

**Mental Health First Aid Training
Evaluation
Preliminary Report**

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1. Summary

Mental Health First Aid (MHFA) training has been delivered in Islington since April 2008. It was initially developed and provided in-house by Islington's Public Health team. The work was then tendered and awarded to Islington Mind from January 2009 for 1 year. This two-stage 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.

2. Background

Mental Health First Aid (MHFA) was developed in Australia and is based on the concept of general first aid training. It is a 12 hour evidenced-based course, developed by Betty Kitchener and Professor Tony Jorm in 2000 with the aim of improving the general public's awareness and understanding of mental health so that they can offer help and comfort to those in distress until professional help can be obtained. It has been adopted at a national or regional level in Hong Kong, Finland, Singapore, Canada, Scotland and Wales. In England a version based on the Scottish MHFA has been developed and is being rolled-out at a local level. In addition to Islington, other London boroughs delivering MHFA include Greenwich, Lambeth and Camden.

The aims are to:

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

MHFA does not teach people to be therapists' counsellors or mental health professionals. However, it does teach people how to recognise the symptoms of mental health problems, how to provide initial help and how to guide a person towards appropriate professional help. MHFA is applied using a five step frame work (known as the ALGEE).

1. Assess risk of suicide or self-harm
2. Listen non-judgmentally
3. Give reassurance and information
4. Encourage the person to get appropriate professional help
5. Encourage self-help strategies

3. Evaluations aims and objectives

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.

The detailed objectives of the evaluation are:

Process Objectives

- Have the aims been met in terms of the delivery of the MHFA training course with regards to content, timescale, number of instructors delivering at each course and number of participants?
- Have the processes for recruiting the target communities worked?
- Has the infrastructure and its components for delivery been adequate and fit for purpose?

Outcome Objectives

- To assess participants' initial reactions to the course in terms of style, content, delivery (pacing and timing, training methods, materials) and their perception of the course's value.
- To assess participants' learning from the course and determine the extent to which the course achieves its objectives i.e. pre- and post- training levels of knowledge/attitudes/skills.
- To assess the level of application of learning from the course and perceived applicability to the workplace and personal life.
- To assess the effectiveness of the course in terms of positive change in self or others' help-seeking or health promoting behaviour

Formative Objectives

- To highlight any specific issues or barriers to delivering MHFA training in specific sectors or particular groups of participants.
- To consider the appropriateness, relevance and effectiveness of the MHFA course with regards to course content and format in the context of Islington's population and needs.

4. Methodology

The evaluation is being conducted in 2 stages. The 1st is complete and the 2nd is in the development phase. Both stages incorporate quantitative and qualitative data and together will help achieve the above objectives.

Stage 1

- Desk-based analysis of mental health promotion strategy, MHFA implementation strategy, MHFA manual and instructor's manual.
- Analysis of monitoring and evaluation forms from participants (n= approx 354)
- Telephone and face-to-face interviews with instructors and course provider (MIND) (n=8)

Stage 2

- Survey to all participants.
- Telephone interviews with self-selected participants – asked in survey (approx 10)

4.1 Terminology

National team – the national trainers who train the instructors which deliver the MHFA.

Instructors/Trainers – Instructors are those who deliver the MHFA training. All trainers, unless otherwise stated, are instructors.

Participants – those who have completed the MHFA training.

4.2 Data Quality

Monitoring and evaluation forms are provided by the national team and once completed are returned to them. The current system of keeping and recording participants' details and evaluation forms could be improved to ensure all data are electronically recorded. At the time of this evaluation some of the forms were missing and are so not included in the analysis. The table below provides details of the missing forms.

Number of missing forms

Date	Number of participant forms	
	Monitoring forms	Evaluation forms
5 June 08	16	16
9 June 08	21	21
20 Nov 08	16	-
15 Jan 09	14	14
20 Jan 09	13	13
Total missing forms	80 (23% of all participants)	64 (18%)

Many of the forms had also only been partially completed by participants as shown below.

Missing data

Variable	Missing entries	%
Email addresses	44	12%
Home postcode	123	35%
Type of organisation	13*	4%
Age	109	31%
Gender	84**	24%

* Not enough information to classify the type of organisation

** This is now reduced to 25 (7%) after guessing some of the participants' gender

The national monitoring forms do not ask important demographic data, such as ethnicity, disability and sexual orientation. This information would assist with monitoring of equity of access.

5. Key results

5.1 Descriptive statistics of participants

Background

- MHFA training has been running for 14 months (April 2008 start)
- 25 sessions had been delivered up until end of May 2009
- 354 people have attended. This equates to an average of 25 per month. In 2008 the average per month was 22 (200 in total) and in 2009 the monthly average was 31. These figures show that the original aim for the pilot of 16-18 participants per month was exceeded. The target for Mind for 2009 is 400 participants, equivalent to 33 per month. This was not achieved in the evaluation period most likely as a result of start-up and transfer issues.

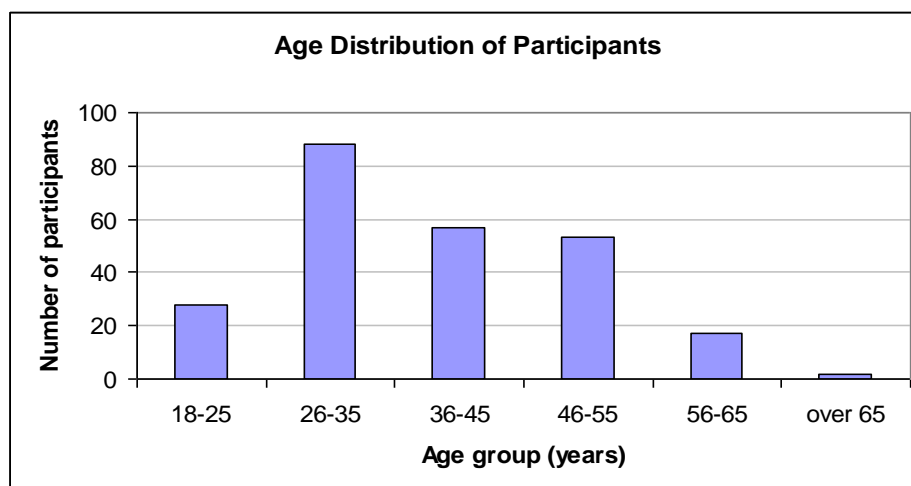
Gender

- The gender balance is as follows

Female	245	74%
Male	84	26%
Unknown	25	
Total	354	
- We know (or have been able to estimate) the gender for 93% of the sample. If we exclude the unknowns the gender ratio is 74:26 female to male.

Age

- 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.

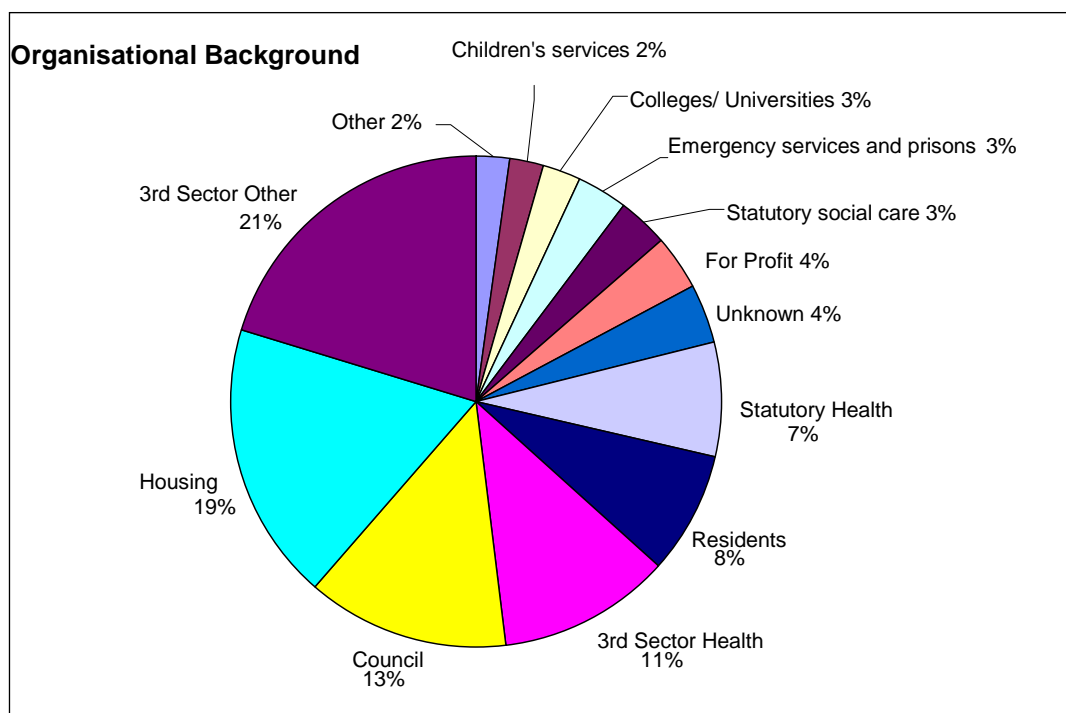


- However the youngest age category, 18-25 covers only 7 years and not 10 like the others.
- The older ages, 56-65 and over 65 made up 7% and 1% of the sample respectively. The latter finding may be due to the fact that the main reasons participants state for doing the training are work related and the majority of people in this age group are no longer in formal employment.

Organisational background

- It was not always clear whether a person attended the training for professional or personal reasons. However if they did not give a work address

or it was clear that work was not their reason for attending they were classified as 'resident'. 29 (8%) Islington residents attended the course.



- The voluntary and charity sector (3rd sector) made up the largest proportion of participants. The housing sector also mainly consisted of 3rd sector organisations.
- 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.
- The housing group included the following

Organisation	Number of participants
Circle Anglia	15
Family Mosaic	12
Peter Bedford Housing Association	9
Irish Centre Housing	9
Mungo's	4
Single Homeless Project	4
Peabody	4
One Housing Group	2
Islington Council	2
Homes for Islington	2
Centrepoint	1
Total	65

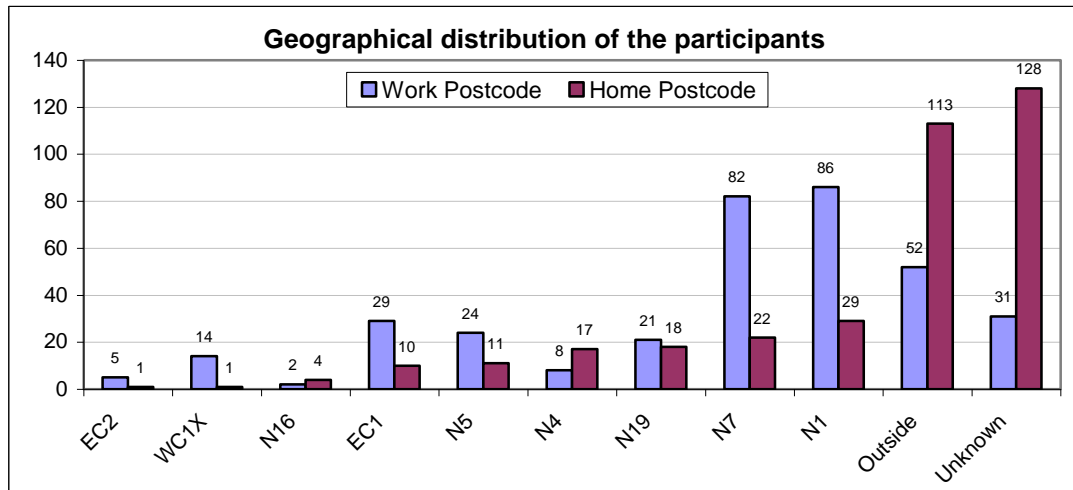
Geographical distribution

In order to ascertain where the participants were coming from in the borough, they were mapped using the postcodes they gave. This posed some challenges as it is not always easy to determine if a postcode is within the borough or not. Islington borough contains approximately 6000 postcodes and although only the 1st part of the

code was being used here many of these spread over 1 borough. Therefore only postcodes that are largely within the Islington borough were included in the analysis.

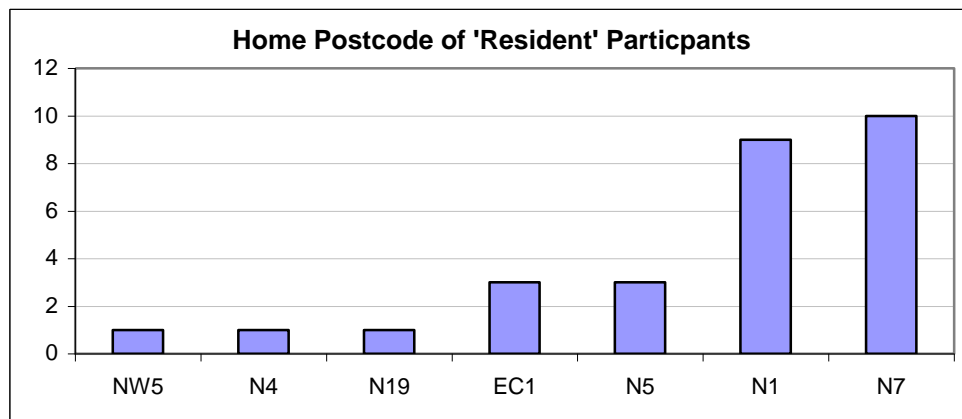
In addition it was often difficult to determine if the address given was a work or home address. Consequently these analyses should be considered with caution.

91% of participants gave a work (or main) postcode and 65% gave a home postcode. 18 participants (5%) gave no postcode at all.



The geographical distribution of the sample is not even. The majority live or work in N1, N7, N19, N4 and N5, which make up the north and middle of the borough. The far south of the borough is poorly represented amongst the sample indicated by the low number from EC1, EC2 AND WC1X. A high number of participants who gave an EC1 work postcode were from the PCT and the council (n=13) and a further 4 from fire service. However, the EC1 and EC2 areas are much smaller than the N postcode areas and so the sample may be proportionally representative. This would need further investigation.

The geographical spread of participants was the same regardless of what type of organisation they came from (data not shown). The graph below shows the participants who came as 'residents' of Islington.



Equality and Diversity

No monitoring statistics were collected on participants' ethnicity, sexuality, religion or ability/disability. However, from March/April 2009 a question regarding the participants' representation of a special interest group was added to the monitoring

form. This is not the same as personal characteristic data collection. Since that time 100 participants have completed the form and 15 answered yes to this question (15%).

'Do you consider yourself as representing a specific group? (Yes / No) If Yes please specify'

Yes / No	Faith Group	Service User Group	Carer Group	Gender Specific Group	BME Group	Sexuality Group	Other - Please State
15	1	6	1	1	6	3	0

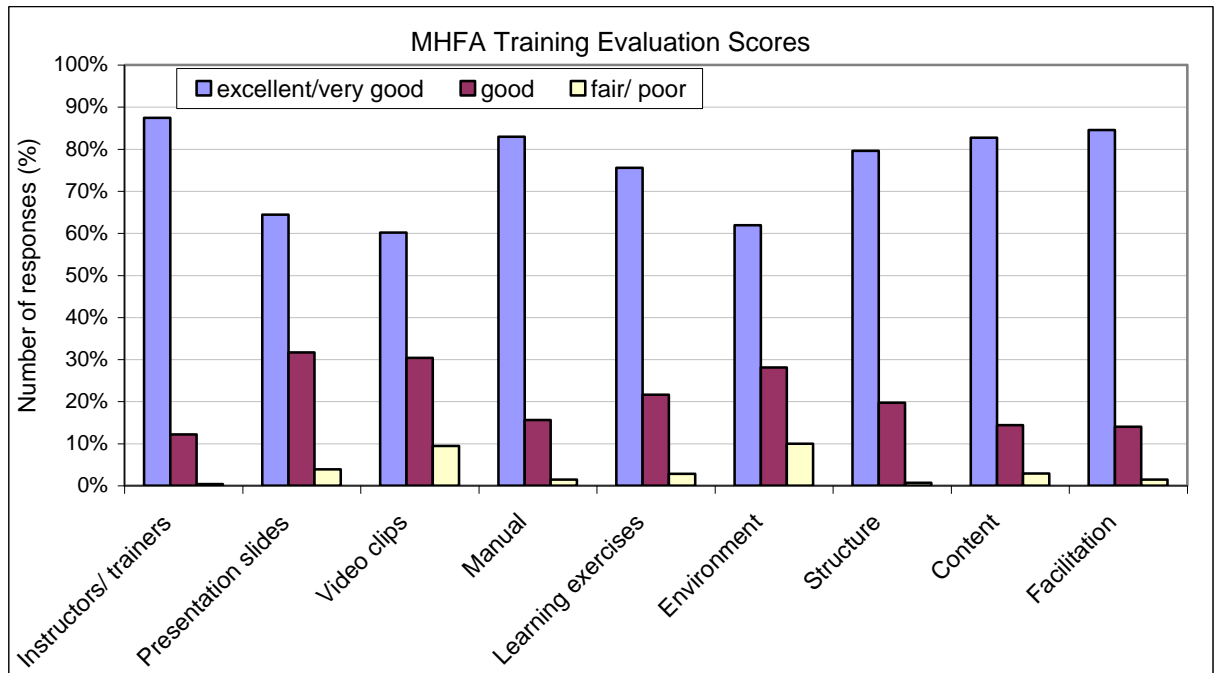
Some participants ticked more than 1 box, for example the service user group and a BME group.

There was no visible pattern from this data about the type of organisation these participants came from or their age or gender.

Participants who said that they 'represented a specific group'	Type of organisation
1	Council
1	Emergency service
4	3 rd sector health
2	3 rd sector other
1	Housing
2	Residents
1	Private sector
3	Other, including a post man, a student and a life coach

5.2 Evaluation forms

The evaluation form provided by the national team contains a series of Likert scales and space for comments for a range of issues. Standard Likert scales provide 2 positive, 1 neutral and 2 negative options. However the ones used in this evaluation form contain 3 positive options instead. This should be noted when looking at the data analysis.

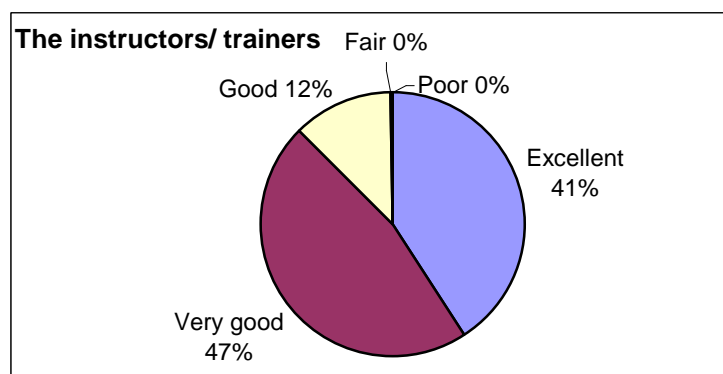


- The overall ratings for the training were strongly positive with high proportions of very goods and excellent.
- More participants rated the instructors, the facilitation, the content of the training and the manual as excellent or very good. The environment, video clips and presentation slides were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

Each component of the training that participants were asked to evaluate is now discussed in more detail.

The instructors/ trainers

All participants rated the trainers as good, very good or excellent.



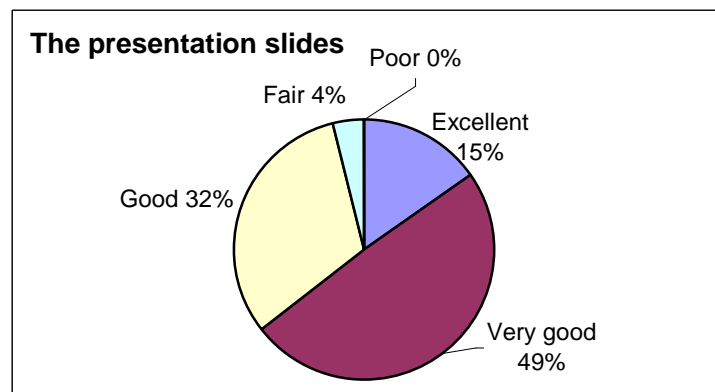
“Very well facilitated - relaxed approach allowed for very useful discussion”
“Encouraging, flexible, adaptable, friendly, knowledgeable”
“I cannot praise them enough”
“Wonderful - both people! Clear, friendly, helpful, very open, good at keeping time and let everybody contribute”

The knowledge of instructors and their capacity to answer questions that came up were identified in participants’ feedback.

“Sometimes felt they did not know enough about the info on the slides when questioned”
“Very engaging, possibly need more info as they couldn’t answer all the questions”
“Helpful additional info from speaker with clinical experience, good pairing with public health perspective”
“Would have been good to have trainers with hands on experience of working with mental health”

Presentation slides

The slides were given the lowest proportion of ‘excellent’ ratings out of all the questions asked, with only 15%.



Common themes among the comments made by participants included ‘too many slides’, ‘repetition of slides’ and lack of up-to-date statistics. A further issue that a few participants raised was that they wanted more information about medication and recovery. Many also said they found the slides a bit too wordy and would have liked less text on each slide with more images, video clips and greater use of visual aids.

“Need more info on recovery / medication”
“Needs current statistical data; some of the data should have been localised; lacks information on different cultures, backgrounds etc”
“Slides too general and practical comments about Islington would be helpful”

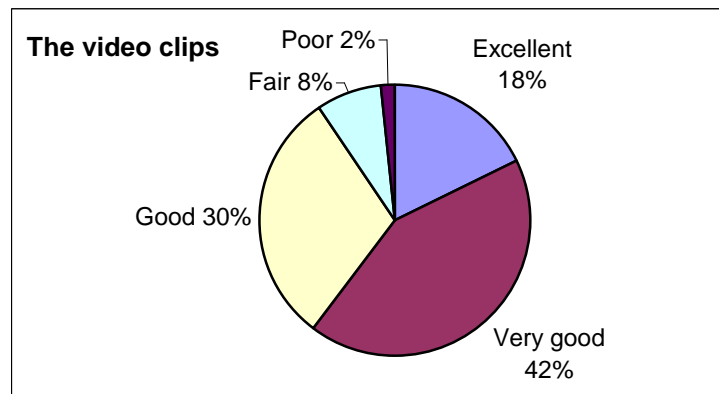
Positive comments focussed on the simplicity of the slides and the fact there were no distracting visuals.

“Really good - no annoying 'trendy' flying logos. Good, simple, straightforward to the point”

Video Clips

Participants valued the opportunity to hear the stories of people with mental health problems. The DVD clips seemed to personalise the facts they were learning. However, some felt they were too short, did not give enough information and over-simplified the process.

This component of the training received the most negative results (along with the environment) with 10% of participants scoring the video clips as fair or poor.



“Good, however I felt they were very short”

“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”

There were strong negative feelings about the music used in the DVD clips.

“Lose the music”

“Content was helpful but music should go”

“Music meant dialogue hard to hear”

Participants wanted DVDs which show how ALGEE could be applied in practice in order to learn how to use it effectively. This finding was mirrored by the many of the instructors.

“More should be incorporated, especially to incorporate ALGEE”

“More examples of ALGEE”

Again cultural diversity came up and participants wanted to see more use of people from a range of different backgrounds.

“Use non-white actors, the setting was depressing and negative, public opinion actually seemed quite informed and not just people off the street”

“Informative but perhaps use wider range of people – too white”

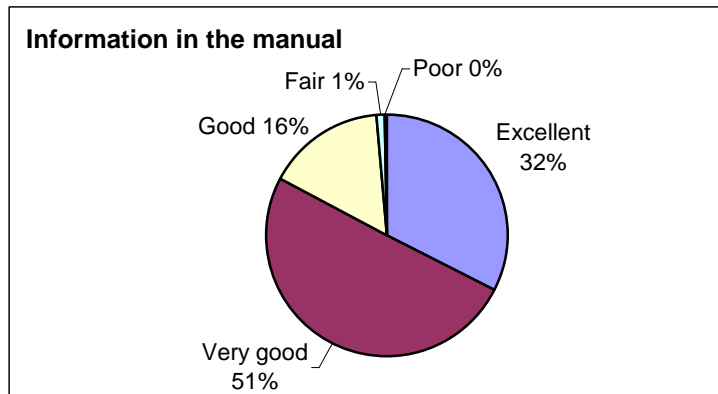
Information in the manual

The way participants used the manual varied a great deal. Some had already looked and said they would continue to read it while others had not looked at it all by the end of the training. In the main, comments were positive.

“Lot of clear information in concise format”

“Clear and well written – helpful”

“Comprehensive, easy to read and follow”
“Having a book is a very good idea - I always loose notes and it relieves need to take notes so can participate more”

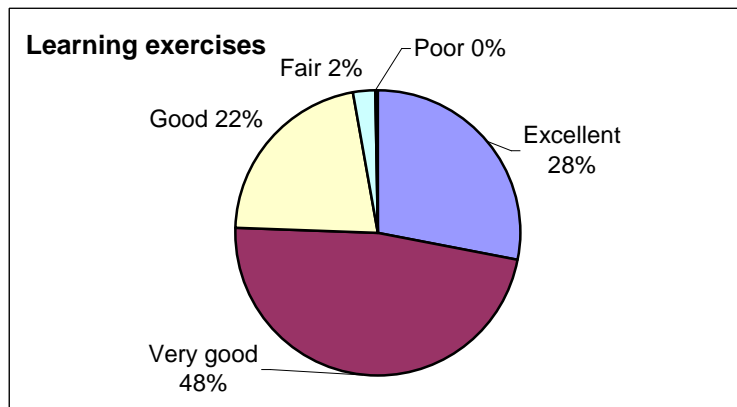


The few negative comments that were made centred on the issue of the practical use of it.

“Sometimes too theoretical / statistical rather than practical / useful”
“Not enough detail around referral and sources of support”
“Out of date”
“A little Eurocentric”

Learning exercises

Over three quarters of the sample thought the learning exercises were excellent or very good. Only 2% thought they were fair.



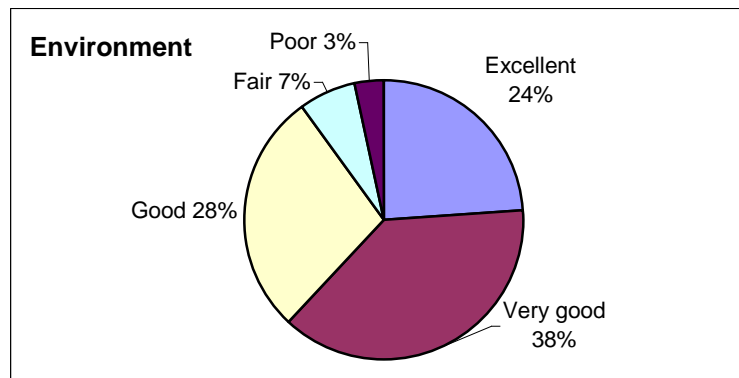
Participants valued the opportunity to share and learn with the fellow trainees and particularly enjoyed the role playing and hearing voices exercise. Many thought it added a welcome break from being ‘presented to’.

“Good way of getting everybody involved, listening to experiences is a good way of learning”
“Fun! Weren’t forced to talk / role-play - everyone was allowed to take it at their own pace.”
“Very good group and very good sharing of experiences and opinions”

Factors that seemed to make the exercises more successful included ensuring all people understood what was about to happen before the materials were given out, mixing up participants more and watching to see when the small groups had finished, as some people thought they went on too long.

One participant felt strongly that the training, particularly the learning exercises did not adequately represent the social model of disability.

The environment



The environment was rated least positively than any other indicator, with 10% rating it as fair or poor. The reasons people gave included room temperature, with 7 saying it was too cold, 2 saying it was too hot and 1 not stating which was the problem and ventilation, uncomfortable chairs and lack of light.

“Room too small and no light”

“Room too cold but good location”

“Very cold all of first day”

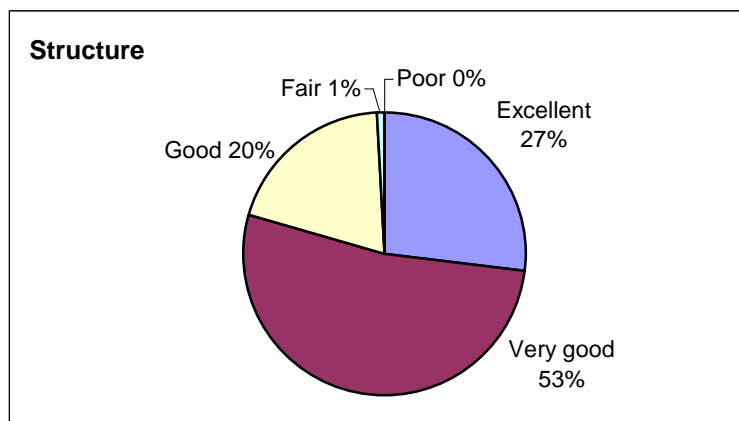
“Bit cold then hot”

Structure

The participants gave a high proportion of excellent and very good ratings for the structure of the training course. Only 2 people (1%) gave it a ‘fair’ mark. There were no ‘poor’ marks. Only 2 comments were made about the structure. One said the training was rushed and the other felt the introductory session was too long. Many of the instructors interviewed for this evaluation agreed with this latter remark. However, they also said the components in the introduction are essential for setting the context and warming up the group.

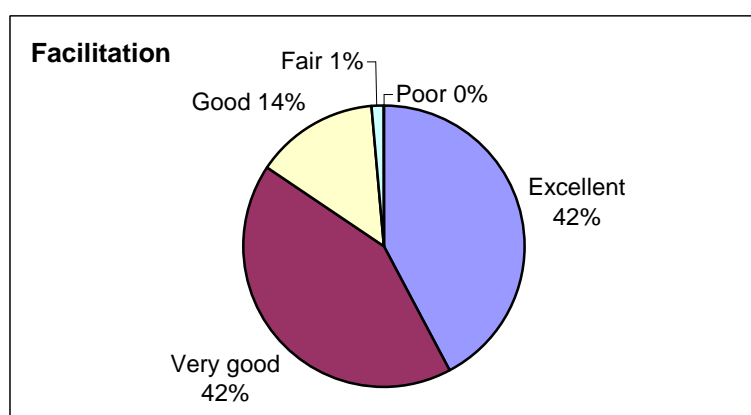
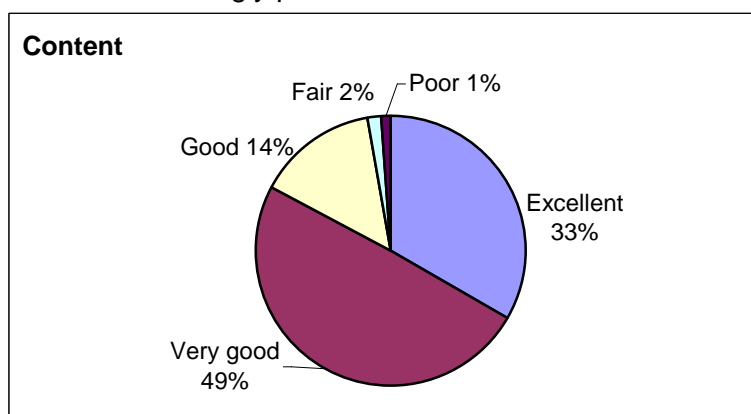
“Intro too long, slightly more challenging case studies [needed]”

“Too rushed”



Content and facilitation

Participants were overwhelmingly positive about both the content and facilitation.



One comment was made about the facilitation:

“Perhaps facilitators should intervene when too much anecdotal info is being given by attendees”

Making use of what was learnt

When participants were asked about how they would make use of what was learnt they were overwhelmingly 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. Quite often people commented “to help my family” and to “help my friends” etc. 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.

Increased knowledge/confidence to help others

“With family, friends, community and work; I'll always remember ALGEE”

“For referring them when faced such situations”

“Better understanding and ability to recognise symptoms”

“Better equipped to deal with serious issues with mental health problems”

Professional development

"Feed back to my team"

"I will now use this in my professional life"

"Feedback info to organisation and include in news letter. Also in personal life"

"Recommend to colleagues across children's services"

"Look at booklet and share with colleagues"

"Discuss with colleagues and friends"

Stigma and behaviour change

"Apply to real life to avoid prejudice and behave more appropriately"

"Changed perspective of mental health clients"

"Will be kinder and use ALGEE if need be"

"Provide better / fairer service to public"

"Changed some bad views I used to have"

"Relook at distinction of mental health / illness"

"I now feel I can understand and empathise with people I work with a little more"

Future Development

When participants were asked about how the course could be improved a significant proportion made no suggestions and many said it could not be improved. Generally people were very positive about the training and wanted more training like this, suggesting follow up courses could be developed that probed a little deeper into the issues. Issues that were raised for improvement that have already been touched upon include the venue, the video clips and the need to cover issues around cultural/ ethnic/ religious diversity. Some participants also wanted to see more local facts and resources and a number of participants thought that the length of the course should be extended. No-one suggested it should be shortened. They felt that by extending it more practical exercises could be incorporated and more time for discussion. 2 participants mentioned that it should be compulsory, one said for anyone working with people with mental health problems and the other said it should be compulsory for everyone.

Course expectations

"Outline roles and responsibilities of MH first aiders at the beginning of the course"

"The course title is misleading - was expecting to learn about crisis management for people experiencing mental health problems. This was quite basic training"

Course length

"More time to be able to cover some of the areas more broadly"

"Extend by an extra day - to allow more time to process / for feedback and for sharing experiences"

"A lot to take in in just two days"

Course content

"More info on sectioning and hospitalisation of people with mental health problems"

"More on what could be done in emergency situations and specific techniques"

“Last section on psychosis a little rushed compared to other sections esp. as was the most important one for me”

“More info on second half of the course”

“Needs to address cultural / religious backgrounds or the BME groups”

“Include local info/ statistics”

Looking at adolescents / children; more detail on local services / pathways in Islington; more on cultural differences

Summary of comments

Participants were generally very positive about the training but several issues emerged.

- Cultural diversity needs to be addressed.
- Participants valued real life experiences/ case studies which helped to illustrate the knowledge being learnt.
- The location and facilities of the venue are important to them.
- Many of them wanted more in-depth information about mental health problems. However this beyond the scope of the MHFA training course.
- Participants and instructors both mentioned that they would like to see DVD clips of ALGEE being put into practice.
- The social model of disability could be reflected more within the training.

5.3 Instructors' views

Background

Eight instructors were interviewed. 2 of these were free lance trainers providing MHFA training all over the country. 6 of them were within the first 3 cohorts of trainees. Between them 55 sessions have been delivered giving an average of 7 each (they ranged from 4 – 10 sessions each).

Training objectives

- The instructors felt the aims and objectives of the training are clear but it is important to emphasise these at the beginning of the course. It was also felt participants' expectations can vary widely so these need managing carefully.
"Participant's expectations can be high and difficult to meet. It is important to remind them of the aims of the course. They often have a thirst for knowledge and want to know about the pathways, treatment, conditions etc."
"The aims and objectives are clear and these are reached. The ALGEE works and people go away feeling confident about mental health."

The trainees

- All the instructors interviewed felt that the course is generally being attended by the right mix of people. It seems that groups tend to be varied and diverse, which instructors cited as being important for a successful session. However there were some concerns about the gender, age and ethnic make up of training groups.
"People are generally 30+, mainly white and female. We need to be reaching a more diverse population"
- Many examples were given where mental health professionals attended the course and this did not work at all as the course is not designed for them. It is aimed at people with very little or no knowledge of mental health issues.
"In the early days MH professionals came along but it was not appropriate for them. But they were happy to know what information people were being given. Since Mind have taken over it seems less health people are attending. There needs to be greater awareness of it amongst health professionals and advertising within the PCT"
- When 8 senior managers from the local Fire Brigade attended the training soon after the pilot started they did not find it helpful and it was not what they expected it to be. This could be due to the fact that it was not appropriately marketed to them and their needs.
"They [Fire Service] see things as black and white. They had different expectations and different way of learning. They wanted facts and practical things they can do like in physical first aid training."
- The issue of providing training to a group of people all from the same organisation came up several times. It was felt that the culture of the organisation had a big impact on how the session went.
"Homogenous groups, such as a group of engineers or health trainers don't work well. They don't feel relaxed and are not able to participate and not as

open. Having a safe space where people feel they can share is crucial to a successful session.”

“If doing training for a group of people from 1 organisation the culture of that organisation has a big impact on how things go. If there is hierarchy or bravado it makes for a tense and difficult session. It feels too risky for people to participate”.

Targeting specific groups

- Many ideas were raised by the interviewees about who should be targeted for the MHFA training. These 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.

We need to target opinion formers and the press. The agony aunt in the gazette gives bad advice. We need to work with these people to ensure the public get the right information.

- Giving cash incentives to encourage hard to reach groups (e.g. café owners) to attend was raised by a couple of instructors. This was suggested more as compensation for time rather than as payment for participation. However, comparisons were made with pharmacists who are paid locum cover for attending training.
- Offering flexible course times was also raised as a way of reaching particular groups. Having morning, evening or weekend sessions might help to facilitate part-time and voluntary staff to attend.

The instructors

- When instructors were asked about the training they received from the national team, feelings were generally positive. Although about 50% of instructors interviewed believed the course was weak on training and facilitation skills.

“The instructor training was good but we all have responsibility to keep-up-to-date. We have the basic tools but need to enhance them by getting the latest stats and looking at recent media coverage of mental health”.

“It’s not very good. I didn’t feel confident after finishing it. It’s out of date, the quality of slides is poor and they kept apologising throughout the training for the poor slides”.

“I thought the training was good, but that’s because I already had a lot of training experience. The instructor training is weak on training skills and I get the impression that no-one fails. Quality assurance is a big issue. They should sporadically test instructors, possibly through mystery shopper model. Instructors should have on-going training around 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.

“It’s good to have a balance of instructors, with some having more knowledge of MH issues, systems and processes. Issues that have come up include “CBT is rubbish” and issues around sectioning, therefore instructors need enough knowledge of MH to deal with queries/comments.”

“Having 1 of the instructors with knowledge of MH services and structures through being a service user or a professional is really helpful. Participants are much more satisfied as their questions can be better answered. However this should not be a requisite. A disadvantage of this can be too much digression.”

- Further training or having briefings on specific issues such as stress, older people, dementia, cultural diversity, medication and treatments were suggested as ways of improving instructors’ knowledge in order to answer the many questions that participants have. Having a FAQ (Frequently Asked Questions) sheet was also suggested.

People ask lots of questions so knowledge about services is important. Instructors need to do their own research. But some questions come up so a FAQ sheet could be put together.”

Quality assurance

- Many of the instructors interviewed felt that monitoring performance of facilitators and providing appropriate support and training was important, although none had come across any problems and believed all the instructors they have worked with were good. The national team maintain contact and provide mentoring throughout the accreditation process but none after that.

“Need to quality assure training. The central team need to review, retrain or remove instructors as needed”.

“On the whole the instructors are pretty good. But there’s no harm in sending in mystery shoppers once in a while just to make sure.”

“The key issue is knowing when and how to manage people [participants] who can’t stop talking. That’s about being a good facilitator.”

- One participant commented that the training was too focused on the medical model of disability and not enough on the social model. This can easily be remedied by introducing local quality standards reflecting Disability Discrimination Act (DDA) compliance and the Council's social model of disability. For example, exercises could be introduced in such a way as to meet DDA requirements by the instructor explicitly stating that the examples illustrate how some people may experience mental health problems, but that this will not be universal experience.

Delivering the training

- The course is demanding in terms of the information that needs to be covered in the time allowed.

“There is a lot to get through. Time is a big issue and you’re always watching the clock. Sometimes have to cut short discussions or skip using a DVD or an exercise.”

“It’s a big course – can’t do all the slides in detail so need to work out which ones to do yourself. It’s a key training skill to be able to balance between didactic giving out information and encouraging people to think and to discuss.”

- Many participants and instructors said the course was too slow to start but all the instructors agreed despite this, the beginning section of ‘hopes and fears’, ‘guidelines’ and introductions are an important and integral part of the training. When the possibility of having pre-written guidelines was discussed the consensus was that for such a sensitive issue it was necessary for the participants to feel ownership over the guidelines, but agreed it could be speeded up.

“Introducing each other and setting the scene takes a bit of time. People get frustrated and just want to start but the beginning bit is important.”

“It’s to understand people expectations at the beginning through the hopes and concerns exercise and ensure they are realistic about what will be achieved.”

Content of training

- The following topics were raised by instructors as missing from the course but that should be included; stress, eating disorders, children and young people, self-harm (in more detail), older people, dementia, Alzheimer’s and cultural diversity. Instructors could also signpost participants to information sources on care pathways and management as many questions are asked about this.

“The course is not culturally diverse enough and many people raise this. It’s difficult to cover all of this in the course but it needs to include something about cultural definitions and perceptions of mental health to make clear that there are different ways of seeing mental health.”

“Stress needs to be covered more. It’s an early sign and cause of mental ill-health.”

Course materials

Presentation slides

- Instructors considered the slides to be heavy with writing and information, too many of them, too many statistics and the sequence in places not logical and occasion repetition. 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.

Short films/ DVDs

- The general consensus on the quality of the DVD clips was that some are better than others. The one featuring the asylum seeker with depression was considered to be bad as it was not a helpful illustration of depression. Another clip featuring Miriam with schizophrenia was popular and considered to be good but it was said that it is not a typical example. 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 discussed having a local service user

instead of the DVDs, with most believing it would be much better for participants to see the real-life situation but saw problems with practicalities of doing this, including time management, consistency, reliability and the value of the session for the service user.

Manual

- The manual is very popular with instructors who think it is an excellent resource. The only recommendation for improvement included adding a document holder flap to the inside of the back page so that all case studies and handouts could be stored more easily.

“The manual is excellent. It has enough information and is a good reference tool. The balance is right.”

Case studies/ exercises

- All instructors mentioned that participants really enjoy these activities. However they need to be handled sensitively as participants may have previous negative experiences of the topic being discussed. With regards to the case studies it was felt that there needs to be more of them and they need to be more relevant.

“There needs to be more of them and more flexibility. I insert my own stories taken from the internet. They need to be basic skeletons that can be tailored to the group to make it more relevant.”

Key recommendations made by instructors

- Instructors should have some information about local services they can share with participants, including IAPT.
- Instructors paired so that experienced trainers work with less experienced ones and that one of the pair should have good knowledge of mental health services.
- On-going training on facilitation and training skills for instructors.
- Add on training for instructors on selected issues such as cultural diversity, care pathways etc.
- a FAQ sheet needs to be developed and distributed amongst instructors
- Delivered in a flexible way using community settings and alternative times (evenings, weekends etc).
- Many of the statistics in the training need to be replaced with local and updated ones.
- Enhanced marketing to target key groups.
- Lunch should be provided in the lobby to limit distraction and noise.

6. 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.

7. Preliminary Recommendations

These recommendations for the development of the MHFA training course are based upon the findings from the 1st stage of the evaluation.

- Electronic collection of participants details and feedback for on-going monitoring and evaluation.
- More localised data and information about local services (IAPT, MH Champions etc) made available to instructors.
- 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 temperature control and lunch location.
- Liaise with the national team about changes to slides and DVDs – make more relevant to topics.
- 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.

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