
<i>excellent</i>	<i>good</i>	<i>limited</i>	<i>poor</i>	<i>none</i>	
8. How will you make use of what you have learned?					

9. In what way or ways has undertaking the MHFA course affected your attitude to people with mental health problems?

10. Do you have any comments on how we might improve future events?

Thank you

References

- Braun, V. & Clarke V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3 (2), 77-101
- Irvine, A. (2008). *Managing Mental Health and Employment*. Department for Work and Pensions report No 537. London: Social Policy Research Unit.
- Hilton, M. (2005) *Assessing the financial return on investment of good management strategies and the WORC project*. WORC Project paper
- Jahoda, M., Lazarsfeld, P. & Zeisl, H. (1993). *Marienthal: The Sociography of an Unemployed Community*. London: Tavistock Publications
- Jorm, A.F., Kitchener, B.A., & Mugford, S.K. (2005). Experiences in applying skills learned in a mental health first aid training course: A qualitative study of participants' stories. *BMC Psychiatry*, 5, 43
- Karidi, M., Stefanis, C., Theleritis, C., Tzedaki, M., Rabavilas, A & Stefanis, N. (2010). Perceived social stigma, self concept and self-stigmatization of patient with schizophrenia
- Kitchener, B.A. & Jorm, A.F (2002). Mental health first aid training for the public: Evaluation of effects on knowledge attitudes and helping behaviour. *BMC Psychiatry*, 2, 10
- Kitchener, B.A. & Jorm, A.F (2004). Mental health first aid training in a workplace setting: A randomized controlled trial. *BMC Psychiatry*, 4, 23
- Lauder, W., Reynolds, W., Reilly, V & Angus, N (2000). The development and testing of the Mental Health Problems Perception Questionnaire. *Journal of Psychiatry and Mental Health Nursing*, 7, 221-226
- Levin-Epstein, J. (2005) *Presenteeism and Paid Sick Days*. Washington: Centre for Law and Social Policy.
- McDonald, K. (n.d) *Mental Health first aid manual*. London: Jellycat Media Limited.
- Kitchener, B.A. & Jorm, A.F. (2002) *Mental Health first aid manual*. Canberra: Centre for Mental Health Research.
- Mental Health First Aid: England (n.d). *Mental health first aid: About us*. Retrieved from <http://www.mhfa.org.uk/aboutus.php?PHPSESSID=667d281eece9e8d05e621c04c81f756b>

Mental Health Foundation (n.d) *Work life balance*. Retrieved from <http://www.mentalhealth.org.uk/information/mental-health-a-z/work-life-balance/>

Perkins, R., Farmer, P & Litchfield, P. (2009). *Realising Ambitions: Better Employment Support for people with a mental health condition*. Department for Work and Pensions review

Rethink (2009). *Briefing: Mental health, stigma and employment*. Retrieved from http://www.rethink.org/how_we_can_help/news_and_media/briefing_notes/briefing_mental_he.html

Sainsbury Centre for Mental Health (2007) *Policy Paper 8: Mental Health at Work: Developing the business case*. London: Sainsbury Centre for Mental Health.

Secker, J., Grove, B. & Seebohm, P. (2001). Challenging barriers to employment, training and education for mental health service users: The service user's perspective. *Journal of Mental Health*, 10 (4) 395-404