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Evaluation of Adult Mental Health First Aid: Findings from 2015-2017 post-course surveys

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Service Learning/ Capstone

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Abstract

Introduction: Lack of knowledge about mental health, lack of access to mental health care, and stigma create substantial barriers to the overall United States adult population from seeking or helping individuals with behavioral health issues. This study evaluated Adult Mental Health First Aid (MHFA) courses, an evidence-based program for increasing mental health knowledge, decreasing stigma, and increasing the community's confidence in helping and frequency of referring people in need.

Methods: This retrospective evaluation of 2015-2017 Adult MHFA courses, utilizes qualitative and quantitative data from post-course surveys completed by course participants. Quantitative data was measured using a five-point Likert Scale. Qualitative data was analyzed by scanning the set of responses and identifying themes.

Results: In three years, 1635 individuals attended an Adult MHFA training course. Questionnaire data was collected from 1425 (Age% 25- 44 = 53.5; Female % = 73.1; Caucasian/White % = 73.8). Participants found the course to be beneficial; where communication of course goals, the presentation of content, and skill application statements were mostly scored with Agree/Strongly Agree. Qualitative data revealed the themes on the following factors: learning methods, presentation, course content, and the ALGEE action plan.

Conclusion: Adult MHFA trainings through Region 6 Behavioral Healthcare have received constructive feedback to its learning outcomes, presentation of course content, and the methods used. This evaluation report concludes, that a relevant course like MHFA can positively influence mental health knowledge, awareness, and support skills, among the population of the Region 6 area.

Recommendations: In terms of recommendations for the future of the course, several suggestions can be made including; useful things for trainers to know, strategic plan for the future, and improvement to the course and process.

Purpose of Report

Region 6 Behavioral Healthcare

The Nebraska Division of Behavioral Health (DBH) directs the administration, supervision, and organization of the state's public behavioral health system. The Division's efforts are in collaboration with Regional Behavioral Health Authorities. The state of Nebraska is split into six behavioral health regions. These are local units of government that partners with the state to do planning and service implementation. This arrangement allows for a unique partnership among the county, state, and federal governments, county residents, and community organizations. The Division of Behavioral Health works with the six Regional Behavioral Health Authorities to purchase community-based mental health and substance use disorder services using state dollars. The organization of interest in this report is Region 6 Behavioral Healthcare (Region 6). This organization plans, develops and evaluates behavioral health services in Cass, Dodge, Douglas, Sarpy, and Washington counties in eastern Nebraska. The publicly funded behavioral health organization, monitors mental health, substance abuse prevention, treatment and rehabilitative services offered by a network of healthcare service providers.

Mental Health

Mental illness is referred to as, "all diagnosable mental disorders and is characterized by sustained, abnormal alterations in thinking, mood, or behavior associated with distress and impaired functioning" (U.S. DHHS, 1999). Mental health is a public health problem that needs attention due to the number of people that have or may potentially have a mental illness. It has

been found that 1 in 5 adults have a mental health condition, approximately half of individuals will develop at least one mental illness throughout their lifetime, and for half of these people, the problem will last longer than a year (Kesslar, 2005, Mental Health America, 2017). In 2016, 18.53% of adults in America reported suffering from a mental illness, a slight increase in percentage from 2015, 18.19% (Mental Health America, 2016). These illnesses can cause abnormal alterations in thinking, mood, or behavior associated with distress that last for a prolonged period of time. These thoughts and behaviors affect daily functioning and result in devastating personal, social, occupational damage, and premature death. The most common mental illnesses in adults are anxiety and mood disorders (CDC, 2011). According to a 2014 SAMSHA survey on drug use and health, a reported 7.9 million adults had co-occurring disorders. In 2015, mental health and substance use disorders were leading causes of disease burden (3,355 DALYs), as well as years lost to disability (2,829 YLD) in the U.S (Cox & Sawyer, 2017). Good mental health is more than the absence or management of mental health problems; it is the foundation for well-being and effective functioning both for individuals and their communities.

Causes of mental illnesses vary from case to case, but when people are showing initial signs and symptoms, the impact and long-term effects can be reduced by intervening quickly and effectively. This can be done by identifying and providing appropriate support to those at higher risk of mental health problems, and by the delivery of quality services at the right time when people do develop a mental illness. There is also increasing evidence of the importance of resilience in order to cope with and support each other through life’s hardships. The earlier a

diagnosis and intervention is in place the quicker a person will be able to recover. Any prevention of mental illness requires collaborative working across services.

Barriers to Accessing Mental Health Care

The barriers to mental health care are significant challenges that many individuals face in the United States. Two of the main barriers to accessing care are the stigma that surrounds mental illnesses, and the lack of access to care because of the lack of insurance coverage and costs.

There is a public stigma on mental illnesses that in turn causes an additional burden on individuals with behavioral health problems (McNair et al. 2002). Stigma arises from multiple sources, and have serious consequences on an individual's life. Researchers believe stigma may originate from personal, social and family sources, and from the nature of the illness itself (Wig, 1997). Several studies show that stigma also may result from lack of awareness, lack of education, lack of perception, and the nature and complications of the mental illness (Arboleda-Florez, 2002). Due to the stigma surrounding mental illness several things happen such as delays in disorder identification and help-seeking, lack of acceptance of mental health care, and individuals with mental disorders the needed and appropriate support from others in the community. Stigma can have negative effects on mental wellbeing resulting in people becoming discouraged from seeking help when they suspect something might be wrong. Stigma also makes it difficult for people to discuss mental health problems with friends and family, leading to social isolation, which can cause mental health problems to intensify (WHO, 2001).

With the amount of individuals who have a mental illness in this country, there should be more accessing treatment. Nationally, 57% of adults with mental illness receive no treatment, and in some states (Nevada and Hawaii), that number increases to 70% (Mental Health America, 2017). This lack of treatment is due to the lack insurance coverage or the cost of behavioral healthcare being too high. The Affordable Care Act built on the Mental Health Parity and Addiction Equity Act of 2008 to increase the access to behavioral health care by; "1) including mental health and substance use disorder benefits in the Essential Health Benefits; 2) applying federal parity protections to mental health and substance use disorder benefits in the individual and small group markets; and 3) providing more Americans with access to quality health care that includes coverage for mental health and substance use disorder services." (DHHS, 2013). Even though more individuals with mental illness have coverage for behavioral health care due to ACA, there are still 17% (over 7.5 million) people who remain uninsured and lack access to behavioral health care (Mental Health America, 2017).

Mental Health Literacy

Mental health literacy has been defined as "knowledge and beliefs about mental disorders which aid their recognition, management or prevention" (Jorm, 2006). Aspects of mental health literacy include knowledge of causes along with signs and symptoms of disorders, abilities to identify specific disorders or signs of distress, the knowledge and beliefs about available professional help, attitudes on suitable help-seeking, and how to find mental health information (Jorm, 2000).

The general population often has inadequate mental health literacy, being that individuals cannot recognize specific disorders or different types of psychological distress, and their views differ from mental health professionals on causes and treatments (Jorm, 2000). Information on mental illness and its treatment has been shown to increase the willingness to look for help in the general population (Han, 2006, Kelly & Jorm, 2007). Beliefs about the responsibility of community members and professionals in being able to identify and help others with a mental illness need to be improved. The gap between mental health literacy and improved mental health is nothing new, and there is a need to evaluate interventions dedicated to diminishing that gap.

Mental Health Promotion

The National Research Council and Institute of Medicine (2009) defines mental health promotion as "efforts to enhance individuals' ability to achieve developmentally appropriate tasks and a positive sense of self-esteem, mastery, well-being, and social inclusion and to strengthen their ability to cope with adversity." Along with other public health programs, mental health promotion programs can be targeted towards communities or just to the individual, and programs can be focused to promote the health of vulnerable groups or society as a whole (Cattan, 2006). Stigma and discrimination can be addressed through social marketing campaigns, education, information and legislation. It is a fundamental element of strategies to achieve social justice and equity for people with mental health problems. Mental health problems are best addressed by having sufficient people with appropriate skills wherever people with mental health problems present.

This research will help Region 6 Behavioral Healthcare identify factors that work well in these Mental Health First Aid courses, and what factors do not work well. Mental Health First Aid follows the fundamentals of traditional first aid by helping someone in crisis until a professional is able to take over the situation. While, no specific behavior change theory is identified for the MHFA program, the context of the course is consistent with the Social Cognitive Theory (SCT). In the SCT, behavior change happens to do the development of knowledge or learning directly linked to the observation of models, and ending with the self-efficacy to partake in behavior (Bandura, 1986). Self-efficacy is a major foundation of action. If people do not believe that they are able to act during a difficult or problematic time, then they will not believe or have the self-confidence that they can produce the desired effect with their actions (Bandura, 1998). This evaluation takes this theory into account, by measuring participants confidence in carrying-out the learned skills from the course.

In three years of Mental Health First Aid training implementation, no evaluation of the program has been carried out. This retrospective evaluation will review the impact of MHFA training on attitudes toward people with mental illness, knowledge about mental disorders, and knowledge about appropriate first aid responses.

Mental Health First Aid

Background

Mental Health First Aid (MHFA) is an educational program designed to train and prepare individuals to recognize the signs of mental illness and substance use disorders and to provide immediate support and assistance (Kitchener and Jorm, 2008). The original idea behind MHFA

was that if people were commonly taught first aid for physical problems, then the same information should be available for mental health problems. The founders of the course claim that MHFA is able to increase knowledge, reduce stigma and increase supportive actions. However, they stress that it is not teaching people how to become therapists, but providing skills to give the initial help before the individual can be directed to professional help. This program was originally developed in Australia, and introduced to the United States in 2008 and has been spreading rapidly throughout the country. President Barack Obama included $15 million for MHFA training in the 2014 fiscal year budget and requested another $15 million for the fiscal year 2015 (National Council for Behavioral Health, 2014). At least 23 states have put forth legislation or appropriations in support of MHFA (National Council for Behavioral Health, 2014). For the state of Nebraska appropriations from state legislature have been put towards Mental Health First Aid courses with the statute, Nebraska Mental Health First Aid Training Program LB 901. These state funds from the Nebraska Department of Health and Human Services, Division of Behavioral Health are subcontracted with the six Behavioral Health Regions in the state and appropriates funds for this programming. These funds allow for the Behavioral Health Regions to offer this course to the community, and at no cost to the participant.

The original concept behind MHFA is to make it possible for anyone in the public or workplace to support individuals experiencing a mental health issue; in the same way as people from the public can support individuals experiencing physical health problems through training on physical first aid. The course is clear from the start that it does not teach individuals to become therapists but to offer initial support.

Content

The MHFA Adult course teaches adults how to provide initial support to individuals who are developing any of the following mental health problems; Depression, Anxiety problems, Psychosis, and Substance use problems. The course also teaches skills on how to provide support for those experiencing a worsening of a current mental health problem or mental health crises, and these crises include suicidal thoughts and behaviors, non-suicidal self-injury, panic attacks, traumatic events, psychotic episodes, and severe effects from alcohol or other drug use. Curriculum content is evidence-based, with the input of mental health professionals, researchers, and consumer advocates.

The aims of MHFA, as set out in the manual, are as follows:

- to preserve life where a person may be a danger to themselves or others
- to prevent the mental health problem deteriorating into a more serious state
- to promote recovery of good mental health; to provide comfort to a person experiencing mental health problems
- to raise awareness of mental health issues in the community
- to reduce stigma and discrimination

Within the training, these aims are addressed by focusing on teaching individuals to recognize the signs and symptoms of mental health problems, provide initial help, and guide people towards accessing appropriate professional help. Another focus of the course in helping individuals apply skills learned is the MHFA action plan, referred to as the acronym ALGEE. This strategy encourages participants to assist someone in distress through five steps: **A**ssess for risk

of suicide or harm, **L**isten nonjudgmentally, **G**ive reassurance and information, **E**ncourage appropriate professional help, and **E**ncourage self-help and other support strategies (Kitchener et al., 2009). The knowledge and skills needed to apply ALGEE are taught through a group training led by one or two trained MHFA instructors using the MHFA curriculum and workbook. Before Fall 2013, MHFA USA training was also 12 hours. It was reduced to 8 hours to make it more accessible (Lucksted et al. 2015). This shorter version is now the standard in the US.

Format

Achieving these aims in an 8-hour timeframe does create a challenge, but has been shown to produce positive outcomes. Each participant receives an accompanying course manual, including information on the following mental health conditions, depression, anxiety, psychotic disorders and co-morbidity with substance use disorders. The course manual was written to supplement a 12-hour Mental Health First Aid course, but it is also a separate resource (Tutchener, 2010). The book is intended to make it possible for members of the public, who may have little or no prior mental health knowledge, to help someone who may be developing mental illness, or who may be experiencing a mental health crisis (Tutchener, 2010). Along with the book, the course is accompanied by a variety of activities and projects in order to get course participants to apply the knowledge that they learn, encourage an open discussion on topics, and offer personal experiences.

Project Goals and Objectives

1. Goal 1: Evaluate the Adult Mental Health First Aid program for effectiveness in training through Region 6 Behavioral Healthcare.

a. Objective 1.1: Determine if course goals were effectively communicated

i. Activity 1.1: Review completed training surveys

1. Clear communication

2. Understandability of content

b. Objective 1.2: Determine participant perception of instructors

i. Activity 1.4: Review surveys for which instructor taught which sessions

ii. Activity 1.5: Determine if each instructor effectively taught courses to trainees.

Looking at:

1. Presentation skills

2. Instructor knowledge of material

3. Activity facilitation

iii. Activity 1.6: Qualitatively review reported opinions of the course

iv. Activity 1.7: Qualitatively review reported strengths and weaknesses of the course

2. Goal 2: Evaluate opinions of practical application from training

a. Objective 2.1: Determine if trainees feel confident in abilities learned in course through completed surveys.

i. Activity 2.1: Review course surveys, identifying trainee's confidence in:

1. Recognizing sign and symptoms of mental illness

2. Reaching out to someone who may be dealing with mental illness

3. Assisting a person who may be dealing with a mental health problem or crisis to seek professional help.

3. Goal 3: Review course demographics
    a. Objective 3.1: Determine the population that has been participating in courses in this area
        i. Activity 3.1: Review survey data
            1. Race/ethnicity
            2. Age
            3. Gender
            4. County
            5. Organization
        ii. Perceptions, by age, gender.
        iii. Confidence based on different demographics.
        iv. Descriptive. Overall. Data by instructor. Racial. Economic. Year 1, 2, and 3.
4. Goal 4: Recommendations for future Adult Mental Health First Aid courses.

While this evaluation focuses on Adult Mental Health First Aid courses, Region 6 Behavioral Healthcare also provides Youth Mental Health First Aid courses. There is data and preliminary results (Appendix D) from these courses, but will not be included in the further review of the evaluation methods and results.

Methodology

Study Design

This evaluation adopted a mixed method approach. A set of primary data was provided to the researcher that included both quantitative and qualitative methods of data collection. The data set was collected from MHFA Adult course participants over a three-year timeframe, 2015-2017.

Data set included:

Quantitative:

- Questionnaire survey of participants' knowledge, attitudes, and confidence in learned skills of the course.
- Questionnaire survey of participants' satisfaction with the delivery/presentation of the MHFA training, and areas for improvement administered at training.

Qualitative:

- Open-ended survey questions, asking participants' opinion of course strengths and weaknesses, overall thoughts, and areas to learn more.

Data Collection Methods

Over the data collection time period (2015-2017), course participants were provided with a multi-section questionnaire, at the end of their MHFA training in a classroom setting by the MHFA certified instructor. This questionnaire (Appendix A) was developed by MHFA

evaluators, and measured participants' quantitative satisfaction with the MHFA training. The questionnaire also quantitatively collected participants' ideas on the practical application of learned skills, including knowledge ("Recognize the signs that someone may be dealing with a mental health problem"), attitudes ("Recognize and correct misconceptions about mental health and mental illness as I encounter them.") and confidence ("Assist a person who may be dealing with a mental health problem or crisis to seek professional help.") around mental health issues at pre-training and post-training. Responses to the knowledge, attitudes, and confidence items were responded to on a five-point Likert Scale (1 = *Strongly Disagree*; 5 = *Strongly Agree).* It also included demographic information (e.g., age, gender, race).

Qualitative data came from the same questionnaire survey. The four open-ended survey questions analyzed were:

22. What is your overall response to this course?

23. What do you consider to be the strengths of the course?

24. What do you consider to be the weaknesses of the course?

25. Was there any issue/topic you expected this course to cover which is did not address?

Analysis

Quantitative: Descriptive statistics are provided to detail the overall satisfaction of the course across the sample, as well as to describe demographics of course participants. Frequencies (means and percentages were calculated) in SPSS Statistics 22 package (IBM).

Qualitative: Analysis took place by scanning the set of responses, themes developed that reflected the items noted in the material. Each theme was broken down into clear, mutually exclusive and exhaustive categories so that any response segment could be assigned to just one, and assigned the corresponding code value. Codes were not preconceived, but observed: each new code marked a discrete idea not previously raised.

Many of the questions received no responses, both quantitatively and qualitatively. These were not taken into account when calculating mean responses or identifying themes.

Participants

From the years 2015-2017, 1635 individuals attended an Adult MHFA training course. Questionnaire data were collected from 1425 course participants who had attended a training in the Region 6 area, over a three-year period (2015- 2017). Participants included religious leaders, law enforcement/corrections personnel, school/university employees, various community organizations, and community members. There were 104 training groups in this three-year time frame. The majority of trainings took place in a one day, 8-hour session. The number of participants ranged from 4 to 31 participants per training.

Results

The majority of participants (87%) completed the evaluation forms. The most common reason for missing evaluations include participants leaving before the end of the training. Of the 1425 course participant characteristics included: Age% 25- 44 = 53.5; Female % = 73.1; Caucasian/White % = 73.8, other demographics Table 1. Below.

Table 1. Demographics of Participants

		Demographics				
	2015		2016		2017	
	(n=)	(percent)				
Total Course Participants	428		490		717	
Total Eval	379		456		59 0	
Gender						
Male	64	16.9	150	32.9	130	22.0
Female	300	79.2	295	64.7	446	75.6
No Response	15	4.0	11	2.4	14	2.4
Age						
16-24	32	8.4	50	11.0	89	15.1
25-44	198	50.7	247	54.2	318	53.8
45-60	111	29.3	113	24.8	123	20.8
61-80	32	8.4	34	7.5	43	7.3
No Response	12	3.2	12	2.6	17	2.9
Race						
American Indian or Alaskan Native	9	2.3	3	0.7	10	1.7
Asian	5	1.3	8	1.8	20	3.4
Black or African American	39	10.3	45	9.9	48	8.1
Hispanic or Latino origin	38	10.0	55	12.1	31	5.3
Native Hawaiian or other Pacific Islander	0	0	3	0.7	1	0.2
Caucasian/ White	271	71.5	316	69.3	464	78.6
No Response	17	4.5	26	5.7	16	2.7

The (N=) in heading rows represents the highest number of individual responses from those who attended trainings in Region 6. Some questions were not answered by all respondents, non responses have been reported.

Findings from data collection focus on their perceived opinions of the program and its impact on their understanding of mental health issues and their confidence to respond. These include general perceptions of the presentation of content and the processes involved, expectations concerning the program and its impact on knowledge, skills and confidence level. Overall, the participants that completed the evaluation forms found the course to be good; where communication of course goals, the presentation of content, and skill application statements were mostly scored with Agree/Strongly Agree.

Section I of the questionnaire rated the course overall, for clear goal communication, achievement of objectives, understandability, and opportunities to practice skills. The group mean rating from these four questions came out to 4.64 (Agree/Strongly Agree). This is an encouraging number meaning participants thought highly of the course as a whole. In section III of the questionnaire, questions on confidence in skills and knowledge learned from the course (all questions can be seen in Appendix A). The group mean of these questions equals 4.55 (Agree/Strongly Agree). (Mean answers for all questions can be seen in Table 3, Appendix B).

Details of mean ratings, percentages, and relevant comments for each identified theme of the training are provided in the following section. Tables of the following themes and subthemes can be seen in Table 4. Strength Themes (Appendix C) and in Table 5. Weakness Themes (Appendix D).

Learning Methods

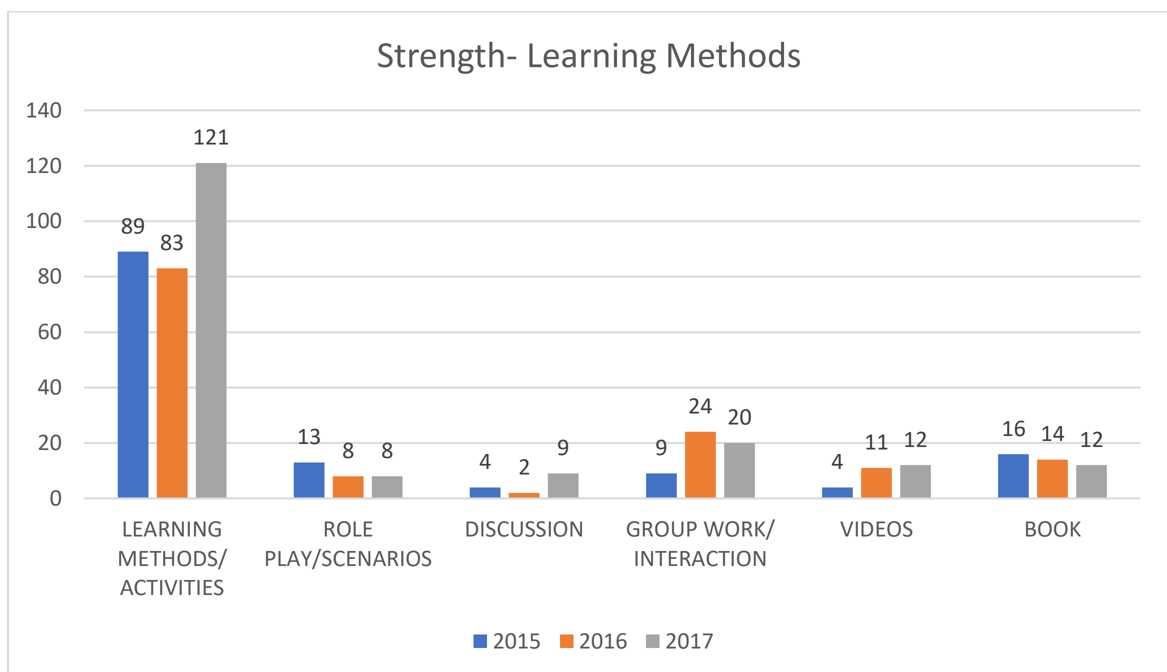
Analysis of comments revealed that the greatest strength of the course was the variety of learning methods used to teach this amount of material. Group interaction provided a

powerful method of allowing participants to formulate a deeper understanding of issues discussed during the course. Course participants collectively reported learning methods a total of 292 times. Learning methods of the course include; videos, book, PowerPoint Presentation, role play activities, scenarios, group discussion, and several other group work activities. Figure 1. shows frequencies of reported subthemes.

Examples of typical comments are given below:

> "The book you give us. The videos were helpful. Having things for kinesthetic learners. Offering variety of activities to keep it participatory as long as they are engaging."
>
> "The group activity for learning to understand talking to someone who has hallucinations."
>
> "Love that we can keep the book to refer to in the future."
>
> "Good material, meant for different learning styles."

Figure 1. Reported Learning Method Subthemes



Weakness of Learning Methods

While the above aspects proved to be strengths, weaknesses of this theme include comments on outdated videos (n=36) and the book and PowerPoint presentation not being matched up with the book (n=30). Some comments revealed suggestions that they would like more videos but in an updated version. Several other comments include:

> "Some of the videos seemed older, made me question how updated some of the info is- does it reflect changes made with the DSM5 vs DSMIV"
>
> "Videos could have been more up to date"
>
> "Organization of presentation and book do not match."
>
> "Textbook was a little hard to follow (the order of the content on the slides versus order of content in the book...a lot of flipping back and forth)"

<u>Presentation</u>

This theme related to perceptions regarding the way in which the course was delivered. The quality of the presentation combined with the knowledge and passion of the instructors, provided the base for successful course. 188 participants across the three years recorded that the strength of the class was due to the presentation of the material. The presentation style theme includes three subthemes: Knowledge/Experience (n=76), Organization (n=33), and Engaging (n=20) (Figure 2). Overall, the median rating for the Instructors skills (presentation skills, knowledgeable, activity facilitation) was 5 (Strongly Agree). Ratings of Instructors were consistently high across the different groups. These comments focused particularly on the Instructors' ability to explain information clearly, clarify information with relatable real-life

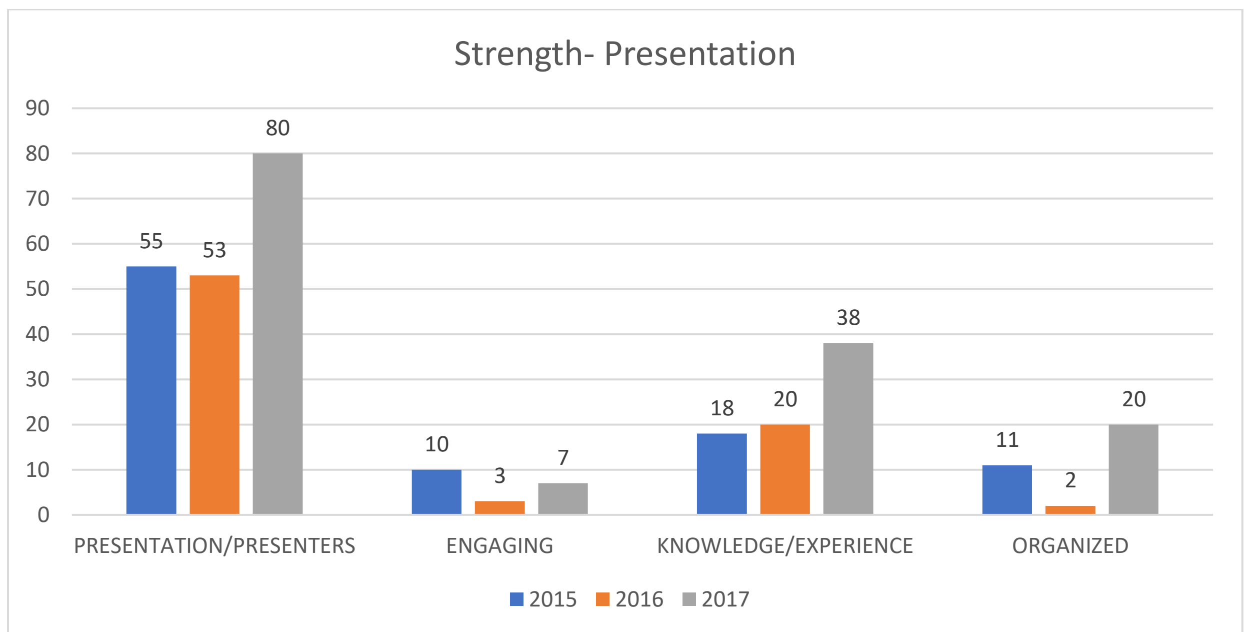
stories, praise for engagement, approachable style, and willingness to take time to answer personal questions.

Examples of typical comments are given below:

> "Quality of presenters and their sharing of examples, exercises, and experiences."
>
> "The instructors are both very personable and relatable. They presented the information very well."
>
> "The instructors were positive and compassionate and there was lots of discussion and engaging interaction."
>
> "Everything was presented well and in a good order"

Given the subject matter, it was also important that courses were delivered in a way to combine serious aspects of mental health with more light-hearted perspectives. The Instructors actively applied this approach which helped promote learning and enjoyment.

Figure 2. Reported Presentation Subthemes



Weakness of Presentation

One of the major weaknesses that falls into this theme is the length of the course and the amount of information presented in the timeframe. The most common weakness to be reported was related to the length of the course (n= 179), following. Another 77 participants reported the amount if info for timeframe seemed like a lot in one 8-hour session. From these comments came several suggestions from participants as well, for example splitting up the course into two sessions and having a session for professionals.

Examples of other comments can be seen below:

> "Length of time, but also understand there's a lot of info to cover"
>
> "The material has to be gone over so quickly"
>
> "Topic is broad/vast has to be covered in short amount of time."
>
> "8 hrs is long! Is there any way it can be shortened?"

Content

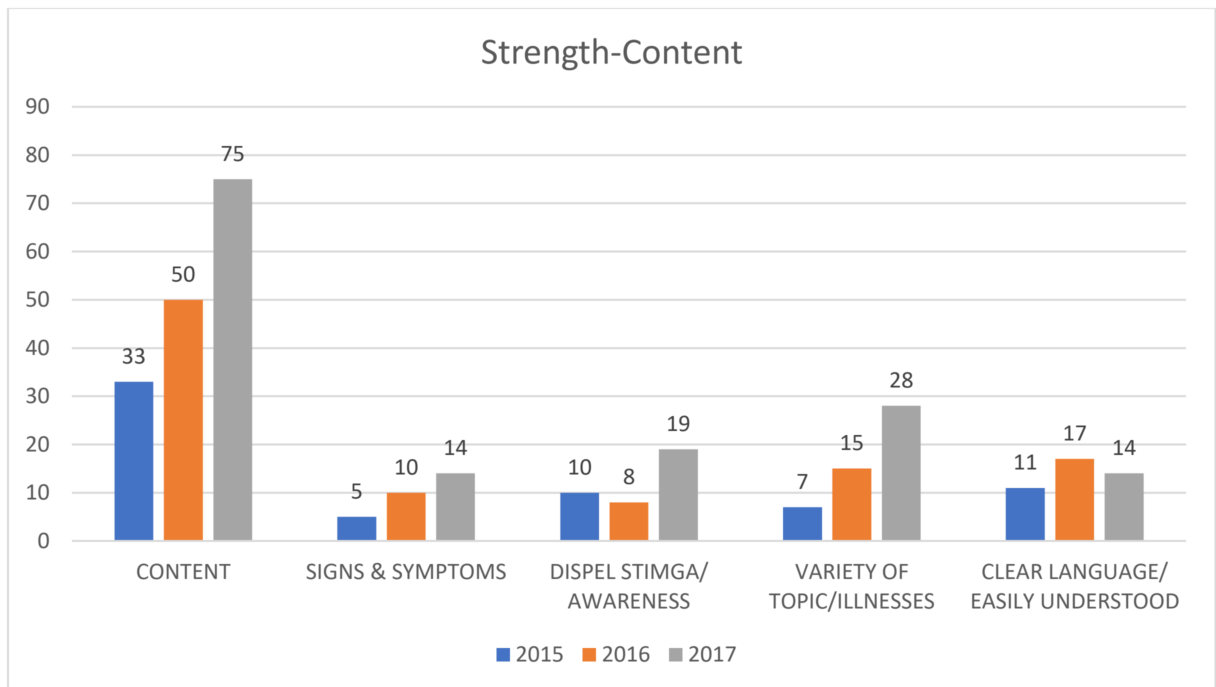
There was broad agreement that the content offered in the program was of a high quality and introduced a much greater level of understanding of mental health. The extensiveness and depth of information provided participants with an appreciation of the diverse conditions within the mental health spectrum and a deeper understanding of how these were experienced by people. Content of the course was the third most reported strength of the course, with the n= 158. Comments on the course content section included; signs and symptoms of mental illnesses, dispelling stigma and raising awareness, the variety of illnesses

discussed, and the clear and understandable language used throughout. Figure 3 shows frequencies of these reported subthemes.

Examples of typical comments are given below:

> "Good info - ability to clarify symptoms/signs of disease."
>
> "Making us aware of some things we might have been doing in an effort to help that may not have been helpful. Making us aware of the things we should NOT say or do in a crisis"
>
> "Helping us get a better view of what someone suffering a mental illness might feel."
>
> "Using basic language for everyone to understand."

Figure 3. Reported Content Subthemes



Weakness of Content

However, participants stated as a weakness that they did not seem to receive enough real-life examples, or have ample amount of time to practice the skills learned in the class. Comments disclosed that participants would have liked more examples regarding certain populations in order to connect skills to the real world. Other comments stated:

> "I wish the parts about addressing mental illness had a more instructive portion with role playing or practice."
>
> "Not enough real-life situations presented to help connect material to reality."
>
> "I wish there had been more time to run through more scenarios or watched more examples of the application of MHFA."
>
> "Specific application of the information to our job serving patron"

Action Plan

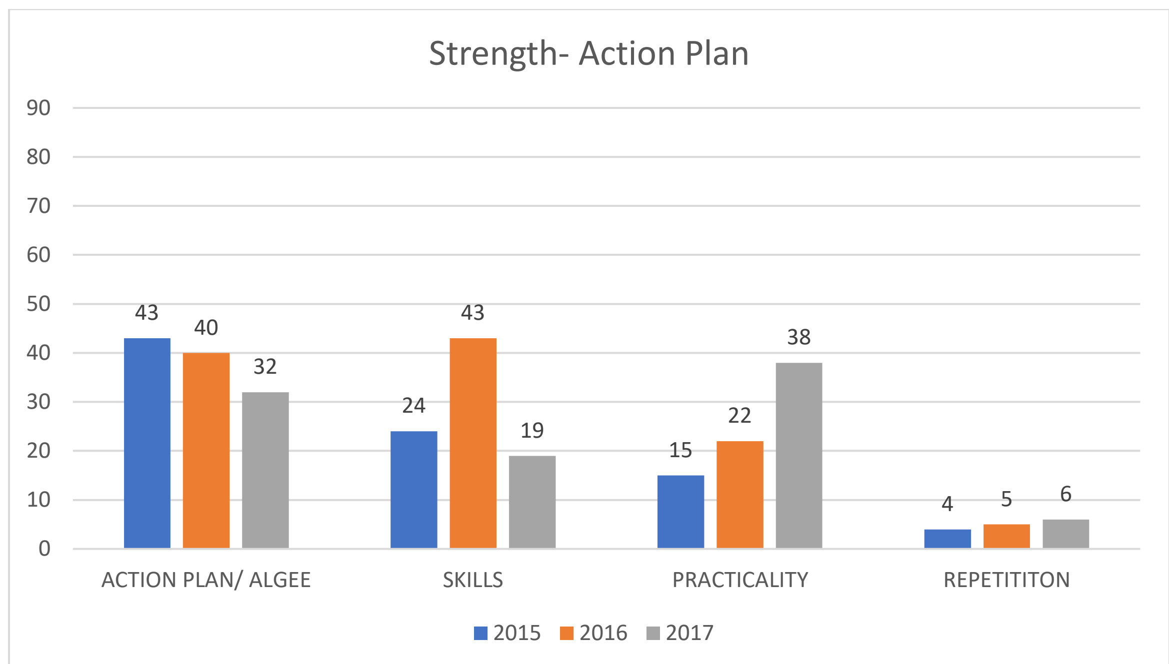
The Action Plan taught in the course seemed to help strengthen the learning taken away from the program, providing a means of drawing on the knowledge and awareness obtained, and putting it into practice. The Action Plan (ALGEE) was beneficial in providing an organized approach that could be applied simply and quickly in a variety of situations. The comments of this theme referenced the following components that made it a strength; the skills learned while using ALGEE, the practicality of if in the "real-world", and the repetition to make the strategy stick. Figure 4. Shows frequencies and reported subthemes of the action plan.

“the ALGEE response system is easy to consistently implement”

“Very good practical applications. I wish everyone had training like this.”

“Re-affirming the ALGEE theme in every type of application helped to get the message clearly”

Figure 4. Reported Action Plan Subthemes



Weakness of Action Plan

When using ALGEE in a real-life setting the use of community resources is a much-needed resource in crisis situations. A more expansive list of mental health resources in the Omaha area was requested several times from course participants (n=18).

“Would like even more info on community supports and resources.”

"Need to provide a list of resources available in the area. one hotline and a card is not enough…"

"I wish I had a list of specific people/places to refer people to."

"Would appreciate a list of specific resources in Omaha."

Discussion/Recommendations

This evaluation reflects the positive findings from earlier evaluations with smaller sample sizes (Borrill 2013; Brandling & McKenna, 2010). Overall, Adult MHFA trainings through Region 6 Behavioral Healthcare have received positive feedback in regards to its learning outcomes, presentation of course content, and the methods used. It was also found that participants believe that they received a good grasp on the skills learned in the course, and have sufficient opportunities to practice skills. However, there is still a need for more practice and application of these skills. Participants call for more real-life examples and the application of these skills to these examples. In order for this to occur in future courses, there is a need for participants to bring their examples and experiences of mental illness to the class. In turn, this can create a dialogue and create for role-playing scenarios to take place. This evaluation reinforces existing evidence that MHFA increases knowledge about mental health, increases participants confidence to help others, and support people in a mental health crisis.

Limitations of the evaluation

This evaluation relies on retrospective surveys. These retrospective surveys are based on a self-report and, therefore, remain an estimated report. Participants can also exhibit

subject bias since they are actively trying to improve their skills and want to see improvement (Pratt et al., 2000). Recall can also be impacted when the length and/or specificity of the pertinent time period is too broad or undefined. The data may be skewed towards participants with a mental health background, females, and age range. There is also a limitation due to several evaluation questionnaires not being entirely completed or participants leaving before evaluations were distributed.

Recommendations

Mental Health First Aid presenters have no control over the course content or methods used to deliver the course. There is not a way for them to alter those components of the program, for they have to teach the course to fidelity. With that, course presenters cannot change the course videos, book content, PowerPoint material, ALGEE etc. However, there are several things that they can change or add in order to potentially increase the effectiveness of the course. In terms of recommendations for the future of the course, several suggestions can be made including; useful things for trainers to know; strategic plan for the future; improvement to the course and processes, communication and coordination.

Course presenters may need a refresher on things that they should stress to the course participants. This refresher should focus on the fact that the course is first aid and not to treat mental illness, the course is meant to be repetitive in order to learn the skills needed to help, and to give the students a reminder about where to follow along in the book. Another useful thing for trainers to know to help deliver courses would be the nature of the community that they are presenting to. Having knowledge on the audience can potentially create for a

smoother and more open environment, so those real-life examples can be shared and provide context when outside of the course.

To understand the sustainability of the impact of MHFA on the mental health literacy of individuals, long term follow-up would be recommended. Perhaps individuals could be tested again after six months to see if information has been retained and also how their perceptions of mental health have developed. Also, for future evaluations it would be beneficial to include a pre-course evaluation of participants knowledge and awareness. This would help eliminate the retrospective design, allowing for more concrete answers from participants. A key way to enhance the quality of primary data collection is through a pretest. The pretest would need not to be too complex, but should cover enough to determine issues of the logistics of the course and data collection.

There is a need to get more community members to take this class. Many of the organizations and participants that took the class in this three-year timeframe work in an area closely related to mental health. Greater promotion of the course and targeting of community members could potentially increase the number of these individuals who take the course. The latest promotion for MHFA is be 1 in 1 Million, referring to the 1 million first aiders who have been trained in the last 10 years (MHFA, 2016). Perhaps greater advertisement of this promotional material in Region 6 community would increase course attendance. In places such as clinics, agencies Region 6 partners with, and the Region 6 website. Somewhere that the population can see that this is available to them, easy to sign up for, and no cost.

In the mental health field, educators and law enforcement are important for they often encounter individuals with mental illness. While these evaluations do get the participants

overall thoughts and their occupation on a supplemental form, there is no way to link the occupation back to their responses. If there was a way for future evaluators to do this, it could lead to more insight on what certain parts of the community would like to see more of in the trainings and what may or may not be successful in their fields of work. Perhaps a small fix for this would be to give all the surveys a unique number, separate form the number that MHFA gives the evaluation. By doing so the supplementary data can be paired with responses at a later date.

Conclusion

The aims of Mental Health First Aid courses are to improve mental illness recognition, improve mental health literacy, improve access to mental health support, and reduce the stigma surrounding mental health issues (Kitchener & Jorm, 2008). Along with previously published research, this evaluation has concluded that MHFA courses can help address stigma and raise awareness surrounding mental health issues (Hadlaczky et al., 2014). The findings from this evaluation also support reported evidence that MHFA is an effective program for increasing participants' knowledge relating to mental health, and increasing confidence and skills for recognizing and helping people with mental health illnesses (Kitchener & Jorm, 2006; Hadlaczky et al., 2014).

This evaluation of the Adult MHFA course has investigated the effectiveness of a variety of factors; presentation, learned skills, course content, length of course, and the ALGEE action plan. Findings support previous research identifying similar themes being reported by course participants. However, there does not seem to be research that covers three years of course

evaluations. These findings provide evidence that the Adult MHFA course delivered through Region 6 Behavioral Healthcare, have helped to improve mental health knowledge, increase the awareness, and reduce the stigma that often follows mental illness among course participants. This evaluation report concludes that a straightforward course like MHFA can positively influence mental health knowledge, awareness, and support skills, among the population of the Region 6 area.

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Service Learning/Capstone Experience Reflection

Describe the experience with the placement site.

-What did you learn about the organization?

Throughout this experience, I learned that Region 6 Behavioral Healthcare is an organization that has many different operations going on all under one roof. From housing services, partnering program, to prevention services. All come to together for the goal of providing a system of quality behavioral health services. Even though I have always had an interest in mental health, I did not think about all the assistance that this population may need. I learned that this is an organization that provides those much-needed services to this population in the community. I have found that they organize and provide efficient and effective services to their clients and partners. I know that the organization puts a lot of hard work and thought in to all of their projects whether that be their prevention services, housing, or partner program. It was really refreshing to see this approach to mental health care, and gave me insight as to what I hope to have and am looking for in a career.

-What was different than what you expected when you started the project?

The main thing that was different than what I expected was the thought I would have a lot more time to experience more and put things together. I guess that is how most things go, the semester started and quickly filled with SL/CE activities, mixed together with course materials. This did require me to make some adjustments to me project. But I do believe that the ending result answers questions that needed to be answered.

Describe how SL/CE activities were performed: what, where, when, with whom, how long, etc.

-What resources, relationships, and skills permitted these activities to occur?

Many new experiences took place during my SL/CE activities. The first activity that I took on during the project was the dissemination of a program through bringing together materials/ packets for a suicide prevention program called Question Persuade Refer (QPR). Materials included, feedback form for trainees to fill out, several instruction pages for the trainer, and QPR books for each trainee. This activity was able to happen due to the help of my Preceptor Crystal giving me a detailed overview of how the packets should look and be put together. I am a very visual learner, so this helped me a great deal throughout this activity. The whole Region 6 office was also very accommodating to my having to print so many pages, which I very much appreciate. To go along with the QPR materials, several packets came back to Region 6 and I finished filling out the Training Activity Summary Page (TASP), a summary information about training events sponsored by GLS state and tribal grantees. Again, Crystal made it uncomplicated for me to ask questions about how to fill the forms out. Knowing that Crystal had and open door for me to come and ask questions made all of the activities that I preformed unproblematic and able to accomplish. I think that this portion of my Service Learning Activities turned out to be my greatest accomplishment. I am glad that I was there to provide this service for Region 6, in order for them to get so many trainings fulfilled. During this activity I learned how to be an organized worker by checking the training materials for accuracy, and I also quickly became comfortable in my new surroundings, something that has always been difficult for me.

Several other eye-opening activities that I got to take part in during this project were several meetings including a Behavioral Health Advisory Committee meeting and a substance abuse prevention epidemiology outcomes workgroup meeting. This workgroup of administrators, epidemiologists, and key decision makers collaborate to make decisions regarding the collection

and reporting of data related to substance use, consequences of substance abuse, and factors that contribute to substance abuse in the state of Nebraska. One of the main things that stood out to me in this meeting was the overview of the most recent epidemiological profile of substance abuse in Nebraska. The profile includes so much data that is beneficial to the state to further establish a set of criteria and facilitate the selection of the state substance abuse prevention priorities. This experience gave me such a good idea as to what issues may be able to be tackles and programs implemented in the state of Nebraska in the future.

Lastly, I utilized my skills of data management and organization and added survey data from MHFA courses from fiscal year ’17 to the data set. This allowed me to preview the data collected from these MHFA trainings. This activity gave me good introduction to how this data currently presented and laid out. It made me more comfortable with my capstone activity of program evaluation, thinking of a way to present the data in a way that is identifiable, easily understood, and ethically sound.

What were the greatest challenges of your Service Learning experience?

-How did you address and overcome those challenges?

The greatest challenge of this Service Learning experience was the effort that if took to get started. The hardest part of the whole process was choosing an organization and a project that may be beneficial to the organization. I wanted a project that would be much needed and also interesting to me. There is no need to do something if there is no personal interest in the matter. I also did not want to be a burden to the organization and provide a useful service to them and their efforts. It is my hope that the services that I provided did help Region 6 in their programs and prevention work.

Working through these challenges, I stuck with the process that UNMC COPH had planned out for us students. While it may have taken me little bit to find and organization, it finally did come around. Trusting the process did work. But advocating for me, asking the right questions, and reaching out to Region 6 turned out to be my best choice.

What were the most important insights that you have from both your Service Learning and your Capstone Experience?

I do feel that I have grown a lot as a public health professional by helping implement a mental health education program, evaluating an education program, and working in a behavioral healthcare setting. This project helped continue my development and understanding of using new information systems, communicating with new populations, understanding new (to me) public/mental health issues, concerns, and needs of the population to work collaboratively to improve population health. As a soon to be public health professional I believe that I will be competent in the skills of program planning, implementation, data management, program evaluation, and relaying information.

Some main takeaways for me from this project include improvements time management and efficiency, the ability to cope with strangers and working in an office setting, communication and presentation skills, and the capacity to draw on learned knowledge to solve problems. I feel proud of the growth and progress I have made, the things that I have learned, and how I have grown in knowledge and confidence in my ability to be successful in the public health field.

How have your views of public health practice been impacted by your SL/CE?

Everyone who works in public health share the goal of preventing disease and promoting health and wellness to all. Through doing work at Region 6 I have seen that individuals there share that idea and made me excited to get out into the field to put my skills to use. Public health practice has so many different activities, from public health observation, community-based prevention and health promotion programs, health assessments, and evaluation of public health activities. I am happy that I got to be a part of several activities in my time at Region 6, and have the information found in my evaluation be used to improve the effectiveness of Mental Health First Aid. That is a rewarding feeling to me. In this public health setting, I have learned that it is important to always have a vision on what the next step is in a project. This will be useful for me in my career.

APPENDIX A

POST-COURSE QUESTIONNAIRE

MENTAL HEALTH FIRST AID

8hr Course Evaluation Form

Location of the MHFA course:____
Dates of MHFA course:____
MHFA Instructor(s):____

I. Overall Course Evaluation

		Strongly Disagree	*Disagree*	*Uncertain*	*Agree*	*Strongly Agree*
1.	Course goals were clearly communicated.	1	2	3	4	5
2.	Course goals & objectives were achieved.	1	2	3	4	5
3.	Course content was practical and easy to understand.	1	2	3	4	5
4.	There was adequate opportunity to practice the skills learned.	1	2	3	4	5

II. A. Presenter Evaluation: Instructor _______________________

		Strongly Disagree	*Disagree*	*Uncertain*	*Agree*	*Strongly Agree*
5.	The Instructor's presentation skills were engaging and approachable.	1	2	3	4	5
6.	The Instructor demonstrated knowledge of the material presented.	1	2	3	4	5
7.	The Instructor facilitated activities and discussion in a clear and effective manner.	1	2	3	4	5
8.	Feedback for this Instructor?					

III. B. Presenter Evaluation: Instructor _______________________ (Leave blank if only one instructor)

		Strongly Disagree	*Disagree*	*Uncertain*	*Agree*	*Strongly Agree*
9.	The Instructor's presentation skills were engaging and approachable.	1	2	3	4	5
10.	The Instructor demonstrated knowledge of the material presented.	1	2	3	4	5
11.	The Instructor facilitated activities and discussion in a clear and effective manner.	1	2	3	4	5
12.	Feedback for this Instructor?					

III. Practical Application

	As a result of this training, I feel more confident that I can...	*Strongly Disagree*	*Disagree*	*Uncertain*	*Agree*	*Strongly Agree*
13.	Recognize the signs that someone may be dealing with a mental health problem or crisis.	1	2	3	4	5
14.	Reach out to someone who may be dealing with a mental health problem or crisis.	1	2	3	4	5
15.	Ask a person whether s/he is considering killing her/himself.	1	2	3	4	5

Over please →

16.	Actively and compassionately listen to someone in distress.	1	2	3	4	5
17.	Offer a distressed person basic "first aid" level information and reassurance about mental health problems.	1	2	3	4	5
18.	Assist a person who may be dealing with a mental health problem or crisis to seek professional help.	1	2	3	4	5
19.	Assist a person who may be dealing with a mental health problem or crisis to connect with community, peer, and personal supports	1	2	3	4	5
20.	Be aware of my own views and feelings about mental health problems and disorders.	1	2	3	4	5
21.	Recognize and correct misconceptions about mental health and mental illness as I encounter them.	1	2	3	4	5

22. What is your overall response to this course?

23. What do you consider to be the strengths of the course?

24. What do you consider to be the weaknesses of the course?

25. Was there any issue/topic you expected this course to cover which it did not address?

26. How did you hear about this course? (circle all that apply)			
a.	My employer asked/assigned me	**f.**	A newsletter/bulletin *which one?*
b.	Word of mouth, not employer *who?*	**g.**	Radio *station?*
c.	A website *which site?*	**h.**	Newspaper *which paper?*
d.	Email notice *from whom?*	**i.**	TV *station?*
e.	Flier or brochure *where obtained?*	**j.**	Other:

27. Would you recommend this course to others? ___Yes ___No

28. What is your gender? ____ Male ____ Female

29. How do you describe your race / ethnicity? (Please circle all that apply)			
a.	American Indian or Alaskan Native	**e.**	Native Hawaiian or other Pacific Islander
b.	Asian	**f.**	Caucasian / White
c.	Black or African American	**g.**	Other:
d.	Hispanic or Latino origin		

30. What is your age?									
a.	16-24 years	**b.**	25-44 years	**c.**	45-60 years	**d.**	61-80 years	**e.**	81 years or older

APPENDIX B

Table 1. Males and Females

	Frequency	Percent
No Response	40	2.8
Males	344	24.1
Females	1041	73.1
Total	1425	100.0

Table 3. Sec 1 & Sec III

Question #	N	Minimum	Maximum	Mean
1. Goals clearly communicated	1412	1	5	4.63
2. Goals and objectives achieved	1409	1	5	4.61
3. Content practical and easy to understand	1408	1	5	4.65
4. Adequate opportunity to practice skills	1408	1	5	4.65
13. Recognize signs & symptoms	1414	1	5	4.53
14. Reach to someone dealing w/ problem or crisis	1414	1	5	4.52
15. Ask a person whether s/he is considering killing her/himself	1414	1	5	4.53
16. Actively listen to someone in distress	1415	1	5	4.60
17. Offer basic "first aid" level info.	1415	1	5	4.52
18. Assist person in crisis to seek professional help	1415	1	5	4.53
19. Assist person to connect with supports	1414	1	5	4.52
20. Be aware of own views/feeling about disorders	1413	1	5	4.60
21. Recognize misconceptions	1297	1	5	4.57

Table shows n= the amount of questions in which participants answered, and thus used to calculate mean answers. Each question had answers from 1 (min) through 5 (max).

APPENDIX C

Table 4. Strength Themes

Year	2015		2016		2017	
	N	%				
LEARNING METHODS/ ACTIVITIES	89	42	85	37	121	27
ROLE PLAY/SCENARIOS	13		8		8	
DISCUSSION	4		2		9	
GROUP WORK/ INTERACTION	9		24		20	
VIDEOS	4		11		12	
BOOK	16		15		12	
PRESENTATION/PRESENTERS	55	29	53	20	80	29
ENGAGING	10		3		7	
KNOWLEDGEABLE/EXPERIENCE	18		20		38	
ORGANIZED	11		2		20	
CONTENT	33	10	50	13	75	15
SIGNS & SYMPTOMS	5		10		14	
DISPEL STIMGA/ AWARENESS	10		8		19	
VARIETY OF TOPIC/ILLNESSES	7		15		28	
CLEAR LANGUAGE/ EASILY UNDERSTOOD	11		17		14	
ACTION PLAN/ ALGEE	44	13	40	10	32	6
SKILLS	25		43		19	
PRACTICALITY	15		22		38	
REPETITITON	4		5		6	

**subthemes include comments that further explained the main themes.*
*** Only valid responses were used in identifying themes (non-responses not included)*
**** % will not equal 100 as there were misc. responses that did not fit into themes*

APPENDIX D

Table 5. Weakness Themes

	2015	2016	2017
LENGTH	52	47	80
AMOUNT OF INFO FOR TIMEFRAME	14	18	45
FEW REAL-LIFE EXAMPLES	10	14	22
LIMITED APPLICATION/ PRACTICE OF SKILLS	10	17	23
OUTDATED VIDEOS	6	15	15
NO RESOURCES PROVIDED	4	3	11
BOOK AND POWERPOINT DISJOINTED	8	13	9

Figure 5. Reported Weakness Themes

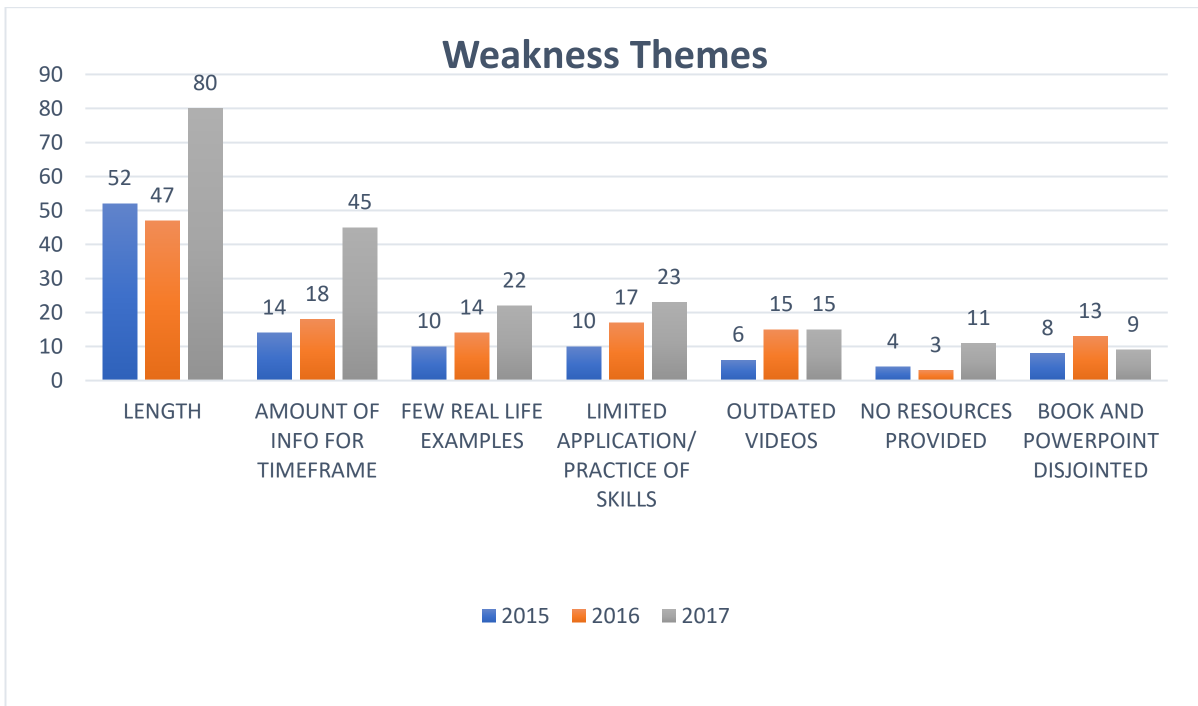

Table 6. Youth MHFA Preliminary data

Youth MHFA				
	2016		2017	
Total (n, %)	41		131	
Females	32	78	109	83.2
Males	8	19.5	20	15.3

No Response	1	2.4	2	1.5