EXPLORING THE THEMES ELICITED AND CONCEPTS DERIVED FROM THE MENTAL HEALTH FIRST AID'S PUBLISHED EVALUATIONS

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Abstract

A decrease in funding for mental health services has had an impact in the number of resources available to the public in England. As a result, governmental interest towards Mental Health First Aid England (MHFAE) has emerged. The goal of MHFAE is to equip citizens with the skills necessary to offer first aid support to those struggling with mental health issues. Governmental support is supplemented by the program's claim of efficiency and recognized success.

The aim of this study was to investigate how the MHFAE surveys are justified as efficient and the implications of using surveys to inform policy. Research was conducted through an assessment of the reports published by MHFAE which contain participant evaluations of the trainings. This exposed what data is measured in the surveys and how this compares to the aims and objectives of MHFAE. Theories produced exposed the program's definition of "efficient" and how this has an impact on policy.

This research was conducted using grounded theory. Literature on Intervention Mapping provided a framework for which was used to achieve the aim and objectives of the research. The data gathered was coded in multiple phases and the concepts discovered were combined to identify a core theme within the surveys. An analysis of the language used was supported by symbolic interactionism.

MHFAE trainings appear to elicit the reaction/feeling experience of the participant. The questions used struggle to fully measure the MHFAE's objectives. Combined, these observations led the researcher to conclude that the surveys do not gather enough information to measure if the objectives are being achieved. As objectives are the foundation in achieving the aims of the program, these too are left unmeasured.

The MHFAQ and responses define the training experience as efficient through the measuring the reaction and feeling of trainees' experience. This exposes potential implications for policy, as the evidence-base does not provide sufficient evidence of learning or behavioral change. Adjustment requires a needs assessment of multiple subcultures, improved surveys for trainings, and researchers to provide a deep analysis of feedback.

The researcher was able to theorize that the MHFA evaluation measurements are variably subjective. This system gauges personal interpretation without specifically directing the questions towards the stated goals of the program. Adjustment requires a needs assessment of multiple subcultures, improved surveys for trainings, and researchers to provide a deep analysis of feedback.

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List of Abbreviations

MHFA	Mental Health First Aid
PHE	Public Health England
IM	Intervention mapping
OC	Open Coding
AC	Axial Coding
SC	Selective Coding
LS	Likert Scale
SI	Symbolic Interactionism
GT	Grounded Theory
MHFAQ	Mental Health First Aid Questionnaire
LGBTQ	Lesbian Gay Bisexual Transgender Queer
MHT	Mental Health Therapy

1. What is Mental Health First Aid?

The Mental Health First Aid (MHFA) training program was piloted in Australia in the year 2000. The program was built using the framework for medical first aid with the intent to increase mental health literacy. In the eighteen years following it's release, 24 countries have incorporated the program into mental health structures [1]. In 2007, England launched this program under the Department of Health's National Institute of Mental Health England [2]. Currently, it receives "interest and support" [2] from all government parties; two of which have trained members, such as the Mayor of London, Sadiq Kahn (Labor), Norman Lamb Member of Parliament (Liberal Democrat), and Jeremy Hunt, Secret of State for Foreign Affairs (Conservative) [2]. The Department of Health has promoted this program [3].

The current goal of the England-based program is to "reach 1/10 people in England.[2]" This is done through "empower[ing] people to care for themselves through reducing mental health stigma [2]" and by "breaking down barriers [2]" in the health system to support those who need to "stay well, recover, [and] manage [2]" mental health. It is self-funded and registered as a community interest company [2].

Recently, governmental interest towards MHFA has emerged. Public Health England (PHE)—an executive agency with a budget supplied by the Department of Health and Social Care— is currently funding £15 million to develop, test and supply a governmental campaign. Teresa May, Prime Minister of the United Kingdom, has pledged £200,000 to assure that there is at least one trained MHFA "Champion" in every state school [2].

A series of austerity measures in the U.K. have resulted in funding cuts from mental health care [4], leaving stark inequalities between biomedical and mental health budgets. Thus, this method of intervention is an effort to expand capacity through decentralization and community involvement.

Data to support the success of this model is presented in the 21 reports published on the MHFA website.

Governmental use of the program is supported by the company's published evidence of success, defined as follows: international recognition with over two million people trained in the countries where it has been integrated; including 250,000 people in England. Their evaluation and research has been conducted independently and demonstrates "positive outcomes in improving attitudes, skills and confidence (mhfa.co.uk)" surrounding mental health. The body of evidence published on the MHFA website supports the company's claim that a positive change is occurring through the training program, as well as those receiving support. Evidence-based elements of the program are supported by the book *10 Keys to Happier Living from Action for Happiness* by Vanessa King and the Mental Capital and Well-Being Project's Five Ways to Wellbeing, as produced by the New Economic Foundation's think-tank [2].

2. Introduction

The government's involvement with MHFA draws a need for assessment into the program's efficiency by an academic unaffiliated with either body. To analyze the program's outcomes, and the scales used to measure, research and examination into the evaluations being published must be conducted. This research will assess the training outcomes compared to the stated aims and objectives of the program.

The MHFA program consists of several subcategories: Standard, Youth, Schools and Colleges, Armed Forces, Lite, and Instructor Training. The length of training ranges between three hours to seven days [2].

The goals of this program are to:

- Prevent a loss of life in a situation where an individual is at risk of self-harm

- Offer assistance to prevent a mental health from progressing to a serious level
- Encourage mental health recovery
- Nurture and offer comfort to an individual struggling with mental health
- Reduce stigma of community-specific mental health issues
- Increase awareness surrounding the mental health; causes, symptoms, and solutions for help [2]

The developed training works to achieve these aims through a curriculum that teaches participants to:

- Identify externalized behaviors signaling distress
- Distinguish the defining characteristics of Mental Health Therapy (MHT) and MHFA
- Instill confidence when providing assistance in a MHFA setting
- Advise and direct the person in need to seek assistance from a mental health professional[2]

Participants are surveyed on the experience in various ways: some use a self-rating scale while others provide an opportunity for general feedback. Surveys are conducted at various intervals, whether before and after the train, immediately following the training, and even up to three-to-six-months after. MHFA has developed a survey, while various trainings have developed questions specific to their audience.

The evaluations used in the program have originated from different sources: the MHFA program; independent organizations offering the training. The surveys use multiple formats to pose a variance of questions and gather responses. Some examples include: a Likert scale (LS), hypothetical situations, and general feedback.

Research into the measurement of MHFA training content literacy will further test for efficiency. Specifically, research into the complexity of how evaluation methodology influences the contextual definition of “efficient.” Thus, an important question remains: If MHFA defines “effective” as a

fulfilment of stated aims and objectives, how does this relate to what is being trained and measured in the program? And, more importantly, to the targeted population struggling with metal health issues?

3. Literature Review

The primary steps for assessing MHFA training requires a review of research conducted by scholars in the field. The following section will review methods for developing evaluations that gather reliable results, to then be used to for adjusting the program to work at maximize capacity. The time sensitivity and costly nature of intervention development and continuous evaluation enforces the salience of efficiency and efficacy [5]. Therefore, the development and implementation that goes into a training program is a process that requires diligence and precision. Thus, it is necessary to research and understand the theories that stand as the building blocks for the frameworks used when designing a training program.

For this section, the researcher used Google Scholar to search the phrases: “how to develop curriculum program”, “steps to develop training program”, “steps to develop intervention program”, “intervention mapping approach”, “training needs assessment”, “develop mental health program”. These phrases generated results for biomedical and mental health programs and both were used. This is intentional, as the MHFA program is structured to address mental health, yet developed using a medical first aid framework. To assess the development of training programs in the context of this paper, both categories must be addressed. The research reviewed spans from the years 2000-current (2018) to incorporate the literature used from the date of program initiation and that which has evolved since its inception.

The literature reviewed made common reference to the Intervention Mapping (IM) approach. The aim of IM is to “develop effective behavior change interventions [6],” synthesizing actual evidence

with theory from previously constructed model. The IM process, as proposed in 1998, is constructed of five steps. First, a set of objectives must be clearly defined and applied. Second, theory-based methods of intervention must be constructed. Third, researchers can specify plans for implementation, specifically addressing the target audience. Fourth, the execution and application of the program using the evidence acquired in steps one through three. The fifth step is to establish clearly defined parameters for evaluation [6].

The MHFA has published a clearly defined set of objectives from which are supported by two pieces of literature: *10 Keys to Happier Living from Action for Happiness* by Vanessa King and Five Ways to Wellbeing as drafted by the think-tank, New Economic Foundation. An intervention has been specifically tailored to the audience, as is seen in the four established programs and the two in development. The program has established defined parameters for evaluation.

Scholars have argued the original IM approach is inefficient at reaching maximum potential due to an indefinite definition of the "theory-base" in step two; causing deficiency to occur throughout the construction of the following steps. Kok et al. argues that a stronger attention toward behavioral theory must be addressed to illustrate the practical parameters of the IM method. Thus was produced an expansion on the initial proposal, titled "A taxonomy of behavior change methods: An IM approach." This taxonomy reduces and eliminates the wrongful translation that occurs between the interpretations of 'theory-based methods' which result in a supposition of outcomes. This variation of the IM approach offers a practical application for implementation [7].

In providing a technical approach, a clearer distinction between theory and application occurs. First, Kok et. al suggests that researchers administer a needs assessment and analysis of the recognized problem. This involves a recognition of the problem and the target population to which it belongs. Second, develop a matrices that includes behaviors and the determinants that work in tandem, defining 'behavioral determinants' as "…generic aggregates of beliefs, which are… specific

to behavior, population, and context [7] ." This helps detect the beliefs that must be targeted in program development. Third, research into theories that best support the intervention methods chosen for the aggregate of determinants which stem from recognized beliefs. Using this evidence to render a practical application fulfils the parameters of the chosen methods. Fourth, synthesize the research accumulated in the previous steps to create an organized program. Fifth, develop a plan for implementation; focusing on the methods necessary to support the target population. Sixth, develop an evaluation to measure the effectiveness of the program.

This method argues that there are three conditions necessary for a behavior method to be effective. First, the objective must target the cause that predicts behavior. A fundamental understanding of an intervention requires the defining of a behavior change method and the determinant it can change. Second, the method used must be capable of creating a change to the stated target. Thus, research into the prediction of relevant behavior must be conducted. Finally, the first two conditions must be rendered into a practical application that is specifically developed for the target population; recognizing the culture, context, and needs. Therefore, when the methods are administered, the targeted measures for effectiveness must be fulfilled.

This theory states that each program must be specifically tailored to a target audience. In tandem, the behavior-specific methods identified must carry through into the evaluation section. This insinuates that an intervention can use a single theory to develop and support a general aim. Yet the application may need to be adjusted depending on an audience's behavioral determinants. This further extends to outcome measurement, for which the survey must be developed with the identified determinants in mind.

Academics in the field of intervention development offer variations to the IM approach. As offered in *Steps in Intervention Research: Designing and Developing Social Programs*, the authors explain that first, researchers must establish an in-depth understanding of the target problem and the

theories that work in tandem to support a change. Second, program developers can begin the design of materials and the measurements applicable for efficacy. Third, researchers must test the efficacy of the program and refine where necessary. Fourth, through a variety of settings, the effectiveness of the refined model must be tested. Fifth, circulation of program material can begin [8].

This proposal offers several of the original concepts. However, this does not suggest creating a central objective. Instead, it begins the process with problem recognition while considering the demands specific to the target population—highlighting the use of 'theory' as it is applicable to support a change. Again, a piece of development involves establishing the measurements necessary to assess outcomes. Yet, this is subjectively stated and does not clearly define how to do so. The next step guides the developers to use the proposed measurements to test the 'success' of the program and to use this information to refine if needed. After this, the circulation of program material can begin. This insinuates that adequate testing must be conducted prior to administering of the program.

The literature surrounding IM has shown a demand for practical application and measurement of outcomes. Kirkpatrick's Four Levels of Training Evaluation in Detail [9] (see Appendix A) provides just this. This contribution provides evaluation techniques specifically developed to elicit the information researchers have identified necessary, taking into account target population, problem, and behaviors. This table is salient to understanding the stratification of outcome measurement.

The information provided in the table is relevant to the IM technique and the MHFA framework. Literature on the IM approach addresses the need for evaluation application, using an incorporation and measurement of behavioral change methods. Kirkpatrick's does this by targeting four different evaluation types which are based on behavior. This recognizes that for different purposes, different outcomes can occur, soliciting different measurement needs. For this research, the

Kirkpatrick's Four Levels of Training Evaluation in Detail will be used as a framework in the research conducted within this paper.

To generate change, a fundamental comprehension of the change—such as aggregate beliefs and behavior determinants-- in focus must be established. Evaluation is valuable tool for measuring this and setting a goal for achievement. This requires insight into what evokes the behavior of interest such as "ideas, or cognitions, or emotions, or beliefs, or processes, or automatic associations." Personal determinants are generic psychological variables or process of operation, whether empirical or theoretical, which influence behavior. Yet, the idea of 'belief' is generic, further complicating the research for development. Therefore, discovering a 'change objective'-- the defining and selection of a belief to be the intervention target-- must be delicately and diligently conducted [7].

Selecting a change objective for a large-scale program is a complex task due to the face that a specific intervention, developed for a target population, may prove to be effective for a specific behavior, but may not prove to have the same outcomes for other groups. This is due to the determinants at hand and the variance that is shown between the types of determinants and the methods used. Therefore, the method must be carefully built on accurate, relevant, and specific theory.

For example, schools are a salient actor and outlet to providing mental health assistance to children and youth. Therefore, it is important to understand the impact of these programs as they apply to their audience. A research review studied references which included multiple research designs with an inclusion of a control group and the use of standardized measurement for outcomes. This computerized search yielded 47 studies. This exploration exhibited that school-based mental health programs do provide evidence of impact. However, further investigation showed the content does not focus on specific clinical syndromes [10], only behavior. Therefore, it can be concluded that

for school age children, a focus is needed for externalizing behaviors that present themselves due to emotional problems.

This review provides actions that must be conducted to successfully implement intervention programs. These are defined as: 1. consistent application of program material; 2. parent, teacher, and peer involvement; 3. synthesis of various procedures and methods; 4. a synthesis of program material into general classroom environment; 5. a provision of contextually relevant concepts [10]. The five steps provided are a variation of the IM approach, developed for a target audience, addressing behavior. This is evidence for the validity of, and further strengthens, the proposed IM approach.

Yet the conflict of interpreting clinical syndromes versus behaviors is an example of how measurement is difficult to interpret because of chosen theory. The study states that the research does provide evidence of impact; focusing on the externalized behaviors that are a result of emotional problems. This can be easily defined as targeting the change objective. However, the programs neglect to recognize the fact that clinical syndromes can be an influence of behavior, as well, but do not fit the definition of a behavior determinant.

In a similar paper covering theories on interventions for changing behavior, technique is linked to theory using two systematic reviews, nine textbooks, and a review from four experts in the field. This was conducted to measure the effectiveness of the techniques in focus. This was then applied to the 11 theoretical constructs that pertain to behavior change [11].

Through this exploration, Michie et. al establishes a ‘best practices’ for developing intervention. The paper states that first, the developer must choose a small, yet concise, group of theoretical frameworks that have empirical evidence to support their hypothesized predictive intervention values. In this research, the evidence-base must support that a theory can effectively predict the behavior in focus and that suggested intervention can actively change the determinants

involved, thus achieving a change in behavior. Therefore, the essential component to development rests in the identification of techniques to change behavioral determinants. This supports Kok et. al.'s contribution of developing behavioral matrices from which theories can be developed.

The conclusion further supports the use of theory during intervention development, suggesting effectiveness increases when a focus is established on "target casual determinants of behavior and behavior change [11]." This requires an in-depth understanding of the nature of the mechanisms for changing theory. Therefore, theory involves the gathering of evidence to develop the appropriate epistemology to support the development of a model. To guarantee this, evaluation and testing must address behavior.

A synthesis of literature provides a general description of behavioral outcomes as presented through empirical evidence. Dean L. Fixsen et al., shares the observation that an ample amount of science related research has been conducted into the development and identification for evidence-based programs, yet a neglect occurs in the research pertaining to the implementation of these programs. Furthermore, Fixsen et. al argues that behavioral change goes beyond the individual's own self. The researchers provide contextually-specific technical suggestions, stating, "implementation is synonymous with coordinated change at system, organization, program, and practice levels [12]." Thus, fundamentally, implementation proves most effective when: actors involved receive coordinated instruction, support and coaching, and regular performance evaluations; necessary infrastructure for a skillful training with recognition for timeliness; all actors are involved in the evaluation process from selection to evaluation; policies and regulations provide a framework for the implementation and sustaining of programs [12]. This further stratifies the complex nature of intervention development and the specificity of evaluations depended on population, need, and the "evaluation level and type," as shown in Kirkpatrick's table.

Fixsen claims that a demand for improvement has inspired efforts to research and enhance developed programs and standard practices. This has occured through the cataloguing and assessment of all evidence-based programs and standard practices. This process works to refine the definition of what constitutes an 'evidence-base.' However, while this effort establishes a collection for analysis, it does not thoroughly discover the factors necessary for effective implementation. This identifies a common hole in current literature [12].

In summary, literature addressing intervention development has been continuously evolving since the year MHFA was implemented. With the information provided, the researcher concludes that each program must be uniquely tailored to multiple variables, such as the ideas, emotions, and beliefs that form from cultural heritage, gender, economic status, etc. Therefore, interventions must be diligently developed with the awareness that they cannot be developed for blanket application. Instead each one must be uniquely designed for the realities of the target population. Most importantly, accurate and substantial evaluations must be developed to ensure constructive criticism is provided.

3.1 How does the literature inform this research?

The literature used works as a guide for the researcher to dissect the MHFA published evaluations. The concepts derived in this section expose the value of creating appropriate evaluations for measuring the outcomes of a program. This gauges efficiency and offers insight into where there is room for improvement. However, there is a multiplicity of evaluation types for what to measure; whether reaction, learning, behavior, or results. Therefore, the MHFA program's claim to be 'efficient' rests in how the researchers have described their objective, which must coincide with the type of evaluation used.

4. Research Aim

The aim of this paper is to investigate how the independent research conducted by MHFA England is justified as efficient and the implications of using surveys to inform policy.

5. Research Question

How are the evaluations used by the MHFA program defined as efficient and what are the implications for constructing public mental health policy on these evaluations?

6. Research Objectives

- To assess and interpret evaluations of MHFA training through coding the evidence published on the MHFA website
- To analyze the definition of "efficient" through the contextual concepts provided by the surveys, exploring the reliability of results from an evidence-based perspective.
- Identify the possible implications of using this evidence to support public mental health programs

7. Methodology

A review and analysis of the literature provided by MHFA will be summarized using an integrative review method. This style is most appropriate as it allows for a synthesis of qualitative and quantitative data (Whittemore and Knafl, 2005). For the context of this study, this design addresses both style of measurements used in the evaluations being reviewed; the surveys aiming to gather quantitative data using a LS and those that allow for qualitative responses.

It has been suggested that this method of review is ideal for assessing evidence-based schemes [13]. Systematic reviews and meta-analysis rest on the pinnacle of the evidence hierarchy (Whittemore and Knafl, 2005), yet these do not allow for the breadth, nor depth, necessary to analyze the complexity of mental health status. This is contextually applicable for the following research, in

which the MHFA uses the success rate of a medical first aid program as the framework to the development of a program that rests within the intersection of pycho-social origins. The content of the training is subjective in nature but presented and researched as a science. Therefore, the integrative review method expands capacity for accessible data from which to draw conclusions from.

The following paper focuses on the evaluations being utilized to exhibit outcomes of the MHFA program. The salience in this research has inspiration from the MHFA program being used to support governmental policy. When used for a purpose of such importance, the supporting evidence for implementation must be appropriately valid. To establish this claim, the data must be delicately and diligently analyzed. In this case, the broad allowance of research supported by an integrative review is ideal; concepts will be defined, theories assessed, evidence questioned, methods used to quantify empirical evidence will be questioned, and theoretical literature will be consulted. Specifically assessed will be the evaluations published on the MHFA in England since 2007.

7.1 Study design; research paradigm overview

A research paradigm consists of four parts: ontology, epistemology, methodology, and methods (Scotland, 2012). When conducting research, it is important for the conductor to carefully understand each part of a paradigm and identify a position. This allows for a recognition of assumptions behind the research and how this can influence the chosen methods. For this research, an Interpretivist paradigm will be used due to its qualitative nature.

The following section will provide an explanation of the research paradigm for which the research situates itself. The literature review used to assess the MHFA program's outcome assessment exhibits a need for qualitative investigation. Therefore, in this section, the researcher will argue the philosophical approach to achieve this. To support the declared aims and objectives, an

epistemology and ontology will be identified and supported. From this, a theoretical perspective will be built as a foundation from which will be drawn a methodology and, sequentially, a method for conducting research.

7.2 Ontology and Epistemology

The state in which reality exists, and the methods through which knowledge is explored, is bifurcated in two principal pathways: relativism/interpretivism and absolutism/positivism [13]. "Ontology is the study of being [14]." Situated within this understanding of reality, is epistemology, defined as "a way of understanding and explaining how I know what I know [14]." Relativists believe that reality does not exist outside of our cognitive experience. Interpretivism, as it is confined within relativism, is grounded in the belief that the acquisition of knowledge is developed through language and the lived experience that is influenced by socially constructed ideas, such as gender, race and class [15]. Absolutists view reality as impartial, seeing the world as objective [13]. Positivists view the world as unified by a single reality for which can be quantifiably measured, therefore "…in positivism, the need for rigour, precision, logical reasoning and attention to evidence is required [16]." Thus, research is focused on developing rational and well-founded tools to procure this data.

For this research, a plethora of beliefs and ideas—each of which is unique in its truth—will be explored. Therefore, a positivist approach exhibits limitations. The scientific methodology that draws from absolutism encompasses an account of all variables from which a prediction is formed. The data used by the MHFA surveys do not allow for this due to a selectivity of what material has been released and the format of data presented. A portion of the evaluations being examined have been developed using a positivist approach; measuring program outcomes through the quantification of the trainee's realities. However, a deconstruction of this must extend further—opening the stage for endless variables.

Knowledge, as a concept and the way(s) in which it is discovered, is subjective. The supportive reasoning behind this claim is that knowledge is synonymous with reality and, as perceptions are formed by a series of choices, knowledge is formed by opinion and feelings. This epistemology correlates with an interpretivist approach; drawing concepts from relative and subjective perceptions.

The quantification of program outcomes, as surveyed by the MHFA program, confines the trainee's experience into a single reality. This conflicts with the opinion of the researcher, who believes that each individual is autonomous of their own reality and that each reality is constructed by an endless number of variables which cannot be captured in a LS. Thus, the researcher is critical of the surveys used. To explore this, the research will combine the qualitative responses with the quantified. It is important to note the researcher's viewpoint in concocting a conclusion is through the belief that the world is an entity whose existence does not sustain independent of the knowledge we contribute to it. Therefore, the outcomes of this research are purely the interpretation of the researcher. To avoid bias, other realities will also be recognized.

Furthermore, the researcher views language as a pivotal piece to our construction of reality. The meanings we associate with the world are not inherent, but socially constructed through consciousness. Yet, just as language is used to form our realities, our experiences construct our personal meaning to words. Therefore, the dissection of the language used within the surveys will be conducted through a subjective lens.

7.3 Approach; Theoretical Framework

The intent of theory is to understand, predict, and make sense of realities (**cite**). Therefore, many of the theoretical frameworks contributed to academia test and dispute previously established norms. As such, a theoretical perspective is a framework that supports the established reality of the proposed research; validating why the identified problem, and the need to explore it, exists.

Symbolic interactionism (SI) is a theory centered on communication. Herbert Blumer summarized that human interaction is influenced by the meanings ascribed to things; meanings, and the things to which humans impute meaning to, are strictly influenced by the interactions that occur between individuals and society. These meanings are then interpreted by individuals depending on the situational variances [17]. This theory represents the complexity of developing surveys, as this is a task of measuring individual reality.

Symbolic interactionism commonly works in tandem with methods that incorporate in-depth interviews or participant research [14]. However, the parameters of the accessible data do not allow for this. Nonetheless, the research will use the framework of this theory to compare the language in the qualitatively produced data to the quantitative; offering the knowledge necessary to support grounded theory (GT).

7.4 Methodology

Methodology is a plan of action for supporting the method(s) of research. It is interpretive in nature, as it works to understand experience through the individual's reality. The unpredictability of human behavior results in the research process being inductive; drawing theories and conclusions from the data of focus [18]. This is the inverse of a positivist, deductive approach, which is commonly conducted through the scientific method, in which a hypothesis is developed then data gathered [14].

Grounded theory, as developed by Glaser and Strauss [19], is style of analysis, that is 'grounded' in material that has been comprehensively collected and examined. The framework allows for exploration into the social relationships and the behavioral dynamics that occur within them. The following list are key components to grounded theory:

- The inductive influence allows for data collection to occur simultaneously to analysis

- The categories chosen for coding are specific to the content being analyzed and are integrated into the chosen theory and framework
- The process is not linear, but instead conducted on a positive feedback loop—data is collected and analyzed, theory is generated, the researcher questions what details are missing, and repeats the process.
- Inductively produced, abstract categories allow for the emergence of social processes embedded within language [20]

A salient component to GT is theoretical sensitivity. This allows for the researcher to provide their interpretation of the data, giving meaning to the material. This comes in three parts: 1) an assessment of literature surrounding the acquired knowledge; 2) an incorporation of knowledge from the experience of the researcher, including, but not limited to, that of academic, professional, and social in nature; 3) analysis of the data [20].

For this research, the data will be quantitative (in the style of surveys) and qualitative (responses to open-ended questions). The categories chosen will be specific to the content; drawing concepts from the MHFA published documents gathered. The social processes discovered will be further investigated.

7.5 Method

The coding process used in GT is conducted in three pages: open (OC), axial (AC), and selective (SC). Open coding is tediously conducted as the researcher looks for key concepts and phrases. Next, these are placed into categories and subcategories. This organization allows for the researcher to have a dense and cohesive understanding of the similarities that are presented within the data. Next, the use of AC draws from concepts extracted during OC to make connections between the categories. Finally, SC condenses the concepts to identify a core theme within the material. From this, a theory, grounded in the data, is presented [21].

The goal of using this method is to assess performance measurements (what is being measured and the results) published as supporting evidence by MHFA England. This assessment will discover what the program defines to be successful and what this definition entails. Therefore, within the following section, the researcher will explain the steps necessary to achieve the research goal.

First, the researcher will access and download all of the papers published in the Research & Evaluation section of the MHFA England website [2]. Four of the 20 evaluations listed are not yet published and four do not provide survey information. This leaves 12 documents for assessment *(*see Appendix B). The surveys within will be extracted. Then, an OC of the questions asked within the surveys will be conducted. A hypothesis will be created using the themes recognized. The researcher will use this theory to conduct AC of the qualitative and quantitative data combined. Simultaneously the researcher will ask, 'does qualitative data represent different or similar realities when compared to the quantitative?' At this step in the process, it is important for the researcher to consider the theme extracted from OC, without allowing it to influence the lens through which the researcher is viewing the qualitative data. Last, SC will occur to develop a theory grounded in the data.

The use of theoretical sensitivity will be conducted using: the researcher's personal knowledge, as gained through life experience and an interdisciplinary academic background in population health and global public health and policy; the literature review of relevant materials; MHFA published material. The researcher's past experience will influence the assessment, but will be used in a non-biased way. Literature on IM will be used, as the researcher believes it is the most applicable to the research being conducted. These two arms of the process—personal experience and literature—will be used to analyze the data set.

8.0 Results

The initial phases of OC used the evaluation questions, not the responses. This is justified by the intent of the research: to explore what is being measured in the survey to then determine what is defined as 'efficient'. Attendees' responses were then included during the AC phase, in which the concepts extracted from the responses were used to make connections between the categories established during the preliminary OC.

In isolating the questions posed from the responses they illicit, insight into behavioral determinants—a concept discussed in the literature review—and single-sided personal realities is offered. This exposes the ways in which responses ultimately dictate what the questions within a survey are asking. Upon integration of the answers during the AC phase, the context—or environment—is shifted, a new realm is introduced, and in this space the questions change shape. The use of coding in the context of this study allowed for insight into the psychosocial processes that are being measured within the MHFA evaluation forms.

Selective coding continued with the survey questions and responses to identify a theory grounded in the data. This was conducted using the concepts discovered during the open and AC phase. Codes were condensed, and a theory was developed from the process.

8.1 Open coding

During the initial scan, words, phrases, and concepts that caught the attention of the researcher [22] were compiled into a table (Table 1). Repeated usage and contextual patterns were then analyzed and coded by what response occurred. A second examination used the 'response' categories to plug the data into Kirkpatrick's Four Levels of Training Evaluation in Detail (see Appendix A).

Kirkpatrick's categories, as outlined in the literature review, provide a framework for the coding process to define clear parameters around the questions used in the surveys and to clearly formulate a theory from these definitions. Open coding highlighted the following categories:

reaction, learning, and behavior. 'Results', a fourth category in Kirkpatrick's, was omitted in the coding process due to a lack of relevance and applicability to the context of the MHFA program.

Measuring 'reaction' was used to categorize data that described participant's feelings toward the training. In the context of this research, it encapsulates the information pursued by those hosting the MHFA course and the survey taker's emotional or intuitive response to the external experience; the environment, a general opinion of the content, and capabilities of the individuals presenting the material. Example questions are: Did the participants enjoy the training? Was the training contextually relevant to the situations for which it is intended to be applied to?

'Learning' measures an increased knowledge of program aims. Within the realm of the MHFA course, this covers awareness of symptoms, treatment, and tools to approach mental health, which eventually instill an increase in confidence for instigating change. A generalized 'learning' question would ask: "To what extent did participants advance their knowledge regarding the information presented?" and provide an open-ended opportunity for response. This format measures a change in technical skill. However, it is difficult to encompass complex learning, as seen with attitudinal development—such as understanding stigma.

'Behavior' is the extent to which the information learned was applied to real settings. The behaviors taught in the program are outlined in the following mnemonic:

A- Assess the risk of suicide or self-harm

L- Listen non-judgmentally

G- Give reassurance and information

E- Encourage the person to seek appropriate professional help

E- Encourage self-help strategies [23]

Contextually, 'behavior' would mesure how the participants used the "ALGEE" framework following the training. The timeframe for evaluation varies depending on the situation and can happen immediately following the training or sometime after. A general example of a sample

question would ask: How did participants apply their learning to the context intended? Were applicable skills and knowledge utilized?

'Results' measures how an improvement in performance had an effect on the business. Performance indicators are quantified using volumes, return on investment, and number of complaints. As the training does not have business-oriented aims, this does not apply to the coding process. Therefore, it is not included beyond recognition in research presentation.

Learning, reaction, and behavior are a summary of the analytical categories deduced from the initial phase of data collection and review of the literature. The following table shows a breakdown of the themes recognized during open coding:

Table 1. Words, phrases, and concepts from initial scan.

Example of words; themes	Response	Code
"I feel…." statements	Personal feelings	Reaction
"Rate the following: environment, structure, content, facilitation."	Personal opinion, preference, and reality	Reaction
Knowledge; gained, practicability	Ability to use knowledge	Reaction/Learning
General feedback	Personal opinion, preference, reality	Reaction
Stigma	Personal reality, learning to expand reality	Reaction/Learning
Standard MHFA questions	Comfort of experience: personal opinion, preference, reality	Reaction
Confidence	Probability of using tools acquired; Personal reality	Reaction/Learning
Hypothetical use of training	Comprehension of tools taught	Learning
Application of training	Actual use of interpretation of learning	Reaction/Behavior

After the initial phase of coding, the researcher deducted the following question: "What component of the attendee's experience is being measured?" The following section is a summary of

data categorization from the second review; conducted with the aforementioned question in mind. At this stage, the data was bifurcated into the: 1) MHFA standard questionnaire and 2) surveys developed independently by each hosting group. The researcher felt that a defined parameter for each data set was salient in the interpretation of the data. This logic was constructed after the indicators showed that the MHFA questionnaire provided a large consistency within the surveys, whereas questions included in the independently developed surveys were unique to the training for which they were developed to survey.

8.1.1. MHFA Standard Questionnaire open coding

The MHFA standard questionnaire, as presented in the published research and evaluation documents, uses a LS (1 representing 'very good' with 5 representing 'poor') to rate nine sections of training experience. These sections and their inclusion in each of the documents was accumulated into a table (Appendix B).

The quantitative nature of this survey creates a strictly defined polarity in potential responses which stem from a specifically expressed idea—meaning the variance for interpretation during the coding process is quite limited. For example:

> "How would you rate the presenters/trainers?" (3) [24]
>
> "How would you rate the following overall from the day?
>
> Environment:
>
> Structure:
>
> Content:
>
> Facilitation:" (3)[24]

Therefore, simple deduction allows the researcher to conclude that the MHFAQ measures the 'reaction' of the participants.

8.1.2 Independently developed surveys open coding

A large portion of the data was concentrated into the 'learning' category, followed by 'reaction'. A small number were conducted 3-6 months post training and allowed for a representation of 'behavior.'

8.1.2.1 "Reaction"

The questions coded as 'reaction' used were that created to target personal, subjective reactions to the experience. Some 'reaction' comments were generalized, expressing personal feelings towards the experience:

> "Tell me about the training and what you felt it did for you." (1) [25]

Other questions mimicked topics addressed in the MHFA standard survey, such as:

> "Were you satisfied with the trainers, the course materials and the venue? If not, what was not satisfying?" (1) [25]

The following question was coded as 'reaction' due to relevance:

> "How relevant was the training to your job?" (11) [26]

The use of a LS stifled opportunity for the participant to show specific examples of how the training was relevant. Therefore, this lack of specificity prevented it from being coded as 'learning.'

The following question inquired about relevance, but in a more abstract manner. For example,

"Would you recommend the MHFA training to your manager, colleagues or staff?" (1)[25]

This question indiscreetly references to relevance through a hypothetical social application. In exhibiting a willingness to share this information with co-workers, relevance is insinuated.

The following question combines relevance and practicability:

"Were there any aspects of research participation that were burdensome or unhelpful?" (1)[25]

The word "unhelpful" used in the following statement measures relevance and practicability; as the antithetical to the key word is in congruence to the measurement of focus. This question also incorporates the topic of "ease and comfort of experience" through the use of participation

Reaction surveys aim to measure the trainee's overall enjoyment of the training. The following question achieves this through subjective ("what do you think…?") presentation and general inquiry:

"What did you think of the course content…?" (1) [25]

8.1.2.2 "Learning"

To determine the extent of learning, the method of measurement must be "closely related to the aims of the training [9]." Furthermore, trainees must exhibit an increase in knowledge from before the training to after. Many of the questions in this category have a 'learning' intent, but do not fit the criteria completely. For example, the following questions are general and not specific to the content.

"What was the most useful/effective part of the training?" (11) [26]

"What did you think of… the knowledge you gained?" (1) [25]

"What do participants feel they have gained from the training?" (7) [23]

Furthermore, these questions were posed only after the training hindering allowance for an accurate measurement of change. Therefore, the researcher deemed these questions to conceptualize a synthesis of 'reaction' and 'learning'.

Participants were given the following open-ended question to demonstrate the knowledge acquired and whether it was concordant to the intended teaching:

"How will you make use of what you have learnt?" (3) [24]

This provided an opportunity for participants to apply their knowledge. Moreso, it allowed those responsible for reviewing the evaluations to observe participant literacy.

The following questions also use hypothetical application for expression, yet a degree of 'reaction' is incorporated due to the use of "I feel..." :

> "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." (1) [25]

> "I feel I know how to treat people (staff or clients) with long term mental health problems." (1) [25]

These were administered before and after the training. The survey used an eleven point LS to gather responses. This method of acquirement significantly restricted the opportunity for participants to show if their personal interpretation of the material was consistent to the teaching. This further reinforced the influence of 'reaction.'

The use of "Would you…?" in the following question results in a yes or no answer:

> "Would you know where to signpost someone who needs help with mental health problems?" (1)[25]

"Close-ended question" was a common theme during the coding process. Many of the questions had the intent of measuring 'learning' but does not allow for such representation. This results in a questions being coded into the learning/reaction category.

Using a short answer format allowed for the following question to show the extent of learning that occurred. This structure provides a higher level of freedom than a LS, thus expanding the possibilities for response.

> "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?" (1)[25]

This question completely conforms to Kirkpatrick's 'learning' category. It is important to note that this was only used in one of the surveys. Therefore, it is not representative of the data as a whole. Therefore, it was marked as deviant, and did not have a presence large enough to influence the next stage of coding.

A plethora of questions in the learning category aim to measure the knowledge gained, but do so through subjective questioning, using phrases like "I feel that I know" and "do you think…?" This results in a less concise question than the open-ended examples included above. Thus, clearly defining the coding for this section proved to be a challenge compared to the 'reaction' category—while intention to explore 'learning' was obvious, the vague application prevented the intention from being achieved.

8.1.2.3 "Behavior"

Behavior measures the application for the learning, thus surveys intended to gather this information must aim to recognize how the learning has been put into effect. According to Kirkpatrick's, this can be measured through the participant's ability to train another person or if there was noticeable change in performance. The following questions were coded as 'behavior':

> "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?" (1) [25]

> "What type of help were you able to offer? Who did you help?" (9) [27]

Each question in this section are in partial fulfilment of what is needed for assessing behavior. This category had a small data set which prevented the researcher from being able to make a stable conclusion. Therefore, each questions was marked as 'behavior'/'reaction'.

In asking how people's behavior, learning, and reaction were being measured, a subsequent inquiry presented itself: how are people actually behaving? What is the training providing? This guided the researcher during the AC stage.

8. 2 Axial Coding

Grounded theory involves the collection and analysis of data to work concurrently [22]. In this endeavor, the psychosocial themes that work in tandem to the aforementioned indicators surfaced. Research into the psychosocial processes was determined relevant contextually, as this is conducted to understand the capacity of personal development within the MHFA training program. This is referred to in several dimensions of the learning environment. These can be viewed as the determinants that predict the interpretation of the learning experience, such as the comfort of the participant, motivation for learning, and ease of engagement. For the purpose of this research, these processes were identified as: doing, feeling, and being. There were applied to the responses provided in the training.

'Feeling' represented subjective answers which encompass a singular reality. 'Being' shows the intention of using the material in the future, as well self-rating of knowledge and confidence. Lastly is 'doing' which looked for the actions that happened a result of training. 'Reaction', 'learning', and 'behavior' can be recognized as the counterpart to 'feeling', 'being', and 'doing.'

Qualitative feedback showed a plethora of responses in regards to the trainers. Some participants recognized moderating techniques that were particularly helpful to the group. This

exhibits a “feeling” response because it highlights the comfortable environment offered by the moderator:

> “One of the facilitators was particularly good at allowing people to have their say but then bringing them back and getting them focused.” (11) [26]

> “[The trainer] expressed patience with a range of questions, welcoming and encouraging throughout.” (12) [28]

Some participants recognized the trainers for their knowledge on the topic. The researcher assumes that this acknowledgement in the trainer’s comprehension also requires an understanding of the content. Therefore, the following responses are categorized as ‘being’:

> “[The trainer] was… very informative, knowledgeable and supportive.” (7) [29]

> “Informative; [the trainer] clearly has a wealth of knowledge on this particular topic.” (7) [29]

> “Superb knowledge base and the ability to translate that to people with less knowledge.” (12) [28]

8.3 Selective Coding

During the first two phases of coding, a duality in coding is apparent. Thus, it must be noted that ‘reaction’ and ‘feeling’ were dominant in the coding process. The selective coding process showed that the data gauged a singular reality—one that was unique to the respondent.

Table 2. Data elicited during the stages of coding

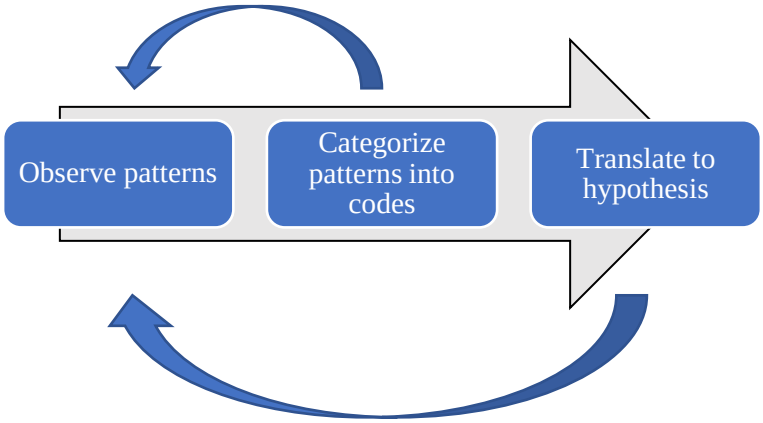
Data analysis exposed a chasm of representation between the questions and qualitative responses. The final theory was described as “perception of evaluation dependent on personal interpretation. The data is subjective; questions and answers gauge individual realities.” This will be covered in the discussion section.

Open coding	Axial coding	Selective coding
Reaction	Feeling	Perception of evaluation dependent on personal interpretation. The data is subjective; questions and answers gauge individual realities.
Reaction/Learning	Feeling/Being	
Reaction/Doing (Reaction; as this research does not take into account the other party’s needs and outcome. Therefore, this data is a single-sided reality)	Feeling/Doing	

9.0 Discussion

The subjective realities represented in the data collected fit within the interpretivist/relativist approach from which the research framework was devised. The data was assessed using an inductive approach [30]. The following table shows the research to be inductively conducted.

Table 3. The inductive process



The major arrow shows the task is linear, however the steps involved are not. The next table provides contextual examples of this process:

Table 4. A contextual example of how the theories were rendered using inductive reasoning

Observe patterns	Categorize patterns into codes	Translate to hypothesis
•I feel statements •Measurement of knowledge; gained and practicability •Application of training	•Reaction •Reaction/learning •Reaction/behavior •Feeling •Being •Doing	•Perception dependent on personal interpretation. subjective; the questions and answers gauge individual reality

Theoretical sensitivity was applied during this process using literature on IM, previous academic knowledge on mental health and policy, and the use of MHFAQ and independent

evaluations. The following section covers the process of data analysis and the extent to which the stated aims and objectives of the research were achieved.

9.1 Key findings

The project involved 13 reports, which covered the training for over 14,250 participants. Five of the documents reported the number of trainings, totaling 107, which were divided by mainly by workplace similarities, both public and private: fire and rescue service, housing council, and an outsourcing management company. Documented survey response rates ranged from 20%-53%. The reports showed a higher attendance of women than men. Only one specified attention towards the BME population. There was no specific reference to the lesbian, gay, bisexual, transgender, queer (LGBTQ) population.

The qualitative responses in this research left the researcher to question the "extent to which claims are supported by convincing evidence [31]." To combat this dilemma, the reliability and validity of the responses was assessed. Validity questioned the objectivity of the training experience. Reliability assessed the applicability of the survey responses as it applies to other contexts [31].

The researcher tested for a consistency in these concepts through coding and comparing the material. Two types of coding were used: one was based on a previously established framework; the other on social theory. Kirkpatrick's table provided a means of categorizing the questions posed within the surveys. Social theory worked as a litmus test for the level of objectivity/subjectivity of the responses. A comparison of the questions and responses allowed for insight into consistency/inconsistencies based on context. A synthesis of these techniques eased the identification of themes within the project.

The LS used for the MHFAQ represents a strong validity and reliability. When plugged into Kirkpatrick's table, MHFAQ symbolized a consistent measurement of 'reaction.' A comparison of

all MHFAQ responses showed a regularity in ratings. However, the relevance of the MHFAQ data was incongruent to the curriculum objectives.

The participants' qualitative responses were more complex than the MHFAQ because the qualitative data exhibited multiple interpretations of the questions. Most of the responses mentioned the MHFA objectives, but did not provide substantial convincing evidence to support applicable learning. These responses only achieved partial fulfilment in addressing the stated objectives. Therefore, the coding resulted in a duality of categories, with 'feeling' being the predominant. Due to the mentioned complexities, the validity and reliability were difficult to measure and do not fairly represent the data.

During the final stages of coding, a theory grounded in the data was exposed as "perception of evaluation dependent on personal interpretation. The data is subjective; questions and answers gauge individual realities." This was contrived through the three essential concepts: discoveries made through plugging questions into Kirkpatrick's framework; the use of social theory applied to categorize responses; symbolic interactionism.

The questions that are intended to elicit quantifiable measurements, result in being coded as 'reaction.' This means that 'learning' and 'behavior' are not represented. Data grounded in reaction it is difficult to understand the applicability of the program. So, when the surveys measure 'reaction' and the survey reports a high number, the training is considered to be 'effective.' But this does not measure the effectiveness of all objectives, which are to learn about and provide assistance.

9.2 Key points

Three key points were salient in drawing a conclusion from the data. These were: the use of SI to read the data, how the data fits with the objects of the course, and what aims are achieved according to the analyzed data. It is important to note that the conclusion is different than the theory

produced during the SC phase. The conclusion draws themes from the research and connects them with the theory, therefore providing a deeper look at the material. The following section provides insight beyond what is communicated through the coding categories; using examples that are deviant due to a small data set, but become significant when combined with the final theory.

9.2.1 Symbolic interactionism

A small set of comments—irregular from the common content, but in tandem with the final code—exposed bold concepts. This observation surfaced through the lens of symbolic interactionism. From this, the researcher inductively produced the following question: How can one analyze the meanings ascribed to topics being taught while taking into account the development of these perceptions, as they are uniquely formed through interactions that occur between the individuals in the training and their relationship with society? The following statements fuel this question:

> "It really depends on the context. What's abnormal in one community might be perfectly normal in another culture/society." (3) [24]

> "Black African Caribbean men can get very excited, enthusiastic when playing Dominos and its seen as mad, crazy, mental health." (3) [24]

> "The stress bucket is Eurocentric e.g., clubbing, debts but does not include race issues, hate crime…" (3) [24]

This expression of ethnicity exposes another layer of reality; marginalized groups are easily neglected in a one-size-fits-all framework. First, this is seen in the training material and further

silenced in the questions posed. In using a LS, the MHFAQ does not allow space to explore culturally-specific feedback from those struggling to have a voice at the table.

Similar feedback was provided in training (6) regarding a lack of attention towards LGBTQ. Report (7) received comments that the case studies addressed only reference to one socio-economic status and that the material was geographically-specific. Yet, in report (11), one participant claimed they could use the material to assist refugees/asylum seekers. This ability to relate the material gives reason to further explore this topic.

9.2.2 Situational variances as the influence for interpretation:

This use of the word "environment" is another variation of SI within the text. In training (7), multiple audience members commented on a poor physical environment. The comments provided describe the training to commence inside of a gymnasium at the end of a long work day. Due to maintenance on the building, noise levels were high and a door was forced to remain open during a snowstorm.

However, in another training, attendees commented on the environment as an intangible experience. One participant attributed the environment's creation "...a result of other people in the group." (1) Another participant commented, "[The trainer] said, 'this is a closed environment here its [sic] completely confidential' and everyone sort of agreed [25]." (1) These comments show the influence of peers on the interpretation of the environment. Specifically, in this situation, the trainer-- the person with the power, thus the most influential-- defined the environment as something that could be internally; emotionally created. Therefore, it can be assumed that this definition was then used for 'environment.'

For this training, environment was measured using a five-point LS, with excellent represented as 1 to poor as a 5. Both surveys provided similar outcomes. However, the qualitative

data exhibited vastly different interpretations of what was being asked. All of the results fit into the general categorization of 'feeling'. However, the former interprets environment in a tactile way and the latter is visceral. This example of personal reality completely detracts the validity of the MHFAQ through introducing the theory of symbolic interactionism.

Symbolic interactionism played a crucial role in the research. This aided the researcher in exploring beyond the compartmentalization of subjectivity/objectivity and into the deepest most meaningful pieces of the objective data. As a tool, it used an individual reality and transformed it into useful, valuable piece of data to be interpreted.

9.2.3. Do the MHFA surveys support the aims of the training?

MHFA uses a defined set of objectives, presented through the curriculum, as means of achieving the stated aims. Contextually, this logic provides that the following four pieces of the training are a measurement for whether or not the aims of the program are being successfully met [23]**:**

Identify externalized behaviors signaling distress

Distinguish the defining characteristics of MHT and MHFA

Instill confidence when providing assistance in MHFA settings

Advise/direct the person in need to seek assistance from a mental health professional

The researcher follows this logic in the following section. Through comparing the objectives to how they are represented in the evaluations, one can conclude whether or not the aims are being met. An accumulation of statements extracted from the evaluations have been categorized into the four components and placed into a table, included in (see Appendix D). This table shows that a minimal number of responses address the objectives of the program.

During the coding process, reaction/feeling was most prevalent. Of the curriculum categories, only one can be coded as reaction/feeling (instill confidence when providing assistance in MHFA settings). The other three are considered technical knowledge and therefore are coded as learning/being. This initial analysis shows a conflict between the common coding pattern observed during research and the MHFA objectives. The following section will assess this further and in more detail.

9.2.3.1 Identify externalized behaviors signaling distress

Only a small fraction of the data references the identification of externalized symptoms. As commonly seen throughout the analysis, a LS was used. This hindered the ability to capture a summary of the topic in its entirety. For example:

> "How confident do you now feel about dealing with people in your workplace who exhibit signs of mental health problems?" (1) [25]

This was coded as 'reaction.' To capture 'learning' the question could be simply rephrased as, "What signs are exhibited when someone is experience mental health problems?" For behavior, the question would appear as, "What ways have you observed signs of mental health problems?"

An attendee's qualitative response was able to show more:

> "Anxiety Disorder has been hugely relevant due to a current issue, and the focus on physical as well as behavioral effects widened my understanding and ability." (7) [29]

This reflection shows the participant is making a contextual connection-- relating the material learned to a current situation. Furthermore, this recognizes that anxiety can have an impact on behavior. This was coded as 'being'. However, specific examples of these maladaptive behaviors are not addressed, therefore evidence of the objective is incomplete. An unfulfilled objective results in being coded as reaction/feeling because it is only shows the reality of a single individual. When material-specific answers are given, the collective reality of material is shown to be understood. Thus, the response is dually coded as 'feeling/being.'

The ability to identify externalized behaviors was coded as 'learning/being.' The common questions used were 'reaction.' The responses showed a combination of 'feeling' and 'being.' The researcher concludes that this objective is not fulfilled to a maximum level.

9.2.3.2 Distinguish the defining characteristics of MHT and MHFA

The material does not distinguishes MHFA from MHT, however, fragments do draw connections to this concept. Again, the use of a LS was inhibitive in measuring the objective:

"Do you think you would know how to help someone with mental health problems?" (1) [25]

The use of "Do you think…" shows a reaction/feeling, whereas the objective is 'learning/being.' This survey question does not allow for participant to express specific techniques learned in the course. From this, it can be concluded that this questions does not capture the information needed to measure the objective.

However, qualitative data showed a common theme of ‘learning/being.’ This claim is supported by audience verbatim references to ALGEE framework. As well, in describing concepts of the training, such as:

> “…learning that it is more important to listen to someone than to give advice.” (8) [32]

Understanding the differences between MHT and MHFA is coded as ‘learning/being’ because it involves an understanding of concepts. However, the questions posed are commonly grouped in ‘reaction.’ The qualitative reactions are a synthesis of ‘feeling’ and ‘being’. The researcher concludes this objective is not fully measured.

9.2.3.3 Instill confidence when providing assistance in Mental Health First Aid settings

The measurement of confidence is subjective and coded as ‘reaction/feeling’. This cannot be a collective reality. Therefore, the use of a LS is appropriate. For example:

> “How confident do you now feel about dealing with people in your workplace who exhibit signs of mental health problems?” (1) [25]

The response provided by this participant exhibits the same coding,

> “It gave the confidence to follow through with a feeling, acting on something.” (8) [32]

This concludes that the objective is reactive/feeling and that the questions and responses run parallel. Therefore, the objectives are achieved.

9.2.3.4 Advise/direct the person in need to seek assistance from a mental health professional

A single question posed attempted to measure this objective. It was as follows:

"Would you know where to signpost someone who needs help with mental health problems?" (1) [25]

This question does not give the respondent an opportunity to provide an example of learning. This inhibits the markers capabilities to affirm the response is accurate. This results in the questions being coded as 'reactive' as it only represents the participant's opinion of their knowledge, not a comparison of the collective reality and understanding.

However, open-ended questions did offer insight into the specific ways in which participants interpreted and applied the data. For example:

> "I listened to a client who suffers from and is medicated for depression, referred this person to psychology and to a specific support group. Encouraged client to see GP about other issues that were affecting their mood and mental health." (8) [32]

This response was coded as 'doing' as it shows an application of the learning.

The goal of this objective is to provide the participant with a technical skill. Therefore, it is coded as behavior/doing. The nature of the question led to it being classified as 'reaction'. However, the theme of qualitative responses mirrored the object, as it was placed into the 'doing' category. The researcher concludes this objective is not fully achieved.

9.2.3.5 Are the MHFA objectives measured to support the aims?

This section exposed three main points. First, the small data set shows a demand for creating more questions oriented towards the program's objectives. Second, many of the questions asked do not fully encapsulate the stated objectives of the program. However, the qualitative responses do. Therefore, the researcher concludes that more data is needed to fully conclude if the aims of the program are being met.

Preventing a substantial conclusion is a lack of open-ended questions oriented towards the objectives. Furthermore, the data needs questions specific to the audience's cultural/experience/collective reality which must be interpreted by someone within this demographic. Currently, literacy cannot translate. This lead the researcher to ask, can the program be considered efficient with the unilateral implementation of a singular objective or is each, equally and mutually dependent?

9.3 Policy implications

Qualitative research is invaluable to policy makers because it offers contextually specific examples of the settings in which a program will be applied [33]. This definition is represented by MHFA's goal to "reach 1/10 people in England [2]". It is to be achieved through the use of the previously explained objectives.

Two discoveries made during the research process support the claim that the MHFAQ does not supply the data required to cover the multitude of contexts in which MHFA is implemented. First, this is seen in the measurements used, which are not in accordance to the program objectives. The MHFAQ is based on tactile experience using a LS and does not measure subcultural contexts. Furthermore, the qualitative responses are not thoroughly interpreted through the use of symbolic internationalism, which gives space to more voices. Second, the outliers in this study exhibit, when compared with the literature review, concepts with highest validity and reliability. These mention the need for more attention towards marginalized groups. Yet, they are only a small fragment of themes represented.

The directionality of interpretation between data and contextual applicably tells two different stories, each resulting in a different implication for policy. If the data presented in the MHFAQ is a complete representation of all contexts for which the training is intended to be applied, then the policy is inherently bias. This is an example of systemic inequalities within the provision of mental health services. Contrary, if the data is recognized as incomplete, then the survey must work to measure this chasm of data to include more voices at the table. Therefore, research must be conducted into whether the data represents systemic inequality or program inefficiency.

As stated, the evaluations do not fully measure the stated objectives of the program. This neglect translates to non-fulfillment in achieving the stated aims. Minimal measurement of important concepts hinders the program from receiving the feedback necessary to improve to full capacity.

9.4 Limitations

The use of an integrative review method; specifically drawing from grounded theory, allowed the researcher to compare the MHFA Training survey questions (the perspective of the program provider) to the responses (perspective of the attendee). In bifurcating the data, the researcher explored the ultimate depth of research through following the chain of reception. Unfortunately, this is the limit of exploration into the MHFA experience, as no research has been published regarding those receiving MHFA assistance from someone trained by the program.

Further limiting the research was the sources and amount of data. The qualitative data provided in the published evaluation summaries was chosen by the author of the report. For this reason, the dataset used can be viewed as bias before it reached the researcher of this study. This also influenced the amount of data presented within each report. For example, many of the quotes referenced to are from report 1 because of it's abundance of material. However, this does not necessarily mean report 1 took the most data—it just reported the most.

This research in this paper was conducted by one person. Feedback was provided by a faculty member assigned to supervise the research, yet they had minimal knowledge of the topic. Therefore, the reliability and trustworthiness is situated within the hands of only one person. This limits the amount of alternative thinking included and explored.

This lead the researcher to ask, can the program be considered efficient with the unilateral implementation of a singular objective or is each, equally and mutually dependent?

9.5 What this research still needs:

The MHFA training program's development and application fits the IM approach as proposed by (Kok et. al.). However, the application is not complete. To improve survey quality, a needs assessment based on the target population must be implemented. An all-inclusive needs assessment will identify the behavior determinants of the target group. As determinants predict

behavior, behavior will be addressed. Contextually, this will expose what mental health problems are commonly presented within the target group and what resources are most likely to be used based on behavior. Currently, this isn't being addressed due to the structure of evaluations; specifically referencing to the MHFAQ.

The MHFAQ is the most consistent set of questions throughout the published data. This consistency is beneficial because it increases the size of the data set and strengthens the representation of the quantified outcomes. However, the questions use a LS, which prevents a portrayal of the situation in its entirety. Using the Kirkpatrick table, the MHFAQ is coded as 'reaction', measuring the experience of the participant. So, while these questions have measurements of 'success' they do not measure the 'learning' or 'behaviors' that occur from the program. The qualitative data shows a different situation than what the quantitative data claims.

The responses show a multiplicity of interpretations to the questions. On one hand, this provides a bounty of useful information pertaining to the training. However, it expands the complexity for understanding the data. The published material does not present a thorough analysis of the qualitative responses. Instead, the data to be presented is selected by the authors of the reports, leading the reader to view these realities through the single lens it is presented by.

To combat this inefficiency, MHFA can improve by minimizing or eliminating the use of a LS. A thorough needs assessment can assist in addressing the learning and behavior that targets the aims and objectives of the program. A combination of provided qualitative data could provide a collective experience of all subcultures. Everyone experiences this differently, so those interpreting and using the data must have a similar life experience.

9.6 What this research has offered to the field of current knowledge:

This research has shown that the current MHFA evaluations tend to seek the reaction/feeling component of the training. Thus, the efficiency of the program is currently measured on subjective, singular realities. However, the stated aims of the program are directed toward learning/being, behavior/doing. The research in this paper has shown that in adjusting the surveys, the program can receive more practical feedback. This will result in an increase of voices to the table, therefore expanding capacity for benefiting mental health issues in England. The researcher achieved the aims and objectives stated.

10. Conclusion

The MHFA England program is intended to decentralize demand for systemic mental health services due to a lack of funding and resources. However, the current measurements used for participant learning do not fully measure the program's efficiency. This hinders the opportunity for the program to receive feedback, therefore it cannot know where and how to improve where necessary.

The MHFAQ defines the training as efficient through measuring the reaction and feeling of participants. This has severe implications for policy, as this definition of success supports a training program that may not support learning. Nonetheless, the improvements necessary are indeed complex tasks. Adjustment requires a needs assessment of multiple subcultures, improved surveys for trainings, and researchers to provide a deep analysis of feedback.

In assessing and interpreting the evaluations, the researcher was able to theorize that the MHFA training program measures the participants' experience as variably subjective. This is due to a

measurement system that gauges personal interpretation with a lack of direction. As a result, an achievement of objectives and aims of the program is not measured.

11.0 References

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Appendices

Appendix A. Kikpatrick's Four Levels of Training Evaluation in Detail [9]

Evaluation level and type	**Evaluation description and characteristics**	**Examples of evaluation tools and methods**	**Relevance and practicability**
Reaction	Reaction evaluation is how the delegates felt, and their personal reactions to the training or learning experience, for example: Did the trainees like and enjoy the training? Did they consider the training relevant? Was it a good use of their time? Did they like the venue, the style, timing, domestics, etc.? Level of participation. Ease and comfort of experience. Level of effort required to make the most of the learning. Perceived practicability and potential for applying the learning.	Typically, 'happy sheets'. Feedback forms based on subjective personal reaction to the training experience. Verbal reaction which can be noted and analyzed. Post-training surveys or questionnaires. Online evaluation or grading by delegates. Subsequent verbal or written reports given by delegates to managers back at their jobs.	Can be done immediately the training ends. Very easy to obtain reaction feedback. Feedback is not expensive to gather or to analyze for groups. Important to know that people were not upset or disappointed. Important that people give a positive impression when relating their experience to others who might be deciding whether to experience same.
Learning	Learning evaluation is the measurement of the increase in knowledge or intellectual capability from before to after the learning experience: Did the trainees learn what was intended to be taught? Did the trainee experience what was intended for them to experience?	Typically, assessments or tests before and after the training. Interview or observation can be used before and after although this is time consuming and can be inconsistent. Methods of assessment need to be closely related to the aims of the learning. Measurement and analysis is possible	Relatively simple to set up, but more investment and thought required than reaction evaluation. Highly relevant and clear-cut for certain training such as quantifiable or technical skills. Less easy for more complex learning such as attitudinal development, which is difficult to assess.

	What is the extent of advancement or change in the trainees after the training, in the direction or area that was intended?	and easy on a group scale. Reliable, clear scoring and measurements need to be established, so as to limit the risk of inconsistent assessment. Hard-copy, electronic, online or interview style assessments are all possible.	Cost escalates if systems are poorly designed, which increases work required to measure and analyze.
Behavior	Behavior evaluation is the extent to which the trainees applied the learning and changed their behavior, and this can be immediately and several months after the training, depending on the situation: Did the trainees put their learning into effect when back on the job? Were the relevant skills and knowledge used? Was there noticeable and measurable change in the activity and performance of the trainees when back in their roles? Was the change in behavior and new level of knowledge sustained? Would the trainee be able to transfer their learning to another person? Is the trainee aware of their change in behavior, knowledge, skill level?	Observation and interview over time are required to assess change, relevance of change, and sustainability of change. Arbitrary snapshot assessments are not reliable because people change in different ways at different times. Assessments need to be subtle and ongoing, and then transferred to a suitable analysis tool. Assessments need to be designed to reduce subjective judgment of the observer or interviewer, which is a variable factor that can affect reliability and consistency of measurements. The opinion of the trainee, which is a relevant indicator, is also subjective and unreliable, and so needs to be measured in a consistent defined way. 360-degree feedback is useful method and need not	Measurement of behavior change is less easy to quantify and interpret than reaction and learning evaluation. Simple quick response systems unlikely to be adequate. Cooperation and skill of observers, typically line-managers, are important factors, and difficult to control. Management and analysis of ongoing subtle assessments are difficult, and virtually impossible without a well-designed system from the beginning. Evaluation of implementation and application is an extremely important assessment - there is little point in a good reaction and good increase in capability if nothing changes back in the job, therefore evaluation in this area is vital, albeit challenging. Behavior change evaluation is possible given good

		be used before training, because respondents can make a judgment as to change after training, and this can be analyzed for groups of respondents and trainees.	support and involvement from line managers or trainees, so it is helpful to involve them from the start, and to identify benefits for them, which links to the level 4 evaluation below.
Results	Results evaluation is the effect on the business or environment resulting from the improved performance of the trainee - it is the acid test. Measures would typically be business or organizational key performance indicators, such as: Volumes, values, percentages, timescales, return on investment, and other quantifiable aspects of organizational performance, for instance; numbers of complaints, staff turnover, attrition, failures, wastage, non-compliance, quality ratings, achievement of standards and accreditations, growth, retention, etc.	It is possible that many of these measures are already in place via normal management systems and reporting. The challenge is to identify which and how to relate to the trainee's input and influence. Therefore, it is important to identify and agree on accountability and relevance with the trainee at the start of the training, so they understand what is to be measured. This process overlays normal good management practice - it simply needs linking to the training input. Failure to link to training input type and timing will greatly reduce the ease by which results can be attributed to the training. For senior people particularly, annual appraisals and ongoing agreement of key business objectives are integral to measuring.	Individually, results evaluation is not particularly difficult; across an entire organization it becomes very much more challenging, not least because of the reliance on line-management, and the frequency and scale of changing structures, responsibilities and roles, which complicates the process of attributing clear accountability. Also, external factors greatly affect organizational and business performance, which cloud the true cause of good or poor results.

Appendix B.

#	Title	Evaluation: dissemination	Evaluation: response
1	Evaluating Mental Health First Aid Training for Line Managers working in the public sector [25]	X	X
2	Mental Health First Aid England: is improving the mental health literacy of the population contributing to a public health priority [34]		X
3	Evaluation of Mental Health First Aid Training for Voluntary and Charitable Services working with Black and Minority Ethnic individuals in Bristol [24]	X	X
4	The use of Mental Health First Aid in supporting people working in the Prevent agenda [35]		X
5	Mental Health First Aid Hull: An Evaluation of the Impact of MHFA Training in Kingston Upon Hull [36]		X
6	Mental Health Frist Aid England and North East Mental Health		X

	Development Unit Partnership Project [23]		
7	Evaluation of Youth Mental Health First Aid Training in the North-East of England [29]		X
8	NHS Camden: Mental Health First Aid Program Review [32]	X	X
9	Mental Health Frist Aid training evaluation: NHS Islington [27]	X	X
10	Evaluation of Mental Health First Aid Training with Northumberland Fire and Rescue Service [37]		X
11	Northumberland Pilot Study: Evaluation of Mental Health Aid Training for Flood Recovery Workers [26]	X	X
12	Mental Health First Aid Training: Initial Evaluation by Private Sector Participants [28]		X

Appendix C.

#	Presenter /trainer	Presentation slides	Video clips	Information manual	Learning exercises	Environment (overall)	Structure (Overall)	Content (Overall)	Facilitation (Overall)
1	X	X	X	X	X	X	X	X	X
2							X	X	
3	X	X	X	X	X	X	X	X	X
4									
5							X	X	X
6						X	X	X	X
7		X	X	X	X	X	X	X	
8									
9									
10									
11	X	X	X	X	X		X	X	
12	X	X	X	X		X	X	X	
13									

Appendix D.

	Identify externalized behavior signaling distress	Instill confidence when providing assistance in Mental Health First Aid settings	Mental health therapy vs MHFA	Advise/direct the person in need to seek assistance from a mental health professional
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 his complaining of a lack of energy and tiredness. What are the first three things you would do? (1)	"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" (1) Do you think you would know how to help someone with mental health problems? (1) How confident do you now feel about dealing with people in your workplace who exhibit signs of mental health problems? (1) "People go, well hang on a minute you seem like a completely normal person and you've had issue yourself so it's obviously not a closed door" (1) How confident do you now feel about dealing with people in your	"ALGEE is embedded… it will stay in my mind" (1)	Would you know where to signpost someone who needs help with mental health problems (1)

		workplace who exhibit signs of mental health problems? (1) Before beginning the training, please score your personal confidence in how best to support others with a mental health problem. (1) 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. (1)		
2				
3		"I will be more confident in both volunteer and professional roles." (3) On a scale of 1-10 please score your personal confidence of how best to support others with a mental health problem before and after the course: (3)		
4				
5		93% of respondents reported an increase in their confidence. (5) "Following the MHFA course I have a greater awareness and confidence in dealing with issues." (5) "The course helps to reduce isolation and stigma. It has given me more	The most common type of help offered was listening (83%) and giving reassurance and information (80%). However, 61% felt able to offer advice or self-help strategies and 65% encouraged people to seek appropriate professional help including contacting the GP (32%) and secondary mental health services such as the Community Mental	

		confidence in recognizing people who need help and asking them!" (5)	Health Team (32%) and the Early Intervention in Psychosis Service (4%). Eleven percent of respondents recommended voluntary support agencies such as Mind to the people that they helped and 5% recommended psychotherapy or counselling. Only 8% of respondents reported any barriers in implementing their training. These barriers were around reluctance of people to seek help, not being listened by a GP and work procedures making it difficult to offer support to a colleague. (5)	
6				
7	'Anxiety Disorder – has been hugely relevant due to a current issue, and the focus on physical as well as behavioural effects widened my understanding and ability.' (7)		"Permission has been granted .. to create a poster linking ALGEE to the school's 6 R's (Resilience, Respectful, Reflective, Resourceful, Responsible, Reasoning) – to be placed in central areas to promote mare awareness of mental health, along with a photograph of each trained YMHFA member so staff and students are aware of who to approach. and for the poster to hopefully create discussions with students in their social areas." (7) Use of scenarios: "Ask her about how she is feeling and raise the issue of self-harm and suicide; listen to her responses and allow her time to vocalise what she is	

			feeling non-judgementally. Then offer reassurance that the issue is not 'weakness' and that it can be dealt with, as well as suggesting ways in which she can access help via the school nurse or her own GP. I would also work with her to investigate self-help strategies to enable her to cope more effectively with her own needs." "If Emma continues to present the above symptoms it would be advisable for a friend or family member to reassure Emma …and listen to how she is feeling, so that they can enable her to seek appropriate support…The school would keep a close eye on Emma and work with her. If there were any changes to her circumstances or symptoms further action would be necessary and support would be offered. This may be in the form of ALGEE and helping Emma to understand her own mental health, identifying strategies that may help her if this happened again." Scenario 2: Social Anxiety ('Paul') One participant did not complete the question identifying the problem. Other participants identified it as anxiety, particular relating to social situations, shyness and possible	

			social phobia. Participants suggested some relevant and appropriate strategies. Two examples of the more detailed responses were as follows: Listen to Paul, try and get him to explain why he is anxious about things and what he is finding the most difficult. Get him to visit his GP, give advice on where help could come from. Possible referral to CAMHS. Encourage self-help : practice relaxation methods daily, encourage him to engage in lunchtime/ after-school activities. Encourage him to talk about his problems, give him website addresses to look at e.g. Young minds; Get Connected Use ALGEE – ask Paul about his concerns to assess any potential risk of self-harm/ suicide. Listen and reassure as well as offering information about the need to focus on what he can control , and looking at the psychological processes rather than on the physical. Enable him to access further advice and support via GP or Counsellor or School Nurse. Work with him (and parents if they are involved) on encouraging self-help strategies – relaxation, leisure	

			and exercise, controlled breathing methods etc. (7)	
8		"Feel I have a better understanding, so feel more confident if faced with someone who may or does have mental health issues. Had no previous training." (8) Overall it gave a boost in confidence in recognising what might be happening and knowing what to do from there. (8) It gave the confidence to follow through with a feeling, acting on something. (8)	What type of help were you able to offer? Listen to them: 79 (83.2%) Give them reassurance: 72 (75.8%) Provide them with information: 68 (71.6%) Encourage them to get professional help: 55 (57.9%) Encourage them to adopt a self-help approach: 30 (31.6%) Put them in contact with an appropriate support group: 36 (37.9%) Other: 5 (5.3%) (8) "I was visiting a local Secondary school when I came across a 14/15yr old girl having a panic attack in corridor. While other help was coming I encouraged her to do the 'breathing out' technique taught in the course - and she soon calmed down. A member of the school staff then came and took over." (8) "One of my clients was feeling anxious about something that had happened while out in the community. I took them through the breathing techniques demonstrated on the course and this seemed to help, the person was able to calm	"I listened to a client who suffers from and is medicated for depression, referred this person to psychology and to a specific support group. Encouraged client to see GP about other issues that were affecting their mood and mental health." (8)

			down enough to explain what had happened." (8) "A friend of mine has had a traumatic and difficult life in the past and struggles to move forward, by listening and trying to offer support and getting her to see a qualified psychiatrist along with helping to put some things in place for her to help herself, she seems to able to cope a little better and in time hopefully will cope just fine." (8) "A close friend has been referred for CBT sessions by her doctor to aid her with depression. She is sceptical, doesn't know what it is and has her own somewhat 'unique' perception and fear of what CBT is and means. I listened to her and reassured her about what I've heard service users say about CBT - good and bad. I've given her a leaflet and pointed her to the CBT online resources." (8) "I was particularly pleased that I was able to advocate very strongly for a young student with schizophrenia to be given a chance at college when he was on the point of not being offered a place because tutors did not feel they would be able to cope with him, due to misconceptions about the nature of his illness." (8)	

			"My friend felt low for days. I encouraged her to go to the doctor after talking to her and listening what she had to say, which she did. Currently I encourage her to find ways to release the stress. For example, we went swimming together a couple of months ago. She now swims regularly." (8) "Being given a practical model - ALGEE model gave us something that could be applied in different situations." (8) "Generally: learning that it is more important to listen to someone than to give advice." (8)	
9				
10				
11	"..it gave me awareness of the signs and symptoms I can now identify as serious or not so serious, I wish I'd had this knowledge before." (11) "I work with physical disabilities, but mental health problems do happen alongside, and I definitely have more confidence about what stages. People need to be referred to mental health services and what to do." (11)	"I work with physical disabilities, but mental health problems do happen alongside, and I definitely have more confidence about what stages. People need to be referred to mental health services and what to do." (11)		"I work with physical disabilities, but mental health problems do happen alongside, and I definitely have more confidence about what stages. People need to be referred to mental health services and what to do." (11)

12				
13				

Italic—dissemination questions
Purple—subjective; personal reality

Appendix D.

#	Reaction	Learning	Behavior	Results
1	*What did you think of the course content…?* *Are there any improvements you could suggest for the MHFA training?* *Would you recommend the MHFA training to your manager, colleagues or staff?* *Were there any aspects of research participation that were burdensome or unhelpful?* *Are there any other areas that you wish to raise regarding MHFA training or the research?* *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?*	*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.* *I feel I know how to treat people (staff or clients) with long term mental health problems* *I feel that I can appropriately advise people (staff or clients) about mental health problems.* *I feel that I have a clear idea of my responsibilities in helping people (staff or clients) with mental health problems.* *I feel that I have the right to ask people (staff or clients) about their mental health status when necessary* *I feel that my staff or clients believe I have the right to ask them questions about mental health problems when necessary.*	*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?*	

	Would you recommend the MHFA training to your manager, colleagues or staff? *Were there any aspects of research participation that were burdensome or unhelpful?* *Are there any other areas that you wish to raise regarding MHFA training or the research?* *How would you rate the instructors?* *How would you rate the presentation slides?* *How would you rate the video clips?* *How would you rate the information in the manual?* *How would you rate the learning exercises?* *How would you rate the following overall from the sessions:* *Environment* *Structure* *Content* *Facilitation* *Do you have any comments on how we might improve future events?*	*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.* *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* *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* *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* *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* *I want to work with people with mental health problems* *I have the skills to work with people (staff or clients) with mental health problems*		

	"It was good to listen to other people and to share… the environment was a result of the other people in the group" (1) "The fact that other people were willing to share their real life experiences made you more willing to open up" (1) "He said, 'This is a closed environment here its completely confidential' and everyone sort of agreed" (1) "It even dredged up somethings for me that I had forgotten about in the past" (1) "Sometimes we have to face our own demons too" (1) "It was nice to talk about it… to share experiences and expectations with different people" (1) "The environment was such that we all felt comfortable" (1) "I'd like to see it rolled out to everyone. Everyone has a chance of coming across something like this; whether it's with a family member or co-worker, etc." (1)	*I feel that I can assess and identify the work related problems of people (staff or clients) with mental health problems.* *I feel there is nothing I can do to help people with mental health problems* *I feel that I have something to offer people with mental health problems* *I feel I have much to be proud of when working with people with mental health problems* *I feel that I have a number of good qualities for work with people with mental health problems* *I am interested in the nature of mental health problems and the treatment of them* *Caring for people with mental health problems is an important part of my role* *In general one can get satisfaction from working with people with people with mental health problems* *In general it is rewarding to work with people with mental health problems*		

	"…by the day 2 she was different person. She came in smiling and willing to share more. It was impressive" (1) "Reflect on myself and my own **knowledge** and skills" (1) "Even more sensitivity to issues that might be with people in the room" (1) "I took things home that it might have been useful to get rid of before I went home" (1) "I don't know if there's anyway you can prepare people for that" (1) "I didn't feel able… I didn't want to share that with the group" (1) "[I] went home and cried" (1) "More time to go into what you were feeling" (1) "Rolled out a pared version" (1) "It's more important for [managers] than anybody" (1) "Everything had gone out of the door by [the second day]. We just wanted	*I often feel uncomfortable when working with people with mental health problems* *In general I feel that I can understand people with mental health problems* *On the whole I am satisfied with the way I work with people with mental health problems* *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 his complaining of a lack of energy and tiredness. What are the first three things you would do?* *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?*		

	to get home by that point" (1) (time pressure for quiz and evaluation completion) "I feel that if you'd asked me the next day [after training], you would have got a better idea of my feedback on the course and with those questions you would have got a much more valid answer" (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 knowledge you gained?*	*A colleague/client you are dealing with a 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?* *Were you satisfied with the trainers, the course materials and the venue? If not, what was not satisfying?* *What did you think of… the knowledge you gained?* *How confident do you now feel about dealing with people in your workplace who exhibit signs of mental health problems?* *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?*		

		How do you think you will be able to use this training in your workplace? *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?* *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?* *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?* *Before beginning the training, please score your personal confidence in how best to support others with a mental health problem.* *Before beginning the training, please score your level of knowledge in how*		

		best to support others with a mental health problem. *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.* *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?* *How do you think you will be able to use this training in your workplace?* *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?* *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?* *Before beginning the training, please score your personal* ***confidence*** *in how best to support others with a mental health problem.* *Before beginning the training, please score your level of* ***knowledge*** *in how best to support others with a mental health problem.* *How will you make use of what you have learned?* *In what way or ways has undertaking the MHFA course affected your attitude to people with mental health problems?* "I hadn't realized that there would be so much [mental health issues] in the room" (1)		

		"People go, well hang on a minute you seem like a completely normal person and you've had issue yourself so it's obviously not a closed door" (1) "If we were all better educated maybe things would be significantly better" (1) "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" (1) "Before I would be likely to think 'for goodness sake pull yourself together'… it has made me change' (1) "Before I'd have thought they're a bit strange.. now I'd think a bit more" (1) "A lot of impact on me… how you think about mental health issues" (1)		

		"It makes me a better colleague and a better neighbour" (1) "ALGEE is embedded… it will stay in my mind" (1) "Recognition of what you already did [know]" (1) "[Gives] confidence that it makes sense" (1) "It's just made me think about it all again and reflect on everything I learned" (1)		
2	*How do you rate course structure?* 48.5% voted "Very Good" 46.5% voted "Good" 2.9% voted "Neither Good nor Poor" .3% voted poor *How did you rate the course content?* 60.4% voted "Very Good" 36.1% voted "Good"	*Personal confidence of how best to support others with a mental health problem.* Pre-course: 4.49 Post-course: 7.99 *Knowledge and understanding of how best to support others with a mental health problem.*		

	1.5% voted “Neither Good nor Poor” .2% voted “Poor” *How did you rate the course overall?* 67.2% voted “Very Good” 29.4% voted “Good” 1.3% voted “Neither Good nor Poor” .1% voted poor	Pre-course: 4.42 Post-course: 8.2 *Is improved knowledge correlated with confidence of how to help other with MH problems?* Pre-course confidence & knowledge correlation: .89 Post-course confidence & knowledge correlation: .81		
3	*How would rate the presenters/trainers?* Excellent/very good: 42 Good: 50 Fair/poor: 8 *How would you rate the presentation slides?* Excellent/very good: 49 Good: 48 Fair/poor: 3 *How would you rate the video clips?* Excellent/very good Good Fair/poor *How would you rate the information in the manual?* Excellent/very good: 63 Good: 32	*How will you make use of what you have learnt?* *On a scale of 1-10 please score your **personal confidence** of how best to support others with a mental health problem before and after the course:* *On a scale of 1-10 please score your **knowledge and understanding** of how best to support others with a mental health problem before and after the course:* “I will be more confident in both volunteer and professional roles.” “Have a better understand of how to deal with people suffering from mental health problems.” “I have a better understanding of mental health, so I can support more clients at my workplace.”		

	Fair/poor: 5 *How would you rate the learning exercises?* Excellent/very good: 52 Good:42 Fair/poor: 6 *How would you rate the following overall from the day:* *Environment* Excellent/very good: 44 Good: 46 Fair/poor: 10 *Structure* Excellent/very good: 32 Good: 57 Fair/poor: 11 *Content* Excellent/very good: 43 Good: 44 Fair/poor: 13 *Facilitation* Excellent/very good Good Fair/poor	"More aware of symptoms when doing direct client work."		

	Do you have any comments on how we might improve future events? *How woud you rate instructor 1?* *How would you rate instructor 2?* "I found this all very useful and interesting." "Thoroughly enjoyed the course and activities." "An excellent course giving insights and raising awareness of mental health problems." "I enjoyed working with a very participatory group of diverse people with a wide range of experience of working in their field. The training was tiring but interesting and engaging." **"It really depends on the context. What's abnormal in one community might be perfectly normal in another culture/society."** **"Black African Caribbean men can get very excited, enthusiastic when playing Dominos and its seen as mad, crazy, mental health."**			

	"The stress bucket is Eurocentric e.g., clubbing, debts but does not include race issues, hate crime…"			
4	"This sort of training, though only 2 days long, was a useful and overdue training for us in the police who come across people who are suffering with mental health issues very frequently. This training needs to be rolled out across the wider police teams. Many thanks." "Very good course; enjoyable. More time to discuss/learn about other areas of MH would be very beneficial." "Very informative and great training style and variety." "I had a very interesting two days and learned a great deal. The instructors were very engaging." "Excellent course materials. The facilitators were excellent. The training is perfect for individuals to have an awareness of mental health issues."			

5	*Training content* *Structure* *Facilitation*	93% of respondents reported an increase in their **confidence**. "Following the MHFA course I have a greater awareness and confidence in dealing with issues." "The course helps to reduce isolation and stigma. It has given me more confidence in recognizing people who need help and asking them!"	89% of respondents stated they had had contact with someone who had a mental health problem since completing their training. 85% offered help with 13% offering a little, 44% some and 28% a lot. The most common type of help offered was listening (83%) and giving reassurance and information (80%). However, 61% felt able to offer advice or self-help strategies and 65% encouraged people to seek appropriate professional help including contacting the GP (32%) and secondary mental health services such as the Community Mental Health Team (32%) and the Early Intervention in Psychosis Service (4%). Eleven percent of respondents recommended voluntary support agencies such as Mind to the people that they helped and 5% recommended psychotherapy or counseling. Only 8% of respondents reported any barriers in implementing their training. These barriers were around reluctance of people to seek help, not being listened by a GP and work procedures making it difficult to offer support to a colleague.	

			Seventy-four per cent of participants reported that MHFA training had had a positive impact on their own mental health. "I've been a physical first aider for over 20 years and never needed to use it. The evening I finished the course, a friend rang who was feeling suicidal. I feel the course gave me the confidence to say the right things."	
6	*Session structure* *Session content* *Facilitation* Session were all rated overall as 4 (very good) The over median rating for Environment was 4 (very good), with 75% rating it as very Good or Excellent.	Level of knowledge: (before) (after) None: 8 (2%), 0 Poor: 69 (18%), 4 (1%) Limited: 182 (48%), 33 (9%) Good: 108 (28%), 231 (60%) Excellent: 15 (4%), 114 (30%)		
7	*Presentation slides* Very good: 86 (38%) Good: 125 (56%) Neither good nor poor: 12 (5%) Poor: 1 (<1%) *Video clips:* Very good: 86 (38%) Good: 123 (55%) Neither good nor poor: 15 (7%)	"Hearing voices exercise good to understand psychosis." "Empathy exercises were really useful to aid understanding." *What do participants **feel** they have gained from the training?* (B: before, A: after) Level of knowledge:	"straight after the first session I was able to use the ALGEE technique with a student .. (who) had anxiety for a number of years which manifested in panic attacks during stressful situations. ..By listening, reassuring her and helping her to recognise her mental health she became more confident in discussing her concerns and we were ale to give	

	Poor: 0 *Training Manual:* Very good: 143 (64%) Good: 81 (36%) Neither good nor poor: 0 Poor: 0 *Interactive exercises:* Very good: 102 (46%) Good: 115 (51%) Neither good nor poor: 6 (3%) Poor: 1 (<1%) *Training environment:* Very good: 57 (25%) Good: 136 (61%) Neither good nor poor: 25 (11%) Poor: 5 (2%) *Training structure:* Very good: 98 (44%) Good: 121 (54%) Neither good nor poor: 5 (2%) Poor: 0 *Training content:* Very good: 137 (61%) Good: 85 (38%) Neither good nor poor: 2 (1%) Poor: 0 *Overall rating:* Very good: 146 (65%) Good: 85 (38%)	0: B: 4 (2%) A: 1 (<1%) 1: B: 7 (3%) A: 1 (<1%) 2: B: 24 (11%) A: 0 3: B 33 (15%) A: 0 4: B: 36 (16%) A: 2 (1%) 5: B: 43 (19%) A: 1 (<1%) 6: B: 33 (15%) A: 12 (5%) 7: B: 25 (11%) A: (32 (14%) 8: B: 13 (6%) A: 70 (31%) 9: B: 6 (3%) A: 85 (38%) 10: B: 0 (0%) A: 20 (9%) “Good mix. Very informative. The video really helped me to understand depression.” ‘ALGEE has made me more aware of what I CAN do realistically and has made the process more manageable’	her the appropriate help during her examinations.” “permission has been granted .. to create a poster linking ALGEE to the school’s 6 R’s (Resilience, Respectful, Reflective, Resouceful, Responsible, Reasoning) – to be placed in central areas to promote mare awareness of mental health, along with a photgraph of each trained YMHFA member so staff and students are aware of who to approach. and for the poster to hopefully create discussions with students in their social areas.” ‘FRAME OF REFERENCE - I used the “Window on the World” with students in highlighting their attitudes to their own mental well-being and to initiate discussion of wider issues of sell-being.’ Participants were asked whether they could identify any barriers to implementation. Only two people commented about this, both raising issues concerned with time pressures: What has prevented me is not enough time to complete and find other resources. Hopefully now the	

	Neither good nor poor: 2 (1%) Poor: 1 (<1%) "(T) was fantastic—great banter, whilst being very informative, knowledgeable and supportive." "Excellent instructor who used very real experience which enabled me to see how skills and interventions could work first hand." "Very sensitively delivered—tutor was aware, humorous and empathetic throughout the 4 sessions." "Informative; (S) clearly has a wealth of knowledge on this particular subject, Made a difficult subject available." "Delivered very well- personal analogy of certain situations was very good." "The tutor kept the class engaged and was very supportive throughout keeping us informed of next steps etc." "(T)'s sense of humor helped immensely to lift the group when the subject matter became difficult. I felt he challenged appropriately and		Year 7s are settled ..I will find more time While changes have been made, it is difficult at the end of the summer term when there is little time to initiate new things with staff ; this is on the agenda for meetings and training from September'; …the only issue at the moment is having the time to put into practice what I have learned as well as balancing a full teaching commitment. Participants may not wish to disclose a lack of activity, hence the small number of comments on barriers to implementation and the small return rate overall. The two comments above reflect the fact that some participants were responding at the very end of a school year; a longer period of time for reflection would probably be helpful future evaluations. All but one of the participants who provided follow-up feedback also demonstrated an understanding of the first scenario and identified issues around depression. Strategies suggested for providing help were appropriate and some were quite comprehensive. One respondent interpreted the scenario as an	

	sensitively. I believe him to be an excellent facilitator." "[The slides were] colourful and easy to read." "[The slides were] easy to read and kept me focused." "Reference to booklet was helpful." "Lots of info with straightforward and clear info." "Accessible and provoked discussion after a days work." "Excellent examples shown, excellent graphics and content." "Slides were good bu the colours and size of font were not good for size of TV used." "Too much info which is already in course manual." "some need updating on percentages of young people affected by different mental health issues." "Some spellings need checking." "Some slides were very repetitive."		example of psychosis rather than depression, although some of the strategies they suggested were helpful. Two good examples of the responses were as follows: • Ask her about how she is feeling and raise the issue of self-harm and suicide; listen to her responses and allow her time to vocalise what she is feeling non-judgementally. Then offer reassurance that the issue is not 'weakness' and that it can be dealt with, as well as suggesting ways in which she can access help via the school nurse or her own GP. I would also work with her to investigate self-help strategies to enable her to cope more effectively with her own needs.' • If Emma continues to present the above symptoms it would be advisable for a friend or family member to reassure Emma …and listen to how she is feeling, so that they can enable her to seek appropriate support…The school would keep a close eye on Emma and work with her. If there were any changes to her circumstances or symptoms further action would be necessary and support would be offered. This may be in the form of ALGEE and helping	

	"In some instances, there were too many [slides]." "The slides in advance or emailed afterwards would really help me as a deaf person. I did request but was told it was not possible. I think this is a major access issue." "Very personal and emotional. Empowering to constantly be linking it to real people and situations." "Nice to see students giving opinions and thoughts." "Gave the course some personalisation." "Current and up-to-date." "Real student with real views and opinions. Varied in age and sex. Wasn't general to the population. Only applicable to that area/school. Interesting clips." "The video clips re: the young people seemed to be from a certain socio-economic background. Would be good to have a perspective from young people in a very poor background."		Emma to understand her own mental health, identifying strategies that may hel[her if this happened again. • **Scenario 2: Social Anxiety ('Paul')** One participant did not complete the question identifying the problem. Other participants identified it as anxiety, particular relating to social situations, shyness and possible social phobia. Participants suggested some relevant and appropriate strategies. Two examples of the more detailed responses were as follows: • Listen to Paul, try and get him to explain why he is anxious about things and what he is finding the most difficult. Get him to visit his GP, give advice on where help could come from. Possible referral to CAMHS. Encourage self-help : practice relaxation methods daily, encourage him to engage in lunchtime/ after-school activities. Encourage him to talk about his problems, give him website addresses to look at e.g. Young minds; Get Connected • Use ALGEE – ask Paul about his concerns to assess any potential risk of self-harm/ suicide. Listen and reassure as	

	"A bit repetitive and obvious, the videos say things that have already been said during discussions." "Fun exercises to do, but accurate and helpful in being able to understand specific factors. Right amount of time spent on exercises." "[interactive learning exercises] lightened the subject matter." "Created discussion and learned about other participants views." "Excellent tool to refer back to when working with young people." "clear, spaced out, good and easy to read." "Good structure." "Need a little updating." "Good use of diagrams. Helpful resources through. Chapters in colour help the manual. Colourful, easy to read." "Clear and easy to use, well linked with areas covered in the course."		well as offering information abut the need to focus on what he can control , and looking at the psychological processes rather than on the physical. Enable him to access further advice and support via GP or Counsellor or School Nurse. Work with him (and parents if they are involved) on encouraging selfhelp strategies – relaxation, leisure and exercise, controlled breathing methods etc.	

	"A very informative, structure course with relevant, up to date material. Relaxed atmosphere." "Enjoyable, well structured course. Info provided was good and the course leader delivered the session well. Everyone was engaged in group discussions and practical exercises." "I think the course could [have] been condensed into a shorter time frame, it's a long time to be out of school/work for 2 days." "I felt the course was too length, too much info to cover, in 2 days. Maybe over 3 days might be more productive or a longer course with half days." "A very valuable course in the present climate, too much to fit into the time given, if you say you'll finish at 4:30, then finishing at 5:05 lost me after a long day." "Thought the section on suicide and self-harm was particularly useful as I think these areas of mental health are not usually covered (more on conditions in my experience)."			

	“A bit repetitive and obvious, the videos say things that have already been said during discussions.” “Fun exercises to do, but accurate and helpful in being able to understand specific factors. Right amount of time spent on exercises.” “Lightened subject matter.” “Created discussion and learned about other participant views.” “Excellent tool to reer back to when working with young people.” “Clear, spaced out, good and easy read.” “Good structure.” “Need a little updating.” “Good use of diagrams. Helpful resources throughout. Chapters in colour help the manual. Colourful, easy to read.“ “Clear and easy to use well linked with areas covered in the course.” “Very intense course, better for people who already have some knowledge of topics.”			

	"More practical guides on how to talk to students rather than just knowledge on disorders." "Would have been nice to change groups at times to gain different perspectives and share ideas with new people. Would also be useful to include some relevant referrals processes barriers and ways to overcome them, positive success stories specific to South Tyneside. As for me, the big barrier is still supporting young people through the referral. Over the last few years I have struggled with this." "The knowledge of the group was already quite well informed and the training would have been better taking this into account. For a Youth course it lacked focus/specialism, with the exception of the videos. The young people specifics felt limited." "Interruptions of tanoy [sic] very annoying, pupils walking past noisy – late start 2:10- waiting for the room to become available." "One of the rooms too smalls, lots of interruptions of staff on intercome, asking staff or certain young people			

	to go to different areas in the school." "Environment was too big for amount of spaced needed to accommodate people numbers and was constantly too cold." "Interrupted by drilling and open doors whilst snowing outside. People coming in and out of the room with furniture was disruptive." "Poor environment due to building works. However, (T) did express concerns to builder but centre manager said work had to continue. Trevor adapted activities well whilst noise was happening." "Safe environment, comfortable, reassuring – good variety of exercises and looking back on exercise changes – videos personally helped me understand better through experience." "Great balance of video clips, exercises and written content. I felt that I took away a lot from the couse and my mental health knowledge is a lot better. The tutor kept the class engaged and was very supportive throughout keeping us informed of the next steps etc."			

	"One of the very best courses I have ever been on. Very informative, lovely instructor, and very well delivered." "Excellent course, and very inclusive trainer. Comprehensive, clear and concise, well paced and good use of activities to developed group dynamics." "Very informative and a stimulating range of activities. There was an honest sharing of thoughts and experiences in an accepting environment. This is one of the best courses I have ever attended! Thank you." "Put some fun into a hard topic, but explained things in a manner we could all understand." "Excellent insight into mental health & how I can support the young people I come in contact with." "I work in 2 CAMHS already so attending course for view of info being provided to primary workers. Very impressed with the idea and this presentation of MHFA."			

	"Very useful on lots of levels as a teacher, manager and parent. Supported prior learning. Opened opportunities for further learning and progression." "Course delivered fantastically well. Will take lots of positives around mental health into the workplace." "This course has made me very aware of how many people have mental health problems and I wish to do further study such as ASSIST-SUICE an anything else I feel would be appropriate to help." "The knowledge of the group was already quite well informed and the training would have been better taking this into account. For a Youth course it lacked focus/specialism, with the exception of the videos, the young people specifics felt limited." "Although really enjoyed enthusiasm of trainer for subject sometimes I found quite submissive of opinions. Would have been nice to change groups at times to gain different perspectives and share ideas with new people. Would also be useful to include some relevant referrals processes, barriers and ways to			

	overcome them, positive success stories specific to South Tyneside." "ALGEE has made me more aware of what I CAN do realistically and has made the process more manageable' 'FRAME OF REFERENCE - I used the "Window on the World" with students in highlighting their attitudes to their own mental well-being and to initiate discussion of wider issues of sell-being.' 'Express the feeling of distress, depression, anxiety and disappointment through drawings.' 'Different case studies and scenarios.' 'Anxiety Disorder – has been hugely relevant due to a current issue, and the focus on physical as well as behavioural effects widened my understanding and ability.' ' That there is a network within the Acadamies that we can go to' 'collaboration, useful information and contacts' ALGEE – creating a poster (see Box 2)			

	‘Having the manual to hand – the helpful resource index is a valuable form of information’ ‘The case studies we built up – this was ..a very good and clear exercise to gather information to enable us to effectively support students and to seek professional help from outside agencies.’			
8	“This course will make me more tolerant with mental health sufferers.” “Will be very, very useful! Very informative.” “I believe that my awareness of mental health issues has been improved and I feel I will be able to use the knowledge gained every day and in one-off situations.” “The exercises were really good but spelling mistakes in handouts.” “A well run and delivered course and a useful tool to have in life.” “Very helpful to remove stigma related to mental illness, helped me			

	think more in terms of mental wellbeing." "A lot to take in but very well put together." "Very detailed information and resources clearly laid out." "I have learned how useful and well-structured this course is and will look to train to deliver it myself." "Feel I have a better understanding, so feel more confident if faced with someone who may or does have mental health issues. Had no previous training." "A well run and delivered course + a useful tool to have in life."			
9	"Very good course. Loads of useful information." "Thought it was truly excellent, useful and very illuminating, have recommended it to work colleagues and friends and clients" "The trainers were fantastic and I wish there were more courses like this!"	*I would not want to live next door to someone who has been mentally ill:* 5% *People with mental illness should not be given any responsibility*: 2% *Virtually anyone can become mentally ill:* 91%	*68.5% (n=100) said they had used the MHFA training to help or advise at least one person since the course.* *Who did you help?* Client/customer through work: 62 (44.3%) Family or friend: 37 (26.4%) Colleague: 16 (11.4%) Yourself: 12 (8.6%) Partner: 6 (4.3%) Stranger: 5 (3.6%)	

	"I feel that it needs to be ensured that proper training is provided for deliverers of the MHFA course. Having attended this course in 2 different areas, on both occasions I was unimpressed." "Course was badly delivered and read mainly from a powerpoint presentation. Lacked creativity and facilitators seemed to lack knowledge and confidence."	*As far as possible, mental health services should be provided through community based facilities:* 79% *People with mental illness are far less of a danger than most people suppose:* 76% *Mental illness is an illness like any other:* 73% *There is something about people with mental illness that makes it easy to tell them from normal people:* 19%	Neighbour: 2 (1.4%) *What type of help were you able to offer?* Listen to them: 79 (83.2%) Give them reassurance: 72 (75.8%) Provide them with information: 68 (71.6%) Encourage them to get professional help: 55 (57.9%) Encourage them to adopt a self help approach: 30 (31.6%) Put them in contact with an appropriate support group: 36 (37.9%) Other: 5 (5.3%) "I was visiting a local Secondary school when I came across a 14/15yr old girl having a panic attack in corridor. While other help was coming I encouraged her to do the 'breathing out' technique taught in the course - and she soon calmed down. A member of the school staff then came and took over." "One of my clients was feeling anxious about something that had happened while out in the community. I took them through the breathing techniques demonstrated on the course and this seemed to help, the person was able to calm	

			down enough to explain what had happened." "I listened to a client who suffers from and is medicated for depression, referred this person to psychology and to a specific support group. Encouraged client to see GP about other issues that were affecting their mood and mental health." "I work at a residential scheme in Islington to people with mental health issues. The course helped me to understand direct ways of working with the clients whom I support." "A friend of mine has had a traumatic and difficult life in the past and struggles to move forward, by listening and trying to offer support and getting her to see a qualified psychiatrist along with helping to put some things in place for her to help herself, she seems to able to cope a little better and in time hopefully will cope just fine." "A close friend has been referred for CBT sessions by her doctor to aid her with depression. She is sceptical, doesn't know what it is and has her own somewhat 'unique' perception	

			and fear of what CBT is and means. I listened to her and reassured her about what I've heard service users say about CBT - good and bad. I've given her a leaflet and pointed her to the CBT online resources." "I was particularly pleased that I was able to advocate very strongly for a young student with schizophrenia to be given a chance at college when he was on the point of not being offered a place because tutors did not feel they would be able to cope with him, due to misconceptions about the nature of his illness." "My friend felt low for days. I encouraged her to go to the doctor after talking to her and listening what she had to say, which she did. Currently I encourage her to find ways to release the stress. For example, we went swimming together a couple of months ago. She now swims regularly."	
10				
11	*How would you rate the…* (average score) Presenters: 4.2 Slides: 3.9 Video clips: 3.6	*Confidence, 1-5:* *Manage your own stress* *Manage a colleagues stress*	*"[I have been able to use the training] everyday, about 20 times a day!"*	

	Manual: 4.3 Learning exercises: 4 Structure: 3.9 Content: 4.2 It really made me think about how I had dealt with people in the past The balance between practical and theory was spot on, the relevance to my work was excellent. The group discussions were very useful because other people brought experience to the group. I loved the focus, (one of the facilitators) was particularly good at allowing people to have their say but then bringing them back and getting them focused. The work in groups was fantastic and well designed. I came back inspired, told my manager it was excellent '….only thing was that a lot of it was on PowerPoint which got a bit boring'. Nothing specific but it was a bit heavy going. (asked for clarification and they meant it was a lot to take in as well as being highly emotive).	*People with mental health problems will struggle with them all their lives* *People should be better protected from people with mental health problems* *People with mental health problems are fundamentally different to other people* What personally appealed to me most was the information on suicide and depression and the ongoing influences on these, as the people I work with are most likely to manifest these problems. The consolidation of the information into a presentation helped me make sense of how everything linked together, which I hadn't been able to do before. Overall it gave a boost in confidence in recognising what might be happening and knowing what to do from there. It gave the confidence to follow through with a feeling, acting on something. Being given a practical model - ALGEE model gave us something		

	What was the most useful/effective part of the training? *How relevant was the training to your job?* *Have you had the opportunity to use the training?* It was pitched at the right level, so I have been able to use the information and it has certainly enhanced the skills I am able to bring to my job. I work with physical disabilities, but mental health problems do happen alongside, and I definitely have more confidence about what stages. people need to be referred to mental health services and what to do. I work with flood victims all over the country, particularly working with the emotional trauma it causes – so consequently the relevance was massive. Very relevant. I'm currently working with flood victims and homelessness at the moment. Good to be able to recognise the signs and to know what to do initially.	that could be applied in different situations. Generally: learning that it is more important to listen to someone than to give advice. Whispering in the ear was a good experience that allowed you to find out what it is like to hear voices. Case studies – interviews with professionals and patients. Discovering that the image most people have of mental illness is one that they get from the media/films which is far from the truth. Very eye opening. It gave me awareness of the signs and symptoms I can now identify as serious or not so serious, I wish Id had this knowledge before. It consolidated a lot of what I know. It made the knowledge more accessible. Put the ideas together. Yes, I definitely learnt something about Depression. I realised I had maybe made a lot of assumptions and		

	I meet people from all walks of life such as refugees and asylum seekers, so it will come in useful. Its difficult to say today as I think its something that will become apparent in the future. Its given me awareness, when talking to people, about picking up on signals, perhaps earlier on, or noticing things I maybe wouldn't have before.	it dispelled some of these for me, put them to one side. It confirmed what I already knew – realised I was wrong on some things. It changed my attitudes towards it (mental health). Yes! Completely different subject than they have every dealt with before. The course took away their pre-conceptions about mental health. A little knowledge is dangerous and I think this was me before the training, it's blown away the assumptions I had made. Before the training had the attitude that people with mental health problems should just 'deal with it' but afterwards understood the difficulties they face. It helped me see it from someone else's perspective, particularly the example with the mobile phone and someone talking to themselves and also the exercise where someone was whispering in your ear as you talked. This really raised awareness again of the particular things people may be experiencing and the impact.		

		More understanding of what people may be experiencing. Fear factor taken away. Learned a different way of looking at things and am now able to better put myself in the shoes of someone who has mental health problems. "[It increased general knowledge about mental health]… particularly the whole area of suicide." "I think my general day to day knowledge of mental health issues has improved, it has definitely raised my awareness." "Its also helped to update my knowledge, since I was trained techniques and thinking has changed but I've never had this update – the training definitely helped with this." "Around particular illnesses – I feel now I have a lot more knowledge."		
12	Excellent, Very good, Good, Fair, Poor Instructors: 72%, 28%, 0, 0, 0 Slides: 35%, 55%, 10%, 0, 0, Video clips: 52%, 45%, 3%, 0, 0	Confidence: Pre Post 0: 10% 0% 1: 17% 0% 2: 21% 0% 3: 7% 0% 4: 14% 0% 5: 14% 7% 6: 7% 3%		

	Manual: 55%, 41%, 3%, 0, 0 Structure: 48%, 48%, 3%, 0, 0 Content: 65%, 31%, 3%, 0, 0 Environment: 38%, 55%, 7%, 0, 0 very good – adequate patience for questions and personal experiences people wanted to talk about expressed patience with a range of questions, welcoming and encouraging throughout superb knowledge base and the ability to translate that to people with less knowledge made everyone at ease and got them involved; …. made to feel very comfortable a lot of passion for what he is talking about interactive ; the instructors were very insightful; detailed and thorough a great team "It seems to me that MHFA is just as important as physical (first aid) knowledge, and having some	7: 3% 21% 8: 3% 41% 9: 3% 24% 10: 0% 3% "I will be more confident to support my workers.. who may need some training; [I have] increased confidence and [am] more competent." "I have come out with a much winder knowledge of mental health; … more aware in such cases; consideration for those around me; [the training] raises awareness." "I will use the background knowledge to support the Real Apprentice scheme; by being a part of the Real Apprentice programme." "I will ensure that both my team and myself are supportive of the apprentice." "I will use the information to influence managers" "....by trying to educate others about what mental illness means" "I will apply it to individuals in the workplace."		

	understanding of mental health issues should be compulsory." "The course was great and I was glad I undertook it." "All people who manage others need to do this course." "Thank you so much for inviting me!"	"I will try and help anybody who needs help, both inside and outside the workplace." "I will use it throughout my day and work settings." "I will lobby to improve services at work." "[I will] use what I have learned with my family members [to] support my family; communicating to my family…" "Use it in my own specific way, to cater for me." "[Use it] when I can see people in need of help around me." "[Use] talking and listening techniques."		

Okay, and..?

"I always said I'd never work for mental health" (1) [due to stigma]

"[Working with mental health] is my job and it has been for awhile" (1)

"Certainly with the way I work at least; the way [clients and colleagues] would be approached would be very different" (1)

“The comments above illustrate that individuals on the training did learn from the training and will put this into practice; as well as finding the training enjoyable.” (3)