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SUMMARY

Introduction and Background

NHS Health Scotland commissioned this evaluation to assess the delivery of the SMHFA course with regards to the mechanisms, infrastructure, and processes involved in implementing the SMHFA Programme as well as the impact on course participants with regards to knowledge, attitudes, skills and behaviour towards individuals with mental health issues and also the impact on their own mental health and self-development.

The evaluation had a number of different objectives designed to assess the extent to which the SMHFA training was delivering the desired outcomes and the effectiveness of the delivery of the national programme of SMHFA training in terms of the infrastructure and processes used to manage the national roll-out of the training. These objectives were divided into three main categories:

- Process Objectives
- Outcome Objectives
- Formative Objectives

The methodology adopted to address the evaluation aims and objectives involved using a range of different quantitative and qualitative research techniques to gather evidence about the implementation of SMHFA from a variety of sources and stakeholders. The following tables show how the methodologies adopted in conducting the evaluation were used to address the evaluation objectives.

<table>
<thead>
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<tr>
<td>Has the vision of the key stakeholders been met with regards to initial delivery of the programme?</td>
<td>• Analysis of documentation relating to the development of MHFA in Australia and the introduction and management of the national roll-out of SMHFA.</td>
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<tr>
<td>Have stakeholders’ expectations been met in terms of the delivery of the SMHFA training course with regards to content, timescale, number of instructors delivering at each course and number of participants?</td>
<td>• A series of semi-structured interviews with key stakeholders with an interest or involvement in the development of SMHFA.</td>
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<td>Has the infrastructure and its components for delivery been adequate and fit for purpose?</td>
<td>• A survey of SMHFA Instructors using a self completion questionnaire that was distributed by e-mail/post and telephone interviews with a sample of SMHFA Instructors.</td>
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<tr>
<td>Has the implementation of the SMHFA training taken place in accordance with Instructors’ initial plans with respect to timescales, numbers recruited, types of participants etc?</td>
<td>• Feedback from participants in SMHFA training courses gathered from Course Evaluation Forms and telephone interviews.</td>
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### Outcome Evaluation

<table>
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<th>Evaluation Objectives</th>
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<tr>
<td>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.</td>
<td>• Course Evaluation Forms distributed to all participants in SMHFA training courses during the evaluation period.</td>
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<tr>
<td>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.</td>
<td>• Participants in SMHFA training courses were also sent a Baseline Survey questionnaire and a Post Training Survey questionnaire.</td>
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<tr>
<td>To assess the level of application of learning from the course and perceived applicability to the workplace and personal life approximately 6 months after taking the course.</td>
<td>• A Follow Up Survey questionnaire sent to all participants who had completed a Baseline Survey questionnaire approximately 20 weeks after they had completed the SMHFA training.</td>
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<td>• Telephone interviews with a sample of participants after they had completed the SMHFA training.</td>
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### Formative Evaluation

<table>
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<th>Evaluation Objectives</th>
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<tr>
<td>To highlight any specific issues or barriers to delivering SMHFA training in specific sectors or particular groups of participants.</td>
<td>• Interviews with key stakeholders with an interest and involvement in the national roll-out of the SMHFA training programme.</td>
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<tr>
<td>To consider the appropriateness, relevance and effectiveness of the SMHFA course with regards to course content and format.</td>
<td>• Feedback from SMHFA Instructors about their experience and the lessons they have learned from this experience, gathered through feedback on individual SMHFA courses delivered by Instructors, the postal survey of Instructors and telephone interviews with a sample of Instructors.</td>
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<td>To identify requirements for infrastructural support, training and networking needs in order to sustain the rolling out of the programme in the future.</td>
<td>• Feedback received from participants about how they feel the content and delivery of the SMHFA training could be improved.</td>
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<td>• The contribution of key stakeholders who participated in a workshop to discuss the merging findings from the evaluation in February 2007.</td>
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Key Findings

Process Evaluation

- Scotland’s Mental Health First Aid was developed following the success of adopting the mental health first aid approach in Australia. It was seen as being a good method of providing people with training on mental health issues and in particular contributing to improving mental health literacy levels in Scotland.

- A total of 177 SMHFA Instructors were trained between March 2005 and February 2007. There are four more cohorts of training for Instructors planned to take place by March 2008 and it should be feasible to achieve the target of having 300 trained SMHFA Instructors in place by this date.

- Over 400 SMHFA training courses took place between March 2005 and February 2007. Over 5,250 participants took part in these courses coming from a range of different backgrounds and different parts of Scotland.

- There is a well established pool of SMHFA Instructors across Scotland who have been trained to deliver the SMHFA training. Overall, these Instructors are enthusiastic and committed to the mental health first aid approach and keen to use the skills and experience they have developed to deliver the training to a wide range of participants.

- Some of these Instructors are delivering substantially more SMHFA training courses than the minimum expectation of four a year. However, a number of other Instructors are finding it difficult to meet this expectation.

- Many Instructors feel that they would benefit from being given additional support from both their employers, and at a national level, to allow them to fulfil their role as a SMHFA Instructor more effectively.

- The training that has been provided for new SMHFA Instructors appears to have been effective and has been well received by the vast majority of Instructors.

- The implementation of SMHFA has been well managed by NHS Health Scotland, often in difficult circumstances and within tight timescales. However, due to the amount of work involved in managing SMHFA, certain activities have not been undertaken as quickly or effectively as anticipated.

- SDC and the National Training Team have made a vital contribution to the national roll-out of SMHFA. The commitment and abilities of the individuals involved in developing the SMHFA training materials and the training for new Instructors is widely acknowledged as having contributed to the success of the programme.
Outcome Evaluation

- Over 800 participants in 92 SMHFA courses that took place during the period between May and September 2006 completed Course Evaluation Forms. Analysis of the characteristics of these participants shows that they came from a broad range of backgrounds. However, some groups appear to have been under-represented including in particular men, people from BME groups, and older people.

- The findings of the evaluation suggest that the participants in the SMHFA courses that took place during the evaluation period had higher levels of prior knowledge about mental health issues than the general population.

- The feedback received from participants who returned Course Evaluation Forms during the evaluation show that SMHFA has been well received. Substantial majorities of participants expressed high satisfaction levels with the content and delivery of the training and said that it had met their expectations.

- The vast majority of participants felt that the training had met its stated objectives and outcomes. A similarly high proportion of participants also said that they felt that the learning they had gained from participating in the training would be useful to them in both their work and in their personal life.

- The surveys of participants that were conducted before and after they had participated in a SMHFA training course show that there were considerable increases in participants’ own perception of their knowledge and awareness of mental health issues, including their ability to recognise if someone was experiencing a mental health problem, and how to help people suffering from specific types of mental health problem.

- The pre- and post-training surveys also showed that there were increases in participants’ ability to answer correctly a range of questions about the material covered in the SMHFA training course.

- The findings of the baseline and post training surveys show that there were also substantial increases in participants’ perceived confidence levels. Participants’ reported increased confidence that they would be able to recognise if someone is experiencing a mental health problem and to advise them about appropriate help.

- There was a notable increase in the proportion of participants who said they would be prepared to help someone they thought was experiencing a mental health problem after they had completed the SMHFA training.

- The evaluation has also identified a range of different circumstances where participants have said they were able to offer help to people experiencing mental health problems in a way they would not have been able to before they completed the SMHFA training.
Formative Evaluation

- The basic structure and the overall content of the SMHFA training has generally been received very positively by participants who have taken part in the training, and by Instructors delivering the SMHFA training.

- The evidence from the evaluation suggests there are some areas where structure and content of the training could be improved or amended to allow it to be tailored to meet the needs of specific groups of participant more effectively.

- There were no major concerns about the quality of training being delivered by SMHFA Instructors during the evaluation. However, there were concerns to ensure that the integrity of the SMHFA training was being maintained and that the core mental health first aid messages were being delivered consistently, and to a high standard.

- A number of stakeholders, including members of the National Training Team and other national stakeholders, said they felt that as the number of Instructors increased there was a need to consider the introduction of some form of quality management procedure.

- Efforts to target specific groups within the workforce (particularly front line workers in specific areas of the public sector) to encourage them to take part in SMHFA training have been patchy, and have had mixed success.

- The development of the training resources, the training of Instructors and the delivery of the training to a substantial number of participants has all been successfully undertaken. There is however it is thought that the lack of a dedicated national coordinator post, until recently, has had an impact on the speed and effectiveness of the implementation of certain aspects of the roll-out of SMHFA.

- The evidence from the evaluation has also raised questions about the realism of the current expectations that all SMHFA Instructors will be able to deliver four training courses per year. This has implications for the number of SMHFA courses that can be delivered and the number of people that can receive SMHFA training.

- While setting a target for the number of people to be trained in SMHFA should not be seen as an end in itself, or the driving factor in the future delivery of the training, having an indicative figure for the number of participants in a particular period of time would help inform decisions about the number of trained SMHFA Instructors that may be required, and the resources needed to train and support these Instructors.
Conclusions

The overall conclusion that can be drawn from the evaluation is that SMHFA is delivering on the desired objectives and outcomes in terms of improving the mental health literacy of those who have participated in the training. This is evidenced by the impact the training has had on participants in terms of changes in their knowledge, confidence, attitudes, willingness and ability to provide support and advice to people experiencing different types of mental health problems.

While the SMHFA training is delivering its stated objectives for those who have participated in the training, the evaluation also suggests that the delivery of the training could be improved in order to increase the number and range of people participating in the training. In particular consideration needs to be given to how the content and structure of the training could be changed to allow it to be delivered to a wider range of participants. In addition, the need to support existing Instructors, and potentially increase the pool of Instructors beyond the target of 300, needs to be considered in order to maximise the number of people the training can be delivered to over a reasonable period of time.

The final section of this report makes a number of recommendations that reflect the conclusions drawn from the evidence emerging from the evaluation. These recommendations are designed to help inform discussion and decision making about the future development of SMHFA beyond the current programme, which ends in March 2008.
1. Introduction and Background

1.1 Introduction

NHS Health Scotland commissioned Hexagon Research and Consulting to conduct an independent evaluation of the implementation of the Scotland’s Mental Health First Aid (SMHFA). SMHFA is a training initiative, which has been implemented by NHS Health Scotland on behalf of the Scottish Executive’s National Programme for Improving Mental Health and Well-Being.

The National Programme for Improving Mental Health and Well-being is part of the Scottish Executive’s health improvement efforts designed to support and facilitate mental health improvement work. The National Programme is located in the SE Health Department and is the overall responsibility of the Mental Health Division. The Mental Health Division has policy responsibility for mental health policy and provides funds for specific projects within the Mental Health Improvement Programme in NHS Health Scotland, including SMHFA.

The evaluation was intended to assess the rollout and delivery of the SMHFA in terms of training the required number of trainers within the given timescale and in the delivery of the programme to the anticipated target groups. The evaluation was also designed to assess participants’ changes in mental health knowledge, attitudes and behaviour towards individuals with mental health issues, as well as the impact on their own mental health and self-development. The evaluation was conducted over a year from March 2006 until March 2007.

This report presents the key findings emerging from the evaluation. There is a separate technical report that presents the full results of the surveys of SMHFA Instructors and participants in the trainings that were conducted during the evaluation.

1.2 Background

The Australian National University’s Centre for Mental Health Research in Canberra has undertaken extensive work on mental health literacy. They found that amongst the general public, knowledge about mental disorders, i.e. mental health literacy, has been comparatively neglected compared to public knowledge of physical diseases. Their conclusion was that if the public’s mental health literacy is not improved it might hinder public acceptance of evidence-based mental health care.

As a result of the above work describing the poor literacy of the Australian public and the proposed consequences this had for the nation’s mental health, the Australian National University began to develop and evaluate a range of interventions to improve the public’s mental health literacy, including a Mental Health First Aid training course. The course is based on the concept of first-aid training for cardio-pulmonary resuscitation, and extends to provide first-aid
training to increase people’s awareness and understanding of mental health and mental illness.

The MHFA course aims to increase mental health literacy and knowledge by equipping participants with the skills and confidence required to be able to offer a first aid response to people with mental health problems. This includes: being able to recognise the symptoms of mental health problems; to listen non-judgmentally; to provide initial help by giving reassurance and information; to encourage people to seek professional help if needed; and to facilitate self help coping strategies.

It is anticipated that the application of MHFA will:

- Preserve life where a person may be a danger to themselves or others
- Provide help to prevent mental health problems developing into a more serious state
- Promote recovery of good mental health
- Provide comfort to a person suffering a mental illness.

MHFA does not teach people to be therapists. However, it does teach people:

- How to recognise the symptoms of mental health problems
- How to provide initial help
- How to guide a person towards appropriate professional help.

Background to the Development of SMHFA

One of the four key aims of the Scottish Executive’s National Programme for Improving Mental Health and Well-Being is to raise awareness and promote mental health and wellbeing. NHS Health Scotland, on behalf of the National Programme, managed the pilot of MHFA in Scotland in September 2003. Following completion of the pilot NHS Health Scotland then developed a Scottish MHFA course, based on the findings from the pilot evaluation, which they are currently rolling out. In October 2004, 6 trainers (the National Training Team) were recruited and trained in the delivery of Instructor Training, and an Instructor Training Programme began delivery throughout Scotland from March 2005.

NHS Health Scotland commissioned this evaluation to assess the delivery of the SMHFA course with regards to the mechanisms, infrastructure, and processes involved in implementing the SMHFA Programme, as well as the impact on course participants with regards to knowledge, attitudes, skills and behaviour towards individuals with mental health issues, and also the impact on their own mental health and self-development.
1.3 Structure of Report

The remainder of this report sets out the key findings arising from the evidence gathered during the evaluation. It is structured around the evaluation objectives set out in the original research brief issued by NHS Health Scotland.

Section 2 of the report describes the evaluation objectives that have been divided into three main categories – process objectives, outcome objectives and formative objectives. It also outlines the methodology and research tools used during the evaluation to address these objectives.

Section 3 presents the evidence gathered during the process element of the evaluation and describes the main findings arising from this evidence about the implementation of the national roll-out of SMHFA.

Section 4 describes the findings of the outcome element of the evaluation, and in particular describes the impact training has had on participants in terms of their learning, knowledge, confidence and perceptions. It also examines how participants have started to apply the learning gained from participating in SMHFA training in both their personal and work lives.

Section 5 outlines the main formative findings arising from the evaluation. It focuses specifically on the lessons to be learned from the implementation of the national roll-out of SMHFA in terms of the national infrastructure and implementation process established to support SMHFA, the effectiveness of the SMHFA training content and structure and finally, how the training has been delivered to different types of participant.

Finally, Section 6 of the report describes the overall conclusions that have been drawn from the three main strands of the evaluation, discusses the implications for the future development and delivery of SMHFA training, and presents a series of recommendations designed to address the key issues highlighted by the evaluation.
2. Evaluation Objectives and Methodology

2.1 Evaluation Objectives

The evaluation had a number of different objectives designed to assess the extent to which the SMHFA training was delivering the desired outcomes and the effectiveness of the delivery of the national programme of SMHFA training in terms of the infrastructure and processes used to manage the national roll-out of the training.

These objectives were divided into three main categories:

**Process Objectives** that relate to the infrastructure that has been put in place to manage the rollout of a national programme of SMHFA training and the processes that have been used to implement the programme.

**Outcome Objectives** relating to the impact that SMHFA training is having on participants in terms of their learning and application of this learning.

**Formative Objectives** designed to assess the effectiveness of the delivery of SMHFA training, the appropriateness of the training content and structure and the type of infrastructural support required to sustain the roll-out of a national programme of SMHFA training in the future.

The detailed objectives that were outlined in the evaluation brief under each of these three key strands of the evaluation were as follows:

**Process Objectives**

- Has the vision of the key stakeholders been met with regards to initial delivery of the programme?

- Have stakeholders’ expectations been met in terms of the delivery of the SMHFA training course with regards to content, timescale, number of instructors delivering at each course, and number of participants?

- Has the infrastructure and its components for delivery been adequate and fit for purpose with regards to:
  - National Training Team
  - Instructor Training Programme
  - NHS Health Scotland Infrastructural Support
  - Organisational Support and Infrastructure
  - Ongoing Support and Networking for Instructors?
Has the implementation of the SMHFA training taken place in accordance with Instructors’ initial plans, with respect to timescales, numbers recruited, types of participants etc?

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 courses' 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, approximately 6 months after taking the course.

Formative Objectives

- To highlight any specific issues or barriers to delivering SMHFA training in specific sectors or to particular groups of participants.

- To consider the appropriateness, relevance and effectiveness of the SMHFA course with regards to course content and format.

- To identify requirements for infrastructural support, training and networking needs in order to sustain the rolling out of the programme in the future.

The evaluation brief also suggests it is anticipated the evaluation of the delivery of the SMHFA programme would involve gathering evidence from a variety of different sources including:

- National Stakeholders with an interest and involvement in the national roll-out of SMHFA

- The National Training Team

- Instructors

- Participants.

The following section of this report summarises the methodology that was used to meet the overall aims of the evaluation and the individual research tools that were used to address the specific objectives described above.
2.2 Evaluation Methodology

The methodology adopted to address the evaluation aims and objectives involved using a range of different quantitative and qualitative research techniques to gather evidence about the implementation of SMHFA from a variety of sources and stakeholders. Some of the research tools employed were designed to address a specific objective of the evaluation while others were used to gather evidence that would contribute to addressing multiple objectives.

Evidence was gathered from a variety of sources using a range of different methods. For the evaluation objectives for which evidence was gathered from a variety of sources using different qualitative and quantitative techniques, this allowed the evidence to be analysed and interpreted in a cumulative manner, using a process of triangulation to produce robust, evidence-based, findings.

The main research methods and tools used to gather the evidence to address the evaluation objectives and produce the findings presented in this report were as follows:

Process Evaluation

- A detailed analysis of documentation relating to the development of MHFA in Australia, the introduction of SMHFA and the process of managing the national roll-out of SMHFA.
- A series of semi-structured interviews with key stakeholders with an interest or involvement in the development of SMHFA and the roll-out of the national programme of training.
- Semi-structured interviews with members of the National Training Team who were recruited to help develop the content and structure of the SMHFA training course and materials as well as providing training and development support to SMHFA Instructors.
- A survey of SMHFA Instructors using a self-completion questionnaire that was distributed by e-mail/post.
- Telephone interviews with a sample of SMHFA Instructors
- Feedback from participants about the content and delivery of the SMHFA training gathered from Course Evaluation Forms completed by participants and telephone interviews with a sample of participants.
Outcome Objectives

The methods used to assess the outcomes of the SMHFA training in terms of the impact on participants was based on the Kirkpatrick model of evaluating training and learning interventions. The Kirkpatrick model describes four different levels that training interventions can be evaluated:

Level 1 – Reaction

Level 2 – Learning

Level 3 – Behaviour

Level 4 – Results

The project brief stated that it was accepted that the longer term outcomes of preserved life, prevention of mental health problems developing into a more serious state and recovery of good mental health, could not be meaningfully evaluated in the context of this evaluation. The evaluation, therefore, focused on the first three levels of the Kirkpatrick model.

The main research tools used to gather evidence about training outcomes and the impact of the SMHFA training on participants were as follows:

- Course Evaluation Forms were distributed to all participants in SMHFA training courses during the evaluation period. The main purpose of these forms was to collect information about the initial reaction of participants to the content and delivery of the training.

- Participants in SMHFA training courses were also sent a Baseline Survey questionnaire and a Post Training Survey questionnaire. The main purpose of these pre and post training surveys was to assess the learning of participants and examine any changes in participants’ knowledge, confidence and perceptions.

- A Follow Up Survey questionnaire was also sent to all participants who had completed a Baseline Survey questionnaire, approximately 20 weeks after they had completed the SMHFA training. The main purpose of this survey was to explore the extent to which participants had changed their behaviour as a result of their participation in the training, including how they had applied the learning in their personal and work lives.

- Finally, telephone interviews were conducted with a sample of participants after they had completed the SMHFA training. The main purpose of these interviews was to gather more qualitative information about participants’ perceptions of the learning outcomes, as well as changes in behaviour, including examples of how they felt they had been able to apply this learning in practice.
Formative Evaluation

All of the research tools described above contributed to addressing the questions posed in the formative evaluation objectives to a greater or lesser extent, as they helped identify the key issues that have emerged from the initial years of the national roll-out of SMHFA. The key research tools that produced the evidence that contributed to the findings outlined in Section 5 of the report included:

- Interviews with key stakeholders with an interest and involvement in the national roll-out of the SMHFA training programme.

- Feedback from SMHFA Instructors about their experience, and the lessons learned from this experience, gathered through feedback on individual SMHFA courses delivered by Instructors, the postal survey of Instructors, and telephone interviews with a sample of Instructors.

- Feedback received from participants about how they feel the content and delivery of the SMHFA training could be improved.

- The contribution of key stakeholders who participated in a workshop to discuss the merging findings from the evaluation in February 2007.

The detailed methodology used in each of the three strands of the evaluation, together with copies of the research tools (questionnaires, topic guides etc.) is described fully in the Technical Volume that has been published alongside this report.
3. Process Evaluation

3.1 Delivering the Vision

The National Programme for Improving Mental Health and Well-being was launched in October 2001. Working nationally and locally, it is a vital part of the Scottish Executive's commitment to improving health and achieving social justice. The National Programme's overall vision is to improve the mental health and well-being of everyone living in Scotland, and to improve the quality of life and social inclusion of people who experience mental health problems.

To achieve this vision the National Programme has identified four key aims:

- Raising awareness and promoting mental health and well-being
- Eliminating stigma and discrimination around mental ill health
- Preventing suicide and supporting people bereaved by suicide
- Promoting and supporting recovery from mental health problems.

SMHFA is seen as having a role in contributing to all four of these key aims.

The origins of the development of SMHFA can be traced back to a proposal developed in 2003 to establish a mental health literacy project in Scotland. The thinking behind the development of this proposal was based on an identified need to improve health literacy, in particular mental health literacy, amongst the Scottish population. Health literacy is recognised as an important aspect of health promotion, and may be defined as ‘the personal, cognitive and social skills which determine the ability of individuals to gain access to understand and use information to promote and maintain good health’ (Nutbeam, 2000). A focus on mental health literacy has, however, until very recently, been relatively neglected.

The term ‘mental health literacy’ was coined by Jorm et al (1997) as an extension of the concept of ‘health literacy’. It may be defined as 'knowledge and beliefs about mental disorders which aid their recognition, management or prevention'. It includes: the ability to recognise specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes; knowledge of self-treatments and of professional help available; and attitudes that promote recognition and appropriate help-seeking.

A report prepared by the Director of the National Programme for Improving Mental Health and Wellbeing in June 2003 proposed developing a mental health literacy programme in Scotland. It suggested that good mental health literacy was where people have an understanding of what promotes good

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1 Scottish Executive, National Programme for Improving Mental Health and Wellbeing, Mental Health Literacy Project, Proposal Outline, June 2003
mental health and the knowledge and ability to know when to seek help, and from whom.

The report went on to suggest that mental health literacy encompassed:

- Having a good basic awareness of mental health and mental illness
- Being able to recognise the common signs of distress, and risk factors that may affect someone suffering from mental health problems
- The ability to distinguish between common mental health problems and more severe problems
- Knowing what to do to help support people who show signs of, or who have developed mental health problems
- Knowing where and how to seek help, and to understand what someone can do for themselves.

The report made reference to the work that had been undertaken in Australia in developing Mental Health First Aid. It also made reference to two awareness raising sessions delivered in Scotland in May 2003 by Betty Kitchener, the instigator of the Australian MHFA programme. Betty had been invited to Scotland to explain the background to the development of MHFA in Australia and discuss the possibility of applying the MHFA principles in Scotland. The report suggested that participants at the events expressed considerable enthusiasm for the MHFA approach, and proposed that the National Programme should support the initial development and implementation of a Mental Health Literacy Programme.

The National Programmes’ three year action plan\(^2\), published in September 2003, described the actions that would be taken to help achieve the key aim of “raising awareness and promote mental health and well-being”. The action plan stated that:

“Over the next three years we wish to raise awareness about the need for good mental health and well-being amongst the general public…..This improved awareness and understanding is essential to enable people to take care of their own mental health, to help others, to prevent mental ill health and to be more aware of where and how to access support and help” (p3)

The action plan set out proposals for developing a National Mental Health Literacy Project, and suggested that one of the key elements of this project should be the development of mental health awareness training, building on the Mental Health First Aid course developed in Australia.

Following the publication of the action plan an initial Steering Group was established to take forward proposals for the development of a National Mental Health Literacy Project, in particular the development of MHFA training.

\(^2\) Scottish Executive, National Programme for Improving Mental Health and Well-Being Action Plan 2003 - 2006
in Scotland. A group of around 30 people with different interests and backgrounds were invited to participate in the initial meeting of this steering group. This group decided to pilot MHFA in Scotland and it was agreed to invite Betty Kitchener to come back to Scotland to help launch the pilot programme.

In September 2003, Kitchener visited Scotland again and provided a training course for 15 MHFA Instructors. These 15 Instructors were expected to play a key part in piloting MHFA training in Scotland and this pilot subsequently took place from October 2003 till March 2004.

The Instructors were from a range of backgrounds, including the Scottish Ambulance Service, the Scottish Prison Service, the Scottish Executive, the Education Sector, the Voluntary Sector, Primary Care and Mental Health service user organisations. NHS Health Scotland was responsible for project managing the pilot on behalf of the National Programme, and commissioned the Scottish Development Centre for Mental Health (SDC) to support them to deliver the national pilot.

Between January and May 2004, these 15 Instructors delivered MHFA training sessions throughout Scotland. It is estimated that approximately 900 people from a variety of different backgrounds participated in MHFA training during this period.

The pilot programme of MHFA training was the subject of an independent evaluation that sought to determine the effectiveness and appropriateness of the training and make recommendations for its future development and roll-out across Scotland.

The main conclusion of the evaluation was that:

“The training has been received very positively across all participant groups, in terms of the overall aims of the training, the content, delivery approaches and enabling participants to apply their learning in meaningful ways, with clear benefits” (68 - 6.6)

The evaluation report went on to state that:

“It is clear that the training has made fairly significant impacts upon both participants learning and behaviour. These changes and potential benefits were reported by both participants and managers and include more confidence in identifying and addressing mental ill health issues; increased knowledge and reduced fear of mental ill health” (72 - 6.19)

Overall, the evaluation of the pilot MHFA programme concluded that the MHFA training had indicated its potential to both promote the importance of good mental health, and to increase knowledge and awareness of promoting

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3 NHS Health Scotland, Scottish Development Centre for Mental Health, York Consulting, Evaluation of Mental Health First Aid Pilot Project in Scotland, January – June 2004 SMHFA-finalreport.pdf [471.70Kb]
recovery. However, it also suggested that the course content was seen as requiring some revisions, and new training materials were needed to reflect mental health policy and practice in Scotland.

The results of the evaluation were presented at a Dissemination Event in Glasgow in July 2004. Relevant selected colleagues were invited to hear the results and contribute to the future development and rollout of Mental Health First Aid training in Scotland. The outcomes from the pilot programme and the results of the evaluation were generally well received by key stakeholders, and it was agreed to develop a Scottish MHFA course and roll-out a programme of SMHFA training courses across Scotland.

One of the key aims of this evaluation has been to assess the extent to which the original vision of the key stakeholders involved in the development of SMHFA has been achieved in practice. In particular, it has examined the contribution that SMHFA has made to improve mental health literacy in Scotland. This has been achieved by assessing the impact the training has had on participants in terms of their knowledge and beliefs about mental health issues, their ability to recognise specific mental health conditions, their understanding of the type of professional help available to people experiencing mental health problems and their attitudes towards providing advice, information and support to people experiencing mental health problems.

The extent to which SMHFA training is contributing to improving the mental health literacy of participants is discussed fully in Section 4 of this report, which examines the outcomes of the training in terms of participants’ learning and how they have been able to apply this learning in practice. The implications of these findings are considered further in Section 5 of the report which describes some of the emerging findings from the roll-out of SMHFA and in Section 6 which presents the main conclusions drawn from the evidence gathered during the evaluation.

3.2 Delivering Expectations in terms of Outputs

A ‘cascade’ approach was adopted to the national roll-out of SMHFA. In October 2004, six trainers (the National Training Team) were recruited and trained to deliver Instructor training to other potential SMHFA Trainers. It was anticipated that the National Training Team would be responsible for delivering “training for trainers” to people applying to become SMHFA Instructors.

The first Instructor Training Programme took place in March 2005 and 38 new SMHFA Instructors were trained at this time. It was originally anticipated that the National Training Team would train and provide training to four groups of Instructors over the period February 2004 – March 2006. This would have resulted in 144 trained and approved SMHFA Instructors being in place. This was subsequently changed when the period for the national roll-out of SMHFA was extended to March 2008.
The evaluation brief stated that it was planned to train a total of 300 Instructors by March 2008. It is not clear, however, how this figure was arrived at, and the extent to which this number was linked to any targets for the number of training courses that could be delivered or the number of participants taking part in SMHFA training.

As can be seen from Table 1 below, a total of 177 SMHFA Instructors have been trained in six cohorts between March 2005 and February 2007. The Instructor training has been delivered in different geographical locations and participants have attended from across Scotland; they are therefore able to deliver SMHFA training across Scotland.

**Table 1 – SMHFA Instructors Trained from March 2005 – February 2007**

<table>
<thead>
<tr>
<th>Cohort</th>
<th>Instructors Trained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cohort 1 – March 2005</td>
<td>38</td>
</tr>
<tr>
<td>Cohort 2 – June 2005</td>
<td>31</td>
</tr>
<tr>
<td>Cohort 3 – September/October 2005</td>
<td>34</td>
</tr>
<tr>
<td>Cohort 4 – March 2006</td>
<td>35</td>
</tr>
<tr>
<td>Cohort 5 - September 2006</td>
<td>16</td>
</tr>
<tr>
<td>Cohort 6 - November/December 2006</td>
<td>23</td>
</tr>
<tr>
<td><strong>Total March 2005 – February 2007</strong></td>
<td><strong>177</strong></td>
</tr>
</tbody>
</table>

There are currently a further four Instructor Training Programmes scheduled between March 2007 and March 2008. In order to meet the target of having 300 SMHFA Instructors trained by March 2008 it will be necessary to train a further 123 Instructors meaning that there needs to be an average of 31 Instructors trained in each of the cohorts planned.

Following completion of the Instructor training programme, Instructors must deliver two SMHFA courses prior to being fully approved as Instructors. In addition, there is an expectation that each Instructor will deliver at least 4 SMHFA courses in the 12 months after being approved. This is clearly stated in the documentation given to prospective Instructors and on the Instructor section of the SMHFA web site. Instructors are also expected to attend and contribute to SMHFA networks at a national and local level, and demonstrate continuous professional development in relation to SMHFA. These expectations are made explicit during the Instructor training and in the contractual agreement with the Instructors employers.
In theory, if there are 300 Instructors trained by March 2008, and they each deliver the minimum requirement of four courses a year, it should be possible to deliver 1,200 training courses across Scotland each year. However, this will only be possible once there are 300 active SMHFA Instructors and they are delivering an average of four courses each year.

Table 2 shows the number of SMHFA courses that had been delivered by Instructors together with the total number of participants on these courses, between March 2005 and February 2007. As can be seen, 193 courses were delivered in 2005/2006 with a further 210 courses being delivered in 2006/2007 which means that over 400 SMHFA courses have been delivered since the first group of Instructors were trained in March 2005.

<table>
<thead>
<tr>
<th></th>
<th>Number of Courses Run</th>
<th>Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005/2006</td>
<td>193</td>
<td>2,224</td>
</tr>
<tr>
<td>2006/2007</td>
<td>210</td>
<td>3,023</td>
</tr>
<tr>
<td>Total</td>
<td>403</td>
<td>5,247</td>
</tr>
</tbody>
</table>

While the number of SMHFA training courses that have been delivered during the first two years of the national roll-out of the programme is impressive, it is less than would have been expected had all Instructors met the expectation of delivering at least four courses in the 12 months after completing their training. For example, there were 103 Instructors trained in 2005/2006; if all of these Instructors had delivered the minimum requirement of four SMHFA courses, it could be expected that 412 SMHFA courses would have been delivered during 2006/2007, substantially more than the 210 courses actually delivered.

It is clear from the monitoring data collected by NHS Health Scotland that many SMHFA Instructors are meeting expectations in terms of the number of training courses they are delivering: some Instructors have even exceeded the minimum requirements of four courses each year. However, it is also clear other Instructors have been unable to meet the minimum requirement of delivering at least four courses in the twelve months following their approval as a SMHFA Instructor. The reasons for this situation, and some of the barriers that Instructors say they have faced in being able to deliver the number of training courses expected, are explored in Section 3.4.1 below.

Having a pool of 300 active SMHFA Instructors in place by March 2008, each delivering the minimum requirement of four training courses a year (or the average number of courses delivered per Instructor is 4), should make it
possible to deliver 1,200 SMHFA training courses per year from this point onwards. Assuming an average of 12 participants in each training course, it is reasonable to expect 14,400 participants could take part in SMHFA training per annum.

While providing SMHFA training to over 14,000 people a year would be a considerable achievement, this would only represent less than 0.5% of the total Scottish adult population. The evaluation was not able to identify any research evidence to suggest that there is a minimum proportion of the population required to have benefited from mental health first aid training to make an impact on mental health literacy levels in the general population, though reports of evaluations of MHFA courses run in Australia has suggested that it should be feasible to aim for at least 2% of the population having received some form of mental health first aid training.  

Given the experience of the delivery of SMHFA training during the initial phase of its national roll-out, it is clear that to deliver the training to even a very small proportion of the Scottish population would require a sustained programme of training delivery over a number of years.

The extent to which the target of having 300 active SMHFA Instructors is realistic and the implications of this for the roll-out of training to participants are considered in detail in Section 5 of this report, which looks at the sustainability of delivering SMHFA training in the future.

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4 Kitchener, BA and Jorm, AF, *Mental Health First Aid Training for the Public*, BMC Psychiatry 2002, 2:10
3.3 Delivery Mechanisms – National Infrastructure

NHS Health Scotland

NHS Health Scotland was given responsibility for overseeing the national roll-out of SMHFA on behalf of the National Programme in 2004. Responsibility for managing the roll-out of SMHFA initially rested with the Learning and Workforce Development Team. At this time, the Learning and Workforce Development Team were seen as the most appropriate team to manage SMHFA, due to having the necessary expertise and experience to manage the roll-out of a national training programme.

NHS Health Scotland took the lead role in managing the early development of SMHFA and in the implementation of the subsequent national roll-out of the SMHFA training programme. In particular, NHS Health Scotland staff were actively involved in:

- the design and implementation of the infrastructure for the cascade of training
- the recruitment; contract negotiations and the initial training of the National Training Team
- programme design and adaptation/rewrite of the Australian resource (including sourcing stats)
- production of materials (including kit, manual, instructor guidance etc)
- Publication of all material, design of branding
- Negotiations with Australia including clarification of copyright issues
- Management and guidance to SDC in relation to activity
- Co-ordination of the initial evaluation
- Ongoing evaluation infrastructure and Quality Assurance
- Awareness raising, launch and instructor recruitment.

NHS Health Scotland were given an extremely tight timescale to develop the SMHFA training course and launch the national roll-out of the training programme. The period from late 2004 until the first training for Instructors programme in March 2005 appears to have been an intense period of activity that involved NHS Health Scotland staff, and in particular the Learning and Workforce Development manager, devoting a considerable amount of time and effort to developing the SMHFA training programme and making arrangements for the national roll-out of the training. The feedback received from stakeholders involved at the time suggests the timescale allowed for the development of SMHFA may have been too short, given the scale of the work involved.

There is also evidence to suggest that some things which NHS Health Scotland would like to have done to develop SMHFA and build upon the
experience of the pilot MHFA training programme were not undertaken, either because of a lack of time, or resource constraints. Some of these issues have subsequently been addressed but others are only now being planned and developed. Perhaps the best example of this is the continued use of CD-ROMs produced for the Australian MHFA training. It appears that consideration was given to producing distinctively Scottish audiovisual materials prior to the launch of the national roll-out of SMHFA. This was not undertaken primarily due to a lack of resources but also because of the limited time available for producing the SMHFA training materials prior to the target date for the launch of the national roll-out.

Responsibility for SMHFA was transferred to Mental Health Programme Team in NHS Health Scotland in 2005. Responsibility for the management of SMHFA was initially the overall responsibility of the Health Improvement Programme Manager (Mental Health) with the part time support of a Programme Officer and Project Administrator, both of whom had a range of other responsibilities.

It is clear from the evaluation and the feedback received from many stakeholders who have been involved in the national roll-out, that the lack of dedicated staff resources has had an impact on the level of support NHS Health Scotland has been able to devote to the training programme. This has resulted in a number of areas of activity being limited or delayed, something which has been reflected in the feedback about the level of national support for SMHFA received from some key stakeholders, particularly some Instructors. Towards the end of the evaluation NHS Health Scotland appointed a new full-time member of staff with specific responsibility for managing and supporting the development of SMHFA.

The lack of dedicated full-time staffing resources, at that time, meant that some activities were not implemented as quickly or as effectively as NHS Health Scotland would have liked. The main areas of activity that appear to have suffered include national marketing of SMHFA, including liaison with key employers and employment sectors to encourage them to support the roll-out of SMHFA training amongst their workforce. It has also meant that some aspects of the national infrastructure required to support the development of SMHFA have been underdeveloped, including facilitating networking amongst Instructors, the development of an inter-active SMHFA web site and the monitoring of the delivery of SMHFA training.

Scottish Development Centre for Mental Health

The Scottish Development Centre for Mental Health (SDC) has played a central role in the development and national roll-out of SMHFA. SDC was commissioned by NHS Health Scotland to support the delivery of the pilot MHFA training programme and was subsequently given the contract to manage the development of the SMHFA training, including the recruitment and training of SMHFA Instructors.
The feedback received from stakeholders, at both a national and local level, demonstrates that SDC’s commitment to SMHFA is recognised and acknowledged. Many stakeholders commented specifically on the role that SDC has played in the effective implementation of SMHFA and the time and commitment that individual members of staff have dedicated to SMHFA. The feedback received from Instructors and other stakeholders about the quality of the training for SMHFA Instructors during the evaluation was generally positive.

SDC’s contract was extended for a period to include additional responsibilities for the administration of SMHFA training delivery, including liaison with Instructors and monitoring of the delivery of the training. SDC appears to have undertaken these responsibilities effectively; however the feedback from some stakeholders (particularly some Instructors) suggests that it may have led to some confusion about the relative responsibilities of SDC and NHS Health Scotland for the management of SMHFA, in particular in building relationships with Instructors. To a certain extent this reflects the fact that NHS Health Scotland has not, until recently, had a dedicated staffing resource that Instructors can identify with as the key contact for issues relating to SMHFA. The appointment of a full time member of staff with dedicated responsibility for managing the SMHFA should help to address these concerns.

SDC’s current contract relating to the national roll-out of SMHFA comes to an end in March 2008. Staff within SDC have clearly built up considerable expertise and experience in the development of SMHFA and have established good working relationships with Instructors. Careful consideration, therefore, should to be given to the role SDC can play in relation to the future development and management of SMHFA beyond 2008. In particular the role that SDC could play in continuing to provide training for new Instructors, developing SMHFA training content and resources, and potentially developing quality assurance systems for the delivery of SMHFA training needs to be considered in the context of the conclusions and recommendations for the future development of SMHFA set out in Section 5 of this report.

The National Training Team

The six members of the National Training Team were recruited in October 2004. There was considerable interest in an open advert recruiting members for the team, which attracted a large number of applicants. Selection of members of the team was undertaken jointly by NHS Health Scotland and SDC, and attempts were made to ensure team members had a good blend of experience and expertise.

Members of the National Training Team played an important role in helping to develop the SMHFA training content and structure, as well as the content and structure of the training for Instructors. The members of the team who were interviewed during the evaluation said they welcomed the fact that they had
been involved from this initial developmental stage; this appears to have helped them feel an integral part of the SMHFA programme, and has fostered a strong sense of ownership.

Following the developmental stage, which involved a substantial time commitment, the main role of members of the National Training Team has been to deliver the training to new SMHFA Instructors and be responsible for the approval of new Trainers during their delivery of their first two training courses. Some members have also been involved in delivering SMHFA training and state this has been valuable as it has allowed them to gain first hand experience of how the training content and materials work with different groups of participants.

There was mixed feedback from Instructors about the support they perceived they had received from members of the National Training Team. Instructors were generally supportive of the role members of the team had provided in the initial training, feeling the feedback and advice they received at this stage was generally supportive and helpful. However, some Instructors said they would have welcomed more support and feedback following the completion of their training. While a number of Instructors said they had a good relationship with the member of the National Training Team responsible for their supervision and approval following their training, others said they would have welcomed more pro-active support. Some of these Instructors, particularly those who were less experienced trainers, or who did not have support within their organisation, appeared to have felt that they would have benefited from more mentoring support than is currently provided by the National Training Team.

Members of the National Training Team themselves said they would welcome a wider role in supporting the future development of SMHFA. A number said that they could envisage taking on a more pro-active role in supporting and mentoring individual SMHFA Instructors where this is felt to be necessary. Some members of the team also said that they saw a need for some form of quality control once Instructors have been approved and said they would welcome the opportunity of being involved in developing and implementing such a system.

Again, careful consideration needs to be given to the role members of the National Training Team can play in the future development of SMHFA beyond 2008, in the context of the conclusions and recommendations for the future development of SMHFA set out in Section 5 of this report.
3.4 Delivery Mechanisms - Instructors

3.4.1 Survey and Telephone Interviews with SMHFA Instructors

To get feedback from Instructors about their experience of being trained as SMHFA Instructors and delivering the training, a postal survey of all Instructors was undertaken in November 2006. Each Instructor was sent a self-completion questionnaire by e-mail or post, or offered the opportunity to complete the questionnaire online via a web link provided to them by the research team. The questionnaire was sent to 130 Instructors and completed responses were received from 82 Instructors: a response rate of 63%. The questionnaire covered a range of different issues about Instructors’ experience and perceptions of being involved in the delivery of SMHFA training. The main issues that were covered included:

- Instructors’ reasons and motivations for becoming a SMHFA Instructor
- Instructors’ perceptions of the training they were given prior to becoming a SMHFA Instructor
- Instructors’ perceptions of the support they had received after being approved as a SMHFA Instructor
- Instructors’ experience of delivering SMHFA training
- Instructors’ views about changes that could be made to the content and structure of SMHFA training.

A copy of the questionnaire sent to Instructors is contained in the Technical Report together with a full statistical analysis of responses. The following sections of this report describe the main findings under each of the themes covered in the questionnaire.

3.4.2 Reasons and motivation for becoming a SMHFA Instructor

Almost three quarters of Instructors who responded to the survey said that they had personally volunteered to become a SMHFA Instructor, and a quarter said that they had been nominated by their employer. The vast majority of respondents (95%) said their employer had supported their application to become a SMHFA Instructor.

Individuals were motivated to train to become SMHFA Instructors for a range of different reasons, generally related to a personal commitment to become more involved in helping to address issues related to mental health and wellbeing. In many cases Instructors had been motivated by their own personal experience in a work context. This had led them to want to do more to raise awareness of mental health issues and help inform people about the impact of mental health problems on individuals and communities. This is illustrated by the following comments made by some of the Instructors who responded to the survey:
“As a Police Officer I had seen at first hand the effect of mental illness within communities, and had always felt there was a distinct lack of information out there for the community. Now that I am retired I have the opportunity to try and do something about this.”

SMHFA Instructor and Retired Police Officer

“Having worked in mental health services for a long time I have always felt that what we deliver is very much reactive to individuals’ problems and had identified need for preventative work to equip everyday people with knowledge of understanding and coping with mental ill health better.”

SMHFA Instructor and Mental Health Worker

“I am interested in helping young people cope better with the pressure of modern life. Being involved in SMHFA has allowed me to raise awareness about mental health and try to increase capacity in services/agencies able to help and support young people with mental health issues.”

SMHFA Instructor and Youth Worker

Many Instructors saw being a SMHFA Instructor as something that would allow them to carry out their job more effectively. This was particularly the case where they already had some responsibility for raising awareness of mental health issues. One Instructor said:

“I work in the mental health improvement field, working towards the objectives of the National Programme to Improve Mental Health and Wellbeing. Delivering training is one mechanism of achieving these objectives. My colleague delivers ASIST and my delivering SMHFA complements this.”

SMHFA Instructor and Health Promotion Worker

While many Instructors who saw being a SMHFA Instructor as complementing their existing work responsibilities worked in the health sector, others worked in a range of different sectors as illustrated by the following quotes:

“It is in my job remit to raise awareness of and disseminate information regarding mental health and wellbeing in the Greater Pilton area of Edinburgh. The SMHFA provided an excellent way of achieving this”.

SMHFA Instructor and Community Worker

“My main motivation was to do something positive for employees and employers with regard to understanding more about how mental ill health affects individuals and for business the financial implications”.

SMHFA Instructor and Occupational Health Professional
Many Instructors said they were attracted by the concept of mental health first aid and liked the philosophy that underpinned the SMHFA training course. As one Instructor said:

“Most people are unaware of mental health and mental illness. Stigma often arises out of ignorance and information and knowledge helps to counter ignorance and therefore, stigma”.

SMHFA Instructor and Health Improvement Worker

This view was supported by another Instructor who said:

“I was very impressed by the idea, content and potential outcomes of the course. I believe that the idea and content smash right through the barrier of people not being sure what to say/do when confronting distress and gives them skills, knowledge and information to do something to help”

SMHFA Instructor and Learning Manager

The fact that many new Instructors saw becoming a SMHFA Instructor as complementing their existing work responsibilities and activities is supported by the fact that Instructors generally had some knowledge of mental health issues before taking part in the SMHFA Instructor training. Over a third of Instructors (35%) responding to the survey said they felt they were very knowledgeable about mental health issues before taking part in the training. A further 40% said they were quite knowledgeable and only 15% said they thought their knowledge and understanding was average or below average.

While a substantial proportion of Instructors said they had above average knowledge of mental health issues prior to becoming involved in the SMHFA training, only 20% said they were very experienced in delivering training on mental health related issues. A further 34% of Instructors said they felt they were quite experienced in delivering mental health related training prior to becoming a SMHFA Instructor, nearly a half of Instructors (46%) said they were either quite or very inexperienced. Over 60% of Instructors said they were quite or very experienced in delivering any form of training prior to becoming involved with SMHFA training; a quarter of Instructors said they were quite or very inexperienced in delivering training.

3.4.3 Perceptions of SMHFA Instructor Training

Instructors were asked about their perceptions of the process of applying to be trained as a SMHFA Instructor. The Instructors who responded to the survey were generally supportive of this aspect of the recruitment and training process. One in five Instructors said they felt the process was excellent, while a further 56% said they felt that the process was good. In fact only one Instructor said they thought the process was poor.
Instructors appear to be generally happy with the application and selection process and this is supported by the fact that only a minority of Instructors suggested any ways that the process could be improved, and the improvements that were suggested were generally minor adjustments. The most commonly suggested improvements related to the time taken to process applications, better marketing of the training for Instructors including targeting people working in particular employment sectors, ensuring that potential Instructors and their employers are aware of the commitment and capacity required to deliver SMHFA training. The latter point was made by a number of Instructors who felt that the investment in training new Instructors could be wasted if people were subsequently unable to deliver training because they did not have the capacity or were not supported by their employers to deliver the training.

There is, however, a limit to the extent to which employers can be required to provide the support to SMHFA Instructors needed. There may be a case for making the level of support more explicit at the application stage e.g. by stating the number of days per year that the commitment of being an Instructor may require.

A number of Instructors said they felt that the requirement that potential Instructors had experience of both mental health issues and delivering training could be off-putting to some applicants. On the other hand, when asked about the criteria that were important in selecting people to train as SMHFA Instructors, over 80% of Instructors (84%) said that professional or personal experiences in the field of mental health was very or reasonably important. A similar proportion of respondents said that it was reasonably or very important that potential Instructors should have experience of delivering training or teaching.

While it was generally agreed that it was important for potential Instructors to have some experience of mental health issues and in training delivery, they were more likely to say that the personal attributes and values of individuals were important. For example, over 90% of Instructors said it was important that potential Instructors had positive attitudes towards people with mental health problems and enthusiasm to reduce the stigma associated with mental ill health. Almost 80% of Instructors also said that it was very important that potential Instructors had good interpersonal and communication skills.

This view was clearly summed up by one Instructor who commented:

“I think that the ability to deliver SMHFA training in a positive and non judgmental way is very important. Knowledge (although it certainly helps) about the content of the training, the range of mental health services, mental health problems etc. can all be acquired through the training for Instructors programme and recommended reading. Getting the message over positively is crucial”.

SMHFA Instructor
Another Instructor emphasised the importance of the personal attitudes and commitment of potential Instructors by saying:

“I have found it to be a rewarding process and as long as you have the commitment to the course and are enthusiastic and willing to continually learn, you have the qualities to successfully deliver the course and change attitudes and perceptions. I have successfully delivered my courses with no prior experience of training delivery”.

SMHFA Instructor

The vast majority of Instructors said they were satisfied with the training they had been given as a SMHFA Instructor and over 40% said they were extremely satisfied. Many Instructors said they felt that the structure and format of the training for new Instructors were well thought out and worked. In particular, many Instructors said they felt it was very important that potential new Instructors took part in a SMHFA training course prior to taking part in the three day Development Centre element of the training for Instructors: 42% of Instructors said it was extremely important and a further 30% said that it was very important. While a small proportion of Instructors said they didn’t think that this element of the training for new Instructors was very important, the majority said they found this very valuable and helped them prepare for the Development Centre element of the training. As one Instructor stated:

“Because as you know you are going to become an Instructor, even if you have already done the course, you listen to it/take part in it in a different way. Although you are just a participant, what you get from it as a future Instructor is different from an ordinary participant. People may have also done the course quite a while back and it is good to refresh structure, content, mode of delivery so that during the development days, the teaching makes more sense”.

SMHFA Instructor

This view was supported by another Instructor who commented:

“I think participating as a participant and participating as a potential instructor are two different experiences. I don’t think you can ever go over the course content too much - every run through helps. Personally it made things easier for me as I was able to deconstruct and reconstruct the course content which made it easier to deliver and facilitate discussion”.

SMHFA Instructor

Instructors were also generally satisfied with the Development Centre aspect of the training for new SMHFA Instructors. Over a third of Instructors (35%) said they were extremely satisfied with this aspect of their training and a further 54% said they were satisfied. When Instructors were asked which aspects of the Development Centre worked best the most commonly mentioned aspects were as follows:
• The support of members of the National Training Team
• Interaction with and peer support from other participants
• The input from external speakers on specific topics
• Small group exercises with other participants
• Gaining experience in delivering the training material

Instructors were less likely to suggest any ways in which they thought the Development Centre element of the training provided to new SMHFA Instructors could be improved. Where suggestions were made these were generally seen as building upon what was perceived as being a good and effective format. The main improvements suggested included providing opportunities for participants to practice the delivery of more than one of the sessions in the SMHFA training course, and having more input from external speakers with expertise in specific issues covered by SMHFA training. A number of Instructors said that they would also have appreciated more input from ‘service users’ or people who had experience of particular mental health problems.

One issue that was raised by a number of Instructors was the need for a more formal approach to giving potential Instructors more training in the use of the IT and audio-visual equipment needed to deliver elements of the training. This was seen as being particularly important as a lack of familiarity with the equipment was perceived to be a problem for some Instructors, one that effected their confidence, and hence the quality of their presentations.

The vast majority of Instructors also said they were satisfied with the Assessment element of the training they received as a SMHFA Instructor. Again, over 80% of Instructors who responded to the survey said they were either satisfied or extremely satisfied with this aspect of the training (36% said that they were extremely satisfied).

When Instructors were asked which aspects of the Assessment element of the training worked well the most commonly mentioned aspects were as follows:
• The support and constructive feedback received from fellow participants
• The supportive and constructive feedback received from members of the National Training Team
• Learning from other participants’ approaches to delivering different elements of the training
• The opportunity to discuss concerns and difficulties in a non-judgemental and supportive environment

Again, Instructors were less likely to mention aspects of the Assessment element of the training that they felt could be improved or be made more effective. The most commonly mentioned improvements made by a number of Instructors included the need for more specific training on using the
different types of audio visual equipment required to deliver different elements of the SMHFA course material. Other issues raised by instructors included doubt about how to raise concerns over individual participants in a supportive and constructive manner, more opportunity to receive one-to-one feedback from members of the National Training Team, and a more structured approach to providing participants with written feedback.

3.4.4 Perceptions of support provided to instructors following their training

Instructors were very positive about the support they had received from members of the National Training Team during the training and assessment period for new instructors. In fact, 30% said that they felt the support they had received from members of the National Training Team during this period was extremely supportive and a further 43% said that they had been very supportive.

While the vast majority of instructors said they felt the support they had received from members of the National Training Team had been positive, a substantial minority (25%) said they felt they would have benefited from more support when they were initially being trained as SMHFA instructors.

One type of additional support that these instructors felt they would have benefited from was more one-to-one support including personal mentoring when new instructors are delivering training prior to being formally approved.

One instructor said they felt they would have benefited from more personal feedback and commented that:

“A telephone call after the first course just to chat over how things went would be really useful. We’re doing the above now as a local network but after my first course it would have been useful to chat things over with someone from the National Training Team”.

SMHFA Instructor

Another instructor expressed similar concerns and said that:

“I would have appreciated further follow up in relation to concerns that myself or participants raised which I fed back and some constructive suggestions of moving this forward. There are issues which I raised that needed to change for me to remain a trainer and this wasn’t explored with me or even taken on board to the extent that I was given ways around it”.

SMHFA Instructor

While these concerns were expressed by a relatively small proportion of participants it does suggest that some instructors, particularly those who are
less experienced in delivering training, may need more pro-active and ongoing support after they have completed the initial training. Given the investment that has been made in the delivery of the training to Instructors, this ongoing support would make sense to ensure that Instructors are able to apply the learning they have received in an effective way when delivering SMHFA training. While there is no evidence that this is a problem for the vast majority of Instructors, it has clearly been an issue for some Instructors who have admitted to struggling to deliver the training and at least one Instructor has cited the lack of ongoing support as the reason why they have “dropped out” from being a SMHFA Instructor.

There appear to be mixed views amongst Instructors about the support they have received from NHS Health Scotland since becoming a SMHFA Instructor. While almost a third (32%) said they felt that NHS Health Scotland had been either extremely or very supportive, a majority of Instructors (56%) who responded to the survey said they were unable to say whether NHS Health Scotland had been supportive or unsupportive. This reflects a general concern expressed by a number of Instructors about the role of NHS Health Scotland in supporting the delivery of SMHFA training.

This confusion was reflected in a number of the comments received from Instructors as the following quotes illustrate:

“I am unsure what NHS Health Scotland’s role is and what support I can expect from them”

SMHFA Instructor

“I wasn’t sure what NHS Health Scotland’s area of responsibility was and how this relates to the role of the Scottish Development Centre. Sometimes it wasn’t clear who to ask for help or support and this was confusing”

SMHFA Instructor

“NHS Health Scotland weren’t always clear about the ‘rules’ with regard to pricing structures, administrative procedures and how the SMHFA training should be marketed. I sometimes got the impression that they were making it up as they went along”

SMHFA Instructor

While most Instructors who expressed a view about the role of NHS Health Scotland said they were not clear about the role the agency had in terms of working with SMHFA Instructors, some said they had received support from staff when they had to contact them. One Instructor in particular said:

“I understand the pressures that NHS Health Scotland is facing but I have to say that I have found the members of staff that I have had to speak to very helpful. Even when they did not know the answer to my questions straight away they did make efforts to get back to me with an answer, whenever possible”

SMHFA Instructor
3.4.5 Instructors Experience of Delivering SMHFA Training

As can be seen from Table 3 below Instructors have been able to deliver a variety of different numbers of SMHFA training courses since they completed their training as an Instructor.

Table 3 – Number of SMHFA Training Courses Delivered per Instructor

<table>
<thead>
<tr>
<th>Cohort 1 – March 05</th>
<th>Cohort 2 – June 05</th>
<th>Cohort 3 – October 05</th>
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<tbody>
<tr>
<td>Number of Courses</td>
<td>Number of</td>
<td>Number of Courses</td>
</tr>
<tr>
<td>Delivered</td>
<td>Instructors</td>
<td>Delivered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Delivered</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>1</td>
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<tr>
<td>2</td>
<td>1</td>
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<td>3</td>
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<td>4</td>
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<td>6</td>
<td>1</td>
<td>6</td>
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<td>7</td>
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<td>9</td>
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<td>9</td>
<td>1</td>
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<td>12</td>
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<td>11</td>
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<tr>
<td>13</td>
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<td>12</td>
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<tr>
<td>14</td>
<td>1</td>
<td>14</td>
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<td></td>
<td></td>
<td>20</td>
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</tbody>
</table>

The number of courses that individual Instructors have delivered relates to when they were trained with those trained in 2005 having on average delivered more SMHFA training courses than those trained in 2006. However, it is also clear that some Instructors appear to be more able to deliver a
greater number of training courses than others. For each of the cohorts of SMHFA Instructors there is a small proportion of Instructors that have been able to deliver a substantially higher than average number of training courses. Equally, there is a similar proportion of Instructors who appear to be struggling to deliver the minimum requirement of four training courses a year after they have completed the training.

The fact that some Instructors are finding it difficult to deliver a sufficient number of SMHFA training courses was also apparent from the feedback received from individual Instructors in response to the survey and telephone interviews that informed part of the evaluation. The main reason given by Instructors for having delivered less SMHFA training than they anticipated mainly related to time pressures and a lack of administrative capacity to market the training and organise training courses.

As one Instructor said:

“I am trying to fit in the SMHFA training on top of my many other duties. It’s not as much the delivery of the training but finding the time to co-ordinate the arranging of courses, registering participants, finding venues etc. This is what really takes up the time and I can’t do it all on my own”

SMHFA Instructor

Other Instructors said the particular type of participants they wanted to encourage to participate in the training found it difficult to find the time to take part in the training. This was particularly the case for some professional groups who find it difficult to get time to participate in training. Doctors, nurses and lecturers in the FE sector were all mentioned as being difficult groups of participants to attract because they were not able to commit the necessary time to participate in the training.

Lack of awareness of SMHFA was seen as being a barrier for some Instructors, particularly those who were seeking to deliver the training to members of the public or to organisations out with the public sector. A number of Instructors said there needed to be more effective marketing of SMHFA at a national level to increase awareness of the training, and in particular to convince managers of the benefits of their staff participating in the training. One Instructor summed up a widely held view that SMHFA needs to be better marketed by saying:

“I find it difficult approaching organisations to get them to consider encouraging their staff to take part in SMHFA training. They haven’t heard of it and don’t understand how it is relevant to them. There needs to be a coordinated approach to marketing the training at a national and regional level”

SMHFA Instructor

A major issue for some Instructors was the fact they were charging for participating in the training and felt they were, in effect, competing for the participants with other Instructors able to offer the training without any cost. This was a major issue for independent Instructors, but was also an issue for
other Instructors, mainly from the community and voluntary sectors who felt they had to charge for participation in the training as a means of raising revenue for their organisation.

The concerns about the charging structures and the lack of co-ordination of the targeting of the training at particular professional groups and employment sectors expressed by a substantial number of Instructors, is illustrated by the following statements made by some of the Instructors who responded to the survey:

“I find it hard to think of charging for the course, when it is delivered free by the NHS, although I cannot afford to do the same. I considered applying for funding so that I could offer free courses to the public, yet be funded in a basic way to do so, but most charities will not fund individuals”.

SMHFA Instructor

“In marketing the course out with the College we have been hit with the fact that we are charging for the course and NHS health promotion departments do not charge. This has had the greatest impact”.

SMHFA Instructor

“I have found it difficult to get people on to the course despite using marketing leaflets. Also competing with NHS Fife who are offering the course free and our delegates have to pay. They have a high demand because of free places while we are struggling to attract participants because we have to charge. It doesn’t seem to make sense”

SMHFA Instructor

The majority of Instructors have a preference for delivering the SMHFA training jointly with another Instructor: 57% of Instructors responding to the survey said they preferred to co-deliver SMHFA training; 14% said they preferred to deliver the training on their own. Almost 30% of Instructors said they had no preference and it was apparent from the feedback received from Instructors that many will deliver the training either on their own or jointly with other Instructors depending on the audience and type of participants that the training is being delivered to.

Instructors gave a variety of reasons for preferring to deliver the SMHFA training jointly. For many Instructors being able to co-train was seen as being an advantage as it was less pressurising and allowed the workload of what is seen as being a very challenging course to deliver to be shared. This is reflected in some of the comments made by Instructors who had experience of co-delivering SMHFA training as these two quotes illustrate:

“Delivering the course takes a lot of energy, sharing the sessions is less time consuming and less pressure. For participants, having two people with different styles of delivery is refreshing, particularly as, at times the course can challenge values and beliefs”

SMHFA Instructor
“Given the amount of information and variety of support materials and exercises etc, I believe 2 instructors can deliver and support the group more effectively and essentially achieve this with the 12 hour time period, more easily. While I as yet have not attempted to deliver the course on my own, I am sure that co-delivery is also much more conducive to my own mental health”.

SMHFA Instructor

The main reason given by Instructors for preferring co-delivery was the fact they wanted to be able to deal with difficult situations effectively and in particular, to provide support to any participants who became upset or disturbed by the training if it raised issues about their own experience of mental health. A number of Instructors said that having co-trainers meant it was easier to deal with difficult situations in particular if one of the participants on the training became disturbed or upset.

As one Instructor put it:

“Because with the subject material in question, it is quite possible that someone becomes upset. Training solo, there is no-one to deal with the situation. Solo is also monotonous for the participants and somewhat draining for the solo trainer. It is also harder to gauge how it is going when you are the only judge when training solo”.

SMHFA Instructor

Another Instructor also made this point and said that:

“I personally do not think that the course should be delivered by one instructor only because on many occasions, especially during the depression, suicide, anxiety sessions, someone needs to get out due to content of material. If you have 2 Instructors, then one can get out and support individual while other trainer can carry on with training”

SMHFA Instructor

Some Instructors went as far as saying that they felt that co-delivery of the training should be seen as the norm and advocated it as being good practice. Others said that co-delivery should be a requirement and should be recommended by NHS Health Scotland and made a condition of Instructors being approved to deliver SMHFA training. If a substantial number of Instructors continue to prefer to co-deliver training courses, this will have implications for the number of courses that can be delivered. For example, if two Instructors co-deliver four courses a year this could be interpreted as them delivering the minimum expectations but it would in effect represent half the number of courses that could be delivered if they each delivered four courses individually. The implications of this for the future delivery of SMHFA training courses are considered in more detail in Section 5.
Instructors were asked whether they targeted any particular groups of participants when delivering SMHFA training. While the majority of Instructors said they did try to target the training they delivered at particular types of participant, it is clear from their responses that many are targeting the training at a wide range of sectors and types of participant. Indeed, many Instructors said they were targeting the training at many different areas of the public sector, as well as the voluntary and community sectors and the general public.

There were some suggestions that this meant that some Instructors felt they were competing to attract the same constituency of participants, and that there was a lack of co-ordination about which particular groups Instructors would be best placed to target. While there have been some efforts in a number of geographical areas to co-ordinate the areas that individual Instructors are targeting, in others there appears to be a degree of duplication.

Table 4 – Participants targeted by sector

<table>
<thead>
<tr>
<th>Sector/Type of Participant</th>
<th>Number of Instructors</th>
<th>Percentage of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statutory Health</td>
<td>40</td>
<td>55%</td>
</tr>
<tr>
<td>Statutory Education</td>
<td>44</td>
<td>60%</td>
</tr>
<tr>
<td>Statutory Emergency Services</td>
<td>23</td>
<td>32%</td>
</tr>
<tr>
<td>Statutory Justice Services</td>
<td>21</td>
<td>29%</td>
</tr>
<tr>
<td>Statutory Social Welfare</td>
<td>41</td>
<td>56%</td>
</tr>
<tr>
<td>Voluntary Sector</td>
<td>44</td>
<td>60%</td>
</tr>
<tr>
<td>Private Sector</td>
<td>25</td>
<td>34%</td>
</tr>
<tr>
<td>General Public</td>
<td>35</td>
<td>48%</td>
</tr>
</tbody>
</table>

While some SMHFA Instructors are targeting the training at particular groups of participants or working within a clearly defined sector, many Instructors are targeting the training very widely and seeking to attract participants from a wide range of professional backgrounds drawn from a range of different organisational and sectoral environments.

The most popular groups to be targeted by Instructors are participants working in the voluntary and education sectors with 60% of Instructors saying that they try to specifically attract participants from these sectors. The sectors where Instructors were least likely to say that they specifically targeted participants included the emergency services (31%), the statutory justice sector (including prisons and the legal service) (29%) and the private sector (34%). Interestingly, almost half of Instructors (48%) who responded to the
survey said they specifically targeted the training at members of the general public.

Some Instructors have a specific remit to deliver SMHFA training within their own organisation or sector as part of their job. These Instructors have been initially targeting their training at professionals and others working within well defined organisational and sectoral boundaries. Other Instructors have a much more general remit across a wide range of organisations and to different types of individuals. These Instructors tend to have adopted a less targeted approach to delivering the training, and have sought to encourage a wide range of participants from different sectors to take part in it. Some of these Instructors appear to have found it difficult to get sufficient participants interested in taking part in SMHFA training, as is illustrated by this quote from one Instructor.

“I am trying to target individuals who on a day to day basis, come into contact with individuals who may be experiencing mental health problems but this seems to be difficult at present. Many people who are likely to come across people with mental health problems cannot afford to take 12 hours of their work to attend the course”.

SMHFA Instructor

On the other hand, some Instructors are finding it difficult to cope with the demand for places on SMHFA training courses. This appears to be the case particularly for Instructors who have well developed networks and existing contact with organisations and individuals who are likely to be interested in participating in training. One Instructor who has recently been approved explained their current position by saying.

“At this early stage there has been so much interest that I haven't particularly targeted any sector but made sure that all sectors are sent course details if I have their contact details. Once I've got through my initial list of interested people I will begin to put posters in the library and in the local press to encourage members of the public to participate”

SMHFA Instructor

It also appears that Instructors who are able to offer the training without charging for participation are more likely to be able to attract participants from a wide range of different backgrounds, including members of the public. Indeed, many of these Instructors have indicated that they are struggling to cope with demand for the training and have waiting lists of people who have expressed an interest in participating.

As previously stated many Instructors said they felt the lack of awareness of and the lack of national promotion of SMHFA made it more difficult for them to market the training to potential participants. The responses to the questionnaire show that the majority of Instructors rely on informal ways of marketing SMHFA training courses. The most commonly used method is including details of training courses in information about general training
programmes, which 62% of Instructors said they did. A similar proportion of Instructors (60%) said that they issued targeted invitations to specific individuals and organisations. More limited use was made of more traditional marketing activities including issuing leaflets (used by 48% of participants) and advertising (42%). Other methods of marketing used by Instructors include attending community events, providing taster training events and giving talks to management teams and community and voluntary organisations.

When Instructors were asked if there was additional support they could be given that would help them market SMHFA training more effectively, almost 40% of Instructors said there was additional help that they felt they would benefit from. The most commonly mentioned types were national publicity campaigns to raise awareness of SMHFA, marketing targeted specifically at employers emphasising the importance of mental health and wellbeing amongst their employees, and publicity material targeted at specific types of participant and/or employment sectors.

3.4.6 Challenges faced by Instructors

Instructors were asked how confident they were that they would be able to meet the expectations required of them when they were approved as an SMHFA Instructor in the future. As can be seen from Table 5 below, while the majority of Instructors said they were at least quite confident they would continue to be able to meet these expectations, a relatively large minority said they were not confident. Perhaps most importantly, almost one in four (23%) of the Instructors who responded to the survey said that they were not confident that they would be able to deliver at least four courses a year in the future.

<table>
<thead>
<tr>
<th></th>
<th>Not Confident</th>
<th>Quite Confident</th>
<th>Very or Extremely Confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliver at least four SMHFA courses per year</td>
<td>23%</td>
<td>31%</td>
<td>46%</td>
</tr>
<tr>
<td>Attend and contribute to SMHFA networks at a local and national level</td>
<td>19%</td>
<td>31%</td>
<td>50%</td>
</tr>
<tr>
<td>Demonstrate Continued Professional Development in relation to SMHFA</td>
<td>13%</td>
<td>32%</td>
<td>55%</td>
</tr>
<tr>
<td>Provide the information required to support ongoing monitoring of the delivery of SMHFA training.</td>
<td>8%</td>
<td>32%</td>
<td>60%</td>
</tr>
</tbody>
</table>

For many Instructors their lack of confidence about their ability to continue meeting the expectations of being an SMHFA Instructor was related to changes in their personal circumstances or changes in their job. One Instructor said:
“The organisation that I work for is currently in the final year of funding. Work pressure is therefore extremely high at present. If future funding is not found then I will need to seek other employment and I may not have the same support from an employer as I have at present”.

SMHFA Instructor

Another Instructor said that they were not confident that they would be able to continue delivering SMHFA training in the future because:

“I feel that four courses per year is quite a lot of work as this is only a part of my work remit - especially with the new Healthy Working Lives Award being launched next year I will be very busy with training and getting all my workplaces up to scratch with that”.

SMHFA Instructor

When Instructors were asked what other barriers they felt they might face in being able to deliver on the expectations placed upon them as SMHFA Instructors the main issues mentioned by Instructors included the following:

- Lack of time/resources to organise and market the training
- Pressure of other work responsibilities and new tasks
- Funding the training (particularly for those who have to charge participants)
- Attracting sufficient participants to take part in the training
- Lack of awareness about SMHFA amongst managers and employers
- Difficulties in getting staff released to take part in a 12 hour training course.

The majority of Instructors estimate they only spend on average one day or less per week on activities related to the delivery of SMHFA training. A majority (55%) of Instructors who responded to the survey also said that their employer had not given them any additional help to allow them to undertake their responsibilities as a SMHFA Instructor. Only 51% of Instructors said they had access to administrative support to help them organise SMHFA training and only 20% of Instructors said they had access to full time administrative support.

Instructors were able to identify a number of ways that they felt they could be given more support by their employers to help them deliver SMHFA training in the future. The most commonly mentioned types of support that Instructors said they would find helpful included:

- Providing Instructors with more administrative support to help organise SMHFA training courses
- Ensuring that Instructors are given sufficient time to deliver SMHFA training
• Demonstrating an ongoing commitment to SMHFA training
• Supporting others to be trained as SMHFA Instructors
• Making SMHFA a training priority and ensuring staff are given time to participate in the training.

3.4.7 Instructors overall perceptions of their experience

Overall, Instructors who responded to the survey generally said they had found their experience rewarding but challenging. A substantial majority of Instructors (73%) said they felt that their role as an Instructor had contributed to their own professional and personal development. Many Instructors also said that becoming a SMHFA Instructor had increased their personal skills and abilities and that had benefited them in other aspects of their work and in their personal life. When asked to identify the main things they felt they had gained by becoming a SMHFA Instructor the issues most frequently mentioned by Instructors were as follows:

• Receiving positive feedback from participants in the training and getting a feeling of making a positive contribution.
• Increased knowledge and understanding about mental health issues.
• Networking with other SMHFA Instructors and others involved in mental health issues.
• Increased confidence in personal abilities as a trainer
• A sense of satisfaction and personal wellbeing in having made a difference for individuals who have participated in the training.

The following quotes from individual Instructors illustrate the enthusiasm demonstrated by many Instructors and the extent to which they feel they have personally benefited from becoming a SMHFA Instructor.

“I have enjoyed the re-awakening of enthusiasm and the excitement participants get towards the end of the course and realise that they can make a difference in their world both personally and professionally”.

SMHFA Instructor

“I am always touched by the number of people who come up after a session and tell me how much difference it has made to their lives. This course could really make a difference in Scotland we just need to reorganise and refocus our attempts to get it out there. On the whole I’m glad to be part of it”.

SMHFA Instructor

“It has given me a greater understanding of mental health issues generally and the opportunity to listen to those who have been affected in some way by mental illness. This has given me a greater awareness of how mental health problems can affect a diverse range of people in many different ways”.

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“It gives me a great sense of satisfaction when the group go away on their final day saying that they have enjoyed it and knowing that the knowledge they have gained may have done something to help reduce the stigma faced by people with mental health issues and increased the support they may expect to get”

While the vast majority of Instructors said that on balance their experience of being a SMHFA Instructor had generally been positive and rewarding, they were also able to identify a number of challenges they have had to face.

The most commonly mentioned challenges identified by Instructors included the following issues:

- Delivering a lot of complex information in a limited timescale
- Dealing with issues relating to participants’ own experiences of mental health problems
- Finding the time to keep knowledge up to date and prepare for training events
- Coping with different types of audiovisual equipment required to deliver course content
- The time commitment required to administer the delivery of the training and market SMHFA effectively
- Managing diverse groups of participants including those with different levels of prior knowledge, expertise and experience of mental health issues.

The following quotes illustrate how some Instructors have expressed the challenges that they have faced as a SMHFA Instructor.

“It’s pretty much what I’d anticipated - striking the balance between delivering a stimulating course which generates relevant discussion and debate, which delivers all the key messages, using as wide a variety of materials and mediums as possible - within 12 hours....and managing your own stress levels at the same time!”

“The major challenges I have faced include moving back and forward from presentation to videos. Not least as the equipment provided is never of the quality promised. Also, the amount of knowledge I am expected to have as an instructor that needs to go much wider that the materials covered in the manual”.

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“One of the biggest challenges has been the diversity of people who attend the training. Their understanding or lack of understanding and at times challenging views of mental health issues. Managing time, in particular when people are having a good discussion and you need to intervene when people get onto their own hobby horses”

SMHFA Instructor

There is a well-established pool of SMHFA Instructors across Scotland who have been trained to deliver the SMHFA training. Overall, these Instructors are enthusiastic and committed to the mental health first aid approach and keen to use the skills and experience they have developed to deliver the training to a wide range of participants. However, the evaluation suggests that some Instructors have found it difficult to meet the expectations in terms of delivering the minimum number of training courses. On the other hand there is a small group of Instructors who have substantially exceeded the minimum expectations and are delivering SMHFA training on a regular basis.

The substantial variation in the number of training courses that individual Instructors have been able to deliver is to some extent inevitable. Individual Instructors will all have specific pressures on their time and some will be better placed to deliver the training than others. Equally, it is understandable that some Instructors will face changes in their personal or employment circumstances that may have an impact on their ability to deliver SMHFA training courses. The effect of these factors does have an impact on the ability to roll-out SMHFA training on a national basis and this has implications for the support for Instructors that is provided both by employers and at a national level. It may also have consequences for future decisions about the number of SMHFA Instructors that are required to be trained in order to sustain the delivery of the training beyond March 2008.
3.5 Summary of Key Findings

- Scotland’s Mental Health First Aid was developed following the success of adopting the mental health first aid approach in Australia. It was seen as being a good method of providing people with training on mental health issues and in particular contributing to improving mental health literacy levels in Scotland.

- A total of 177 SMHFA Instructors were trained between March 2005 and February 2007. There are four more cohorts of training for Instructors planned to take place by March 2008 and it should be feasible to achieve the target of having 300 trained SMHFA Instructors in place by this date.

- Over 400 SMHFA training courses took place between March 2005 and February 2007. Over 5,250 participants took part in these courses coming from a range of different backgrounds and different parts of Scotland.

- There is a well-established pool of SMHFA Instructors across Scotland who have been trained to deliver the SMHFA training. Overall, these Instructors are enthusiastic and committed to the mental health first aid approach and keen to use the skills and experience they have developed to deliver the training to a wide range of participants.

- Some of these Instructors are delivering substantially more SMHFA training courses than the minimum expectation of four a year. However, other Instructors are finding it difficult to meet this expectation.

- Many Instructors feel that they would benefit from being given additional support from both their employers and at a national level to allow them to fulfil their role as a SMHFA Instructor more effectively.

- The training that has been provided for new SMHFA Instructors appears to have been effective and has been well received by the vast majority of Instructors.

- The implementation of SMHFA has been well managed by NHS Health Scotland, often in difficult circumstances and within tight timescales. However, due to the amount of work involved in managing SMHFA, certain activities have not been undertaken as quickly or effectively as anticipated.

- SDC and the National Training Team have made a vital contribution to the national roll-out of SMHFA. The commitment and abilities of the individuals involved in developing the SMHFA training materials and the training for new Instructors is widely acknowledged as having contributed to the success of the programme.
4. **Outcome Evaluation**

A major objective of the evaluation was to examine the experience of participants who had taken part in SMHFA training courses delivered during the evaluation period. This involved exploring participant perceptions of the delivery of the training by collecting and analysing feedback received from participants in Course Evaluation Forms, which they were asked to complete immediately after the training. The evaluation also attempted to measure learning outcomes from the training by comparing participants' responses to a range of questions before and after the training. This was supplemented by a follow up survey of participants, approximately 20 weeks after they had completed the SMHFA training, and telephone interviews with a sample of participants, to explore how participants had been able to apply the learning in both their jobs and in their personal life.

This section of the evaluation report describes the findings from this element of the evaluation and in particular examines feedback from participants about their perceptions of the delivery and content of the training, the learning participants gained from their participation in a SMHFA training course and how they have been able to start applying this learning in practice.

4.1 **Delivery of the Training**

4.1.1 **Course Evaluation Feedback from Participants**

At the start of the evaluation Hexagon Research and Consulting was asked to analyse the feedback received from participants in SMHFA courses prior to the evaluation period. A total of 838 Training Evaluation Sheets completed by participants and submitted to NHS Health Scotland by SMHFA Instructors were analysed. The key findings of this analysis were as follows:

- 68% of participants said they felt the course content was highly relevant to them and a further 25% said it was quite relevant.
- 57% of participants said they had personally learnt a great deal and a further 30% said they had learnt quite a lot.
- 50% of participants rated the activities and methods used during the courses and the pacing and timing of the delivery as excellent. A further 38% of participants rated each of these aspects of the courses as good.
- 73% of participants rated the SMHFA Instructor's mental health knowledge as excellent; 70% rated the way they facilitated discussions as excellent and 69% rated the quality of their presentations as excellent.
Table 6 below shows a summary of responses from participants, in participating SMHFA courses completed prior to this evaluation, in response to being asked “To what extent they felt each of the objectives of the training had been met”:

### Table 6 – Historical Feedback from Participants

<table>
<thead>
<tr>
<th>Objective</th>
<th>Partially Met</th>
<th>Quite Well Met</th>
<th>Fully Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>To be aware of the key mental health issues in Scotland</td>
<td>2%</td>
<td>35%</td>
<td>64%</td>
</tr>
<tr>
<td>To understand what depression is and how it affects people</td>
<td>1%</td>
<td>31%</td>
<td>67%</td>
</tr>
<tr>
<td>To be aware of the prevalence of suicide and the risk factors</td>
<td>3%</td>
<td>37%</td>
<td>60%</td>
</tr>
<tr>
<td>To recognise and respond appropriately to anxiety and panic disorders</td>
<td>3%</td>
<td>33%</td>
<td>64%</td>
</tr>
<tr>
<td>To understand and respond appropriately to people with psychosis</td>
<td>5%</td>
<td>47%</td>
<td>47%</td>
</tr>
<tr>
<td>To apply ALGEE appropriately</td>
<td>2%</td>
<td>30%</td>
<td>67%</td>
</tr>
</tbody>
</table>

Over 60% of participants said that five out of the six SMHFA course objectives had been fully met and over 94% of participants said that all of the objectives had either been fully met or met quite well. The objective which participants were least likely to say had been fully or quite well met was “to understand and respond appropriately to people with psychosis”. Only 47% of participants said this objective had been fully met, although a further 47% of participants said it had been quite well met.

As part of the agreed evaluation methodology, revised and expanded Course Evaluation Forms were produced to obtain more detailed feedback from participants taking part in SMHFA training courses during the evaluation period. These Course Evaluation Forms were designed to get feedback from participants on their perceptions of the content and delivery of the training, their personal learning, and the extent to which they felt the course objectives and intended outcomes had been met for them.

The forms also allowed participants an opportunity to comment on their perceptions of how useful they felt the training had been to them and how they thought they would be able to apply the skills and knowledge they had gained in their workplace and personal lives. Finally, participants were asked whether they would encourage others to participate in SMHFA training and suggest any improvements they would make to the training based on their own experience of attending a SMHFA training course.

Course Evaluation Forms were issued to participants in SMHFA training courses that took place between May and September 2006. A total of 1,159 completed Course Evaluation Forms were received from participants in 100 SMHFA training courses that took place during this period. It is not possible to state the actual number of participants who took part in all of the SMHFA
training courses that took place during the evaluation period as Instructor Monitoring Forms (which provide details of the number of participants on individual courses) were not returned for a number of training courses for which Course Evaluation Forms were issued. Monitoring Forms were received for 92 courses and these courses had a total of 1,083 participants taking part in the training. A total of 816 completed Course Evaluation Forms were received from participants on these courses, a response rate of 75%.

### 4.1.2 Characteristics of Participants

Participants who completed Course Evaluation Forms were asked to give details of their characteristics. An analysis of the responses received from the 816 participants who completed Course Evaluation forms during the period of the evaluation is shown in Table 7.

<table>
<thead>
<tr>
<th>Gender</th>
<th>No.</th>
<th>%</th>
<th>Employed</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>173</td>
<td>20.4%</td>
<td>No</td>
<td>46</td>
<td>4.0%</td>
</tr>
<tr>
<td>Female</td>
<td>653</td>
<td>79.6%</td>
<td>Yes</td>
<td>763</td>
<td>95.8%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>No.</th>
<th>%</th>
<th>Employment Sector</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-24</td>
<td>64</td>
<td>9.5%</td>
<td>Health</td>
</tr>
<tr>
<td>25-34</td>
<td>159</td>
<td>18.5%</td>
<td>Education</td>
</tr>
<tr>
<td>35-44</td>
<td>260</td>
<td>33.5%</td>
<td>Emergency Services</td>
</tr>
<tr>
<td>45-54</td>
<td>214</td>
<td>28.8%</td>
<td>Justice</td>
</tr>
<tr>
<td>55-64</td>
<td>69</td>
<td>9.0%</td>
<td>Social Welfare</td>
</tr>
<tr>
<td>65 +</td>
<td>9</td>
<td>0.7%</td>
<td>Voluntary Sector</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnic Origin</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>725</td>
<td>97.5%</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>2.5%</td>
</tr>
<tr>
<td>Private</td>
<td>94</td>
<td>14%</td>
</tr>
</tbody>
</table>

The key issues arising from the analysis of the characteristics of the respondents can be summarised as follows:

- 80% of participants were female.
- 61% of participants were under the age of 45
- Only 2.5% of participants came from a non white ethnic background
- 94% said the main reason for taking part in the training was connected to their work

Participants were asked how knowledgeable they perceived themselves to be about mental health issues prior to taking part in the SMHFA training using a five-point scale ranging from “extremely knowledgeable” to “not at all knowledgeable”.

The responses received from participants are shown in the following table. As can be seen, the majority of participants perceived they were reasonably knowledgeable about mental health issues, different types of mental health
problems and the symptoms of different types of mental health problem prior to taking part in the SMHFA training.

Table 8 – Participants’ perceptions of their knowledge prior to the training

<table>
<thead>
<tr>
<th></th>
<th>Extremely Knowledgeable</th>
<th>Very Knowledgeable</th>
<th>Reasonably Knowledgeable</th>
<th>Not Very Knowledgeable</th>
<th>Not at All Knowledgeable</th>
</tr>
</thead>
<tbody>
<tr>
<td>About mental health issues</td>
<td>1%</td>
<td>8%</td>
<td>63%</td>
<td>26%</td>
<td>1%</td>
</tr>
<tr>
<td>Different types of mental health problems</td>
<td>1%</td>
<td>8%</td>
<td>54%</td>
<td>35%</td>
<td>2%</td>
</tr>
<tr>
<td>The symptoms of different types of mental health problems</td>
<td>1%</td>
<td>5%</td>
<td>48%</td>
<td>42%</td>
<td>4%</td>
</tr>
</tbody>
</table>

A large minority of respondents felt that they were either not very knowledgeable or not at all knowledgeable, ranging from 46% in terms of their knowledge of the symptoms of different types of mental health problems to 27% in terms of their perceived knowledge about mental health issues in general. Less than 10% of respondents said they felt they were either extremely knowledgeable or very knowledgeable prior to taking part in the SMHFA training.

Participants working in the public sector were more likely to say that they were extremely knowledgeable about mental health issues than those working in the community or voluntary sectors. However, those working in the voluntary/community sectors were less likely to say that they were not very knowledgeable about mental health issues. Again, participants from the voluntary and community sectors were more likely to say they were reasonably knowledgeable about different types of mental health problems than those who worked in the public sector.

Participants were asked whether they had received any training on mental health issues prior to taking part in the SMHFA training. While 40% of participants said that they had previously received some form of training, the majority of participants (56%) said they had not received any training on mental health issues prior to taking part in the SMHFA training.

Participants from the voluntary and community sectors were more likely to say they had received training on mental health issues (52%) than those working in the public sector (34%).

The remainder of this section of the report highlights the key findings emerging from the feedback received from participants immediately following their participation in the SMHFA training based on a detailed analysis of the Course Evaluation Forms that were returned during the evaluation period.
4.1.3 Participants’ Overall Evaluation of Training

Participants were asked to give their overall perceptions of the SMHFA training course they attended by rating various aspects of the training on a four point scale ranging from “excellent” to “very poor”. Table 9 below shows the proportion of participants who rated each of the aspects of the training as either excellent or good.

Table 9 – Participants’ overall perceptions of the training

<table>
<thead>
<tr>
<th></th>
<th>Excellent</th>
<th>Good</th>
</tr>
</thead>
<tbody>
<tr>
<td>Content</td>
<td>70%</td>
<td>28%</td>
</tr>
<tr>
<td>Personal Learning</td>
<td>59%</td>
<td>35%</td>
</tr>
<tr>
<td>Learning Activities/Methods</td>
<td>54%</td>
<td>40%</td>
</tr>
<tr>
<td>Presentations</td>
<td>66%</td>
<td>29%</td>
</tr>
<tr>
<td>Facilitation of Discussion</td>
<td>64%</td>
<td>32%</td>
</tr>
<tr>
<td>Interaction amongst Participants</td>
<td>62%</td>
<td>33%</td>
</tr>
<tr>
<td>Venue and Refreshments</td>
<td>47%</td>
<td>38%</td>
</tr>
<tr>
<td>Value for Money</td>
<td>67%</td>
<td>21%</td>
</tr>
</tbody>
</table>

As can be seen from the table 70% of participants rated the content of the training as excellent and 59% said that they felt their personal learning had been excellent. Participants also rated the delivery of the training very positively with over 60% of participants saying the presentations, facilitation of discussion, interaction amongst participants were excellent. A majority of participants said that the learning activities and methods used had been excellent and a further 40% said they had been good.

Many participants commented very favourably about the training and said that they had found it of value. Two typical comments made by participants were as follows:

“This was one of the best training courses I have been on. It has really increased my knowledge of mental health issues and I feel more confident about dealing with people who may be experiencing mental health problems”

SMHFA Participant

“First class. I thought the delivery of the training was excellent and the training materials were good. It really met up to my expectations...in fact it exceeded them”

SMHFA Participant
There was also strong praise for the Instructors and the way they delivered the training. In particular, many participants commented on the style of the delivery of the training and the knowledge of the Instructors as is illustrated by the following two quotes.

“The Instructor was excellent she was able to get sometimes complex information across in a clearly understandable manner. There was also a good balance between talking to us and encouraging members of the group to discuss issues amongst themselves and with the Instructor”

SMHFA Participant

“The Instructor had a really good approach; he was able to blend giving us hard information with personal experiences and real life examples that made the material much more accessible and enjoyable. I am sure I learned more because of the quality of the way the training was delivered”

SMHFA Participant

A number of participants said they felt the fact the training had been delivered by two Instructors was a positive aspect of the course they had taken part in. Some participants said they felt this made it easier to work in a group context while others said they felt the contrast of different delivery styles and types of knowledge and experience was valuable. As one participant said:

“There was a lot of material to cover in the two days but having different Instructors with different styles helped provide a contrast that made the delivery of the material more interesting”

SMHFA Participant

Another participant added that:

“Having two Instructors was really good. It made it easier to understand some of the issues as they bounced ideas of each other and were able to intervene when one of them was having difficulty in getting her ideas across to some members of the group”

SMHFA Participant

Another issue participants commented favourably on was the mix of learning techniques and methods used in delivering the training. Participants in particular seemed to enjoy the more interactive aspects of the training and said they got a lot out of the interaction with one another. As one participant said:

“I really enjoyed the group exercises; they gave you an opportunity to explore issues with others and to share experiences. This was a really good way of learning about the issues”

SMHFA Participant
Another participant added:

“I really liked the hearing voices exercise. It really made you think and hopefully get a better understanding of what it feels like. I think this is a really good way of learning about how people with mental health problems may be thinking and how it may affect how you interact with them”

SMHFA Participant

Participants particularly commented on the group interaction aspects of the training and being involved in a mixed group with participants from a range of different backgrounds and professional disciplines. One participant summed up the views expressed by many others by saying:

“It was good that there were people on the course from a range of different backgrounds. I learnt a lot from listening to others, hearing about their experiences and how they had dealt with issues in the past”

SMHFA Participant

Another participant echoed this point by saying

“I didn’t just learn a lot of facts. I was able to explore issues with people from different professional backgrounds and gain a better understanding of different perspectives and approaches. To me that was a valuable aspect of the training from which I personally really benefited”

SMHFA Participant

4.1.4 Participants’ Evaluation of Training Content

Participants were asked to rate the relevance of the content of the training on a four-point scale from ‘very relevant’ to ‘not relevant’. As can be seen from Table 10 below, around 70% of respondents rated the relevance of the content of each of the four main sessions in the SMHFA training course as being very relevant and over 90% of respondents rated the content of each of the sessions as being either very relevant or quite relevant.

Table 10 – Participant’s perceptions of the relevance of training content

<table>
<thead>
<tr>
<th>Content</th>
<th>Very Relevant</th>
<th>Quite Relevant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session 1</td>
<td>71%</td>
<td>23%</td>
</tr>
<tr>
<td>Session 2</td>
<td>70%</td>
<td>22%</td>
</tr>
<tr>
<td>Session 3</td>
<td>70%</td>
<td>24%</td>
</tr>
<tr>
<td>Session 4</td>
<td>69%</td>
<td>22%</td>
</tr>
</tbody>
</table>
The vast majority of participants said they felt that the course had met their expectations in terms of the content of the material covered. Some said that they would have liked more detail on particular issues or about specific types of mental health condition but they understood that it would be difficult to go into more detail given the length and structure of the course. Others stated they understood that the purpose of the course was not to make everybody an “expert” on every aspect of mental health, but rather to give them sufficient knowledge and skills to be able to identify when someone may be experiencing a mental health problem, and provide them with initial help and support.

This suggests many participants grasped the first aid concept underlying the SMHFA approach. This is illustrated by the following quotes from participants that reflect the views expressed by a substantial number of participants.

“There were some issues that I would have liked to have seen covered in more depth but I understand this would have been difficult to do in two days. Overall, I was happy with the balance of the content of the training and feel it has given me enough information to apply the principles in practice”

SMHFA Participant

“I don’t think I would describe myself as an expert in any of the issues covered by the training but I don’t think that was the point of the training. It is after all supposed to be about first aid not about being able to treat complex mental health problems. I think the amount of detail given was right given this context.”

SMHFA Participant

Many other participants said they felt that one of the most valuable aspects of the training was the fact it provided them with knowledge and confidence to find out more about specific issues they were particularly interested in. Many participants commented positively on the reference material they were given, including the sources of further information and material relating to specific issues covered by the training. This view was summed up by one participant who commented:

“It has really stimulated my interest in mental health issues and I now know where to get more information about specific conditions and types of mental health problems. The sources of further information given in the handouts will be really useful to me and hopefully I will be able to use them to encourage others to learn more about specific mental health issues”.

SMHFA Participant

While the vast majority of participants said they were generally happy with the content of the material covered by the SMHFA training, there were a few issues which a number of participants said they felt they would like to have had more information about, or for more time to have been devoted to discussion of the issues.
The issues that were most frequently mentioned by participants were:

- Issues relating to self harm
- Eating disorders
- Mental health issues for older people
- Links between alcohol and drug misuse and mental health problems
- Specific mental health problems affecting children and young people
- Post natal depression

Many of the participants said that they felt the elements of the SMHFA training dealing with suicide were very informative and would help them in identifying if someone was feeling suicidal, and know what to do in such circumstances. Others said they felt they would have liked to have had more time to explore these issues in more depth. Some participants had participated in ASIST training and said they felt there was an element of duplication, some saying they felt that the ASIST training was more effective as it went into more depth about how to deal with situations when someone is having suicidal thoughts or is contemplating suicide or self harm. One of these participants summed up the views of a number of others by saying:

“Suicide is a big complex issue and it is one of the most difficult issues people have to deal with. I think ASIST deals with this issue better and gives people more time to explore the issues and consider how they should deal with different types of situations”

SMHFA Participant

Another participant added:

“Clearly suicide prevention is a key element of mental health first aid but I’m not sure there is enough time devoted to it at the moment. I’m not sure how this can be addressed but perhaps there could be some link with the ASIST training especially for those who may want more in depth training”

SMHFA Participant

### 4.1.5 Participants’ Evaluation of Learning Outcomes

Participants were asked to provide feedback on how much they felt they had learned as a result of participating in the SMHFA training course. They were asked to rate their personal learning from each of the four main sessions of the SMHFA training course on a four point scale ranging from ‘a great deal’ to ‘none at all’.
Table 11 – Participants’ perceptions of their personal learning

<table>
<thead>
<tr>
<th>Learning</th>
<th>A Great Deal</th>
<th>Quite a Lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session 1</td>
<td>56%</td>
<td>32%</td>
</tr>
<tr>
<td>Session 2</td>
<td>60%</td>
<td>29%</td>
</tr>
<tr>
<td>Session 3</td>
<td>62%</td>
<td>29%</td>
</tr>
<tr>
<td>Session 4</td>
<td>64%</td>
<td>25%</td>
</tr>
</tbody>
</table>

As can be seen from Table 11 above, a majority of participants said they felt they had learnt a great deal from each of the sessions in the SMHFA training course. While the percentage saying they had learnt a great deal was consistently high for all four sessions in the training course, a slightly higher percentage said that they had learnt a great deal from Session 4 and a slightly lower proportion of participants felt they had learnt a great deal from Session 1.

4.1.6 Participants’ Evaluation of Delivery of Training

Section 4.1.2 showed that the vast majority of participants felt that overall the delivery of the SMHFA training on the course they attended was either excellent or good. Participants were also asked to rate the various aspects of the delivery of the training in each of the training sessions using the same four-point scale. As Table 12 below shows, over 90% of participants said that each of the aspects of the delivery they were asked to rate was either excellent or good for each of the four sessions on the training course they attended.

Table 12  Participants’ evaluation of the delivery of SMHFA training

<table>
<thead>
<tr>
<th></th>
<th>Session 1</th>
<th>Session 2</th>
<th>Session 3</th>
<th>Session 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activities and Methods</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>94%</td>
</tr>
<tr>
<td>Pacing and Timing</td>
<td>94%</td>
<td>93%</td>
<td>95%</td>
<td>94%</td>
</tr>
<tr>
<td>Instructors Presentation</td>
<td>97%</td>
<td>96%</td>
<td>96%</td>
<td>95%</td>
</tr>
<tr>
<td>Facilitation of Discussion</td>
<td>96%</td>
<td>96%</td>
<td>94%</td>
<td>93%</td>
</tr>
<tr>
<td>Training Materials</td>
<td>94%</td>
<td>94%</td>
<td>94%</td>
<td>93%</td>
</tr>
</tbody>
</table>
4.1.7 Perceptions of Extent to which Training Objectives were met

Participants were asked to state the extent to which they felt that various objectives of SMHFA training had been met by rating this on a four-point scale ranging from the objective being ‘fully met’ to ‘not at all’. The responses from participants who returned Course Evaluation Forms are shown in Table 13 below.

Table 13 – Perceptions of training objectives

<table>
<thead>
<tr>
<th>Objective</th>
<th>Fully Met</th>
<th>Quite Well</th>
</tr>
</thead>
<tbody>
<tr>
<td>To be aware of the key mental health issues in Scotland?</td>
<td>42%</td>
<td>50%</td>
</tr>
<tr>
<td>To understand what depression is and how it affects people</td>
<td>65%</td>
<td>30%</td>
</tr>
<tr>
<td>To be aware of the prevalence of and risk factors for suicide in Scotland</td>
<td>55%</td>
<td>39%</td>
</tr>
<tr>
<td>To recognise and respond appropriately to anxiety and panic disorders</td>
<td>56%</td>
<td>38%</td>
</tr>
<tr>
<td>To understand and respond appropriately to people with psychosis</td>
<td>42%</td>
<td>46%</td>
</tr>
<tr>
<td>To apply ALGEE appropriately</td>
<td>61%</td>
<td>32%</td>
</tr>
</tbody>
</table>

As the table shows, most of the time a majority of responding participants said that they felt that five of the six key objectives had been fully met. The highest rating was for the objective of “understanding what depression is and how it affects people”, with almost two-thirds (65%) of participants saying that they felt that this objective had been fully met. The next highest rating was for the objective of “applying ALGEE appropriately” with 61% saying that this objective had been fully met.

The two objectives where less than 50% of responding participants said that the objective had been fully met was the objective of making participants “aware of the key mental health issues in Scotland” and “understanding and responding appropriately to people with psychosis”. While only 42% of participants said they felt that these objectives had been fully met a further 50% and 46% respectively said that they felt that these objectives had been met “quite well”.
The extent to which participants felt the training objectives had been met in practice on the SMHFA course they had attended is illustrated by the following comments made by some participants.

“I am definitely more aware about mental health issues and think I would be better able to recognise if someone is suffering from a specific type of mental health problem”

SMHFA Participant

“I now understand how common some mental health problems are and how seriously they can impact on people. I know people who say they suffer from depression but have never really known how to talk to them about it but am sure that after the training I would know what to do”

SMHFA Participant

“Before the training I would never have been able to know if someone was feeling suicidal or how to help them. I think I would now be able to recognise if someone was feeling that way and be able to provide them with some form of support...even if it was just talking to them”

SMHFA Participant

Many of the participants said they found the ALGEE principle helpful and that it provided a framework they could use in both their personal lives and work context. One participant summed up a more general view by commenting:

“The ALGEE approach is really useful. It seems to be a really good way of approaching issues and helping you think through what issues someone experiencing mental health problems may be facing and how they can be helped”

SMHFA Participant

Another participant agreed and said:

“I am sure I will be able to use the ALGEE framework in my work and it will help me respond to people when they may be having mental health issues and understand why they may be reacting in certain ways”

SMHFA Participant

4.1.8 Perceptions of extent to which training outcomes were met

Participants were asked their opinions of how well they felt a number of desired learning outcomes had been achieved in the SMHFA training course they attended. They were asked to rate each of these desired outcomes on a five-point scale, ranging from ‘extremely good’ to ‘very bad’.
Table 14 - Participants’ rating of learning outcomes

<table>
<thead>
<tr>
<th></th>
<th>Extremely Good</th>
<th>Very Good</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helping you to be more able to recognise if someone is experiencing a mental health problem?</td>
<td>44%</td>
<td>43%</td>
</tr>
<tr>
<td>Helping you to be more skilled in helping people who are experiencing a mental health problem</td>
<td>37%</td>
<td>46%</td>
</tr>
<tr>
<td>Giving you the knowledge you need to be able to help people experiencing mental health problems towards appropriate professional health</td>
<td>40%</td>
<td>44%</td>
</tr>
</tbody>
</table>

Table 14 above shows the percentage of responding participants who said they felt the training they received was either “extremely good” or “very good” in terms of achieving each of the outcomes. Over 80% of participants said they felt the training was either “extremely good” or “very good” in terms of delivering the three desired outcomes. While the proportion of respondents rating each of the outcomes as extremely or very good was consistently high, slightly more respondents said that the training was extremely or very good in terms of the outcome of “helping you to be more able to recognise if someone is experiencing a mental health problem”.

4.1.9 Participants views on usefulness and applicability of training

Participants were asked how they would rate the usefulness of the SMHFA training to them in their job or workplace and in their personal life. The participants were asked to rate their perception of the usefulness of the course on a four-point scale ranging from excellent to very poor.

As Table 15 below, shows, a slightly higher proportion of respondents said they felt the usefulness of the training was excellent in terms of its applicability in their job or workplace than said it was excellent in terms of its perceived applicability in their personal life. However, a majority (55%) of participants said that they thought that the training was excellent in terms of its applicability in both their job and in their personal lives.
Table 15 – Participants’ perceptions of usefulness of training

<table>
<thead>
<tr>
<th>Usefulness?</th>
<th>Excellent</th>
<th>Good</th>
</tr>
</thead>
<tbody>
<tr>
<td>In Job or Workplace</td>
<td>67%</td>
<td>28%</td>
</tr>
<tr>
<td>In Personal Life</td>
<td>55%</td>
<td>38%</td>
</tr>
</tbody>
</table>

4.2 Participants Baseline Position

4.2.1 Baseline Survey of Participants

In order to measure the impact of SMHFA training it was necessary to establish a baseline position by assessing participants’ knowledge, skills and attitudes prior to them taking part in the training. This baseline position provided information about the characteristics of participants in SMHFA training courses during the evaluation period. It also provided a benchmark against which participants’ knowledge, skills and attitudes after the training could be compared to assess any changes as a result of their participation in the training.

To gather baseline data it was necessary to survey participants prior to them taking part in the SMHFA training. To do this SMHFA Instructors were asked to provide details of participants who had registered to take part in training so that before the training commenced they could be sent a baseline questionnaire. This was not always possible as Instructors were not always aware of the names or contact details for participants in advance of the training. However, it was possible to send baseline questionnaires to 811 participants in 75 SMHFA training courses that took place between May and September 2006. Completed Baseline Questionnaires were received from 506 participants: a response rate of 62%.

A copy of the Baseline Questionnaire sent to participants prior to them taking part in SMHFA training is included in the Technical Report together with a full statistical analysis of the responses received from participants. The remainder of this section of the report describes the main findings arising from an analysis of the responses to the baseline survey.

4.2.2 Participants Baseline Confidence

The baseline survey was also used to ascertain participants’ perceptions of their confidence in dealing with issues relating to mental health or in helping people who are experiencing mental health problems prior to taking part in the SMHFA training.
Table 16 – Participants’ assessment of their confidence prior to the training

<table>
<thead>
<tr>
<th>Ability to recognise if someone is experiencing a mental health problem?</th>
<th>Extremely Confident</th>
<th>Quite Confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability to help someone with a mental health problem in your job or work place?</td>
<td>1%</td>
<td>23%</td>
</tr>
<tr>
<td>Ability to help a member of your family or a close personal friend if they have a mental health problem?</td>
<td>3%</td>
<td>19%</td>
</tr>
<tr>
<td>Ability to identify if someone is at risk of attempting suicide or harming themselves?</td>
<td>4%</td>
<td>29%</td>
</tr>
<tr>
<td>Ability to assess how high the risk is of someone attempting suicide or harming themselves?</td>
<td>2%</td>
<td>19%</td>
</tr>
<tr>
<td>Ability to guide a person with a mental health problem to appropriate professional help?</td>
<td>2%</td>
<td>12%</td>
</tr>
<tr>
<td>Ability to advise someone with a mental health problem about steps they could take to help themselves?</td>
<td>4%</td>
<td>30%</td>
</tr>
</tbody>
</table>

As can be seen from Table 16 above, while only a small proportion of participants said they were extremely confident in relation to their ability to deal with particular mental health related issues a higher proportion said they felt quite confident. The highest levels of self-perceived confidence related to helping family members or friends if they have a mental health problem, with a third (33%) of participants saying they were confident of their ability to do this. A similar proportion of participants said they were extremely or quite confident of their ability to guide a person with a mental health problem to appropriate professional help.

The lowest levels of confidence reported by participants prior to them taking part in SMHFA training related to their ability to assess how high the risk is of someone attempting suicide or harming themselves (24% saying they were extremely or quite confident) and their ability to advise someone with a mental health problem about steps they could take to help themselves. (21% saying they were extremely or quite confident).

Participants from the voluntary and community sectors were more likely to say they were confident of their ability to recognise if someone is experiencing a mental health problem than those working in the statutory public sector. They were also more likely to say that they were confident of their ability to help someone with a mental health problem and advise someone with a mental health problem about the appropriate type of help that they might benefit from.

4.2.3 Participants Baseline Attitudes towards Mental Health Problems

In order to assess participants’ attitudes towards mental health problems they were asked to indicate whether they agreed or disagreed with a number of attitudinal statements relating to mental ill health. These attitudinal questions were the same as those used in the National Scottish Survey of Public
Attitudes to Mental Health, Mental Health Wellbeing and Mental Health Problems 2004. This means that the attitudes of participants prior to taking part in the SMHFA training were compared with the attitudes of a representative sample of the Scottish population.

Table 17 Participants’ attitudes about mental health prior to training

<table>
<thead>
<tr>
<th>% Agreeing with Statement</th>
<th>SMHFA Participants Baseline</th>
<th>General Population of Scotland</th>
</tr>
</thead>
<tbody>
<tr>
<td>If I was suffering from mental health problems, I wouldn’t want people knowing about it</td>
<td>55%</td>
<td>45%</td>
</tr>
<tr>
<td>I would find it hard to talk to someone with mental health problems</td>
<td>9%</td>
<td>15%</td>
</tr>
<tr>
<td>People are generally caring and sympathetic to people with mental health problems</td>
<td>11%</td>
<td>39%</td>
</tr>
<tr>
<td>The public should be better protected from people with mental health problems</td>
<td>4%</td>
<td>24%</td>
</tr>
<tr>
<td>The majority of people with mental health problems recover</td>
<td>46%</td>
<td>46%</td>
</tr>
</tbody>
</table>

Table 17 shows the responses of participants in the Baseline Survey and compares these with the results of the 2004 Public Attitudes Survey. This reveals a complex picture. Those who had registered to take part in SMHFA training were slightly more likely to say that if they were suffering from a mental health problem they wouldn’t want people to know about it than the general population were in response to the 2004 Public Attitudes Survey. They were also less likely to say that people are generally caring and sympathetic towards people with mental health problems. However, on the other hand, participants in SMHFA training were slightly more likely to say they wouldn’t find it difficult to talk to someone with a mental health problem and were much more likely to disagree with the statement that the public should be better protected from people with mental health problems.

One possible interpretation of these figures is that those who have registered to participate in SMHFA training are more understanding of people with mental health problems but are also more aware of broader societal stigmatisation of mental health problems and mental ill health. This would explain why they are less likely to suggest that people are generally caring and sympathetic towards people with mental health problems and indeed less likely to want to acknowledge their own mental health problems than the general population. However, the fact that they are more likely to say they wouldn’t find it difficult to talk with someone who is experiencing a mental health problem suggests that they think they are more sympathetic towards people with mental health problems than the general public. This appears to be confirmed by the fact that SMHFA participants were more likely to disagree with the statement that the public should be better protected from people with mental health problems.
Participants were asked to respond to the same attitudinal statements after they had completed the training to assess the extent to which their attitudes may have changed as a result of their participation in the training.

### 4.2.4 Participants Personal Experience of Mental Health Problems

Participants were asked in the Baseline Survey to say whether anyone they were close to had experienced a mental health problem and whether they had ever personally experienced a mental health problem. Similar questions were asked in the Survey of Public Attitudes to Mental Health, Mental Wellbeing and Mental Health Problems 2004, allowing comparisons to be made between those participating in SMHFA training and the general population in Scotland. The results of this comparison are shown in Table 18 below.

**Table 18 – Participants Personal Experience of Mental Health Problems**

<table>
<thead>
<tr>
<th>% saying yes</th>
<th>SMHFA Participants</th>
<th>Scottish Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has anyone close to you ever experienced a mental health problem?</td>
<td>33%</td>
<td>26%</td>
</tr>
<tr>
<td>Have you ever personally experienced a mental health problem?</td>
<td>76%</td>
<td>62%</td>
</tr>
</tbody>
</table>

The figures suggest that the respondents who had registered to take part in SMHFA training were more likely than the general population to have personal experience of mental health problems, either themselves or through someone they were close to. While this may partly be explained by the fact that participants in SMHFA training might be more likely to reveal their personal experience of mental health problems it is equally likely to be explained by the fact that they have more direct experience of mental health problems and indeed that this may have been a factor in motivating them to participate in the training. However, only 4% of respondents to the Baseline survey said that their own mental health or the mental health of family members or close friends was their main motivation for participating in the SMHFA training.

### 4.2.5 Participants Baseline Attitudes towards Specific Symptoms of Mental Ill Health

The final section of the Baseline Survey was based on two scenarios depicting people with symptoms of depression and schizophrenia adapted from a study by Link *et al* (1999) on public recognition of mental illness. Each scenario was constructed to meet the criteria of the Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition) for the disorder in question. The person in the scenario was either male or female giving four scenarios in total. Each participant was presented with one of these four scenarios (without
being given a diagnosis) and asked a series of questions about the person and the symptoms he/she displayed. (Copies of all four of the scenarios that were used are included in the Technical Report published in conjunction with this report).

The questions focused on the likely cause(s) of the symptoms, possible sources of help, and the extent to which respondents would be willing to interact with the person described in the scenario. At the end of the section, respondents were asked to say what condition they thought was being described in the scenario they had been shown. This was a similar approach to that adopted in the 2004 National Survey of Public Attitudes to Mental Health, Wellbeing and Mental Health Problems and allows comparisons to be made between the responses from SMHFA participants and the general population. A number of evaluations of MHFA training in Australia adopted an approach like this and again, where appropriate, comparisons have been drawn between the responses of participants in SMHFA training and the comparable results from the Australian MHFA evaluations.

Participants were asked to state whether they thought specific types of treatment would be either helpful or harmful to the person described in the scenario.

Table 19 – Participants’ perceptions of treatments that would be helpful for specific mental health conditions

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Helpful All</th>
<th>Helpful Depression</th>
<th>Helpful Schizophrenia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Becoming more physically active</td>
<td>61%</td>
<td>71%</td>
<td>50%</td>
</tr>
<tr>
<td>Reading about how people with similar problems have dealt with them</td>
<td>50%</td>
<td>50%</td>
<td>49%</td>
</tr>
<tr>
<td>Getting out and about more</td>
<td>48%</td>
<td>53%</td>
<td>43%</td>
</tr>
<tr>
<td>Attending courses on relaxation or stress management</td>
<td>57%</td>
<td>59%</td>
<td>56%</td>
</tr>
<tr>
<td>Counselling</td>
<td>75%</td>
<td>78%</td>
<td>75%</td>
</tr>
<tr>
<td>Cognitive Behavioural Therapy</td>
<td>45%</td>
<td>43%</td>
<td>47%</td>
</tr>
</tbody>
</table>

Participants were asked this question again after they had participated in the SMHFA training and their post training responses are compared to those in the baseline survey below.

Participants were also asked who they thought would be the best person to help someone experiencing the problems described in the scenario they had been presented with. This was the same question as respondents to the National Attitudes Survey were asked and participants in both surveys were asked to suggest up to three people that they thought would be the most appropriate to help the person described in the scenario they had been given.
The responses of SMHFA participants to the Baseline Survey are shown in Table 20 below and they are compared to the responses from the general public in the 2004 National Attitudes Survey.

As can be seen from the above table participants in the SMHFA training courses were less likely to be certain about who the most appropriate person would be to help the people described in both the depression and the schizophrenia scenarios. They were, however, more likely to suggest that the person described in the schizophrenia scenario was likely to benefit from psychiatric help than the person described in the depression scenario. This is similar to the responses from the general public. The SMHFA participants were also more likely to say that a family doctor would be able to help the person in the depression scenario than the person described in the schizophrenia scenario. This is again broadly similar to the responses from the general public, although a substantially higher proportion of the public thought that a family doctor would be able to help the person described in the schizophrenia scenario.

Table 20 – Participants’ perceptions of the best people to help someone experiencing specific mental health problems.

<table>
<thead>
<tr>
<th></th>
<th>SMHFA Participants</th>
<th>General Public</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Depression</td>
<td>Schizophrenia</td>
</tr>
<tr>
<td>Someone in the family</td>
<td>13%</td>
<td>19%</td>
</tr>
<tr>
<td>A friend or neighbour</td>
<td>8%</td>
<td>14%</td>
</tr>
<tr>
<td>A nurse</td>
<td>3%</td>
<td>4%</td>
</tr>
<tr>
<td>A carer</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>A psychiatrist</td>
<td>9%</td>
<td>31%</td>
</tr>
<tr>
<td>A psychologist</td>
<td>10%</td>
<td>13%</td>
</tr>
<tr>
<td>A family doctor</td>
<td>29%</td>
<td>11%</td>
</tr>
<tr>
<td>A social worker</td>
<td>2%</td>
<td>7%</td>
</tr>
<tr>
<td>A qualified counsellor</td>
<td>31%</td>
<td>22%</td>
</tr>
<tr>
<td>A voluntary or community</td>
<td>11%</td>
<td>12%</td>
</tr>
<tr>
<td>organisation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Someone with the same</td>
<td>2%</td>
<td>7%</td>
</tr>
<tr>
<td>problem</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Finally, participants were asked what specific mental health problem the person in the scenario was most likely to be experiencing. Participants were asked to select a specific mental health problem from the same list of conditions that was used in the 2004 Public Attitudes Survey. Again, this allowed comparisons to be made between the responses of participants in SMHFA training and those of the general public.

Table 21 – Participants ability to identify the signs of a particular mental health problem

<table>
<thead>
<tr>
<th></th>
<th>SMHFA Participants</th>
<th>General Public</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Depression</td>
<td>Schizophrenia</td>
</tr>
<tr>
<td>Alzheimer's Disease/Dementia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety disorder</td>
<td>1%</td>
<td>6%</td>
</tr>
<tr>
<td>Depression</td>
<td>90%</td>
<td>2%</td>
</tr>
<tr>
<td>Manic depression (bipolar affective disorder)</td>
<td>1%</td>
<td>5%</td>
</tr>
<tr>
<td>Nervous breakdown</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>Panic attacks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personality disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phobias</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-natal depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>1%</td>
<td>66%</td>
</tr>
<tr>
<td>Severe stress</td>
<td>1%</td>
<td>2%</td>
</tr>
</tbody>
</table>

As can be seen from the table SMHFA participants were more likely to be able to identify the correct mental health condition in both the depression and schizophrenia scenarios. Over 90% of SMHFA participants identified depression as the most likely mental health problem when presented with this scenario compared to 72% of respondents to the 2004 Public Attitudes Survey. Almost two-thirds of SMHFA participants who had been shown this scenario correctly identified schizophrenia as the most likely mental health problem compared to only 40% of the general public in response to being asked the same question in the 2004 Public Attitudes Survey.
4.3 Participants’ Learning Outcomes

4.3.1 Post Training and Follow Up Surveys of Participants

In order to measure the impact the SMHFA training had on participants, in terms of their personal learning, all participants who had completed a Baseline Survey questionnaire during the evaluation period were sent two further questionnaires following their completion of the training.

The first Post Training Survey was sent to participants approximately one week after they had completed the training and was designed to measure any changes in their levels of knowledge, confidence, attitudes and ability to recognise specific mental health conditions following their completion of the SMHFA training. To do this, participants were asked to answer the same questions as they had responded to in the Baseline Survey. This allowed their pre- and post-training responses to be compared in order to ascertain if there had been any changes following their participation in the training.

The Follow Up Survey questionnaire was also sent to all participants who had completed a Baseline survey approximately 20 weeks after they had completed the training. This questionnaire again asked participants to respond to many of the same questions they had been asked prior to undertaking the training and in the Post Training questionnaire. It also asked some additional questions about how participants had been able to apply the knowledge and skills they had gained as a result of participating in the training in both their work and personal lives.

A total of 506 Post Training and Follow Up questionnaires were sent to all participants that had completed a Baseline Survey questionnaire. A total of 306 completed Post Course questionnaires were received: a response rate of 60%. A total of 223 completed Follow Up Survey Questionnaires were returned representing a response rate of 44%.

Copies of the Post Training Survey and 20 Week Follow Up Surveys that were conducted during the evaluation are included in the Technical Report together with a full statistical analysis of the responses to these questionnaires. The following sections of this report describe the main findings from the analysis of participants’ responses to these two surveys, following their completion of the training and compare these responses to those from to the Baseline survey in order to examine changes between participants’ pre- and post-training responses.

4.3.2 Changes in Participants Perceived Knowledge

Participants were asked for their own assessment of their knowledge of mental health issues in general, different types of mental health problems and the symptoms of different types of mental health problems (in all three questionnaires). Table 22 below shows how participants own perceptions of their knowledge about these issues changed after they had completed the SMHFA training and 20 weeks after they had completed the training.
### Table 22 – Participants’ Perceptions of their Knowledge before and after the training

<table>
<thead>
<tr>
<th>Proportion of Participants saying they were Extremely or Very Knowledgeable About.......</th>
<th>Baseline Survey</th>
<th>Post Training Survey</th>
<th>20 Week Follow Up Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>About mental health issues</td>
<td>9%</td>
<td>41%</td>
<td>38%</td>
</tr>
<tr>
<td>Different types of mental health problems</td>
<td>9%</td>
<td>36%</td>
<td>34%</td>
</tr>
<tr>
<td>The symptoms of different types of mental health problems</td>
<td>6%</td>
<td>37%</td>
<td>26%</td>
</tr>
</tbody>
</table>

As can be seen from the Table there were clear changes in participants’ perceptions of their knowledge after they had completed the SMHFA training. These changes were evident in all three of the areas of perceived knowledge participants were asked about. The proportion of participants who said they felt they were extremely or very knowledgeable about mental health issues increased by 32% between the Baseline and Post Training Surveys. There were corresponding increases in the proportion of participants saying they felt extremely or very knowledgeable about different types of mental health problems (a 27% increase) and the symptoms of different types of mental health problems (a 31% increase).

Comparisons of the responses from participants to the Post Training Survey (which was sent out to participants immediately after the training) and the Follow Up Survey (which was sent to participants 20 weeks after they had completed the training) shows that there were some reductions in participants’ perceived levels of knowledge. These changes were relatively small in relation to participants’ perceived levels of knowledge about mental health issues and different types of mental health problems and are probably not statistically significant.

There was a reduction of 11% in the proportion of participants who said they felt extremely or very knowledgeable about the symptoms of different types of mental health issues. This suggests that this is an area where participants felt least confident about having retained the knowledge they gained from participating in the SMHFA training and is possibly the area where they would most benefit from some form of refresher training or further follow up information to help them retain their knowledge levels.

#### 4.3.3 Changes in Participants’ Actual Knowledge

As shown in the above section, participants themselves perceived that their knowledge about issues relevant to the SMHFA training had increased as a result of their involvement in the training. However, in order to test these perceptions, participants were asked a series of questions designed to objectively test their actual knowledge about mental health issues. The
questions were based on a series of questions devised by the Australian founders of MHFA who have used them successfully in a number of unpublished studies.

Participants were asked the same 10 questions about mental health issues in the Baseline Survey, the Post Training Survey and the 20 Week Follow Up Survey. These questions all addressed issues that should be covered in SMHFA Training and were based on information contained in the training materials.

Table 23 below shows the proportion of respondents that gave the correct answer to each of these questions at each stage of the evaluation process. As can be seen from the table, a substantial number of participants showed relatively high levels of knowledge prior to taking part in the SMHFA training. Substantial proportions of respondents answered the questions about depression, anxiety disorders and suicidal behaviour correctly prior to the training.

However, the proportion of participants answering correctly still increased in the two post training surveys. On the other hand, only a minority of participants were able to answer the questions about psychosis; how to deal with people suffering from delusions; panic attacks and those who have had a traumatic experience, correctly before the training. There were, however, substantial increases in the proportion of participants who were able to answer these questions correctly following the training. A majority of participants were able to answer these questions correctly in the Post Training Survey indicating improvement in the levels of knowledge about these issues exhibited by participants in the pre-training Baseline Survey.

While there was some reduction in the proportion of participants answering many of the questions correctly between the immediate Post-Training Survey and the 20 week Follow Up Survey, for many of the questions the reduction was not large, and levels of knowledge amongst participants in the Follow Up Survey remained substantially higher than those demonstrated in the Baseline Survey. This suggests that many participants not only increased their knowledge following participation in the training, but that they were also able to maintain this knowledge for a considerable time after they had completed the training.
Table 23 – Participants’ Mental Health Knowledge

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Post Course</th>
<th>20 Weeks Post Course</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is not a good idea to ask someone if they are feeling suicidal in case you put the idea in their head.</td>
<td>63%</td>
<td>98%</td>
<td>95%</td>
</tr>
<tr>
<td>If someone has a traumatic experience, it is best to make them talk about it as soon as possible.</td>
<td>36%</td>
<td>48%</td>
<td>41%</td>
</tr>
<tr>
<td>It is best to get someone having a panic attack to breathe into a paper bag.</td>
<td>24%</td>
<td>57%</td>
<td>41%</td>
</tr>
<tr>
<td>A first- aider can distinguish a panic attack from a heart attack.</td>
<td>30%</td>
<td>48%</td>
<td>49%</td>
</tr>
<tr>
<td>Exercise can help relieve depressive and anxiety disorders.</td>
<td>88%</td>
<td>97%</td>
<td>96%</td>
</tr>
<tr>
<td>It is best not to try to reason with people having delusions.</td>
<td>26%</td>
<td>56%</td>
<td>46%</td>
</tr>
<tr>
<td>People who talk about suicide don’t commit suicide.</td>
<td>70%</td>
<td>89%</td>
<td>85%</td>
</tr>
<tr>
<td>Psychosis is a lifelong illness.</td>
<td>34%</td>
<td>58%</td>
<td>53%</td>
</tr>
<tr>
<td>A depressed person is likely to feel better under the influence of alcohol</td>
<td>81%</td>
<td>88%</td>
<td>89%</td>
</tr>
<tr>
<td>Anxiety disorders are better treated with counselling and psychological techniques than medication</td>
<td>78%</td>
<td>72%</td>
<td>63%</td>
</tr>
</tbody>
</table>

4.3.4 Changes in Participants’ Confidence

One of the key aims of the SMHFA training is to increase participants’ confidence in dealing with mental health issues and helping people who may be experiencing mental health problems. Participants were therefore asked about their confidence relating to dealing with particular situations before they participated in the training and in the two post training surveys. Participants were asked the same questions about their confidence in all three surveys and the responses received from them to each of the surveys are summarised in Table 24.
Table 24 – Change in Confidence of Participants

<table>
<thead>
<tr>
<th>Proportion of Participants saying they were Extremely or Quite Confident in their ability to.....</th>
<th>Baseline</th>
<th>Post Course</th>
<th>20 Week Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognise if someone is experiencing a mental health problem?</td>
<td>24%</td>
<td>70%</td>
<td>60%</td>
</tr>
<tr>
<td>Help someone with a mental health problem in your job or work place?</td>
<td>22%</td>
<td>69%</td>
<td>57%</td>
</tr>
<tr>
<td>Help a member of your family or a close personal friend if they have a mental health problem?</td>
<td>33%</td>
<td>77%</td>
<td>69%</td>
</tr>
<tr>
<td>Identify if someone is at risk of attempting suicide or harming themselves?</td>
<td>20%</td>
<td>51%</td>
<td>45%</td>
</tr>
<tr>
<td>Guide a person with a mental health problem to appropriate professional help?</td>
<td>34%</td>
<td>78%</td>
<td>69%</td>
</tr>
<tr>
<td>Advise someone with a mental health problem about steps they could take to help themselves?</td>
<td>22%</td>
<td>72%</td>
<td>60%</td>
</tr>
</tbody>
</table>

Participants demonstrated increased confidence in relation to their ability to deal with all of the issues they were asked about. The largest increases in confidence levels appear to be in relation to advising someone with a mental health problem about steps they could take to help themselves (a 50% increase in the proportion of participants saying they were quite or extremely confident) and helping someone in their workplace who has a mental health problem, a 47% increase in confidence levels.

While there was a substantial increase in the proportion of participants who said they were quite or extremely confident in being able to identify if someone is at risk of attempting suicide between the pre- and post-training surveys, there was still a large proportion of participants (49%) who said they were not confident in their ability to do this.

4.3.5 Changes in Participants’ Attitudes

Section 4.2.4 above described how the attitudes of participants were measured in the Baseline Survey before they took part in the SMHFA training. It also described how these attitudes compared with the general public in Scotland, as measured by the National Public Attitudes Survey. In order to measure any changes in participants’ attitudes after they had completed the SMHFA training, participants were asked the same attitudinal questions in the post-training follow up survey, 20 weeks after they had completed the training.
Table 25 - Participants attitudes pre- and post-training

<table>
<thead>
<tr>
<th>% Agreeing with Statement</th>
<th>SMHFA Participants</th>
<th>General Population of Scotland</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline</td>
<td>Post Training</td>
</tr>
<tr>
<td>If I was suffering from mental health problems, I wouldn’t want people knowing about it</td>
<td>55%</td>
<td>31%</td>
</tr>
<tr>
<td>I would find it hard to talk to someone with mental health problems</td>
<td>9%</td>
<td>7%</td>
</tr>
<tr>
<td>People are generally caring and sympathetic to people with mental health problems</td>
<td>11%</td>
<td>16%</td>
</tr>
<tr>
<td>The public should be better protected from people with mental health problems</td>
<td>4%</td>
<td>2%</td>
</tr>
<tr>
<td>The majority of people with mental health problems recover</td>
<td>46%</td>
<td>65%</td>
</tr>
</tbody>
</table>

Table 25 above shows that there were some discernable changes in participants' attitudes after they had completed the training. Perhaps most noteworthy was the substantial reduction in the number of respondents who said that if they were suffering from mental health problems, they wouldn’t want people knowing about it (down from 55% to 31% of respondents). This suggests that participants in the training may have become more accepting of mental health problems and more comfortable with the fact that having mental health problems is not something to be embarrassed about.

On the other hand, almost a third of respondents still said they wouldn’t want people knowing if they themselves were suffering from mental health problems suggesting that there is still a reluctance to acknowledge the existence of these problems, even amongst people who have completed the SMHFA training. This can perhaps be attributed to a greater understanding of the wider societal stigma associated with mental ill health and the impact this has on participants attitudes.

Another important finding relates to participants’ attitudes to whether or not people can recover from mental health problems. In the pre-training Baseline Survey only 46% of respondents agreed with the statement “the majority of people with mental health problems recover”. This was the same proportion as found amongst the general public in the Public Attitudes Survey of 2004. However, in the post training follow up survey the proportion of respondents agreeing with the statement increased to 65%. This suggests that respondents were more likely to think that people who are experiencing mental health problems are able to recover after they had completed the training. This may be partly attributable to the fact that the training has given them a greater awareness of the help that is available to people with mental health problems.
heath problems and by exposing participants to examples of people who have suffered from mental health problems and have recovered.

4.3.6 Changes in Participants’ Ability to Recognise Specific Mental Health Conditions

Section 4.2.5 above described how participants were presented with a number of scenarios in the pre-training Baseline Survey describing people exhibiting symptoms of depression and schizophrenia. Participants were presented with the same scenarios in both the Post Training and 20 week Follow Up surveys and asked the same questions as in the Baseline Questionnaire to measure whether there had been any changes in their reaction to the scenarios.

Table 26 below shows the proportion of participants that were able to correctly identify the mental health condition that someone exhibiting the symptoms described in both the depression and schizophrenia scenario were likely to be suffering from. As can be seen there was a substantial increase (15%) in the proportion of participants that were able to correctly identify the schizophrenia scenario after they had completed the SMHFA training. There was also a small increase in the proportion of respondents that correctly identified the depression scenario, although as previously discussed participants had already demonstrated a very high level of recognition of this scenario in the pre-training Baseline Survey.

Perhaps most importantly, the level of awareness of the mental health conditions in both scenarios amongst participants in the SMHFA training was consistently higher than in the results of the Public Attitudes Survey. While there was a small reduction in the proportion of participants that were able to correctly identify the condition described in the scenarios in the Follow Up Survey that took place 20 weeks after respondents had participated in the SMHFA training the levels of recognition were still considerably higher than for the general public.

Table 26 Participants ability to recognise specific mental health conditions pre- and post- training

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Post Training</th>
<th>20 Weeks Post Training</th>
<th>General Public</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>66%</td>
<td>81%</td>
<td>71%</td>
<td>40%</td>
</tr>
<tr>
<td>Depression</td>
<td>90%</td>
<td>91%</td>
<td>85%</td>
<td>72%</td>
</tr>
</tbody>
</table>
4.4 Participants’ Application of Learning

The above sections of this report have shown that participants in SMHFA courses appear to have gained considerable knowledge and confidence by participating in the training. The evaluation also tried to establish the extent to which participants had been able to apply this learning in both their personal lives and in their job or workplace. To do this, participants were asked whether they had contact with anyone with a mental health problem in the last six months in both the Baseline Survey prior to the training and in the Follow Up Survey that was conducted approximately 20 weeks after they had completed the training. Participants were then asked if they were able to offer this person help and if so what type of help they were able to offer.

The vast majority of participants (86%) who completed the Baseline Survey said that they had come into contact with someone who was experiencing a mental health problem in the six months prior to taking part in the SMHFA training. A similar percentage (88%) that responded to the Follow Up survey 20 weeks after they had completed the training said they had come into contact with someone experiencing a mental health problem in the previous six months.

Participants who said they had contact with someone who was experiencing a mental health problem were then asked if they had been able to offer the person any form of help. Before taking part in the training, just over two thirds of participants (68%) said they felt that they had been able to help the person they had come into contact with. In the Follow Up survey the percentage of respondents who said that they felt they had been able to help rose slightly to 77%, representing an increase of 9%.

Respondents to both the pre-training Baseline Survey and the post-training 20 week Follow Up survey were asked what type of help or assistance they had been able to offer someone with a mental health problem. As can be seen from Table 27 below there were considerable changes in the responses from participants between the pre-training survey and the post-training follow up survey.

There were notable increases in the proportion of participants who said they were able to provide someone who was experiencing mental health problems with different types of help. The largest increase was in the proportion of participants who said they felt they were able to encourage the person to get appropriate professional help (+14%), and there were also increases in the proportion of participants that said they were able to encourage someone to adopt a self help approach (+11%), and who were able to refer someone to an appropriate support group (+8%).
The scenarios depicting someone showing the signs of experiencing depression and suffering from schizophrenia, described above, were also used as a measure of the extent to which participants in SMHFA training were more likely to be able to help someone experiencing these types of mental health problem following their participation in the training.

Respondents to both the Baseline Survey and the 20 week post training Follow-Up Survey were asked if they met someone experiencing the type of problems described in the scenario they were given, whether or not they would offer them help. The responses to this question for both scenarios before and after participants had completed the SMHFA training are shown in Table 28.

**Table 27 – Type of help given to someone experiencing a mental health problem**

<table>
<thead>
<tr>
<th>Type of Help</th>
<th>Before</th>
<th>After</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Help</td>
<td>68%</td>
<td>75%</td>
</tr>
<tr>
<td>Listen to them</td>
<td>69%</td>
<td>75%</td>
</tr>
<tr>
<td>Give them information</td>
<td>44%</td>
<td>60%</td>
</tr>
<tr>
<td>Encourage them to get professional help</td>
<td>41%</td>
<td>55%</td>
</tr>
<tr>
<td>Encourage them to adopt a self help approach</td>
<td>25%</td>
<td>34%</td>
</tr>
<tr>
<td>Refer them to an appropriate support group</td>
<td>22%</td>
<td>30%</td>
</tr>
</tbody>
</table>

**Table 28 – Likelihood to help someone experiencing particular mental health problems**

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Post Training</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Very Likely</td>
<td>Likely</td>
</tr>
<tr>
<td>Family or Friends</td>
<td>79%</td>
<td>17%</td>
</tr>
<tr>
<td>Workplace</td>
<td>48%</td>
<td>35%</td>
</tr>
</tbody>
</table>

The proportion of respondents to the pre-training Baseline Survey that said they would be more likely or very likely to help a member of their family or a close personal friend experiencing the type of problems described in either the schizophrenia or depression scenario, was very high (96%). It remained at a similarly high level after the training as shown in the responses to the post training Follow Up Survey. However, there was an increase of 10% in the
proportion of respondents that said they would be very likely to offer help to someone experiencing the type of problems described in the scenarios if they came into contact with them in their job or in the workplace.

The majority of respondents (52%) to the post training Follow Up Survey said they were very likely to offer help to someone experiencing mental health problems similar to those described in the scenarios they were shown. The proportion of respondents shown the depression scenario who said they were more likely to offer help following the training was 56%. This was slightly higher than the proportion of participants that were shown the schizophrenia scenario, which was 49%.

A high proportion of respondents to the post-training Follow Up Survey also said they felt that the SMHFA training would enable them to provide more practical support to someone experiencing the same mental health problems as those described in both the scenarios. A substantial proportion of participants (76%) said they felt that they would be more able to provide practical and appropriate support.

The proportion of participants that said they felt they would be more able to provide practical and appropriate support was higher for those shown the schizophrenia scenario (89%) than those shown the depression scenario (31%). This reflects the fact that many participants felt confident that they would be able to help someone suffering from depression before taking part in the training than was the case for someone suffering from schizophrenia. It is, therefore, unsurprising that a higher proportion of participants felt more able to provide practical and appropriate support to someone suffering from schizophrenia following their participation in the SMHFA training.

In addition to the 20 week Follow Up Survey, telephone interviews were conducted with a small sample of participants. In total 54 individual telephone interviews were undertaken approximately 20 weeks after they had completed the SMHFA training. Participants in these interviews were asked to reflect on their perceptions of the training and in particular to discuss how they had been able to apply the training in both their work and personal life.

Many of the participants who were interviewed were able to give actual examples of how they were able to apply the knowledge and skills they had gained in both their personal lives and in their work. The following quotes illustrate the range of different circumstances where participants said they felt the training had been beneficial to them:

“We work with 16-25 year olds in homeless accommodation and try to settle them in to their new accommodation. I find a lot of them are feeling low because of their circumstances and many of them have mental health problems. I feel I have been better able to deal with some of these issues and relate better to the young people since I took part in the training”

SMHFA Participant
“Over the last 6 months I have been supporting someone with acute anxiety; the course has been very useful to encourage and reassure her. She was anxious about medication and wasn’t taking it. Eventually a different approach and medication seemed to work for her but the extra understanding was useful”.

SMHFA Participant

“I was able to advise a client who hadn’t realised he was a manic depressive. He went back to his GP on my recommendation. He was with his family all the time so they didn’t see the small changes in him, whereas I only saw him once week so could notice a change in him. I am now more confident to advise and direct people to the right resources and know who to refer them to now”.

SMHFA Participant

“Because of our client group I have used the course a lot – I bear the information in mind all the time and try to ensure that I am looking at the bigger picture and not just what clients present with: I try to look deeper than the initial problems”.

SMHFA Participant

Many participants also commented on how the SMHFA had helped them deal with mental health issues in their personal lives. The following quotes illustrate some of the ways that participants said that it had benefited them personally or helped them deal with mental health problems being experienced by members of their family.

“I worked with one family where mental health problems were deeply entrenched and then the lady suffered a horrific bereavement. I was part of the team to support this woman. I think without the training this could have impacted on me emotionally a lot more but I have developed resilience”.

SMHFA Participant

“One of my friends has a daughter suffering from mental health problems and she is furious with her behaviour. My friend can’t see it but I can, so I have been trying to tell her that what she can do to support her daughter”.

SMHFA Participant

“I was quite worried about a friend of mine and I was able to raise issues with her that before the training I would have felt unable to do as she might have thought that I was just sticking my nose in. I advised her to go and see a doctor and look into counselling. Prior to the training I would not have been brave enough to speak to her about mental health issues, and I wouldn’t have known what to look for or what to advise her to do”.

SMHFA Participant
4.5 Summary of Key Findings

- Over 800 participants in 92 SMHFA courses that took place during the period between May and September 2006 completed Course Evaluation Forms. Analysis of the characteristics of these participants shows that they came from a broad range of backgrounds. However, some groups appear to have been under-represented including in particular: men, people from BME groups, and older people.

- The findings of the evaluation suggest that participants in the SMHFA courses that took place during the evaluation period had higher levels of prior knowledge about mental health issues than the general population.

- The feedback received from participants who returned Course Evaluation Forms during the evaluation show that the SMHFA has been well received. Large majorities of participants expressed high satisfaction levels with the content and delivery of the training and said that it had met their expectations.

- The vast majority of participants perceived that the training had met its stated objectives and outcomes. A similarly high proportion of participants also said that they felt that the learning they had gained from participating in the training would be useful to them in both their work and in their personal life.

- The surveys of participants that were conducted before and after they had participated in an SMHFA training course show that there were substantial increases in participants own perception of their knowledge and awareness of mental health issues, including their ability to recognise if someone was experiencing a mental health problem and how to help people suffering from specific types of mental health problem.

- The pre- and post- training surveys also showed that there were considerable increases in participants’ ability to answer correctly a range of questions about the material covered in the SMHFA training course.

- The findings of the Baseline and Post-Training Surveys show that there were substantial increases in participants’ perceived confidence levels. Participants are now more confident they would be able to recognise if someone is experiencing a mental health problem and to advise them about appropriate help.

- There was a substantial increase in the proportion of participants who said they would be prepared to help someone who they thought was experiencing a mental health problem after they had completed the SMHFA training.

- The evaluation has also identified a range of different circumstances where participants have said they were able to offer help to people experiencing mental health problems in a way they would not have been able to do before they completed the SMHFA training.
5. Formative Evaluation

5.1 Appropriateness and Effectiveness of Training Content and Structure

Earlier sections of this report have demonstrated that the basic structure and the overall content of the SMHFA training has generally been received very positively by participants who have taken part in the training. The overall structure and content of the training is also seen as being both appropriate and effective by Instructors who have been delivering the SMHFA training. However, both participants and Instructors have suggested areas where they feel the structure and content of the training could be improved. Some of the stakeholders who have been engaged in the evaluation process, including SMHFA Instructors, have suggested ways that the structure and content of the training could be tailored to meet the needs of specific groups of participant more effectively.

The remainder of this section of the report summarises the key issues arising from the evaluation regarding the structure and content of the training. This is based on the feedback received from participants in the training, SMHFA Instructors and the key stakeholders who were interviewed as part of the evaluation process. The emerging findings from the evaluation were also discussed with a small number of key stakeholders that were invited to participate in a workshop in February 2007. The issues raised during this workshop have helped inform the development of the formative evaluation findings as well as the conclusions and recommendations presented in Section 6 below.

5.1.1 Structure of Training

The SMHFA training is designed to be delivered in four sessions, lasting three hours each, with the total training course lasting 12 hours. The majority of courses are currently delivered over two days with two of the three hour sessions being covered on each day. While many Instructors prefer to deliver the training on two consecutive days, others choose to have some time between the two days.

The Instructors who deliver it on two non-consecutive days suggest that this gives participants the opportunity to reflect on what they have learned on the first day. However, there are also often more pragmatic reasons as it is reported that it is sometimes difficult to get participants to attend on two consecutive days. This is clearly a particular issue for participants who are in employment, especially those working in smaller organisations, where it is difficult to get released for training on two days in a single working week.

The flexibility in how the four sessions in the SMHFA training course are actually delivered is generally seen as a positive aspect of the training by Instructors and participants. However, some stakeholders, particularly some Instructors have said they would like to see even more flexibility in how the training is delivered and the structure of the training courses.
Two main issues emerged from the evaluation in relation to the overall structure of the training course and how these can be delivered. Firstly, some instructors and participants suggested that there would be advantages in being able to deliver the training in two hour, rather than three hour, sessions. This issue was raised in particular by instructors who are interested in delivering the training to community representatives and the general public.

Some instructors suggested that if the training is being provided in the evenings, for example as part of an adult education or community learning programme, then it would be unrealistic to expect people to participate in a session that lasts more than 2 hours. It has also been suggested that it is often logistically difficult to organise evening sessions that last longer than two hours, given the constraints of access to community facilities, schools etc. Some instructors, therefore, suggested that there would be merit in investigating how the SMHFA training could be broken down into individual sessions lasting 2, rather than 3, hours. It would then be possible to offer the training as an evening class with sessions running over a six-week period.

The second main issue with regard to the overall structure of the SMHFA training and how it is delivered relates to the possibility of developing a shorter “taster” SMHFA course that can be delivered over a shorter number of hours. This has been suggested by a number of stakeholders, including instructors.

The main reason given for the development of a shorter “taster” course is that it is sometimes difficult to get people who are in employment to make the commitment to attending a 12-hour training course. The logic is that it would be easier to encourage people to attend a shorter, say 3 hour, “taster” session, which would provide an introduction to the mental health first aid approach. Some instructors have suggested that if people found this valuable they would then be more likely to attend the full SMHFA training course. Others said that while they could see the attraction of this approach they felt that there would be a danger that this could be seen as an alternative training session, rather than simply an introduction to the full SMHFA training course. They also felt that many participants might not take the training any further and would not, therefore, fully benefit from the full training course.

It is also suggested that being able to offer a shorter “taster” course to employers as well as voluntary and community organisations would provide an effective tool for marketing SMHFA which would promote more awareness and encourage more people to consider participating in the full training course.

In terms of the overall structure of the 12-hour SMHFA training course the vast majority of participants and instructors said they felt that the balance between the four sessions was about right. This is reflected in the feedback received from participants in their Course Evaluation Forms where they rated the content and structure of individual sessions within the course equally highly.
Some Instructors did suggest that there was scope for making some minor changes to the overall structure of the basic SMHFA course. The main areas where it was suggested that there could be some minor changes to the structure of the training course to make it more effective were as follows:

- Allowing more time to discuss other expressions of mental health ‘distress’, particularly self-harm
- Having a clearer distinction between the issues covered in Session Two relating to depression and suicide
- Spending less time in Session 1 on general mental health awareness and in particularly the more theoretical aspects i.e. the description of the mental health continuum.

5.1.2 Content of Training

The evidence from the evaluation suggests that the content of the SMHFA training course is seen as being both appropriate and effective in delivering positive learning outcomes amongst participants.

The content and materials used throughout the four sessions of the training were generally well received by the vast majority of participants, as evidenced by the feedback from the Course Evaluation Forms distributed during the evaluation. The vast majority of Instructors were also very supportive of the content of the SMHFA training, and were comfortable with most of the materials they are provided with to support their delivery of the training. There were, however, some potential improvements in the course content and materials that were identified by both Instructors and participants in the SMHFA training. These suggested improvements were generally seen as building upon and enhancing the existing SMHFA training rather than a fundamental rethinking of the content of the training courses and the materials used to support the delivery of this training.

The main improvements or changes that were identified during the course of the evaluation can be summarised as follows:

- The use of video clips first developed for the Australian version of MHFA was mentioned by a considerable number of both participants and Instructors. While it was generally accepted that the content of these video clips was good and they were effective in getting their message across, some participants and Instructors said that the use of Australian accents could be an unnecessary ‘distraction’ and act as a barrier to some people learning from the material.
- The need for more up to date statistics was another issue that was mentioned frequently, particularly by Instructors, some of whom said they
found it difficult to use the statistics because they were seen as being out of date and that this reflected badly on the discussion about the importance of mental health awareness.

- The need for more/better information about the connections between drug and alcohol abuse and mental health problems was also seen as being a potential area of improvement by a substantial number of participants as well as some Instructors who participated in the evaluation.

- Some participants and a number of Instructors felt there was a need for more background material about other forms of mental health problems and their impact e.g. self harm, eating disorders etc. particularly when the training is being delivered to participants who work with young people.

- A number of participants and some Instructors also suggested that the training should place less emphasis on the description of specific mental health conditions and more emphasis on the practical skills that people require to apply their learning. They specifically mentioned a need for more information about the type of interventions people can make to support people experiencing different types of mental health problem.

- Many Instructors also said that they would like a broader range of case study material that they could choose from to support the delivery of the SMHFA training. This reflects a desire to reflect cultural diversity as well as being able to use case studies that are seen as being appropriate to different types of participants.

- Finally, some Instructors said they felt some of the material included in the participants’ manual reflected what they perceived to be an undue emphasis on a medical model of mental health. This appears to have been particularly in relation to the sections of the course material that describe treatments for specific conditions where their effectiveness is supported by scientific evidence. A notable minority of Instructors said they felt uncomfortable with some of this material, though many others said they did not see this as being a major issue. A large number of Instructors emphasised the importance of ensuring that the materials in the handbook dealing with treatments were placed in context and that reference needed to be made to the importance of social and cultural dimensions of treating mental illness as well as medical interventions.

There were no major concerns about the quality of training being delivered by SMHFA Instructors during the evaluation. The feedback from participants demonstrates that the vast majority thought the quality of delivery of the training was good. There was, however, a feeling amongst some stakeholders that the regular feedback given by participants on Course Evaluation Forms (which is not as comprehensive as collected during the evaluation) did not give sufficient information about the quality of the training being delivered.
There were also concerns to ensure that the integrity of the SMHFA training was being maintained and that the core mental health first aid messages were being delivered consistently to a high standard.

In response to the issues described above a number of stakeholders, including members of the National Training Team and other national stakeholders, said they felt that as the number of Instructors increased there was a need to consider the introduction of some form of quality management procedure. Many Instructors said they felt there was a need for some form of quality assurance system and a substantial number of Instructors said they would welcome this as it would support their own personal development, and help ensure they were able to improve the quality of the training they are delivering to participants.

5.2 Applicability of Training to Different Groups of Participants

As was shown in Section 4.1.2 above, participants in the SMHFA training to date have come from a range of different backgrounds. It is also apparent from the feedback received that the training has been well received by participants from different backgrounds and that there are no substantial differences in the learning outcomes of different groups. This suggests that the structure and content of the SMHFA training is suitable for a wide range of different participants with different levels of experience and prior knowledge of mental health issues.

However, the findings of the evaluation, including the feedback received from Instructors and other stakeholders also suggests that there would be merit in investigating whether or not the core SMHFA training structure and content could be adapted to make it more applicable, and therefore attractive, to certain groups of participants. This would include considering how SMHFA training could be made more applicable to groups who appear to have been under represented in terms of participation on SMHFA training courses to date. It could also involve giving consideration to whether SMHFA training needs to be tailored to meet the needs of specific target groups of participants who it is felt may particularly benefit from the training. The remainder of this section of the report considers specific groups of participants that may fall into each of these two categories.

The evidence about the characteristics of participants who have taken part in SMHFA training shows that they have come from a wide range of different groups within the population. There are, however, some groups that appear to have been under represented. These groups include:

- Men
- Black and Ethnic minority groups
- Older people
Men represented only 20% of the participants that took part in SMHFA training during the evaluation period, though there are no obvious differences in the feedback received from men and women. Similarly, there are no notable differences in the learning outcomes for male and female participants. This suggests that there are challenges in getting men to agree to participate in the training. The issue that may need to be addressed therefore, is how SMHFA training is marketed, including the particular groups and sectors within the workforce that are being targeted.

Just over 2% of participants in the SMHFA training courses that took place during the evaluation period, said they came from a black or minority ethnic group. While this is roughly the proportion as in the population of Scotland as a whole the absolute number of participants from minority ethnic groups was relatively small.

The small number of participants from black and minority ethnic groups that took part in the evaluation means that it is not possible to say with any degree of certainty whether there were any specific reasons why people from different ethnic backgrounds may be deterred from participating in SMHFA training. However, NHS Health Scotland has undertaken its own research into the perceptions of black and minority ethnic groups of the SMHFA training. The findings of this research should be used to inform any future plans to market SMHFA training and in particular how it can be targeted at specific minority ethnic groups. There may also be scope for reviewing how diversity issues are tackled in the training of new SMHFA Instructors and any new guidelines that are issued to existing Instructors.

Finally, over 60% of participants in the SMHFA training courses that took place during the evaluation period were under the age of 45. This may to some extent reflect the fact that SMHFA training appears to have been predominately targeted at people in employment, particularly in the public and voluntary sectors. However, there is also some evidence from other research to suggest that older people are less aware of mental health issues and may be less understanding of people experiencing mental health problems.

Given that Scotland has a growing older population, and it is increasingly being recognised that mental health issues are a particular concern for older people, there may be some merit in considering how SMHFA training can be made more attractive to older people and any ways in which the content and structure of the training can be made more relevant to their needs. Some SMHFA Instructors have experience of delivering SMHFA training to groups of older participants and it may be useful to draw on this experience. There would also be value in entering into discussions with national voluntary organisations representing the interests of older people to explore how SMHFA training could be developed to complement any existing activities relating to promoting the mental health and wellbeing of older people.

It is clear from the evaluation that efforts have been made to target specific groups within the workforce, particularly front line workers in specific areas of the public sector, to encourage them to take part in SMHFA training.
Health Scotland led the national targeting of SMHFA by attempting to recruit Instructors in a number of key agencies as follows:

- Jobcentre Plus
- NHS – Primary Care/CHPs
- NHS – Ambulance Service
- NHS – A&E
- NHS 24 & Breathing Space
- Choose Life network
- Prison Service
- Police
- Further Education
- Local Authorities – Community Learning/Education
- Voluntary and community health organisations

These efforts to target the delivery of SMHFA training appear to have had mixed success. Attempts to roll-out SMHFA training to workers within specific employment sectors have worked best where there has been strong support for the concept of mental health literacy skills and a commitment to supporting the delivery of SMHFA training from within the sector itself. The best examples of this approach include the delivery of SMHFA training within the Prison Service and in the further and higher education sectors. Attempts to target the delivery of SMHFA training in other sectors e.g. in the ambulance service and to staff working in Job Centres have been less successful and this is largely attributed to a lack of commitment to support the delivery of the training from senior management within these sectors.

While there appears to have been some intentions that SMHFA training should be targeted at participants working within certain key employment sectors, the extent to which this was identified as a clear objective is unclear. Perhaps more crucially, it is not clear from the evaluation the extent to which responsibility for marketing SMHFA within specific sectors was clearly established and importantly whether sufficient resources were available to do this effectively.

The feedback from stakeholders at both a national and local level, gathered during the evaluation, suggests that a more strategic approach to rolling out SMHFA within specific sectors would be appreciated. This does not mean that this approach should replace the flexibility of Instructors to market and target SMHFA training to a wide range of potential participants. However, a national strategic framework for targeting specific sectors would potentially assist Instructors to gain interest in sectors where they may currently be struggling to attract participants or where they are facing reluctance from employers to the delivery of SMHFA training to their staff.
NHS Health Scotland should continue discussions with employers in key sectors to establish how SMHFA can best be delivered to participants in these sectors. These discussions could inform the development of a strategic plan that would set out clear guidelines, actions and timescales for rolling out SMHFA training in sectors where it is felt that staff would benefit most from participating in SMHFA training.

The evidence from the evaluation in terms of participants’ various backgrounds, as well as feedback from Instructors about the type of participants they find it difficult to recruit, suggests that consideration should be given to identifying ways of increasing the numbers participating in the training in the following sectors:

- The police
- Job Centre staff
- Primary care workers including GPs and others working in GP surgeries
- Advice staff in the statutory and voluntary sectors
- Further and Higher Education lecturers
- Emergency services workers
- Public transport workers
- Housing managers
- Social care workers and other ancillary staff

This list is not intended to be exclusive and it is likely that other groups may be identified during consideration of the findings of this evaluation by stakeholders and in discussions with representatives of employers in specific employment sectors.

The evidence from the evaluation suggests that the targeted role out of SMHFA in specific sectors is likely to be most effective when it is tailored to the needs of the sector. Crucially, this means gaining the commitment of employers to support the roll-out of SMHFA training and to take appropriate action, including dedicating staff time and resources, to support the roll-out. There is, therefore, a need to take a flexible, ‘case by case’ approach to any plans to target the roll-out of SMHFA within specific employment sectors. However, the approach may include consideration of developing plans to:

- Undertake targeted recruitment of Instructors and delivery of training to new Instructors within specific sectors.
- Development of a ‘training the trainers’ course that can be rolled out within specific targeted sectors.
Changes in the structure and content of SMHFA training that could be made to facilitate the roll-out of the training within particular sectors and make it more contextually relevant to staff working within these sectors.

5.3 Infrastructural Support and Delivery Mechanisms

Section 3.3 of this report outlines the national infrastructural support that has been put in place to support the introduction and national roll-out of SMHFA. It is clear that NHS Health Scotland has had responsibility for the overall implementation of SMHFA since early 2004. However, management responsibility for the programme has changed during the period of the roll-out, and until recently there has been no dedicated full-time staffing resource with specific responsibility for the development and roll-out of SMHFA.

The evidence from the outcome element of the evaluation shows that these difficulties do not appear to have had a major impact on the delivery of the core elements of the national roll-out of SMHFA. The development of the training resources, the training of Instructors and the delivery of the training to a substantial number of participants have all been successfully undertaken. However, the feedback received from stakeholders during the process element of the evaluation reported that some areas of activity were not taken forward as quickly they would have anticipated. It was perceived that this was due to a lack of dedicated full-time staffing within NHS Health Scotland to coordinate SMHFA.

The areas of activity where this is most apparent include:

- Developing networking and other forms of support for SMHFA Instructors after they have completed the training.
- Developing rigorous monitoring systems including the collection of information about the number of SMHFA courses being run as well as the number and characteristics of those who have participated in the training.
- Developing additional materials to be used by SMHFA Instructors including up to date statistics and additional audio-visual materials.
- Adopting a more pro-active approach to exploring the possibility of targeting the roll-out of SMHFA training in specific sectors.
- Developing links with NHS Boards and Community Health Partnerships to discuss how SMHFA can form part of their overall approach to mental health issues and specifically raising levels of mental health literacy within their areas.

Many of these activities have been happening but perhaps not to the same extent as would have been possible had there been more resources allocated to the SMHFA programme to take them forward at an earlier date. It is also clear that considerable steps have been taken to implement many of these
activities towards the end of the evaluation period, following the appointment of a full time National Co-ordinator for SMHFA within NHS Health Scotland.

SDC and the National Training Team have developed considerable experience and skills in relation to SMHFA. Their possible future role in relation to SMHFA needs to be carefully considered prior to the end of existing contracts in 2008. It is a matter for NHS Health Scotland to consider what future management arrangements may be required for SMHFA at a national level. There would be advantages in maintaining their expertise in some form, possibly in a continued role of training new SMHFA Instructors and providing support to Instructors. There could potentially be a role for the National Training Team in helping to develop and implement a quality management system designed to ensure the quality of the delivery of SMHFA training is maintained in the future.

The evidence from the evaluation has also raised questions about how realistic the current expectations placed on SMHFA Instructors are. In particular, it is clear that some current Instructors are not able to deliver four SMHFA courses a year. There has, inevitably, also been a drop out of Instructors, which is to be expected given changes in individuals’ personal and employment circumstances. This has implications for the number of SMHFA courses that can be delivered and the number of people that can receive SMHFA training.

The evaluation brief referred to a target of 300 Instructors being trained to deliver SMHFA by March 2008. However, the basis for establishing this target is not clear from the evaluation evidence. There is limited evidence about how this figure was derived and whether it was based on any expectations about the number of participants it was intended should take part in SMHFA training during the initial roll-out period. The findings of the evaluation suggest that even if there was a base of 300 active SMHFA Instructors, there is no guarantee that these Instructors would be delivering SMHFA training to sufficient numbers in the sectors where the training may be most needed.

Setting a target for the number of people to be trained in SMHFA should not be seen as an end in itself, or the driving factor in the future delivery of the training. However, having an indicative figure for the number of participants who could reasonably be expected to be able to take part in the training over a particular period of time, e.g. one year, may be useful. This would help inform decisions about the number of trained SMHFA Instructors that may be required and the resources that would be needed to train and support these Instructors.

A target for the number of people that it is reasonable to expect to participate in SMHFA training in any one year may in itself be insufficient to ensure that the training is delivered to those who may benefit most from the training. It may, therefore, be preferable to identify key groups within the community and specific sectors of the workforce that could be targeted for the delivery of SMHFA training and set more specific targets for the delivery of training within these groups or employment sectors.
A final question raised during the evaluation was whether or not a programme of the scale of SMHFA could be fully supported at a national level or whether there was a need for some additional area or regionally based infrastructure support. While it is clear that there is some informal networking currently taking place at a regional level, this is largely at the instigation of individual Instructors.

As SMHFA develops, and specifically as the number and diversity of Instructors increases, there may be a case for considering whether there is a need to provide additional resources to support the management and co-ordination of the role of SMHFA training at a regional level. This is something that could be discussed further with NHS Boards and Community Health Partnerships to establish what form of support would best fit the needs and circumstances of individual areas of Scotland.
5.4 Summary of Key Findings

- The basic structure and the overall content of the SMHFA training has generally been received very positively by participants who have taken part in the training, as well as by Instructors who have been delivering the SMHFA training.

- The evidence from the evaluation suggests that there are some areas where the structure and content of the training could be improved or amended to allow it to be tailored to meet the needs of specific groups of participants more effectively.

- There were no major concerns about the quality of training being delivered by SMHFA Instructors during the evaluation. However, there were concerns to ensure that the integrity of the SMHFA training was being maintained and that the core mental health first aid messages were being delivered consistently to a high standard.

- A number of stakeholders, including members of the National Training Team and other national stakeholders, said they felt that as the number of Instructors increased, there was a need to consider the introduction of some form of quality management procedure.

- Efforts to target specific groups within the workforce, particularly front line workers in specific areas of the public sector, to encourage them to take part in SMHFA training have been patchy and had mixed success.

- The development of the training resources, the training of Instructors and the delivery of the training to a substantial number of participants has all been successfully undertaken. However it is thought that the lack of a dedicated national coordinator post, until recently, has had an impact on the speed and effectiveness of the implementation of certain aspects of the roll-out of SMHFA.

- The evidence from the evaluation has also raised questions about the realism of the current expectations that all SMHFA Instructors will be able to deliver four training courses per year. This has implications for the number of SMHFA courses that can be delivered and the number of people that can receive SMHFA training.
6. Conclusions and Recommendations

6.1 Overall Conclusions

6.1.1 Delivery of the Training

Since March 2005, over 400 SMHFA training courses have been delivered in Scotland and almost 5,250 people have participated in the training.

The evaluation has shown that the participants in the SMHFA training courses that have been delivered to date have come from a wide range of different backgrounds. However, there are some groups within the population that appear to be less likely to participate in the training than others. These groups include men, people from BME communities, and older people.

The evaluation evidence also suggests that the participants who took part in SMHFA training courses during the evaluation period had more awareness of mental health issues before they took part in the SMHFA training than the general population. The participants also appear to have higher levels of prior knowledge about mental health issues and specific conditions than those exhibited by the general population.

This suggests that SMHFA training may be attracting participants who already have more than a basic understanding of mental health issues. These people may be more interested in being able to increase their knowledge and skills in order to be able to offer support to people experiencing mental health problems. If SMHFA is to achieve its objectives of increasing mental health literacy levels across a wide section of the population, it will need to attract participants who do not have higher than average levels of prior knowledge about mental health issues. This will be a substantial challenge that all those involved in the delivery of SMHFA, and in particular Instructors, will have to face in the future.

The evaluation evidence about the national roll-out of SMHFA also suggests that efforts to target the delivery of the training in particular sectors have been patchy and produced mixed results. There have been efforts to target the delivery of the training in particular sectors where it is felt that employees are most likely to be in a position to provide advice and support to people experiencing mental health problems. These efforts have produced mixed success and in general appear to have been most successful when the original initiative to provide SMHFA training to employees has come from within the sector itself. There are lessons that can be learned from how SMHFA has been rolled out in these sectors, particularly in relation to the need for a strong commitment to the delivery of the training from senior managers, which could be applied in attempting to roll-out SMHFA in other employment sectors.

A total of 177 SMHFA Instructors have been trained to date and there are a further four Instructor Training Programmes scheduled between March 2007
and March 2008. It should, therefore, be feasible to meet the target of having 300 trained SMHFA Instructors by March 2008. If each of these Instructors were delivering the minimum requirement of four training courses per year then it should be possible to deliver 1,200 training courses a year from March 2008 onwards. If there were an average of 12 participants on each of these courses then this would mean, in theory, it should be possible to have 14,400 people participating in SMHFA training per year.

However, the evaluation has identified that not all Instructors have been able to meet the minimum expectation of delivering four SMHFA courses a year. It is clear that while some Instructors, particularly those who have received support from their employers to deliver SMHFA within their organisation or sector, are delivering more than the minimum expected number of training courses, others are struggling to meet this minimum expectation. In addition, a number of people who have been trained as SMHFA Instructors are not able to continue delivering training as a result of changes in their work or personal lives. Finally, it is clear that the majority of SMHFA Instructors prefer to co-deliver the training. This in effect would halve the number of participants that are able to participate in SMHFA training, unless Instructors deliver twice the minimum expected number of training courses per year. This is not currently the case for the vast majority of Instructors.

It is inevitable that there will always be an element of turnover in Instructors and that some Instructors will not be able to meet expectations in terms of the delivery of training courses once they have been trained. However, it is also clear that it will be difficult to increase the number of SMHFA courses delivered, and therefore the number of people participating in the training, substantially beyond the current level of just over 200 per year without either providing additional support to existing Instructors, or increasing the pool of Instructors beyond the anticipated 300 that will have been trained by March 2008.

6.1.2 Training Outcomes

MHFA training, as first developed by the Australian National University’s Centre for Mental Health Research, aims to increase mental health literacy and helping skills by equipping participants with the skills and confidence required to be able to offer a first aid response to people with mental health problems. This includes being able to recognise the symptoms of mental health problems, listen non judgmentally, provide initial help by giving reassurance and information, encouraging people to seek professional help if needed and facilitating self help coping strategies. A major aim of this evaluation was to explore the extent to which SMHFA has contributed to the achievement of these objectives.

The evidence from the evaluation suggests that the SMHFA training is making a contribution towards meeting these objectives. Feedback from participants who have completed the training shows that the vast majority believe that all of the objectives set for SMHFA training were either fully or quite well met in
the training course they attended. Participants also rated the content and
delivery of the training very highly, with over 70% saying the content was
excellent and over 90% saying that the delivery of all aspects of the training
was either excellent or very good. Participants also felt that they got a lot out
of the training with almost 60% saying that their personal learning was
excellent and 67% saying that they felt the usefulness of the training to them
in their job was excellent.

The evaluation evidence also shows that SMHFA training is meeting the
desired learning outcomes. Comparison between the pre-training survey of
participants and the survey conducted immediately following the training
shows that there were substantial increases in participants’ perception of their
knowledge about mental health issues, different types of mental health
problem and the symptoms of different types of mental health problem. The
surveys of participants conducted before and after the training also showed
that there were substantial increases in participants’ actual knowledge about
issues covered in the SMHFA training, as measured by their responses to a
series of questions about different types of mental health issues. This
included analysing both participants’ own perceived knowledge and actual
knowledge, measured by responses to a series of questions about the
material covered in the SMHFA training materials.

Participants reported increased confidence in dealing with mental health
issues following their participation in the training. For example, the proportion
of participants who said they were confident that they would be able to
recognise if someone was experiencing a mental health problem increased
from under a quarter before the training to over 70% immediately after the
training. Importantly, participants’ confidence in their ability to guide
someone experiencing mental health problems to appropriate professional
help increased by 44%. In addition, their confidence that they could advise
people with mental health problems about steps they could take to help
themselves increased by 50% after they had completed the SMHFA training.

One of the objectives of the SMHFA training is to increase participants’
awareness about mental health issues and by so doing, tackle some of the
stigma that is associated with mental illness. The evaluation evidence shows
that while participants in the training generally had positive attitudes towards
mental health issues before they participated in the training, their attitudes still
changed following their participation in the training. For example, the
proportion of participants who agreed with the statement that “the majority of
people with mental health problems recover” increased from 46% before the
training to 65% after the training.

Finally, the evaluation shows that participants report having been able to
apply the learning they have gained from participating in the SMHFA training
in a variety of different situations. Participants said they felt they were better
equipped to help people experiencing mental health problems after taking part
in the training and were better able to encourage them to get appropriate help
or take steps to help themselves. Participants also said they would be able to
provide more practical and appropriate help to people experiencing different
types of mental health problems following their participation in the SMHFA training.

Overall, the evaluation findings show a very positive picture in terms of the SMHFA training outcomes. They suggest the training is successfully meeting all of its objectives in terms of learning outcomes and this is resulting in an improvement in participants’ mental health literacy. In particular it is having a positive impact on participants’ knowledge, skills and confidence in dealing with people experiencing mental health problems. It also shows that many participants have been able to use their learning to offer practical and appropriate support to people experiencing mental health problems.

The evaluation has identified some potential improvements and changes that could be made to both the structure and content of the SMHFA training. The suggested changes in content are relatively minor and they certainly do not appear to have made any impact on the ability of the training to deliver the desired objectives and learning outcomes. It would make sense to review the content of the training after the initial period of the national roll-out, not least to reflect the experience of Instructors delivering the training and to maintain their confidence in the quality of the training materials.

The potential changes in the structure of the training that have been identified during the evaluation are largely designed to increase the flexibility in how the training is delivered. For example, a substantial number of Instructors have suggested that being able to deliver the training in two hour modules would allow the training to be delivered to a wider range of participants e.g. by providing the training as an adult education class. There is also scope for investigating how the basic format of SMHFA training can be tailored to meet the needs of specific groups of participants, by reflecting the environment they work in, which again might increase the attractiveness of the SMHFA training to a wider range of potential participants.

6.1.3 Overall Conclusion

In summary, the overall conclusion that can be drawn from the evaluation is that SMHFA is delivering on the desired objectives and outcomes in terms of improving the mental health literacy of those who have participated in the training. This is evidenced by the impact the training has had on participants in terms of changes in their knowledge, confidence, attitudes, willingness and ability to provide support and advice to people experiencing different types of mental health problem.

While the SMHFA training is delivering its stated objectives for those who have participated in the training, the evaluation also suggests that the delivery of the training could be improved in order to increase the number and range of people participating in the training. In particular, consideration needs to be given to how the content and structure of the training could be changed to allow it to be delivered to a wider range of participants.
Finally, the need to support existing Instructors, and potentially increase the pool of Instructors beyond the target of 300, needs to be considered to ensure the roll-out of SMHFA training can be sustained beyond March 2008. In addition, further consideration should be given to the need to recruit Instructors who can deliver the training to groups in the community or sectors of the workforce that would most benefit from SMHFA training.