

Summary evaluation of the Mental Health First Aid pilot programme in the CAWT region

Background

The Cooperation and Working Together (CAWT) mental health sub group, through a conference in 2003, identified the promotion of positive mental health among young people aged 16-25 years as a key priority.¹

As CAWT looked for ways to engage young people, they were made aware of a need in further education settings for training of staff who work closely with young people to:

- recognise the symptoms of mental health problems;
- provide initial help;
- guide people towards appropriate professional help.

In seeking approaches to address this need, CAWT identified Mental Health First Aid (MHFA). In 2005, a partnership of CAWT, Aware Defeat Depression and the Health Promotion Agency (HPA) commenced work to deliver a pilot programme of MHFA in the CAWT region. This pilot programme was evaluated by the Health Promotion Agency.

Mental Health First Aid

MHFA is 12 hours of evidence-based training that teaches participants how to recognise the symptoms of mental health problems such as depression, anxiety and psychosis.

The programme was originally developed in Australia and was adapted for the Scottish Executive's national programme for improving mental health and wellbeing.

The course, as the name implies, provides training in mental health first aid, which is help given to a person experiencing a mental health problem, before professional help can be obtained. The aims of MHFA are:

- to preserve life where a person may be a danger to themselves or others;
- to help prevent the mental health problem developing into a more serious state;
- to promote the recovery of good mental health;
- to provide comfort to a person experiencing a mental health problem.

The course shows participants how to provide initial help to a person with symptoms of a mental health problem, and how to guide a person with symptoms to seek professional help.

The five basic steps to MHFA are:

- **A**ssess the risk of suicide or self-harm;
- **L**isten non-judgementally;
- **G**ive reassurance and information;
- **E**ncourage the person to get help;
- **E**ncourage self-help strategies.

Overall aims of MHFA pilot programme in CAWT region

- To examine how acceptable and appropriate MHFA is in third level education settings.
- To test the feasibility of delivering MHFA across CAWT, and in partnership with the voluntary sector.

Aims of the evaluation

To evaluate the *process* of implementing a Mental Health First Aid training programme in the CAWT region, and to assess the impact on instructors and participants in order to make recommendations for infrastructural and resource needs and adaptations that would enable successful roll out of the programme.

Objectives

- To assess the feasibility and sustainability of MHFA, including the necessary infrastructure, resources and personnel required to implement the programme, with its focus on young people aged between 16-25 years.
- To investigate participants' experiences and attitudes towards the training programme, including views on the organisation and delivery of the course.
- To assess the impact of the course on participants' attitudes towards mental health, reported knowledge of mental health issues, and skills in dealing with these issues. Also, to assess any perceived benefits to the client group.
- To make recommendations for improvement and roll out of the programme in order to maximise sustainability.

Sample

A total of 15 instructors across the CAWT area were fully trained to deliver Mental Health First Aid. Instructors were based in the Southern and Western Health and Social Services Boards in Northern Ireland, and the former North Eastern and North Western Health Boards in the Republic of Ireland.

They were employed by the statutory health sector and Aware Defeat Depression, and were required to work in pairs to deliver at least two MHFA courses in their area between January and May 2006. Instructors delivered 21 courses to approximately 234 participants in this period. All instructors and all participants were included in the evaluation.

Methodology

Prior to the training, 15 instructors completed a baseline questionnaire to assess attitudes, knowledge and current views of MHFA. A second questionnaire was completed after training to measure changes in attitudes and to establish initial views on delivering MHFA (n=10). Thirteen instructors also participated in three focus group discussions, which focused on effectiveness of delivery, content of training and participants' reactions.

Instructors were also asked to complete diary feedback after each course delivered, to highlight issues around MHFA participant suitability, group dynamic, and practical issues around preparation and need for supporting resources.

MHFA course participants completed pre- and post-training questionnaires focusing on knowledge and attitudes towards mental health issues, and willingness to help someone with a mental health problem.

The pre-training questionnaire was completed by 231 participants, and after an interval of three months, 110 participants completed a follow-up questionnaire. This resulted in a response rate of 48%, with the resultant post-training sample broadly representative of the original sample of 231. The post-training questionnaire also tested participants' recall of the MHFA approach and asked whether or not they had made use of it.

Summary findings

Effective targeting?

- The original aim of the pilot was to improve the mental health of young people aged 16-25 years in the CAWT region. The pilot training appears to have successfully attracted a substantial number of participants who work with this client group in a range of settings. Information on the settings in which participants work showed that 52% work in health, 29% in education, 1% in health and education, and 18% in a different setting. These different settings included: youth work; child protection and family support; supported accommodation; telephone helpline; and voluntary work.
- Participants were asked if they work with a particular client group and 70% said they did. These groups included: people with depression; young people aged 14-25 years; students aged 17-21 years; parents and children; occupational health; victims of conflict; gay and bisexual men; those who call a telephone helpline service; those aged 16 years and over leaving care; mature third level students; people with suicidal tendencies; and carers of people with depression.

Participants' views on MHFA training and its impact on confidence and motivation to provide help

- 99% of participants welcomed the training. 97% said they were satisfied or very satisfied that MHFA *'shows you how to provide initial help to a person with mental illness'*. 95% were satisfied that MHFA provided *'information that will allow you to recognise the symptoms of mental illness'*. When asked *'did MHFA provide information to you on how to guide a person with a potential mental illness towards professional help?'*, 93% said they were satisfied or very satisfied that it did.
- Four questions assessed the effect of MHFA on participants' confidence, skill, motivation and knowledge to offer someone help. At least 9 out of 10 respondents answered positively to all of the statements, with high levels of strong agreement for confidence and motivation. Three months after training, 90% of all participants were able to recall the five basic steps of MHFA.
- Of those who had encountered someone experiencing a mental health problem prior to training (89%), 30% said they gave a lot of help, 41% said some help, 24% said a little, and 4% said none at all. The most frequent types of help offered prior to MHFA included: listening and offering advice on how to see a doctor or other professional who could help (67%); kind words of encouragement and helpful information given in confidence (15%); support (11%); advice on how to cope (4%); and sharing their own experience with the person (4%) (Base=75).
- After training, 79% (Base=110) of participants said they had encountered someone experiencing a mental health problem in the last three months. Of these, 98% offered MHFA. After training, participants added to the type of help they would have offered before training. For example, in addition to recommending professional help and offering words of encouragement, participants drew on the specific steps outlined in MHFA (ALGEE). The use of ALGEE looks to have provided a structure to how participants offered help. Although participants were offering help before training, the MHFA steps may have acted positively in allowing participants to articulate the type of help they were offering, and provided a more standardised approach to doing so.

- To establish if there were any benefits for the person to whom help was offered, participants were asked what resulted from offering people MHFA. The six most common responses were: the person felt at ease to talk about how they were feeling (21%); they visited their doctor (19%); they sought further help (17%); they had a more positive outlook (6%); the person went to a counselling programme or started therapy (5%); the person left feeling better, with knowledge of coping strategies (5%). Six percent of participants reported that they were unaware of the outcome or were a helpline volunteer and so, again, would not have been aware of the outcome.
- The original aim of the project was to target those who work with 16-25 year olds, so that over the longer term, the mental health of 16-25 year olds could be improved. In an attempt to gauge who in the population are benefiting from participants' support after MHFA, participants were asked to give some indication of the age of those they helped. Estimates are crude as participants could not be expected to recall exactly the gender and age of everyone they had helped. Results show that 60% of participants who responded to this question helped clients or colleagues aged 37+ years, while 55% helped clients or colleagues aged 16-25 years. Among family and friends, 65% of participants helped people aged 37+ years, while 21% helped those aged 16-25 years. Among 'others' who were offered help, 76% of participants helped those aged 16-25 years, and 64% helped those aged 37+ years. 'Others' include callers to a helpline, those attending a support group, general public, a neighbour etc.
- Participants gave examples of the additional information they would have liked included in MHFA training. Just over a third responded with suggestions (35%, n=38). Suggestions could be divided into information needs and skills-based needs. With regard to information needs, the most popular were: more real-life stories of people with mental health problems (n=5); more medical information (n=3); support from voluntary organisations (n=3); video of people with mental health problems (n=3); and more detail on the various conditions (n=3). In relation to skills-based needs, listening skills was the most common suggestion (n=2).

Some participants suggested that delivering training to the public should be separate from the courses delivered to organisations (n=2). In the context of government strategy, participants suggested that MHFA should be more widely available and it should be accredited to educational institutions, in order to improve mental health awareness in general (n=3).

Instructors' views

- Instructors comprised statutory (n=6) and voluntary (n=9) personnel. In all, 10 worked in a health setting, 2 worked in an education setting and 3 said they worked in both.
- The majority of those trained as instructors work directly with clients, specifically: those who suffer from depression or their carers; those who work with adults with any mental health problem; third level students; young people in the school setting and substance misusers.
- Prior to training, all instructors welcomed the initiative and said that MHFA will "address an issue we have needed to address in our area". The majority (13 out of 14) also said that MHFA will address one of the key priority areas for the organisation they work in.
- Few instructors had many concerns at the outset. About half were concerned about the time commitment necessary for their own instructor training, six (out of 14) were concerned about the time burden of delivery, and five were concerned about what support they could offer participants during delivery.
- After receiving instructor training, concerns increased. The number voicing concerns rose from about a third of instructors to 8 out of 10. These concerns centred on: time to deliver the training; administration time; participant recruitment; content; and concerns for what support they can offer participants.
- Instructors made several recommendations about content, delivery, participant information and roll out, as outlined below.

Instructors' reporting of participants' reactions

- Feedback at the end of the course was overwhelmingly positive. Instructors talked of participants discussing how they would view other people, how their feelings have changed, and for some, how their actions will change.
- Instructors who received anecdotal feedback from participants reported that MHFA contributed further to the participants' knowledge of what is mental health and how to help someone. Participants who could see how MHFA would fit into their roles or lives also made some comments to instructors. Comments received from instructors are presented below.

"The out of hours people were saying that it was going to help them deal with the crisis calls, of which they receive a lot, particularly anxiety and panic...they gained more skills in terms of dealing with those."

"One medical professional said she knew that you had to ask about suicide ideation but never knew where to take it after that, and now she does."

"One girl stopped at the end of the course to ask us more questions and then said 'I'm going to listen to people, I don't care what anybody says, I'm going to listen to people.'"

"Another girl used it when she was with somebody who had a panic attack ...they said it was absolutely brilliant, they didn't realise how important the simple things are and realised how much we can do if we just sit and listen."

Specific recommendations from instructors and participants

Course content and materials

- The main issues with the content and materials involve a need for more local context, information and statistics. Instructors were also of the view that examples/video etc should be of local people.
- Instructors found the participants' manual to be an excellent resource. However, some instructors considered whether the manual should be adapted for use with lower literacy participants.
- Instructors debated some of the content and were of the opinion that some sessions could be edited. They were keen that the order of sessions is examined, in particular to ensure that the course sessions end on a positive note, eg self-care, relaxation. Instructors should be included in any discussions around amending or adapting materials.

Delivery of MHFA

- Instructors did not deviate much from the two-day approach and those who did found no major problems. However, the majority felt that two consecutive days was most effective as it allowed for better group bonding and participation, but highlighted that this was intense and exhausting.
- Delivery in pairs was preferred as course delivery is intense, and instructors felt they needed the support of another instructor. This also allowed for additional support for participants if needed.

- Some instructors felt that consideration should be given on whether MHFA courses should only get scheduled at the beginning of the week, to avoid the lack of support or services available at the weekend if a problem should arise for participants.

Instructor recruitment

- With some groups of participants, instructors had the view that training in the delivery of MHFA was not enough to address some of the questions and discussions raised. When questioned, instructors had to rely on their background knowledge of mental health going beyond just reading the MHFA manual. This would suggest that the rigorous process of selecting instructors with prior experience is a necessity.
- It was suggested that potential instructors should attend MHFA as a participant before deciding to become an instructor.

Support for instructors

- There is a need for adequate emotional support for instructors (post course delivery) in the form of mentor or peer support.
- Regular updating of course materials.
- Regular networking for instructors.

Participant recruitment

- Ability and background did not seem to be a factor in effective delivery or participant interaction in the pilot. However, instructors were of the view that they would like to know more about participants' backgrounds and experience. A pre-course background form may be helpful.
- Instructors were of the view that future participants should be willing attendees rather than being referred by their employers. There is a need for potential participants to be fully informed of the nature of the course and its intended outcomes in advance of attending. Pre-course information should inform people of the universal level of course content and pitch.

Initial recommendations regarding sustainability/roll out of MHFA

- All instructors were of the view that there is a need for MHFA and a demand for training. A broad range of potential participants were suggested by both the instructors and the participants themselves. However, it must be remembered that most participants in the pilot were from a relevant background, had a reasonable level of experience and good educational ability. Examples of those suggested as future participants included GPs and the police, through to taxi drivers and 'anybody'. Some consideration should be given to how appropriate the participant manual may be for low literacy participants.
- Instructors were of the view that there needs to be an all-island coordinating body. The appointment of an MHFA training coordinator/officer was perceived to be vital for sustaining MHFA. Their role would involve: organising and coordinating future training; making available relevant equipment; booking venues; and recruiting participants so instructors are left to solely deliver training. The training coordinator/officer was perceived to be a person/organisation that promotes MHFA and places it within the regional mental health policy context and actions for Northern Ireland and the Republic of Ireland. They should also make it recognisable to the general public.

- Instructors recommended organisers for MHFA, and believed that ASIST should coordinate the delivery of both training courses, with MHFA being a precursor to participants receiving ASIST. Consideration of the objectives and content of each course needs attention to identify if one course can complement the other.
- Charging a fee to attend training was suggested as a potential means of financially sustaining the programme. Instructors recognised the benefits to financing the programme; however, introducing a fee was perceived as a potential barrier restricting some participants from attending. Some instructors said they had been approached and offered payment to deliver training, which suggests that there is a willingness from some organisations to pay for MHFA. These particular instructors were approached by employers.
- Continuing development for instructors was raised as a point of consideration for sustaining MHFA. It was suggested that MHFA in Ireland should have its own trainers using the expertise already present in Northern Ireland/Republic of Ireland, without a reliance on Scotland.
- Establishing a direct link with Australia and Scotland to identify best practice in sustaining MHFA was considered helpful. It was suggested that we could learn from the process Scotland followed in adapting information contained in the original Australian MHFA manual. Current instructors should be consulted about revisions and it was suggested that the statutory and voluntary body should come together in partnership.
- Future delivery of MHFA should have evaluation built in to the training to ensure the quality of the programme delivered by instructors is maintained and has an impact at community level. Accountability and monitoring of the programme was emphasised, with the view that after two or five years, the effectiveness of the programme could be determined.

Recent developments

Following the success of the pilot, and the growing demand for MHFA, the HPA has purchased the licence for the MHFA training programme and is currently adapting the original teaching materials specifically for use within Northern Ireland.

This is happening in consultation with the instructors who took part in the pilot delivery of MHFA, and with a number of key individuals and organisations who have specialist knowledge and expertise in this area.

In the Republic of Ireland, the HSE is currently looking at the implementation of MHFA across all counties. However, further discussion is required before any decisions can be made about how MHFA can be rolled out within HSE.