

## Mental Health First Aid Training Evaluation Preliminary Report - Summary

### 1. Background

Mental Health First Aid (MHFA) training has been delivered in Islington since April 2008. This evaluation is intended to help us understand how it has worked locally, what it has achieved and how we may want to extend and/or expand training.

MHFA aims to preserve life where a person may be a danger to themselves or others and to provide comfort to a person experiencing a mental health problem

### 2. Evaluations aims

The purpose of this evaluation is not to look at whether MHFA works, but to look at how it is working in Islington. It is important to know who has attended the course and where they are from, how many people have attended the course and what they thought of it. We also need to know if the local Islington context is adequately reflected in the training. This information will help NHS Islington in partnership with MIND to develop and improve the MHFA course. In addition key findings can also be fed into the national development project as well as other areas providing MHFA.

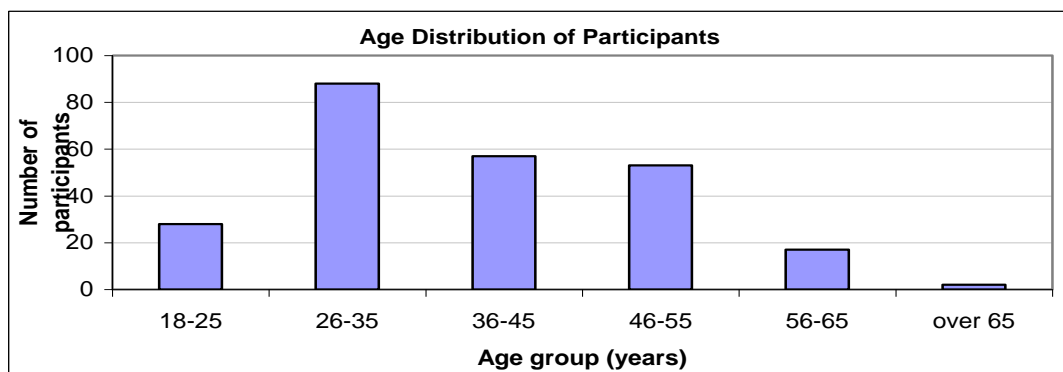
### 3. Methodology

The evaluation is being conducted in 2 stages. The 1<sup>st</sup> incorporates desk-based analysis and telephone and face-to-face interviews with instructors and the course provider (Mind). The 2<sup>nd</sup> stage will include a survey to all participants and telephone interviews with a self-selected sample of participants. This report provides findings from the 1<sup>st</sup> part.

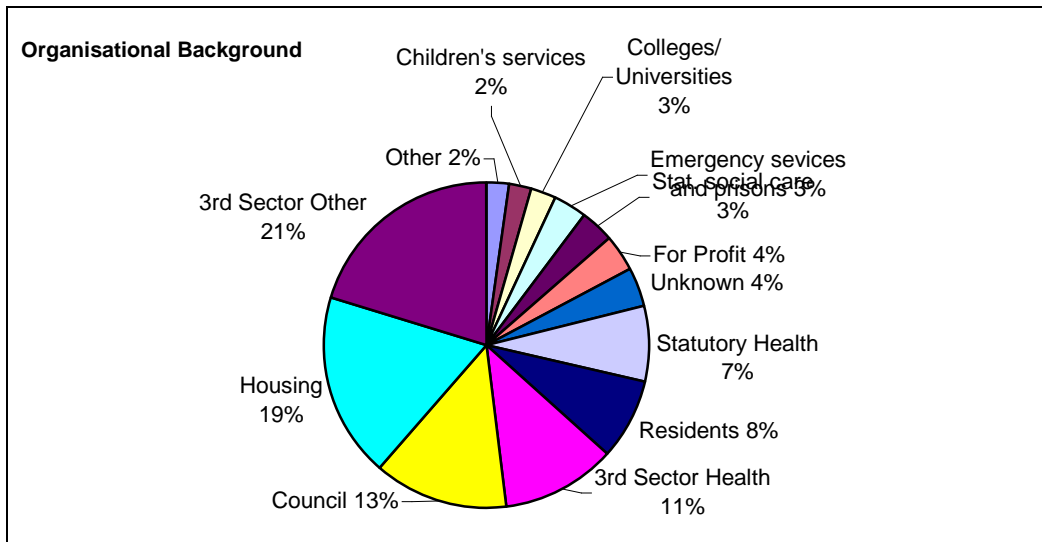
### 4. Key results

#### 4.1 Descriptive statistics of participants

- 25 **sessions** of MHFA were delivered in the 14 months between April 08 to May 09
- 354 **people attended**, averaging 25 per month.
- The **gender** balance was 74% female and 26% male (excluding 25 unknowns).
- The **age** distribution is not evenly spread with the 26-35 years group disproportionately represented, making up 36% of the total sample for which age was known.



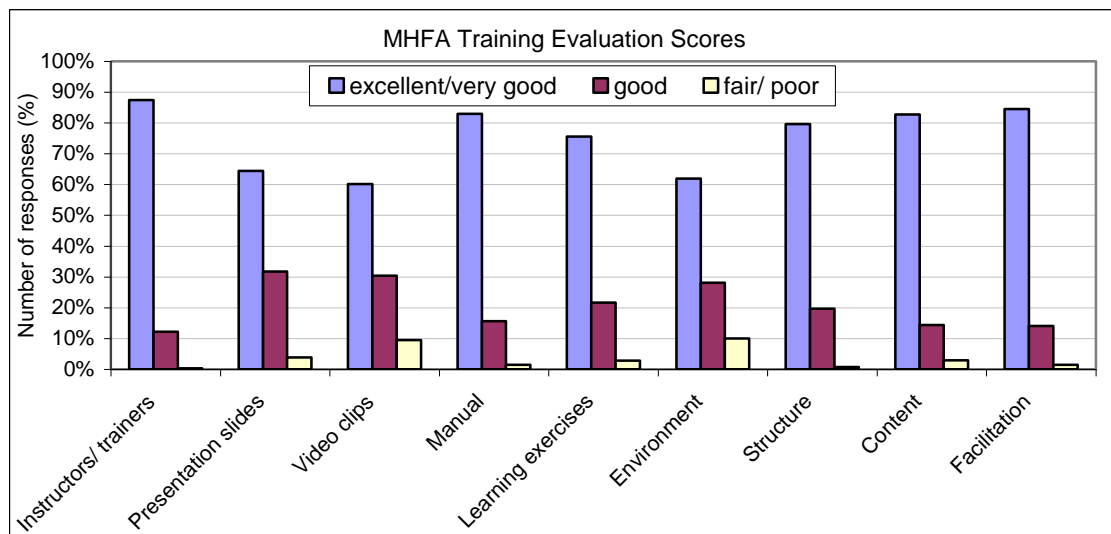
- The **older ages**, 56-65 and over 65 made up 7% and 1% of the sample respectively. The latter finding may be due to the fact that the main reasons participants state for doing the training are work related and the majority of people in this age group are no longer in formal employment.
- The **organisation background** of participants was diverse and the largest proportion was from the voluntary and charity sector (3<sup>rd</sup> sector). The 11 participants from the emergency services and prisons included 8 from the Fire Service, 1 police officer, 1 prison officer and 1 from the probation service.



- The 'other' category included 2 students, a bus driver, a postman, a carer, a Life Coach/Workshop Facilitator, and an interpreter.
- No monitoring statistics were collected on participants' **ethnicity, sexuality, religion or ability/disability**.

#### 4.2 Evaluation forms

- The **overall ratings** for the training were strongly positive with high proportions of very goods and excellent. More participants rated the instructors, the facilitation, the content of the training and the manual as excellent or very good. The environment, video clips and presentation slides were less favourably rated.



- Only 1 participant did not rate the **instructors/trainers** as good, very good or excellent, but several commented on the instructors' capacity to answer questions.

*"Sometimes felt they did not know enough about the info on the slides when questioned"*  
*"Helpful additional info from speaker with clinical experience, good pairing with public health perspective"*

- The **presentation slides** received the lowest proportion of 'excellent' ratings, with only 15%. Common themes raised by participants included 'too many slides', 'repetition of

slides' and lack of up-to-date statistics. Many also said they would have liked more images, video clips and greater use of visual aids.

- The **DVD clips** received the most negative results (along with the environment) with 10% of participants scoring them as fair or poor. Some felt they were too short, did not give enough information, unrealistic and over-simplified the process. Participants also wanted to see more use of people from a range of different backgrounds.

*"Would be good to show some that perhaps don't have happy outcomes as this can be a reality"*

*"Good to view experiences of people managing their various conditions and leading fulfilling lives"*

*"Felt info missing about what help the people with MH problems got, what worked for them and how do they maintain recovery"*

- Over three quarters of the sample thought the **learning exercises** were excellent or very good. One participant felt strongly that the training, particularly the learning exercises did not adequately represent the social model of disability.
- The **environment** was rated very negatively with 10% saying it was fair or poor. The reasons people gave included room temperature, either too cold or too hot and ventilation, uncomfortable chairs and lack of light.
- The participants gave a high proportion of excellent and very good ratings for the **structure** of the training course. Yet a couple of participants said the training was rushed and the introductory session was too long. Many of the instructors interviewed for this evaluation agreed with this latter remark.
- Participants were overwhelmingly positive about both the **content and facilitation**. The only negative comments were about the discussion facilitation skills of the instructors, i.e. knowing when to intervene to rein in a discussion.
- When participants were asked about how they would **make use of what was learnt** they were very positive. Only 2 responses (0.6%) were negative, saying they did not find the course useful. Largely participants felt they would use it in their work but a significant proportion also mentioned using the new knowledge and skills in their personal and social lives. Participants felt they have increased knowledge and skills and were better able to identify problems and to deal with them appropriately. Many also mentioned how the training had changed their views on mental health and people with mental illness. The third issue to emerge was the extent to which participants planned to share the information and discuss what they had learnt with colleagues.

#### 4.3 Instructors' views

- Eight **instructors were interviewed**. 2 of these were free lance trainers providing MHFA training all over the country. Between them 55 sessions had been delivered in Islington giving an average of 7 each (they ranged from 4 – 10 sessions each).
- **Missing groups** identified by the instructors for targeted marketing included the private sector, small and big employers, café workers, kebab shop owners (as this is often where people with MH problems go), carers and occupational health workers. Emergency staff such as the police, ambulance workers, A&E as well as general hospital staff were also picked out as key potential targets for MHFA. One instructor also suggested the targeting of faith groups, community/faith leaders and councillors as they have an influence over public attitudes.
- Offering **flexible course times** such as morning, evening or weekend sessions might help to facilitate part-time and voluntary staff to attend.
- Instructors were generally positive about the **instructor training** they received from the national team, but 50% believed the course was weak on training and facilitation skills.
- Managing the **bookings of trainers** carefully to ensure a good balance of skills and knowledge was raised several times. Having at least one instructor with good mental health knowledge, either as a service user or professional was considered to be beneficial by most of the instructors.

- The following **missing topics** were identified from the course; stress, eating disorders, children and young people, self-harm (in more detail), older people, dementia, Alzheimer's and cultural diversity. Issue specific training or briefing papers as well information about local services such as IAPT, mental health champions and health trainers could be made available. Having a FAQ (Frequently Asked Questions) sheet was also suggested.
- The instructors said there are too many **presentation slides** in the training, that they are overloaded with text and statistics and the sequence in places is not logical and occasionally repetitive. All agreed the information on the slides needs to be localised. One instructor suggested inserting a blank slide in the epidemiology section so each local area could insert their own statistics.
- The general consensus on the quality of the **DVD clips** was that some are better than others. Some give atypical examples of a condition which do not serve as helpful illustrations. A few people suggested making them a bit longer and having more of a selection. They also wanted to see ALGEE being used.
- All instructors mentioned that participants really enjoy the **case studies and exercises**. However they need to be handled sensitively as participants may have previous negative experiences of the topic being discussed.

## 5. Discussion

The implementation of MHFA from April 2008 to May 2009 has been successful, with targeted numbers of participants being achieved. However the gender, age and type of organisation the participant comes from is not evenly distributed. Men, older people and the private sector are less likely to attend the training and need to be targeted.

Most participants overall ratings were strongly positive with high proportions of very good and excellent ratings. There were areas of variation with some indicators being rated less favourably than others. These included the environment, video clips and the presentation slides used in the training. The instructors agreed with the participants on the quality of the slides and video clips and would like to see these improved by either the national team or at a local level.

The instructors were overall very positive about MHFA in Islington and considered it to be an important component of the mental health promotion campaign. Issues that they felt needed addressing to improve the service included localisation of content, managing time, provision of factsheets, on-going training, updating of training materials, quality assurance standards and careful partnering of instructors to maximise experience and knowledge.

## 6. Preliminary Recommendations

- Electronic collection of participants' details and feedback for on-going monitoring and evaluation.
- Instructors should have some information about local services they can share with participants, including IAPT, MH Champions and health trainers.
- More localised data needs to be incorporated into the training.
- Consistency and on-going quality assurance of instructors, including training formats, FAQs, post-training debriefs, regular instructor team debriefs and training opportunities.
- Planned partnering of instructors to maximise experience and knowledge available during the course.
- Look at venue issues such as temperature control and lunch location.
- Liaise with the national team about changes to slides and DVDs – make more relevant to topics.
- Ensure the training materials and content reflect the cultural and ethnic diversity of Islington.
- Ensure the training appropriately reflects the social model of disability.
- Develop a marketing strategy to target the groups identified as priority groups
- Deliver the course in a flexible way making use of evenings, weekends and half-days.