Session 43
5:00 pm – 6:30 pm
90 Minute Symposium ~ Palma Ceia 4

Mental Health First Aid Evaluation

Chair and Discussant: Bruno J. Anthony, Ph.D.
Panelists: Mary B. Wichansky, LCSW-C
Irene Yoon, M.Sc.
Youth Mental Health First Aid
Mary B. Wichansky, LCSW-C
Director of Instructor Support and Curriculum Development
What Is Mental Health First Aid?

- Help offered to a person developing a mental health problem or experiencing a mental health crisis
- Given until appropriate treatment and support are received or until the crisis resolves
- Not a substitute for counseling, medical care, peer support or treatment
- Mental Health Literacy, early intervention and stigma reduction are primary goals
- First Aider and public safety is always primary
Mental Health First Aid

- Origins in Australia and currently in 23 countries
- Adult MHFA course for individuals 18 years of age and older; available in both Spanish and English
- Youth MHFA is designed to teach caring adults how to help an adolescent (age 12-18) who is experiencing a mental health or addictions challenge or is in crisis, Spanish available (June 2015)
- Included in SAMHSA’s National Registry of Evidence-based Programs and Practices
- Partnership with Maryland and Missouri State Governments
First Aider Growth By the Numbers

2008: 1,305
2009: 6,159
2010: 22,690
2011: 42,997
2012: 83,697
2013: 150,178
2014: 306,381

2015 GOAL: 600,000 MENTAL HEALTH FIRST AIDERS TRAINED
Instructor Growth by the Numbers

MORE THAN 6,500 CERTIFIED INSTRUCTORS

MORE THAN 2,500 unduplicated instructors were certified in Mental Health First Aid

MORE THAN 3,000+ YOUTH INSTRUCTORS

In 2014, we trained more than 3,000 additional instructors
ALGEE-OMETER

More than 310,000 First Aiders in the US Trained by more than 6,300 Instructors

Reported through December 2014

<table>
<thead>
<tr>
<th>State</th>
<th>Number of First Aiders</th>
<th>Percentage of Population Trained</th>
</tr>
</thead>
<tbody>
<tr>
<td>AK</td>
<td>2,217 (41)</td>
<td>0.075% - 0.149%</td>
</tr>
<tr>
<td>WA</td>
<td>6,485 (130)</td>
<td>0.025% - 0.039%</td>
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<tr>
<td>OR</td>
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<tr>
<td>ID</td>
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<td>1,107 (62)</td>
<td>0.15% or more</td>
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<td>0.04% - 0.074%</td>
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<tr>
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<td>14,467 (248)</td>
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<tr>
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Audiences

(through April 2014)

31.4% General Community/Not Specified
24.7% Behavioral Health
15.9% Higher Education
7.0% Social Services
6.9% Primary Care
6.7% Law Enforcement/Public Safety
5.6% Faith Communities
4.5% Youth-focused entities
0.6% Business/Corporations
2.2% Other
Why Mental Health First Aid for Those who Work With Youth?

- Mental health problems are common
- Mental health problems often develop during adolescence
- Youth and young adults may experience mental health problems differently than adults
- Youth may not be well informed
- The sooner an individual gets help, the more likely they are to have a positive outcome
- Misunderstanding and discrimination are often associated with mental health problems
- Professional help is not always on hand
Rationale

- Half of all lifetime cases of mental illness begin by age 14.
- Treatment works, but there are long delays between onset and treatment.
- Untreated mental disorder can lead to a more severe, more difficult to treat illness and additional co-occurring mental disorders.
- 75% of mental illnesses appear by the age of 24, yet less than half of children with diagnosable mental illness receive treatment.
Typical Adolescent Development

- Physical, Mental, Emotional and Social Changes
- Most youth pass through adolescence with relatively little difficulty despite all of these challenges.
- When difficulties are encountered, youth tend to be quite resilient:
  - Thrive
  - Mature
  - Increase their competence
What MHFA Participants Learn

- Risk factors and warning signs of mental health concerns.
- Information on common mental health disorders such as depression, anxiety, trauma, psychosis, eating disorders and substance use.
- A 5-step action plan to help someone developing a mental health concern or in crisis.
- Gain knowledge to community professional, peer, and self-help resources.
Where Mental Health First Aid Can Help

Where Mental Health First Aid can help on the spectrum of mental health interventions
What is included in the Youth Mental Health First Aid Course?

- What is the role of the First Aider?
- The prevalence of mental illness and substance use disorders among youth
- Typical adolescent behavior
- Signs and Symptoms of possible disorders
- Risk Factors
- Resilience
- Protective Factors
- Applying the ALGEE action plan to various scenarios
- And a host of additional interactive exercises…
Median Age of Onset

One-half of all lifetime cases of mental illness begin by age 14, three-quarters by age 24

- Anxiety Disorders – Age 11
- Eating Disorders – Age 15
- Substance Use Disorders – Age 20
- Schizophrenia – Age 23
- Bipolar – Age 25
- Depression – Age 32
MHFA Action Plan

- Assess for risk of suicide or harm
- Listen nonjudgmentally
- Give reassurance and information
- Encourage appropriate professional help
- Encourage self-help and other support strategies
Assess for Risk of Suicide or Harm

Youth may be at risk for a variety of crisis situations:

- Suicide or suicidal thoughts
- No suicidal self-injury/other personal safety issues
- Medical emergencies due to alcohol or drug related issues
- Extreme distress
- Aggression
Listen Nonjudgmentally

- Using “I” statements, state nonjudgmentally what you have noticed
- Ask questions, but don’t push
- Realize it may be a relief for the young person to talk about how they feel
- Remember it’s about **them** not **us**
  - Their experiences are not the same as ours
  - Their perspective is not the same as ours or necessarily of other youth in the family or peer group
  - Their culture may not be the same as ours
  - They need our empathy
  - They may use language that makes us uncomfortable
Listen Nonjudgmentally

How to Effectively Communicate with Youth:

- **Be** genuine and respectful
- careful about using slang
- comfortable with silence
- in the present with them without comparing to your own youth
- aware that the young person’s feelings are very real
- accepting even though you may not agree
- aware of your body language and facial expressions
- positive with your feedback
- helpful with language without telling them how they feel or “should” feel
# Give Reassurance and Information

<table>
<thead>
<tr>
<th>Do</th>
<th>Do Not</th>
</tr>
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<tbody>
<tr>
<td>Have realistic expectations</td>
<td>Make promises you cannot keep</td>
</tr>
<tr>
<td>Offer consistent emotional support</td>
<td>Give Advice</td>
</tr>
<tr>
<td>Give the young person hope</td>
<td>Dismiss the problem or emotions</td>
</tr>
<tr>
<td>Provide practical help</td>
<td>Focus on “right” vs. “wrong”</td>
</tr>
<tr>
<td>Provide information</td>
<td>Focus solely on weight, food, drugs, alcohol, injury or specific external factors unless there is an emergency</td>
</tr>
<tr>
<td>Acknowledge the limits of what you can do</td>
<td>Try to fix the problem yourself</td>
</tr>
<tr>
<td></td>
<td>Engage in communication that is: sarcastic, hostile or patronizing</td>
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</table>
## Information vs. Advice

<table>
<thead>
<tr>
<th>Reassuring Information</th>
<th>Advice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breakups can be tough. It’s natural for you to be hurt and upset.</td>
<td>I remember my first breakup, here’s what you need to do...</td>
</tr>
<tr>
<td>I’m here for you if you want to talk. There are also people who are trained to help</td>
<td>You really need to talk to a counselor about that.</td>
</tr>
<tr>
<td>you work through these feelings.</td>
<td></td>
</tr>
<tr>
<td>You are not alone.</td>
<td>You’ll get over it. Just don’t worry about it so much.</td>
</tr>
<tr>
<td> What would you say?</td>
<td>You’ll get over it soon.</td>
</tr>
</tbody>
</table>
Encourage Appropriate Professional Help

Types of professionals

- Doctors (pediatricians/primary care physicians/Psychiatrists)
- Nurse practitioners/physician assistants
- Mental health professionals (e.g. Social Workers, licensed counselors)
- Drug and alcohol specialists
- School counselors
- Nutrition experts
- Certified peer specialists
- Other professionals
Encourage Appropriate Professional Help

Types of professional help:
- Individual, family and/or group therapy
- Alcohol/drug treatment, withdrawal management
- Brief intervention or therapy
- Problem-solving, decision making, or social skills training
- Academic counseling
- Dietary management
- Medication
Encourage Self-Help and Other Support Strategies

- Identify others who may be helpful
- Explore activities that might help manage symptoms
- Find strategies that interest the young person
- Discuss self-help strategies with a health professional
- Engage the family as well as the young person
Keisha’s Story - Scene 1

Keisha is a 14-year-old girl who just never seemed to fit in. She doesn’t have a lot of friends, often seems to struggle to find people to sit with at lunch, is usually selected last in PE and is picked on by Fred, a boy who likes to make a public display of his comments. She has a few close friends, and other kids don’t seem to pick on her, but avoid Keisha so that Fred doesn’t turn his attention on them. You’ve noticed that Keisha seems less outgoing lately and does not engage as much as she used to in group activities.

You are Keisha’s youth group leader. How would you approach her?
Keisha’s Story - Scene 2
Keisha seems embarrassed that you’ve noticed that she gets picked on. She tells you everything is okay, pointing out that her grades are good, she just got a role in the school play and that she just placed in the state art contest. As you talk, however, she begins to open up about just wanting to disappear when Fred starts picking on her.

What aspects of ALGEE would you employ?
Scenario

Keisha’s Story - Scene 3
As the conversation continues, Keisha seems relieved to have someone to talk to. She eventually admits to “playing sick” a lot recently to avoid going to school—and thus avoiding Fred. She says she’s having trouble concentrating and shares that she got a lower than usual grade on her algebra test last week. She’s even thinking of dropping out of the school play, because she’s afraid that it will only give Fred more reason to pick on her.

How would you respond now? What would you say to her? What actions would you take, if any?
Scenario

Keisha’s Story – Scene 4

A few weeks later the group goes swimming and you see several cuts on Keisha’s thighs. You pull her aside to ask what happened and she starts to tell you a long, complicated story about falling. You note that the cuts don’t look like injuries from a fall, and that some look infected. She eventually admits that she’s been cutting herself with a nail file.

How would you respond now? What would you say to her? What actions would you take, if any?
Mary B. Wichansky, LCSW-C
Director of Instructor Support and Curriculum Development
MaryW@thenationalcouncil.org
Mental Health First Aid USA Evaluation

A collaboration of Georgetown University Center for Child and Human Development and the National Council for Behavioral Health

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MY K. BANH, PH.D. M.SC.
SYBIL GOLDMAN, MSW
Mental Health First Aid
Evaluation Efforts: Past and Present
Previous Studies (International)

• 8 uncontrolled studies with different populations
  – Civil servants, community leaders, minority groups

• 5 randomized controlled trials – wait list controls
  – Adult version: General public (rural), government officials, public sector employees, professional students
  – Youth version (1): teachers and students

• Pre, Post and Follow-up surveys

• Two examples of randomized control trials
Improvements in Mental Health Knowledge

• Information taught in course
• Video vignettes of depression and schizophrenia.
  – What is wrong?
  – Does the person need help?
• Beliefs about the effectiveness of interventions for mental health problems.

![Graph showing percent correctly recognizing disorder over time for Depression-I, Depression-C, Schiz-I, and Schiz-C.](image-url)
Reduction in Some Aspects of Stigma

• Attitudes.
  • Personal (e.g., “a mental health problem is a sign of weakness, people with a mental health problem are dangerous”)
  • Perceived (“most other people believe...”)
• Social distance
# Increased Confidence and Help Provided to Others

<table>
<thead>
<tr>
<th>Question</th>
<th>Group</th>
<th>Pretest</th>
<th>Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Feeling confident in helping someone</td>
<td>MHFA</td>
<td>54.5</td>
<td>74.5</td>
</tr>
<tr>
<td></td>
<td>Control</td>
<td>49.7</td>
<td>57.4</td>
</tr>
<tr>
<td>Had contact with anyone with mental health problem</td>
<td>MHFA</td>
<td>71.5</td>
<td>72.9</td>
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<tr>
<td></td>
<td>Control</td>
<td>70.8</td>
<td>65.6</td>
</tr>
<tr>
<td>Provided help</td>
<td>MHFA</td>
<td>37.0</td>
<td>39.0</td>
</tr>
<tr>
<td></td>
<td>Control</td>
<td>37.5</td>
<td>36.2</td>
</tr>
<tr>
<td>*Advised professional help</td>
<td>MHFA</td>
<td>28.1</td>
<td>29.4</td>
</tr>
<tr>
<td></td>
<td>Control</td>
<td>27.1</td>
<td>16.8</td>
</tr>
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Change in Perceptions of Personal and Family Mental Health

• Some studies showed significantly greater improvement in mental health for MHFA trainees than controls.

• In a general population study, a higher percentage of MHFA group reported that they possessed a mental health problem.
Randomized Controlled Trials of Youth Training*

- 327 staff in 14 Australian schools randomized to training (221) wait-list control (106)
  - 65% female; 45% with > 20 years experience
  - 63% classroom teachers
- 1,623 children in grades 8-10, ages 12-15
  - 55% female
- Modified version of Youth Mental Health First Aid course
  - Day 1 (all staff): departmental MH policy, common disorders, MH action plan
  - Day 2 (wellness staff): crisis management, less common disorders (psychosis, eating disorders, substance abuse),
Staff Results: Knowledge

• Increased Knowledge
  – Information taught in course
  – Beliefs about treatment

• Trained staff more likely to agree with strategies to support a student with a mental health problem:
  – Review curriculum options/classroom practices,
  – Review/change school policy
  – Improve relationships within the school

• Trained staff were more likely to report that the school had a written policy to deal with students with mental health problems and that the policy had been implemented.
Results: Stigmatizing Attitudes

• After course, MHFA Trained staff
  – More likely to disclose depression to others but less likely to believe that others will disclose.
  – Less likely to see depression as due to personal weakness but more likely to believe that others see depression as personal weakness
  – No difference in personal beliefs that depression is not a “real” illness and that those with MH problems can just snap out of it are dangerous, unpredictable or need to be avoided,
Staff Results: Expectations of Helping

- Trained teachers more likely to say
  - Would discuss their concerns with another teacher
  - Discuss their concerns with a counselor
  - Have a conversation with the student.

- No difference between Trained and controls
  - Contact family
  - Talk with peers
  - Talk with administration
Staff Results: Helping Behaviors

• Trained staff were more confident in their ability to help students and colleagues.
• Not more likely to engage in helping behaviors.
• No change in staff mental health.
• No change in seeking of information about mental health problems.
Student Results

• Very few student outcomes showed an impact of training
• Students of trained teachers were more likely to report that they received general information about mental health problems.
• No difference in reported personal help received from teachers or in students’ mental health
Moving Ahead

• Consistent results
  – Increases in mental health knowledge
  – Reductions in some aspects of stigma
  – Increased confidence in helping

• Less consistent results
  – Engagement in helping behaviors

• New directions
  – Comprehensive evaluation, tied to MHFA training goals
  – Focus on impact of MHFA training on behaviors
  – Based on well documented theories of behavior change
  – Psychometrically sound
Georgetown MHFA Evaluation Tools: Goals

• Implementation
  – Who was trained (Reach)
  – The structure of the training
  – The perceived usefulness (structure, content, presenters)

• Immediate impact
  – Pre-post changes in measures developed to tap attitudes about and knowledge of MHFA and motivation for and confidence in carrying out action steps

• Longer-term impact
  – Same measures used in the immediate impact assessment and self-reports of intentions to perform MHFA behaviors and actual behaviors and a small number of
Unified Theory of Behavior (UTB): Constructs Relevant to MHFA

Behavioral Intentions

- Self Efficacy
- Social Beliefs
- Attitudes

Knowledge and Skills

Cues to Action

Behavior
Impact Scales

• The strength of *behavioral intentions* and *key determinants* of intentions and actual behaviors that we expect to change following training,

• Based on literature as well as feedback from the practical experience of trainees and trainers.

• Scales using this format have been used in hundreds of previous studies using UTB concepts

• Administered prior to and post training as well as at 3- and 6-month follow-up with scales to measure whether individuals carried out MHFA actions.

• Linked closely to the goals of training: ALGEE
Key UTB Constructs Relevant to MHFA

- **Self Efficacy**: Motivation to take action to help someone address his/her mental health problem through MHFA.
- **Social Beliefs**
- **Attitudes**
- **Behavioral Intentions**: Understanding the role of self-efficacy, social beliefs, and attitudes in shaping behavioral intentions.
- **Cues to Action**
- **Behavior**
Behavioral Intentions

Please select the response that best describes the likelihood that you would carry out the following actions

Not at all likely       Extremely likely
1      2      3        4      5

I will approach someone with a mental health problem if I feel I have the knowledge to talk to them About the problem

I will help someone experiencing mental health symptoms to find supports if I know the resources available in the community
Key UTB Constructs Relevant to MHFA

- Self Efficacy
- Social Beliefs
- Knowledge and Skills
- Beliefs about the rewards, difficulty, usefulness and positivity of performing MHFA actions
- Behavioral Intentions
- Cues to Action
- Behavior

Attitudes
Attitudes or Beliefs

Each statement relates to different areas of mental health. Please pick the answer choice that best describes how you currently feel.

Talking with someone experiencing a mental health problem(s) about his/her problem(s) is:

- Not at all difficult 1 2 3 4 5 Extremely difficult
- Not at all rewarding 1 2 3 4 5 Extremely rewarding
- Not at all useful 1 2 3 4 5 Extremely useful

For each statement below, please select the response that best describes your opinion about how likely a person with mental health problems will respond to a specific action you carry out.

If I ask about suicidal thoughts directly, a person with such thoughts will feel a sense of relief.

- Not at all likely 1 2 3 4 5 Extremely likely
Key UTB Constructs Relevant to MHFA

- **Self Efficacy**
- **Social Beliefs**
- **Attitudes**

**Behavioral Intentions**

**Knowledge and Skills**

**Behavior**

Personal and perceived (i.e., important others) beliefs (stigma) about mental health problems, people with mental health problems and performing MHFA actions.
## Personal and Perceived Stigma

I believe that people with mental health problems.

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<thead>
<tr>
<th></th>
<th>Do not agree at all</th>
<th></th>
<th>Strongly agree</th>
</tr>
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<tbody>
<tr>
<td>Are seeking attention</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Are easy to talk to</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Have only themselves to blame</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
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</table>

*People who are important to me believe* that people with mental health problem(s):
Key UTB Constructs Relevant to MHFA

- **Self Efficacy**: Confidence in ability to carry out MHFA actions and control their success.
- **Behavioral Intentions**: Confidence in ability to carry out MHFA actions and control their success.
- **Social Beliefs**:
- **Attitudes**:

The constructs influence behavior through cues to action and skills.
Self-Efficacy: Self Confidence and Control

Please rate your confidence in performing the following actions

Do not agree at all 1 2 3 4 5
Strongly agree

Refer a person with mental health problems to appropriate help

Talk with someone who is suicidal

Please select the response that best describes the likelihood that you would carry out the following actions.

Not at all likely 1 2 3 4 5
Extremely likely

I will approach someone with a mental health problem(s), if I feel I have the knowledge to talk to them about their problem.

I will help someone with a mental health problem(s) if I have practice in asking about suicidal thoughts or harm.
Key UTB Constructs Relevant to MHFA

Understanding of mental health problems and methods to address them

Behavioral Intentions

Knowledge and Skills

Cues to Action

Behavior

Social Beliefs

Attitudes

Understanding of mental health problems and methods to address them
Knowledge and Skills

Please select the response that best describes your level of agreement with the following statements (do not agree, agree, don’t know).

• At least 1 in 5 people in the US have one or more mental health disorder(s) in any one year.
• Around half of mental disorders start during childhood or adolescence.
• It is not a good idea to ask someone if they are feeling suicidal in case you put the idea in their head.
• Use of alcohol or other drugs increases the risk of suicide or harm.
• Schizophrenia is one of the most common mental disorders in the US.
• When talking to people with eating disorders, it is important to criticize their body size.
• Exposure to traumatic event(s) is a risk factor in almost every type of mental illness.
Key UTB Constructs Relevant to MHFA

- **Behavioral Intentions**
- **Behavior**
- **Knowledge and Skills**
- **Self Efficacy**
- **Social Beliefs**
- **Attitudes**

Exposure to those with risk factors and warning signs for mental health problems
Cues to Action

• In the past year, have you encountered anyone displaying the following mental health related signs and symptoms (yes/no, how many times):
  • Physical signs like changes in normal patterns or appearance?
  • Emotional symptoms like depressed mood, irritability, excessive anxiety or worry?
  • Behavioral signs like crying, withdrawal, aggression, phobias, excessive use of alcohol or drugs?
  • Extreme distress?
  • Difficulties in school, social settings, or daily activities?
Key UTB Constructs Relevant to MHFA

- Self Efficacy
- Social Beliefs
- Attitudes
- Behavioral Intentions
- Knowledge and Skills
- Cues to Action

Behavior

Performance of MHFA-related actions
Behavior: Referrals

- In the past year, have you referred anyone to services and supports (no/yes)?

If yes, what type of services and supports did you refer the person(s) to? (Mark all that apply.)

- Individual mental health professional
- Community mental health agency providing mental health services
- Private practice providing mental health counseling
- National crisis hotline phone number
- Local crisis hotline phone number
- Local hospital
- Clergy
- Local support groups
- Self-help strategies (e.g. books, websites, yoga, meditation, etc)
- Other (Please specify): ______________________________________
Behavior: Helping Actions

In the past year, have you reached out to anyone whom you believe has a mental health problem(s) in any of the following ways (yes/no, how many times):

• Assessed the situation for the presence of a crisis (A)
• Talked to someone about his/her suicidal thoughts (A)
• Spent time listening to someone (L)
• Gave someone information about his/her problem(s) (G)
• Helped someone to calm down (G)
• Suggested options for getting help (E)
• Encouraged someone to seek professional help (E)
• Recommended self-help strategies (E)
• Encouraged someone to get other supports (E)
• Engaged family members to help (E)
## Consistency of UTB Constructs

<table>
<thead>
<tr>
<th>Construct</th>
<th>Cronbach’s alpha (α)</th>
<th>Consistency Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Intention</td>
<td>.69 - .74</td>
<td>Acceptable-Good</td>
</tr>
<tr>
<td>Attitudes and Beliefs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How Rewarding</td>
<td>.83 - .92</td>
<td>Good – Excellent</td>
</tr>
<tr>
<td>How Difficult</td>
<td>.87 - .91</td>
<td>Good - Excellent</td>
</tr>
<tr>
<td>How Useful</td>
<td>.67 - .91</td>
<td>Acceptable – Good</td>
</tr>
<tr>
<td>How Positive</td>
<td>.67 - .83</td>
<td>Acceptable - Good</td>
</tr>
</tbody>
</table>
## Consistency of UTB Constructs

<table>
<thead>
<tr>
<th>Construct</th>
<th>Cronbach’s alpha (α)</th>
<th>Consistency Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Social Beliefs (Stigma)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal beliefs about MH problems</td>
<td>.40 - .55</td>
<td>Unacceptable - Poor</td>
</tr>
<tr>
<td>Personal beliefs about people with MH problems</td>
<td>.26 - .49</td>
<td>Unacceptable</td>
</tr>
<tr>
<td>Personal beliefs about performing ALGEE</td>
<td>.75 - .95</td>
<td>Good - Excellent</td>
</tr>
<tr>
<td>Perceived beliefs about others with MH problems</td>
<td>.58 - .69</td>
<td>Poor - Acceptable</td>
</tr>
<tr>
<td>Perceived beliefs about my performing ALGEE</td>
<td>.90 - 92</td>
<td>Excellent</td>
</tr>
</tbody>
</table>
## Consistency of UTB Constructs

<table>
<thead>
<tr>
<th>Construct</th>
<th>Cronbach’s alpha (α)</th>
<th>Consistency Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self Efficacy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self Confidence</td>
<td>.92 - .94</td>
<td>Excellent</td>
</tr>
<tr>
<td>Control</td>
<td>.88 - .92</td>
<td>Good – Excellent</td>
</tr>
</tbody>
</table>
Revised Survey Instruments

• Reliability analyses showed that 10 or 12 constructs related to MHFA training possessed acceptable, good or excellent internal consistency across all four time points. Based on frequency and distribution of items, reliability, pre-post change scores, several modifications were made:
  – Complete removal (1),
  – Removal from post evaluation (2),
  – Reduction in items (5)
  – Rewording of items (2).

• Changes also a made in demographic section
Mental Health First Aid Evaluation: Study Findings
Recruitment Process

- Participants drawn from a sample of N=1657 trainees identified by the Council
  - **Cohort 1**: Pre-Post group
  - **Cohort 2**: 3-month follow-up group
  - **Cohort 3**: 6-month follow-up group

- Trainees who completed the Pre-Survey were invited to complete the Post-Survey

- Invitations were sent via email

- Surveys were completed on-line through SurveyMonkey
Pre-Post Cohort Findings

PRE-POST RESPONSE RATES

• Pre-Survey response rate of 41% for Adult and Youth trainings combined (n=272)

• Post-Survey response rate 63% for Adult and Youth trainings combined (n=170)

• Analyses for the Pre-Post Cohort were performed only on those who completed both the Pre- and Post-Surveys (n=170)
Geographic Distribution

[Map image showing the geographic distribution of trainees across the United States, with color-coded pins indicating the number of trainees in each location.]

NUMBER OF TRAINEES
- Yellow: ≤1
- Purple: ≤5
- Green: ≤7
- Blue: ≤12
- Red: 12+

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Demographic Characteristics

**Gender (n=167)**

- Male: 16%
- Female: 84%

**Age (n=166)**

- 55+: 35.5%
- 45-54: 24.7%
- 35-44: 18.1%
- 25-34: 18.1%
- <25: 3.6%
Demographic Characteristics

Race/Ethnicity

Number of people (n)

White
Black, African American
Hispanic (any race)
American Indian or Alaska Native
Asian
Hawaiian or Pacific Islander
Some other race

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Demographic Characteristics

**Highest level of schooling completed (n=167)**
- 36%: Bachelor’s degree
- 34%: Post-graduate degree
- 8%: Associate degree
- 2%: Vocational school certificate
- 14%: High school degree
- 6%: Other (please specify):

**Received any previous mental health training (n=164)**
- 54%: No previous mental health training
- 46%: Previous mental health training
Level of Mental Health Training

Level of Mental Health Training Completed

- Workshop about mental health problems: 51 people
- Mental Health First Aid Training for Adult: 12 people
- Mental Health First Aid Training for Youth: 6 people
- Medical training in psychiatry: 2 people
- Doctoral level coursework on mental health: 2 people
- Master’s level coursework on mental health: 32 people
- Bachelor level coursework on mental health: 39 people
- High school classwork on mental health: 8 people
- Other: 11 people

Number of people (n)
Why are you taking MHFA?

Why are you interested in taking MHFA training?

- Other: 10%
- My general interest about mental health: 20%
- A family member or friend has mental health problems: 5%
- Important for my work: 30%
- Friend recommended it to me: 15%
- My own mental health history: 10%
- Required for work: 5%

Previous MH training: 29%
No previous MH training: 31%
In what role might you come into contact with someone experiencing a mental health problem(s)?

- Family, friend, neighbor, parent: 347
- Medical or behavioral health professional: 140
- School and/or camp: 110
- Clergy: 18
- Government employee: 54
- Business owner: 9
- Other: 42
In what role might you come into contact with someone experiencing a mental health problem(s)?

- Other (please describe): 38
- Parent: 60
- Family member: 113
- Neighbor or colleague: 73
- Friend: 101
- Business owner: 9
- Airline personnel: 4
- Other government personnel: 18
- Military personnel: 8
- Law enforcement: 14
- First responder: 21
- Probation officer: 14
- Family advocate: 33
- Clergy: 18
- Case manager: 48
- Other school staff: 43
- Teacher: 36
- Coach: 20
- Camp/recreational counselor: 11
- Substance abuse counselor: 13
- Medical professional: 25
Training Satisfaction

Rate your level of agreement with the following statements
(1=Do not agree at all, 5=Strongly agree)

<table>
<thead>
<tr>
<th>Statement</th>
<th>Previous MH training</th>
<th>No previous MH training</th>
</tr>
</thead>
<tbody>
<tr>
<td>I felt safe sharing my opinions with the group.</td>
<td>4.66</td>
<td>4.68</td>
</tr>
<tr>
<td>I received adequate practice in using ALGEE to apply the action steps.</td>
<td>4.58</td>
<td>4.60</td>
</tr>
<tr>
<td>My questions were answered adequately.</td>
<td>4.61</td>
<td>4.76</td>
</tr>
<tr>
<td>Information was provided clearly.</td>
<td>4.70</td>
<td>4.73</td>
</tr>
<tr>
<td>I gained a lot of new knowledge about how to help someone presenting with mental health signs and symptoms.</td>
<td>* 4.19</td>
<td>4.72</td>
</tr>
<tr>
<td>My instructor was effective in teaching the material.</td>
<td>4.64</td>
<td>4.78</td>
</tr>
</tbody>
</table>
Rate the response that best describes the usefulness of various teaching formats used in the MHFA training (1=Not at all useful, 5=Extremely useful)

- Powerpoint slides
- Video clips
- Group activities (e.g. discussing scenarios)
- Class exercises (e.g., opinion quizzes)
- Manual
- Overall MHFA training

- Previous MH training
- No previous MH training
UTB Constructs

• Paired t-tests were conducted on constructs with acceptable-to-excellent internal consistency to examine changes from pre- to post-MHFA training

• Significant improvements (p-value ≤ 0.05) in Post-Training mean scores were found for the following constructs:
  – Attitude: How rewarding?
  – Attitude: How difficult?
  – Beliefs: How positive?
  – Behavioral Intention
  – Personal Stigma: Personal beliefs about ALGEE actions
  – Perceived Stigma: What people important to me believe about others with mental health problems
  – Self-efficacy: Self-confidence
  – Self-efficacy: Control
Knowledge

• **16 items** tapped into trainees’ **knowledge** of a range of mental health facts covered in the MHFA training or MHFA manual.

• Knowledge **increased** significantly from Pre- to Post-Training
  — Pre-Survey:
    • **Mean # of Correct Responses =** 11.82; **SD=2.7**
  — Post-Survey:
    • **Mean # of Correct Responses=** 13.97; **SD=1.84**
    \[ F(1,126) = 9.09, \text{ } p < .000 \]
3- and 6-Month Cohort Findings

3- AND 6-MONTH RESPONSE RATES

• 3-Month Follow-Up Survey response rate of 38% for Adult and Youth trainings combined (n=188)
• 6-Month Follow-Up Survey response rate 32% for Adult and Youth trainings combined (n=160)

3- AND 6-MONTH DEMOGRAPHIC CHARACTERISTICS

• Same as Pre-Post Cohort
3- and 6- Month Follow-Up Training – Behaviors Reported

ENCOUNTERING SIGNS & SYMPTOMS

• 3- and 6-Month Follow-Up Survey respondents were asked if they had encountered anyone displaying certain mental health related signs and symptoms

• Time frame considerations
  – 3-Month Follow-Up Survey: Past 3 months
  – 6-Month Follow-Up Survey: Past 6 months

Top 3 most frequently reported mental health related signs and symptoms were:

<table>
<thead>
<tr>
<th>3-MONTH FOLLOW-UP</th>
<th>6-MONTH FOLLOW-UP</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Emotional symptoms (56.9%)</td>
<td>1. Emotional symptoms (55.6%)</td>
</tr>
<tr>
<td>2. Difficulties in school, social</td>
<td>2. Difficulties in school, social</td>
</tr>
<tr>
<td>settings, or daily activities</td>
<td>settings, or daily activities</td>
</tr>
<tr>
<td>(42.6%)</td>
<td>(43.1%)</td>
</tr>
<tr>
<td>3. Behavioral signs (39.9%)</td>
<td>3. Behavioral signs (40.0%)</td>
</tr>
</tbody>
</table>
3- and 6- Month Follow-Up Training – Behaviors Reported

REACHING OUT THROUGH DIFFERENT ACTIONS

• 3- and 6-Month Follow-Up Survey respondents were asked whether they had reached out to someone with a mental health problem in the *past 3 and 6 months*, respectively.

<table>
<thead>
<tr>
<th>Top 3 <strong>most frequently</strong> endorsed actions were:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3-MONTH FOLLOW-UP</strong></td>
</tr>
<tr>
<td>1. Spent time <strong>listening</strong> to someone (61.7%)</td>
</tr>
<tr>
<td>2. Offered <strong>emotional support</strong> (58.0%)</td>
</tr>
<tr>
<td>3. Encouraged someone to seek <strong>professional help</strong> (48.9%)</td>
</tr>
<tr>
<td><strong>6-MONTH FOLLOW-UP</strong></td>
</tr>
<tr>
<td>1. Spent time <strong>listening</strong> to someone (58.8%)</td>
</tr>
<tr>
<td>2. Offered <strong>emotional support</strong> (56.3%)</td>
</tr>
<tr>
<td>3. Helped someone <strong>calm down</strong> (52.5%)</td>
</tr>
</tbody>
</table>
## Perceived Behavioral Change

<table>
<thead>
<tr>
<th>PERCEIVED BEHAVIORAL CHANGE</th>
<th>3-MONTH (% of Strong Agreement)</th>
<th>6-MONTH (% of Strong Agreement)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. I am more aware of the signs and symptoms of my own mental health.</td>
<td>70.1</td>
<td>72.5</td>
</tr>
<tr>
<td>b. I am more aware of the signs and symptoms of other people’s mental health.</td>
<td>76.7</td>
<td>78.8</td>
</tr>
<tr>
<td>c. I have greater empathy towards someone experiencing mental health challenges.</td>
<td>75.9</td>
<td>83.1</td>
</tr>
<tr>
<td>d. I am more likely to ask someone if he or she is “ok” if I see him or her showing signs and symptoms of distress.</td>
<td>82.9</td>
<td>86.7</td>
</tr>
</tbody>
</table>
### Perceived Behavioral Change (cont.)

<table>
<thead>
<tr>
<th>PERCEIVED BEHAVIORAL CHANGE</th>
<th>3-MONTH (% of Strong Agreement)</th>
<th>6-MONTH (% of Strong Agreement)</th>
</tr>
</thead>
<tbody>
<tr>
<td>e. I feel more comfortable being around someone who is talking to himself or herself.</td>
<td>67.9</td>
<td>66.4</td>
</tr>
<tr>
<td>f. I am less likely to avoid someone showing signs and symptoms of a mental health problem.</td>
<td>70.8</td>
<td>69.0</td>
</tr>
<tr>
<td>g. I feel more comfortable talking to someone about mental health related signs and symptoms that I had observed in another person.</td>
<td>71.1</td>
<td>72.6</td>
</tr>
<tr>
<td>h. I have been using the information I learned from the MHFA training.</td>
<td>74.5</td>
<td>73.2</td>
</tr>
</tbody>
</table>
Limitations of Impact Findings

1. Primary purpose of study was to assess psychometric properties of the surveys
2. Cannot make comparisons among the Pre-Post, 3-month, and 6-months cohorts
3. Trainees asked to reflect upon different time periods when making their assessments about MHFA behaviors and actions
4. No control group included
5. Skewed towards trainees with previous mental health training, females, limited geographical distribution and age range
Conclusions

• Development of evaluation tools with strong psychometric properties
• Study provides preliminary evidence that MHFA training in the US has immediate positive effects with respect to:
  • changing trainees’ attitudes and beliefs about MH
  • improving knowledge
  • Increasing recognition of mental health problems
  • Increasing self-confidence
  • Perceived behavioral change at 3- and 6-months
• Trainees rated high satisfaction with quality and usefulness of the trainings provided
Next Steps

• Complete longitudinal study with a new cohort of trainees using the revised questionnaires
• Follow the same cohort of trainees taking the Youth or Adult MHFA trainings at four different time points:
  1. Pre-,  
  2. Post-,  
  3. 3-month, and  
  4. 6-month follow-up
• Need ways to look at end-user effects
Acknowledgments & Contacts

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