MENtal health first aid in The wORkplace (MENTOR): A feasibility study

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Research report

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Abstract

Background

Mental Health First Aid (MHFA) is an international training programme which trains individuals to recognise the signs and symptoms of mental health problems. This enables them to initiate appropriate responses, such as listening, advising and signposting to other supports and services. In the UK, employers are increasingly funding members of their workforce to receive MHFA training, as it is regarded as an effective public health intervention for improving knowledge, attitudes and behaviours towards mental health problems. However, MHFA is not specifically a workplace intervention and there has been little research conducted around its impact in the workplace or on the mental health of those receiving this support. The aim of the MENTOR study (MENtal health first aid in The wORkplace) was to investigate the implementation, use and utility of MHFA in the workplace.

Methods

There were three parts to the study. The first part was a scoping review to identify other training courses addressing mental health and suicide awareness used in workplaces. These were then compared with MHFA. The second part was a survey to investigate the extent and variability of the implementation of MHFA in organisations where at least one member of the workforce had received MHFA training. The third and final part involved interviewing participants from some of these organisations in order to gain richer insight into workplace MHFA implementation, use and utility.

Results

The findings of the scoping review suggested that other mental health courses and initiatives were available and used in workplaces. Although contents were broadly similar, costs were variable. Survey and interview data suggested that the active ingredients of successful workplace MHFA included clear rationales for introducing training, well-motivated MHFA coordinators and the existence of MHFA networks. Barriers to organisational success of the MHFA programme within organisations included the challenges around measuring impact, establishing boundaries within the role of the MHFA-trained person and inconsistent strategies for identifying trained workplace members and promoting their role. Specific issues around MHFA courses were also identified, including duration of the courses, opportunities for evaluating MHFA in the workplace and refresher training.

Conclusions

MHFA is one of a number of programmes to raise awareness of mental health issues in the workplace but seems to be the most widely used. Although the majority of survey and interview participants were largely positive about MHFA, a number of areas were identified which merit further attention: the use of training by organisations as a way of demonstrating that they were taking mental health seriously; inadequate operationalisation of boundaries for the trained person; and concern around the lack of evidence for MHFA. Focus should also be centred on whether and how the impact of MHFA on end users can be measured and recorded. Without further research and evaluation into the effectiveness and cost-effectiveness of MHFA training, it cannot be ascertained whether MHFA is the best means of addressing and managing mental health issues in the workplace.

Executive summary

Background

Mental health problems cost the UK economy between £70 billion and £100 billion annually and account for around 15.8 million working days being lost per year. For employers, the consequences of poor mental health among the workforce can include increased staff turnover, burnout, exhaustion and presenteeism. The annual cost to UK employers is estimated to be between £33 billion and £42 billion, aside from the personal costs to the individual. There is therefore increasing recognition of the need to address mental health in the workplace, and a number of initiatives have arisen in response.

Mental Health First Aid (MHFA) is an international programme which trains individuals to recognise the signs and symptoms of mental health problems. This enables individuals to initiate appropriate responses, such as listening, advising and signposting to other supports and services. In the UK, employers are increasingly funding members of their workforce to receive MHFA training, as it is regarded as an effective public health intervention for improving knowledge, attitudes and behaviours regarding mental health problems. However, MHFA is not specifically a workplace intervention and there has been little research conducted around its impact or success in the workplace or on the mental health of those receiving MHFA.

Aims

The study sought to investigate the implementation, use and utility of MHFA in the workplace. The objectives were:

- to investigate the extent and variability of the implementation of MHFA in organisations where at least one member of the workforce had received MHFA training
- to explore the perceptions and experiences of key stakeholders regarding the active ingredients of MHFA, including the awareness, acceptability, delivery and impact of MHFA within their organisation, and facilitators of and barriers to implementation
- to identify how the impact of MHFA might best be measured from the perspective of stakeholders, particularly employees who used MHFA support in the workplace
- to make recommendations as to the content and delivery of the intervention in the workplace, and how it could best address the mental health needs of employees.

Methods

The study had ethical approval, and was conducted in three parts.

The first part was a scoping review of workplace training courses in the UK that addressed mental health and suicide awareness. Internet searches were conducted using keywords. Specific information was extracted to enable a comparison of content, format, duration and cost.

The second part was a survey of organisations in which at least one person had attended MHFA training. Participants were asked to complete an online questionnaire exploring their perceptions around the implementation and use of MHFA in their workplaces. Data were subjected to descriptive

analysis to provide an overview of the extent and variability of the implementation of MHFA in different workplaces.

The final part was an interview study conducted with participants from a sample of these organisations in order to gain richer insight into workplace MHFA. Six organisations were selected from the public, private and third sectors. The lead contacts identified from the survey were recontacted and information about the interviews was circulated among the workforces of the six organisations. Semi-structured interviews explored the perceptions and experiences of the MHFA programme in relation to the workplace, including awareness, acceptability, delivery and impact. Mini case studies of the six organisations were produced, which provided descriptions and examples of implementation of MHFA in the workplace. Interview data were analysed thematically. Seven themes were identified that captured participants' thoughts around the implementation, use and facilitators of, as well as the barriers to, workplace MHFA.

Results

The scoping review identified 25 mental health awareness courses and 14 suicide awareness courses in the UK. For the survey, a total of 139 responses were received from 81 different organisations. Twenty-seven interviewees were recruited: four MHFA coordinators (who were also MHFA trained), nineteen MHFA-trained employees and four employees who were not MHFA trained. Seven themes were identified following analysis of the data.

The findings showed that other mental health courses and initiatives were available and used in workplaces. Although contents were broadly similar across courses, costs were variable. Survey and interview data suggested that the active ingredients of successful workplace MHFA included clear rationales for introducing training, well-motivated MHFA coordinators and the existence of MHFA networks. These elements appeared to contribute to a positive perception of workplace MHFA. Barriers to the success of the MHFA programme within organisations included the challenges around measuring impact and success, establishing boundaries within the role of the MHFA-trained person, and inconsistent strategies to identify trained workplace members and promote their role. Such factors were considered to restrict the success of the MHFA programme. In addition, specific issues around MHFA courses were identified, including duration, opportunities for evaluating MHFA in the workplace and the need for refresher training.

Conclusions

MHFA is one of a number of training programmes to raise awareness of mental health issues in the workplace, but seems to be the most widely used. Although the majority of respondents were largely positive about MHFA, a number of areas were identified which merit further attention, namely: the use of training by organisations as a way of demonstrating that they were taking mental health seriously, inadequate operationalisation of boundaries for the trained person and concern around the lack of supporting evidence for MHFA. Focus should also be centred on whether and how the impact of MHFA on end users can be measured and recorded. Without further research and evaluation into the effectiveness and cost-effectiveness of MHFA training, it cannot be ascertained whether MHFA is the best means of addressing and managing mental health issues in the workplace.

List of abbreviations

BITC	Business In The Community
BMJ	British Medical Journal
CEO	Chief Executive Officer
DH	Department of Health
DWP	The Department for Work and Pensions
EY	Ernst & Young
HR	Human Resources
IOSH	Institution of Occupational Safety and Health
IT	Information Technology
MENTOR	MENtal health first aid in The wORkplace
MH	Mental Health
MHFA	Mental Health First Aid
MHFAider	Mental Health First Aider
NHS	National Health Service
NIHR	National Institute for Health Research
OCD	Obsessive Compulsive Disorder
OECD	Organisation for Economic Co-operation and Development
ONS	Office for National Statistics
Org	Organisation
pp	Per Person
PTSD	Post-Traumatic Stress Disorder
REC	Research Ethics Committee
SME	Small and Medium Enterprises
SPSS	Statistical Package for the Social Sciences
UK	United Kingdom
VAT	Value-Added Tax

CHAPTER 1. INTRODUCTION AND OVERVIEW OF LITERATURE

1.1 Introduction to the research

In the UK, it is estimated that 1 in 6.8 people in the workplace have a mental health problem (1). As well as resulting in health and financial costs to both individuals and families, there are also significant costs incurred by employers, healthcare providers and the government. According to the Office of Economic Co-operation and Development (OECD), mental health problems cost the UK economy between £70 billion and £100 billion per year (2). Furthermore, around 15.8 million working days are lost per year due to mental-health-related sickness absence (3). Stress, depression and anxiety accounted for a loss of 23.8 working days per person in 2016/2017 – almost a week longer than the 17 working days lost for overall work-related ill health and non-fatal workplace injuries (4). For employers, the consequences of poor mental health among the workforce can include increased staff turnover, burnout and exhaustion (5). Additionally, an independent review into mental health (6) identified that the annual cost of mental health problems to UK employers was between £33 billion and £42 billion. For the individual, mental ill health may also lead to presenteeism (being at work but being unable to function effectively due to ill health), which constitutes the largest proportion of economic loss due to mental health problems (7).

There is therefore increasing recognition of the need to address mental health in the workplace. A government report highlighted the strong business case for workplaces to create inclusive environments to accommodate individuals with long-term conditions and disabilities (7). The Institution of Occupational Safety and Health advocates that mental health is given the same priority as physical health within the workplace (8). A number of approaches have emerged to address this, most notably the NHS's Mindful Employer initiative (9), which provides information to organisations; the charity Mates in Mind (10), which aims to increase understanding of mental health issues across the construction industry; and Mind's Workplace Wellbeing Index (11), which enables organisations to assess their approaches to workplace wellbeing.

Mental Health First Aid (MHFA) is an international training programme which trains individuals to recognise the signs and symptoms of mental health problems and crises, and initiate appropriate responses such as listening, advising and signposting (12). UK employers are increasingly funding members of their workforce to receive MHFA training, and it is considered to be an effective public health intervention for improving knowledge, attitudes and behaviours towards mental health problems (13). It has received government funding to train members of the public (14) and teachers (15). However, there has been very little research conducted to investigate the impact of MHFA on the mental health of workplace recipients. There is consequently little evidence of what the active ingredients of this intervention are and how MHFA is being implemented and used across different workplaces.

1.2 Research aims and objectives

This study sought to investigate the implementation, use and utility of MHFA in the workplace.

The research objectives were:

- to investigate the extent and variability of the implementation of MHFA in organisations where at least one member of the workforce had received MHFA training

- to explore the perceptions and experiences of key stakeholders regarding the active ingredients of MHFA, including the awareness, acceptability, delivery and impact of MHFA within their organisation, and facilitators of and barriers to implementation
- to identify how the impact of MHFA might best be measured from the perspective of stakeholders, particularly employees who used MHFA support in the workplace
- to make recommendations as to the content and delivery of the intervention in the workplace, and how it could best address the mental health needs of employees.

1.3 Background to the study

1.3.1 Addressing mental health in the workplace

Increasing people's awareness of mental health, reducing stigma, and promoting and facilitating early help-seeking are recognised as key strategies for a mentally healthy workplace (16). However, there remains a general lack of awareness and confidence among employers around how to provide support to employees experiencing mental health problems and how to access external support (5, 6). A survey conducted by Business in the Community and YouGov found that nearly a third of people in the workplace had a formal mental health disorder diagnosis, but only 13 per cent were comfortable in disclosing this to their line manager (17). Furthermore, 300,000 people living with long-term mental health problems are reported to lose their jobs each year (6). The World Health Organization suggests that implementing positive approaches to managing mental health within the workplace is likely to lead to less absenteeism, improved productivity and significant economic gains (18). This might include the creation of healthy working environments where the health and wellbeing of employees are promoted and protected.

The UK government has acknowledged the seriousness of poor mental health management in the workplace. The Chief Medical Officer's Annual Report into Public Mental Health Priorities suggested that managers should be trained to understand and recognise mental illness in the workplace (19). In addition, a commissioned independent review into workplace mental health support (6) found that only 39 per cent of organisations had implemented policies and systems to assist employees who had common mental health problems.

1.3.2 Current workplace mental health initiatives

Approaches and initiatives to address mental health in the workplace have been identified across various industries. These include the NHS initiative Mindful Employer, which provides information and resources to enable organisations to support members of their workforce who are experiencing mental health issues (9). The UK construction industry also launched a charitably funded project called Mates in Mind, which is informed by key mental health organisations. Using education and tools, the charity aims to improve understanding around mental health across the construction workforce (10). The mental health charity Mind has also developed the Workplace Wellbeing Index to enable organisations to assess their approaches to workplace wellbeing (11).

Companies are increasingly embedding the mental health agenda into their strategies to transform their workplace cultures. The construction company Willmott Dixon has launched the All Safe Minds campaign to promote mental health, achieve parity of esteem and improve mental fitness across the sector (20). Similarly, professional services firm EY is committed to its Thinking Differently strategy, which covers mental health awareness and prevention of mental health problems, and involves

reassimilation into work (21). In addition, Network Rail set up a strategy called Everyone Fit for the Future to encourage employees to take a positive approach to their wellbeing and improve their mental fitness (22, 23). A number of other specific training courses targeted towards mental health in the workplace have been identified and are presented in Chapter 2.

1.3.3 Mental Health First Aid

MHFA as a training programme aims to raise mental health literacy, which has been defined by Jorm et al. as "knowledge and beliefs about mental disorders which aid their recognition, management or prevention" (24). MHFA was developed in Australia in 2000 to increase awareness of mental ill health, improve attitudes and educate people about the ways to support those experiencing a mental health problem or crisis (25). It has since been adopted in over 20 countries (13). In England, approximately 1,300 instructors have received instructor training to deliver MHFA courses and over 200,000 people have attended the training to acquire MHFA skills (26, 27). MHFA teaches individuals how to identify the signs and symptoms of mental health problems and crises and how to respond appropriately, while promoting an open culture of conversations around mental health (12). There are different levels of training. Qualifications vary depending on which course is attended, with the two-day course enabling the trainee to attain Mental Health First Aider status. The one-day course enables the trainee to become a Mental Health First Aid champion, while the three-hour course makes attendees aware of the key issues (12). As well as standard training courses, MHFA England also provides a business-to-business service through its Client Experience Team (28), whereby organisations can receive a tailored training experience. UK employers are increasingly funding members of their workforce to attend training.

MHFA has been acknowledged as offering prompt and early intervention in the management of mental ill health. It is considered to be an effective public health intervention for improving mental health knowledge and attitudes, resulting in an increase in supportive behaviours towards people experiencing mental health problems (13). MHFA has been the focus of government funding, with Public Health England announcing its intention to allocate £15 million towards the training of up to 1 million people in MHFA skills (14). In addition, £5 million is being invested in training teachers to respond to the mental health needs of primary school children (15). MHFA is recognised as a strategy for engaging employers throughout the UK with mental health awareness and as such providing support for employers (17). A resource for line managers has been published (29), although it is not specifically a workplace intervention.

In the context of the workplace, MHFA would appear to have huge potential benefits for the management and support of employees experiencing a mental health crisis, with a consequent reduction in avoidable sickness absence. Anecdotal evidence has been captured in a range of organisational case studies on MHFA England's website, outlining how MHFA training has been used with the workforce to positive effect (30). Among the five key recommended mental health core standards for workplaces within the Stevenson and Farmer report were encouraging open conversations about mental health and the support available, and developing mental health awareness among employees (6). However, there has been very little research on the impact of MHFA on workplace recipients (31, 32). Much of the literature to date has focused on the experiences and/or effects of MHFA training from the perspective of trainees (13, 33–36) or instructors (37–41) rather than the experience of the recipient. Although Morgan et al.'s systematic review aimed to assess the impact of MHFA on different mental health outcomes, this was not specifically focused on the workplace (42). Where impact has been explored, this was largely on changes to the confidence, knowledge, attitudes and beliefs of the trainees post-training (31, 34, 43, 44). When impact has included examining the first aid provided by trained individuals, this has not been specific to

workplace settings (45) and/or has not investigated issues around wider organisational impact such as the monitoring and promotion of MHFA (46).

The majority of workplace MHFA studies have focused on one particular work setting and/or occupation, including high school teachers (47), nursing and medical students (48–50), pharmacy students (44), the fire service (34) and Australian government departments (46). In addition, an NIHR-funded study (51) has been announced which will employ a randomised controlled trial to evaluate the effectiveness of MHFA in secondary schools in Bristol, Cardiff and surrounding areas. The impact of MHFA training will cover two aspects: impact on teacher wellbeing, including effects on depression, sickness absence and underperformance at work; and impact on student mental health and wellbeing.

Bovopoulos and colleagues have investigated multiple workplace settings and reported on MHFA instructors' experiences and perspectives of delivering MHFA courses in Australian workplaces (41). They sought to ascertain whether current courses were meeting the needs of these settings. Findings suggested that sectors such as the legal, financial and IT industries were less likely to have received training compared to white-collar human service organisations, despite a high prevalence of mental health problems in the aforementioned sectors. Another key finding was instructors' recognition that flexibility was needed to tailor and adapt courses to suit the needs of members within different workplaces, and across sectors. These authors do note, however, that the study was limited by potential bias since, arguably, instructors were being asked to assess their own performance, and thus may not have been able to provide an objective view. The article highlighted the need for future studies to report on organisational perspectives.

Bovopoulos et al.'s continued focus on MHFA and the workplace (52, 53) has resulted in recommended guidelines on how people in the workplace can best respond to a co-worker or employee whose mental health is causing concern. It was intended that these guidelines, available from MHFA Australia, would assist in more tailored MHFA courses. However, an independent evaluation that assessed the impact of existing MHFA training from the perspective of those in the workplace has not yet been reported. Although a recent study of instructors suggested that MHFA has led to positive organisational changes in Australian workplaces (39), the authors did not present objective evidence to support this conclusion and acknowledged that future studies of MHFA were needed to survey workplaces directly and explore how MHFA was delivered.

1.3.4 Systematic reviews and meta-analyses

A review conducted by Hadlaczky et al. (13) identified 15 relevant published evaluations of the MHFA training programme. The authors concluded, through meta-analysis, that MHFA improved participants' mental health knowledge, increased supportive behaviours and reduced negative attitudes, and thus could be recommended for public health action. However, the focus of these were MHFA's potential for public health action related to mental health awareness as opposed to other impact elements. The founders of MHFA, Kitchener and Jorm, carried out a review of studies evaluating MHFA training (31). Three published trials were included in the final selection, but only one of those was based in a workplace setting. The review concluded that changes in knowledge, attitudes and helping behaviours could be attributed to MHFA; however, the authors highlighted that there should be further evaluation of the effects on those who had received or been offered support from an MHFA-trained individual. Other reviews have not specifically focused on MHFA, but have identified it as an intervention in their study selection criteria. These include Reavley and Jorm's review of interventions aiming to prevent anxiety, depression and/or alcohol misuse in higher education students (54); Hanisch et al.'s systematic review of the effectiveness of interventions

targeting the stigma of mental health problems in the workplace (55); and Booth et al.'s systematic review of the effectiveness of mental-health-focused training programmes for non-mental-health-trained individuals who were likely to come into contact with individuals with mental health problems (56). Findings suggested that for the training interventions that were identified, despite short-term positive changes in behaviour, there was little evidence showing benefits to those whom trainees assisted.

1.3.5 Randomised controlled trials

Kitchener and Jorm (46) conducted a randomised controlled trial of MHFA in two workplace settings. The settings were two large Australian government departments, with 301 employee participants being randomly assigned either to receive MHFA training immediately or to wait five months. The authors reported that the MHFA training led to increased confidence in participants around the provision of help and advice, less stigmatising attitudes, and improved mental health within participants. However, the authors highlighted that the evaluation did not determine effectiveness and that the findings may not be generalisable to other work settings. In addition, the evaluation focused on courses delivered by one instructor, which further limits the generalisability of the findings. Similarly, a protocol published in 2015 describes a Danish proposed mixed-methods study that will use a randomised waitlist-controlled superiority trial design (35) to investigate the effects of MHFA training on employees. The research aims to recruit 500 participants from 10 different workplaces who will be allocated either to receive training immediately (intervention group) or to receive training six months later (control group), with additional focus groups being held to support the analysis. Although this study intends to recruit participants from multiple Danish workplace settings, the authors will not report on organisational outcomes. Moreover, the authors have also highlighted the possibility of contamination between the intervention and control groups, since both may include employees from the same workplace.

Another randomised controlled trial reported by Jorm et al. (33) involved 262 members of the Australian public and, as with the other trial research studies described above, used a waiting-list control group. However, the MHFA training course used in this study had an e-learning format and an additional MHFA manual. The findings suggested that the training improved some elements of knowledge and confidence, while reducing stigma. The authors also carried out a cluster randomised controlled trial to assess the effects of MHFA training on Australian high school teachers (47). The allocation groups were again either immediate training or a waiting list for future training. As well as assessing changes in participants' knowledge, attitudes, confidence and self-reported behaviour, the authors also reported on the effects of MHFA on the recipients, in this case students. There were no changes identified in individual student support or mental health, although the authors suggested that the follow-up time point may have been too early post-training to identify changes. A longer follow-up time (two years) following training was used in Svensson and Hansson's randomised controlled trial of MHFA effectiveness for Swedish public sector employees (43). Knowledge and confidence levels were found to be improved among trained individuals. However, although the trial focused on self-reported effects on the trained individuals, it did not measure the effects on those who had received MHFA.

1.3.6 Other publications

A recent opinion piece in the *Independent* newspaper (57) noted that while MHFA courses are acknowledged to improve attitudes and confidence around mental health, evidence is yet to verify whether the skills attained actually impact on people experiencing a mental health crisis. Similarly, a 'views and reviews' piece featured in the *British Medical Journal* (58) suggested that there are still

uncertainties that need addressing around MHFA beyond focusing on increased confidence and empathy among trained individuals. These uncertainties include whether MHFA helps those who have received it; whether there are other options or interventions that people prefer; and whether there are any potential side effects, such as overdiagnosis.

1.3.7 Summary of the literature

In summary, there is a lack of formal, independent evaluations of MHFA in a UK workplace context that investigate how organisational impact can best be measured. Consequently, there is no data on: what the active ingredients of MHFA are perceived to be; how it is being delivered and received; facilitators of and barriers to implementation; and how the impact of workplace MHFA might best be measured. MHFA is a complex intervention (38, 59) and, as such, there are areas of uncertainty that need to be addressed before its effectiveness can be tested with an experimental study design. Examination of the content, implementation and outcomes measurement for MHFA in the workplace is therefore essential.

1.4 The MENtal health first aid in The wORkplace (MENTOR) study

The study comprised three parts:

Scoping review

A scoping exercise was conducted to identify similar interventions to MHFA in the UK. Using internet searches and the expertise of research team members and the study's expert panel, relevant mental health and/or suicide awareness training packages being used in workplaces were collated. These were summarised and documented.

Questionnaire survey study

An online questionnaire was developed to survey public, private and third-sector organisations where at least one member of the workforce had been trained in MHFA skills. Respondents to the survey were largely those who had attended any of the Adult MHFA or Armed Forces MHFA training courses provided by MHFA England. The survey data was analysed descriptively using the Statistical Package for the Social Sciences (SPSS) to describe key characteristics of the data and provide an overview of the implementation and use of MHFA across different workplaces.

Interview study

Organisations which had taken part in the questionnaire survey were narrowed down to 18 using inclusion criteria generated by the research team and expert panel. Six were selected for the interview study, and a further 12 were identified as reserve organisations. A total of 27 semi-structured interviews were carried out with members of the six organisations, which included:

- individuals who had attended MHFA training
- individuals who had not attended MHFA training
- MHFA coordinators
- individuals who had received help and support through MHFA
- individuals with experiences of mental health problems
- managers/line managers
- health and safety representatives.

The six organisations were described as mini case studies. Thematic analysis was used to identify common themes from the data across all the organisations.

CHAPTER 2. SCOPING REVIEW

2.1 Methods

The scoping review was developed using the expertise of research team members and the study's expert panel, in order to identify relevant mental health and/or suicide awareness training packages that were being used in UK workplaces. Internet searches of mental health and workplace training websites were conducted and keywords (mental health, suicide awareness, workplace, training, course(s)) were entered into search engines (such as Google). Interventions were included in the review if they were:

- focused on mental health and/or suicide awareness
- identifiable as a training course
- independent of MHFA England
- identifiable as having been used within, or available to, UK workplaces.

Information was taken from websites, and was ascertained from enquiries made directly to the course or training providers. Specific information was extracted to enable a comparison of course objectives, content, format, duration and cost. Some mental health course providers were more forthcoming with details of their courses than others. Some disclosed full details on their website or fully supported the research when approached (via phone or email), whereas others indicated they only disclose further information for customers. The findings were documented, and a summary can be found in Figures 1 and 2; complete details are located in Appendix 1. The scoping review identified 25 mental health training courses and 14 suicide awareness training courses.

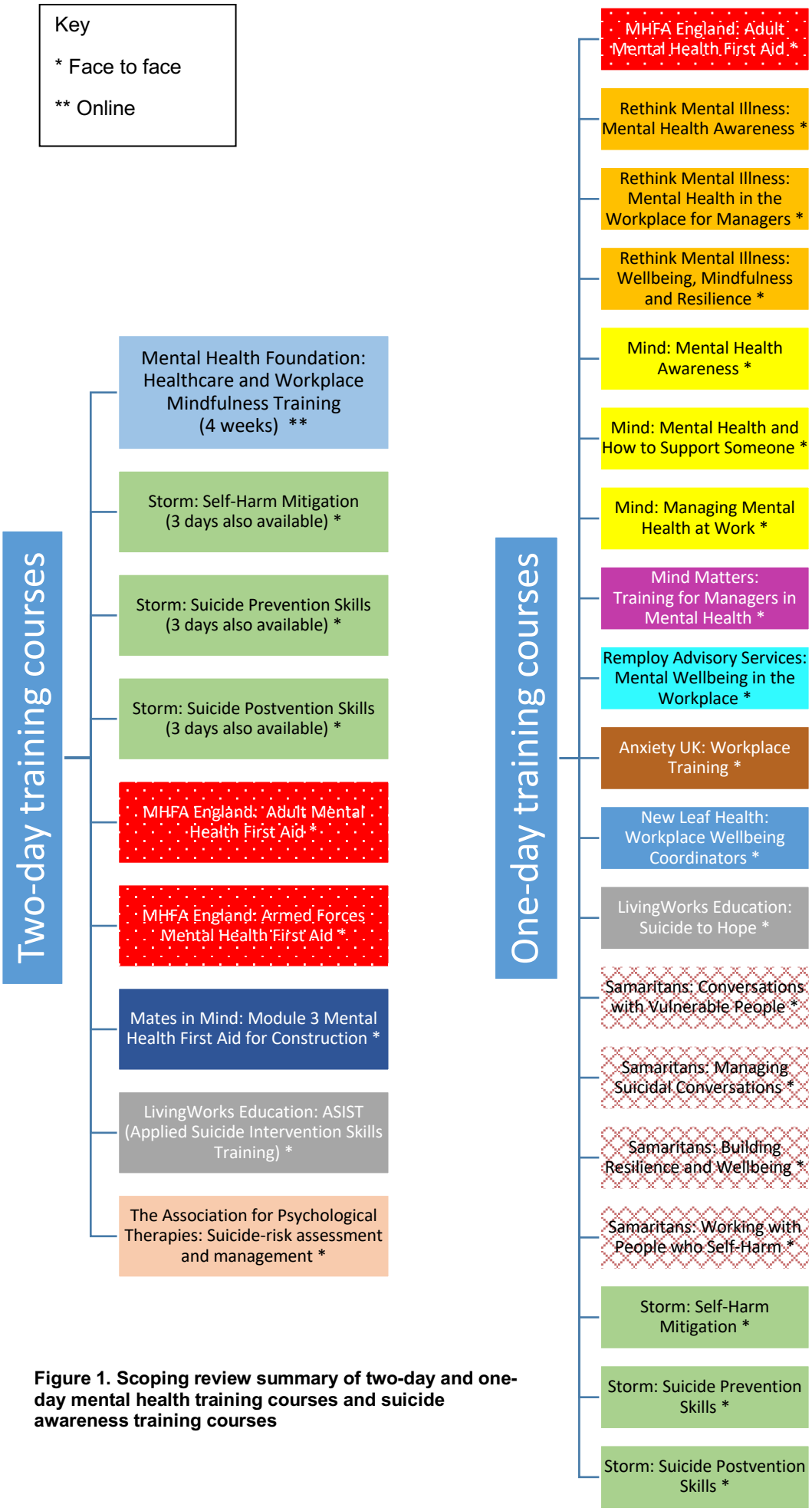


Figure 1. Scoping review summary of two-day and one-day mental health training courses and suicide awareness training courses

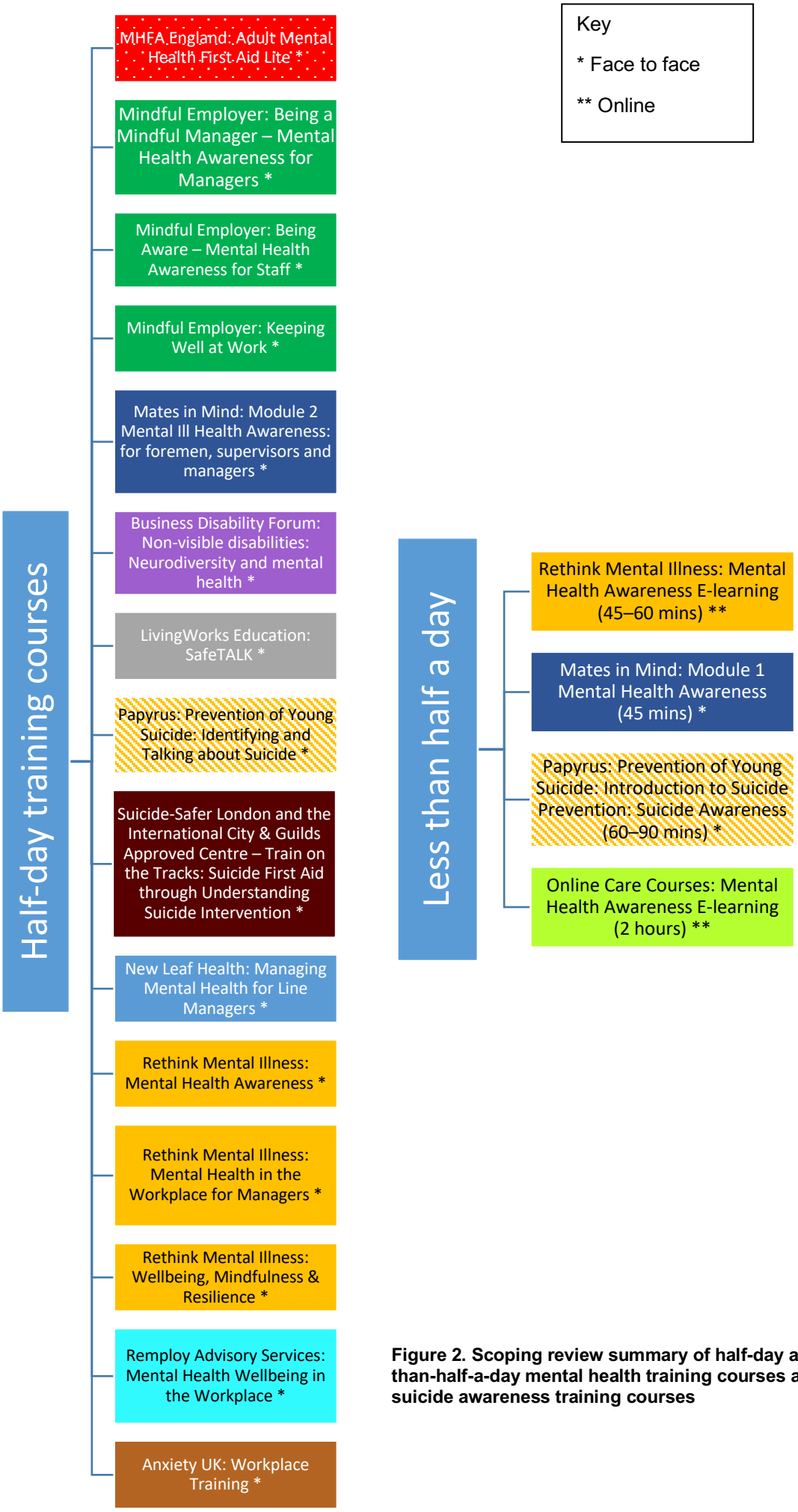


Figure 2. Scoping review summary of half-day and less-than-half-a-day mental health training courses and suicide awareness training courses

2.2 Overall findings

The training courses were reviewed for similarities and differences across objectives, content, format, duration and costs.

Content

In terms of content, all training packages were broadly similar, covering the identification and understanding of common mental health issues, addressing stigma, and approaching conversations. All MHFA England courses covered mental health topics such as depression and suicide, anxiety disorders, bipolar disorder, schizophrenia, psychosis, and eating disorders. Likewise, other training providers also covered specific mental health topics, aiming to provide an understanding of common mental health conditions (such as stress, anxiety disorders and depression) and less common mental health conditions (including bipolar disorder and schizophrenia). However, additional health issues such as substance use and abuse appeared to be covered less: only MHFA England and one other training provider were identified as covering these topics according to their course descriptions. In addition, only MHFA England appeared to cover post-traumatic stress disorder, which was included in their two-day Armed Forces MHFA course. One training provider additionally covered general health and wellbeing, while another addressed the impact of race and gender.

Based on information provided on websites, there were some further differences in course content, specifically around workplace issues. Other courses elaborated on specific workplace matters that would be covered in their training, such as legal frameworks in the workplace (eg sick leave, managing absences and returning to work), creating action plans both at work and at home, assessing workplace wellbeing, and health promotion in the workplace. There was one training provider that addressed the construction industry exclusively. In contrast, workplace-specific issues were not listed in the course descriptions for MHFA England, other than 'depression in the workplace'. However, this could be because MHFA is not marketed specifically as a workplace intervention. Although MHFA England had a Client Experience Team to provide in-house MHFA training to workplaces, the course structure description (28) was the same as the two-day Adult MHFA course (12) (that is, there were no specific descriptions of workplace topics that would be covered).

Finally, there were also mental health training courses that focused on identifying and preventing risk of suicide and self-harm. These courses covered action plans, listening skills, challenging stigma and potential causes of suicide and self-harm, including but not limited to mental health conditions. Other topics included life promotion, prolonged and complex grief, postvention planning (short-term and continued support for staff), self-care, and emotional resilience. Apart from the suicide-focused training courses that were identified (Figures 1 and 2), only MHFA England and one other training provider appeared to routinely cover the topic of suicide.

Format, duration and cost

In-house face-to-face training, where instructors deliver the course in individual workplaces, was offered by many training providers, including MHFA England. Recommended delegate numbers ranged from 12 to 20 people.

Course lengths were also broadly similar. The shortest identified was a taster session for 60 minutes. Other taster sessions went up to 90 minutes; this was similar to the Adult MHFA Lite course, which

lasted for three hours. The longest training session identified was three days, while MHFA England's longest courses lasted two days. Generally, courses that lasted less than half a day and more than two days were not routinely offered, although some training providers offered bespoke duration options.

However, unlike MHFA England, some training providers offered e-learning courses either instead of, or in addition to, a range of face-to-face options. This delivery method provided a cheaper alternative to face-to-face courses, with prices ranging from £4.99 to £35, with some offering monthly instalments of £0.99. Generally, these online courses lasted for one to two hours, with the exception of a mindfulness course with the Mental Health Foundation, which offered a four-week online course.

Courses that were half a day or less were priced between £25 and £250 per person. The recommended price for MHFA England's Adult MHFA Lite course was £75. However, where price could be ascertained, it was noted that MHFA England courses were generally more expensive than courses from other training providers. The current recommended pricing for the two-day MHFA courses (Adult and Armed Forces) is £300 per person, while the one-day MHFA course is £200 per person. However, these are only recommended prices from MHFA England, and it is up to individual instructors to decide how much they wish to charge. Most training providers offered reductions for face-to-face courses, depending on location, organisation type, group or company size, multiple bookings, or even the individual trainer and location. One particular course was free for trainees who lived, worked or volunteered in a certain area.

Summary

The scoping review found a number of UK training courses addressing broadly similar content and lasting for similar lengths of time to those offered by MHFA England. However, the content of some of these courses seemed to be more specific to the workplace compared to MHFA England courses. Other than specific suicide training courses, only MHFA England and one other training provider appeared to cover the topic of suicide. Where prices could be ascertained, longer MHFA England courses were found to be among the most expensive. This was partly due to the fact that other training providers offered online options, which were costed lower.

CHAPTER 3. QUESTIONNAIRE SURVEY

3.1 Development of questionnaire

The questionnaire was designed to cover: individual and organisation demographics; pre-training circumstances, such as selection processes for attending the course; the training experience; and post-training circumstances, such as workplace changes, and MHFA promotion strategies within the organisation – for example, how people are made aware of the identities and contact details of those who have been trained. Initial questionnaire items were informed by the study's research team. Specific items that intended to explore the potential effects of MHFA training and promotion strategies used in workplaces were informed by consulting MHFA England's course details and organisation case studies, as found on their website (12, 30). These resources were used to enable the questionnaire to accurately reflect what MHFA England's courses might achieve. In addition, consulting the website case studies provided insight into how organisations have been implementing MHFA in the workplace, which further helped formulate realistic examples of potential promotion strategies post-training. However, to cater for the possibility that the response choices were not relevant or adequate, 'Not sure' options and open-ended comment boxes were included.

The questionnaire underwent three rounds of review. The first round involved face-to-face consultation with the research team and expert panel members to assess the questionnaire items against relevancy of content, wording and response choices. Relevant modifications were made, and the second version was circulated among the research team and expert panel. As well as rewording some items, it was also agreed that questions around demographics should be moved to the end to reserve earlier items for MHFA-specific questions. When items had been agreed by the research team and expert panel members, the questionnaire underwent a piloting stage (see Section 3.1.1).

During the piloting stage, feedback comments were assessed by the research team and applied where appropriate. This represented the third and final round of reviews.

The final questionnaire consisted of 27 questions and, based on feedback from the piloting stage, was estimated to take between 10 and 15 minutes to complete.

3.1.1 Piloting

A convenience sample of individuals was used, based on contacts established through the study and recommendations from the research team and expert panel. Advertisements on social media were used during piloting; however, this method did not prove successful as a way of recruiting people who were interested in completing the questionnaire.

A total of 10 individuals agreed to pilot the questionnaire and were asked to complete the questionnaire and provide feedback on the questions posed in Figure 3. These questions were devised to ensure that issues around content, structure and length would be assessed. The individuals were informed that only the feedback on the questionnaire would be used.

- How easy is the questionnaire to follow?
- How easy is the questionnaire to navigate?
- Do the questions make sense?
- Are the questions worded and presented in an appropriate way?
- Are response categories appropriate?
- Are all necessary response categories available?
- Do any questions cause negative feelings?
- Does the questionnaire retain your interest/attention throughout?
- Is the questionnaire an appropriate length?
- How reasonable did you find the time taken to answer the questionnaire?

Figure 3. Questions addressed by individuals piloting the survey

3.1.2 Results of piloting

Feedback was generally positive; participants thought that the questionnaire was easy to follow and navigate, was generally well presented, and did not cause negative feelings. Some participants commented on the length and the time required to complete the questionnaire and how this impacted on their ability to retain attention. As a result, two questions were removed and several statements in the question matrices were condensed or removed. Other participants suggested some wording changes to certain questions and these were made where appropriate. An extra response column was included in the question matrix to capture responses from individuals who had plans to implement changes that had not yet been completed. More opportunities to include additional information or clarification of responses were introduced overall.

3.2 Questionnaire study

3.2.1 Methods

Ethical approval was obtained from the University of Nottingham Faculty of Medicine and Health Sciences ethics committee on 08 May 2017 (REC ref: 14-1704). The online survey questionnaire was uploaded onto the Bristol Online Survey tool, which is the approved survey tool website for studies conducted within the University of Nottingham.

3.2.1.1 Participant sample

We aimed to recruit participants who worked in:

- small and medium-sized enterprises (SMEs) and large employer organisations, where at least one member of the workforce had received Adult MHFA or Armed Forces MHFA training from MHFA England
- SMEs and large employer organisations from across the corporate, statutory and voluntary sectors.

Participants were recruited in three ways:

(1) Through MHFA England's Client Experience Team. This team work with associate instructors to provide tailored MHFA training to large organisations and SMEs across the different sectors. The team agreed to send MENTOR study information to employer organisations listed on their database. The email directed individuals who were interested in taking part to make personal contact with the MENTOR research team. The research team then liaised with these interested organisations to provide further details around the study and establish who would be completing a questionnaire. In some organisations, more than one member agreed to complete a questionnaire. At least 33 of the organisations represented by survey responders were trained by the Client Experience Team. It was difficult to ascertain the precise number of organisations who took part in the survey and were also trained by the Client Experience Team due to the fact that some individuals emailed the main researcher without mentioning this.
(2) MHFA England also sent details of the study to individuals listed on their network of instructors. These are self-employed instructors who have provided MHFA training to clients. Fifteen of these listed instructors agreed to pass on survey information to their clients. Each instructor was offered a £20 discount to use on MHFA membership fees or training materials.
(3) Social media, newsletters and attendance at relevant events were used to invite both instructors and employer organisations to take part in the online survey. Although social media generated interest around the study in the form of increased networks and retweets on Twitter (where individuals promoted MENTOR study tweets to their followers), it did not lead to a large number of participants being recruited to the study. Events such as mental health conferences, HR forums and MHFA England's 10-year-anniversary event (November 2017) were also attended by the researchers to share study information and recruit prospective participants.

3.2.1.2 Procedure

Individuals were invited to complete the questionnaire anonymously, but could use a unique code which would enter their organisation into a free prize draw to win a tablet computer. The final survey questionnaire contained items on the following:

- demographics of the organisation (eg size, sector, type of work)
- number of staff trained in MHFA, and when trained
- staff selection criteria/processes for attending training
- location of training – workplace based or external
- frequency/regularity of training uptake by the organisation
- whether/by what method MHFA is delivered in the organisation
- whether/how the take-up of MHFA is monitored/recorded
- whether/how the impact of MHFA is monitored/recorded
- expected and unexpected outcomes of training staff in/delivering MHFA.

The survey went live in early September 2017 and closed on 15 December 2017.

3.2.1.3 Data analysis

Following checking and cleaning, data was analysed using the Statistical Package for the Social Sciences (SPSS) version 24.

3.2.2 Results

All three recruitment strategies enabled prospective participants to initiate contact with the research team if they wished to take part. Newsletter advertisements were more successful in leading to expressions of interest in participating, notably in the first couple of weeks of them being published and circulated. Many of these expressions of interest did lead to participants being recruited to the study. One HR forum that was attended resulted in an HR consultant being recruited to the study's expert panel, while the 10-year-anniversary event led to the recruitment of further participants to the survey.

The survey captured responses from individual respondents as well as from respondents participating on behalf of the whole organisation.

3.2.2.1 Responses

A total of 139 responses were received from 81 organisations. Figure 4 provides an overview of the sector breakdown of these organisations, and Figure 5 provides an overview of the regional breakdown.

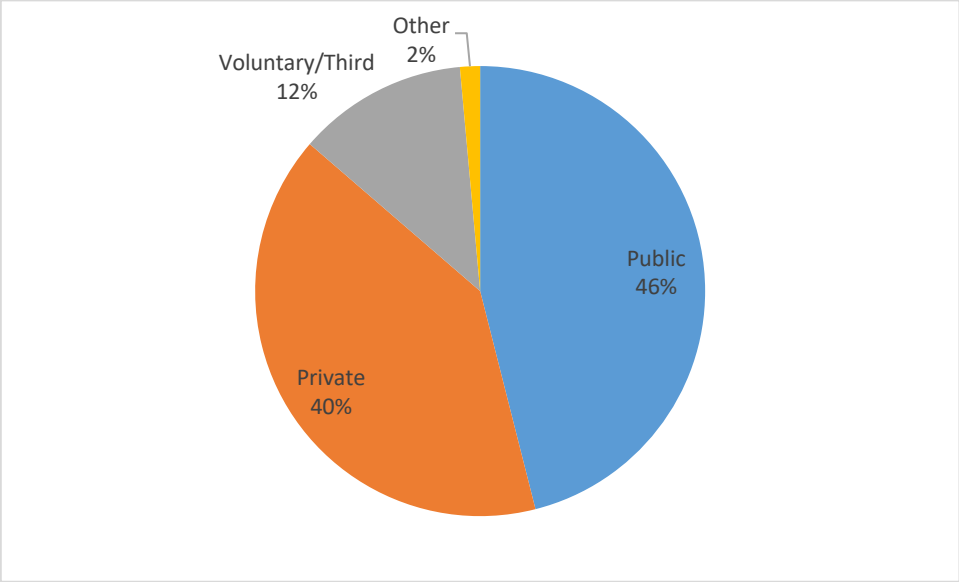


Figure 4. Overview of responses across job sectors

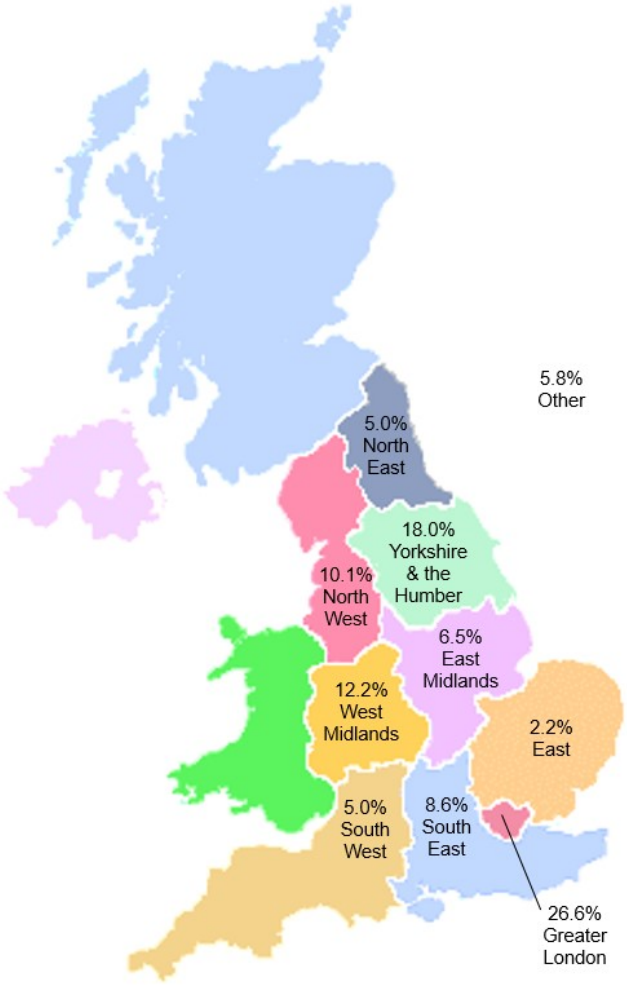


Figure 5. Overview of responses across the regions of the UK

Table 1 shows the different industries in which the respondents' organisations were based. Most respondents worked in the higher education industry, followed by construction/engineering/rail and health-focused industries.

Table 1. Industries in which respondents were based

Industry (n=139)	Frequency	%
Higher education institution	23	16.5
Construction and/or maintenance/engineering/rail industries	15	10.8
Health/health institution	15	10.8
Professional services	12	8.6
Accountancy and/or finance	9	6.5
Local authority	8	5.8
Manufacturing and/or supply	8	5.8
Media/broadcasting/communications	8	5.8
Mental health	6	4.3
Education	5	3.6
Research	5	3.6
Criminal justice system	4	2.9
Advisory, consultancy, tax, audit	3	2.2
Armed forces/veterans	3	2.2
Government/government agency	3	2.2
Legal/legal services	3	2.2
Leisure/tourism	3	2.2
Welfare	3	2.2
Retail	2	1.4
IT	1	0.7

3.2.2.2 MHFA training funding sources

Funding sources for MHFA training are summarised in Table 2. The majority of respondents were unclear about or did not know the funding source for the MHFA training that had been undertaken in their organisation. Almost a third of respondents indicated that MHFA training had been funded from business finances that could not be attributed to HR or specific training/staff development funds. Nearly 20 per cent of respondents specified that HR had funded MHFA training.

Table 2. Funding source category for training

Funding budgets (n=139)	Frequency	%
Not sure/don't know/unclear	48	34.5
Other business/corporate/company/department	41	29.5
Human resources	26	18.7
Training/staff/developmental/CPD	11	7.9
External funding, eg MHFA England	8	5.8
Combination of business and external funding	2	1.4
Combination of human resources and other business	1	0.7
Combination of training/staff development and other business	1	0.7
Other	1	0.7

3.2.2.3 Location of MHFA training

The majority of respondents indicated that training had taken place at the workplace, while the remaining respondents stated that training had taken place at other locations, as shown in Figure 6. These external training locations included local/regional hotels, another local or regional venue that was not a hotel, other associated business locations, another city/regional location, or an unspecified external location (Figure 6).

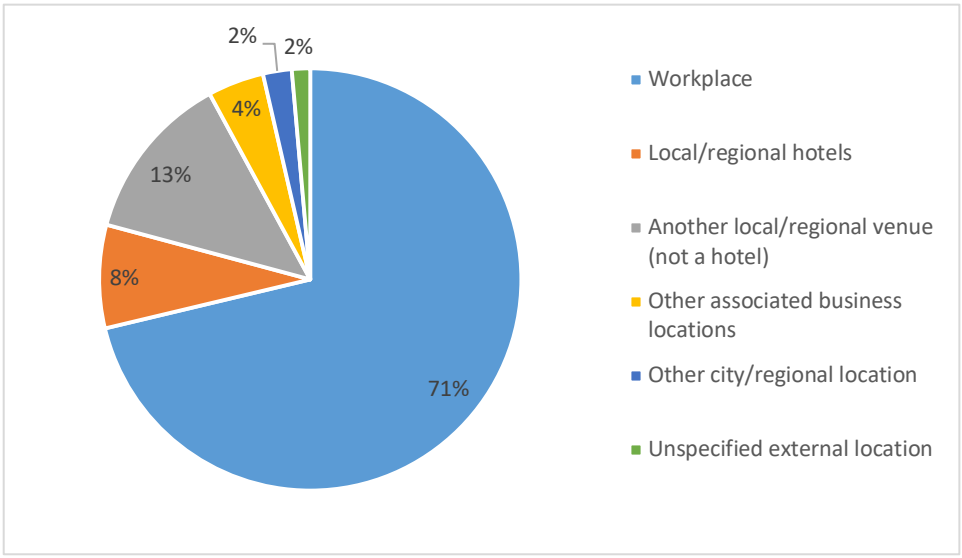


Figure 6. Location of MHFA training

3.2.2.4 Types of MHFA courses undertaken

As shown in Table 3, the majority of respondents (62.6 per cent) specified that members of their organisation had undergone the standard Adult two-day course with MHFA England only. A combination of the standard Adult two-day course and the Adult Lite course was the second most common method, with 12.9 per cent of respondents' organisations opting for this. Only four respondents indicated that their organisation had undertaken the Armed Forces training, with an additional respondent specifying that their organisation had undertaken this training and another type of training.

Table 3. Type of course undertaken with MHFA England

MHFA training course (n=139)	Frequency	%
Adult two-day	87	62.6
Adult two-day and Adult Lite	18	12.9
Adult one-day	14	10.1
Adult Lite	7	5
Armed Forces	4	2.9
All three Adult courses	3	2.2
Adult two-day and other	2	1.4
Other	2	1.4
Armed Forces and other	1	0.7
Adult two-day and Adult one-day	1	0.7

3.2.2.5 Selection processes for training

There were a variety of ways in which organisations identified/selected members of the workforce to attend training, as summarised in Table 4. The most common was that all employees had been invited to undertake training, with 36.7 per cent of respondents indicating that this was the case and an additional 15.4 per cent stating that this method was used in conjunction with another selection criterion. The second most common way was by employee(s) making a request (28.8 per cent), while 22.3 per cent suggested that only selected employees had been invited.

In terms of specific selection procedures, open-ended comments from the survey suggested that for some organisations, key staff members were invited or encouraged to undertake training – for example, those from HR departments, frontline staff, managers and those in leadership roles. Other respondents further suggested that selection was prioritised based on roles, location and individual interest in mental health. In addition, some respondents indicated that the organisation wanted to get a spread across sites and/or departments. Finally, two respondents suggested that a formal process was used in their workplace to collect expressions of interest, with individuals subsequently shortlisted.

Table 4. How employees were selected for training

Selection for training (n=139)	Frequency	%
All employees invited	51	36.7
Employee(s) requested	40	28.8
Selected employee(s)	31	22.3
Selected employee(s) and employee(s) requested	7	5
Other/not sure	4	2.9
All invited and selected employee(s)	2	1.4
All invited and other/not sure	1	0.7
All invited, selected employee(s) and employee(s) requested	1	0.7
Selected employee(s) and other/not sure	1	0.7
Selected employee(s), employee(s) requested and other/not sure	1	0.7

3.2.2.6 MHFA promotion strategies within organisations

The survey explored the strategies used by organisations to promote MHFA awareness among members of the workforce, including informing staff of the identities of those who had been trained. As shown in Table 5, the most common strategies were posters, circulation of MHFA information in the workplace, mental health days and intranet links. The least common strategy was the use of MHFA accessories.

Table 5. MHFA awareness strategies within organisations

MHFA awareness strategies in organisations (n=139)	Frequency	%
Posters	72	51.8
Circulation of MHFA info	69	49.6
Mental health days	63	45.3
Intranet links	55	39.6
Email signatures	48	34.5
Presentations	45	32.4
MHFA first responder notices with contact details	40	28.8
Leaflets	33	23.7
Badges	30	21.6
Postcards	25	17.9
Buddy scheme	22	15.8
Mental health safe havens	20	14.4
Accessories	14	10.1
Other	14	10.1

3.2.2.7 MHFA within the organisation

Table 6 summarises the methods used to ascertain the impact of MHFA within organisations. Nearly all of the survey respondents had personally taken part in some form of MHFA training (*n*=125). This may suggest that the survey was more likely to appeal to those who had personal experience of the MHFA training programme. A small number of respondents were not sure if they had indeed received MHFA training.

In terms of knowledge of internal methods implemented by the organisation to evaluate MHFA training, over a third of the respondents suggested there were none. However, a similar proportion specified that their organisations did have methods in place. Many of the respondents were not sure whether internal evaluation methods were in place. Open-ended comments suggested that the majority of evaluation strategies (*n*=30) were course feedback forms/questionnaires after the course, with the exception of one organisation, which has a debriefing session one month after training. One other respondent indicated that their organisation was in the process of creating a method to evaluate the courses. Other open-ended comments suggested that respondents interpreted the term 'evaluation' to mean ways in which MHFA interactions/conversations could be monitored to assess impact (*n*=9), rather than evaluating experiences of the actual course attended. These included keeping confidential logs/documentation of MHFA conversations/interactions, and reviewing uptake

numbers and anonymised case details of those who had received help from trained members (including regular meetings to discuss MHFA). One respondent suggested that absence rates would be monitored in the future with the view that declining absences would be indicative of a positive impact.

Those trained in MHFA were generally considered to be identifiable in the workplace (Table 6). Methods of making those trained identifiable, as ascertained from open-ended responses, included notices around the workplace (such as in medical areas) promoting the names of those trained, in the same way as notices would be posted for members of staff trained in physical first aid; posters; internal communications or bulletins, websites or the intranet, or spreadsheets; badges or lanyards; email signatures; or appointing trained members to a specific team. Perceived accessibility of those trained in MHFA was also high. Respondents reported that those trained could be accessed via phone, Skype, email or face to face. Some organisations had a register of MHFAiders or a department MHFAider. Other methods of accessing those trained could be through line managers, mental health groups, network or buddy systems, communication updates, contact details published via the organisation's website, or posters in the workplace. More respondents believed that trained members in the workplace were accessible than felt that they were identifiable.

Generally, the uptake of MHFA was perceived not to be recorded (Table 6). Respondents were largely unsure if MHFA impact was monitored within their organisations and were unsure if there were strategies for measuring the mental health of the workforce. For those who did indicate that uptake was recorded, 17 respondents suggested the actual numbers of people using the service was recorded within their organisations and/or indicated that some details around the conversations that took place were captured via forms, spreadsheets or registers. However, 16 of the open-ended comments simply confirmed that recording happened, but did not elaborate on what this involved and what details were captured.

Regarding monitoring impact, the majority of respondents were not sure. For those respondents that did feel that impact was monitored, their open-ended comments suggested that impact was ascertained via anecdotal evidence/disclosures or other informal methods, such as through networks and feedback; or the respondents simply indicated that impact was monitored without specifying any further details. Six respondents referred to how uptake of MHFA was recorded, suggesting that they associated impact with uptake of the service. Three respondents mentioned staff/organisation wellbeing surveys, and two focused primarily on absence figures.

Regarding respondents' assessment of the training that had been received, Table 6 shows that the majority of respondents did not have any improvements to suggest. However, over a quarter did. Thirty-three respondents believed that there were strategies in place to measure mental health in their workplace. Although the majority of organisations used a single strategy for measuring mental health in the workplace, others used or planned to use multiple strategies. Fifteen respondents stated that their organisation conducted surveys that either partially or completely covered questions on mental health. Eight respondents mentioned that their workplace had full or partial plans (some already had something else in place) in progress for measuring mental health, which may have included staff surveys. Eight respondents claimed their workplace measured mental health via sickness absence statistics, and six indicated that mental health was recorded via the number that used their current interventions (including MHFAiders). One respondent said that this could be measured in their workplace, but did not state if it currently was.

Table 6. Details of MHFA training and use in organisations

Variables (n=139)	Yes	Not sure	No
Personally attended training	125	7	7
MHFA trained person is accessible	104	24	11
MHFA trained person is identifiable	83	30	26
Internal methods for evaluating training	48	41	50
Recorded uptake of MHFA	38	39	62
Suggested improvements to training	34	19	86
Measuring MH at work	33	70	36
Impact monitored	27	68	44

3.2.2.8 Suggested improvements

More than 75 per cent of the respondents did not feel that improvements to the training were needed, while 14.4 per cent felt that improvements should be made to MHFA England's course content. Only three respondents believed that the organisation could be doing more to improve the impact of MHFA training. Regarding improvements to actual course content, qualitative data showed that the most common request was for more role play to enable MHFA to be seen in practice, and to increase confidence in dealing with 'real-life' situations. Similarly, other respondents mentioned the need for more practical advice and exercises. Other suggested areas of improvement were for more workplace-specific advice and guidance, including current internal policies within organisations, legal requirements within businesses and more detail on assisting colleagues through their difficulties. Two respondents wanted more time on 'common' mental health problems, eg stress, anxiety and depression; however, another would have liked more information on other mental health issues such as psychosis and personality disorders. Another respondent reported that they thought it was challenging to balance coverage of more complex conditions with those considered more commonplace. However, they also suggested that the course should focus on common mental health problems, because those trained were probably more likely to use their skills to assist people with these issues.

In addition, respondents proposed changes to the course time/duration (2.9 per cent), changes to the individual trainer/instructor (2.2 per cent), organisational improvements (2.2 per cent) and 'other suggested improvements' (2.9 per cent). These included the need for refresher training, for a blended course consisting of e-learning and face-to-face components, for clearer guidance about managing panic attacks, and to target the course towards people who do not have experiences of mental health problems. Organisational improvements suggested included monitoring how trained staff are implementing MHFA, setting up of MHFA networks, and shorter courses to address the difficulties faced by organisations in freeing up staff for two days of the standard training.

3.2.2.9 Anticipated and actual effects of MHFA training

The survey questionnaire also allowed respondents to indicate what effects they had anticipated would occur within their workplaces as a result of training. Another set of questions then asked them to specify whether these effects had actually occurred after training. These potential effects included the provision of help to another employee using MHFA skills, increased understanding around mental

health issues, reduced mental-health-related absences, improved signposting procedures and improved wellbeing among employees. Scores were assigned to responses, with 'Yes' responses being attributed the highest scores, and 'No' responses scoring the lowest. The highest total score that organisations could have attained for 'anticipated effects' and 'perceived actual effects' was 34.

Table 7 provides an overview of the average scores attained. The mean anticipated effects score was 28.07, which is close to the maximum possible score. This total score changes when looking at scores assigned for actual effects of training, where the mean score reduced to 24.22 (Table 8). However, while applying a scoring system is useful for making comparisons between anticipated and actual effects of training, the researchers note that such scores should be used cautiously, and discussed in context. The results for these are presented below around specific anticipated effects (Table 7) and perceived actual effects (Table 8) of training.

Generally, employees went into training with positive expectations of how it would impact on the workplace (see Table 7). The top four anticipated outcomes were increased understanding of mental health issues, increased confidence around mental health issues, increased mental health conversations and decreased stigma. Table 8 suggests that on the whole these expectations were met. However, in practice some were not sure whether this did in fact happen as a result of the MHFA training, and others felt this did not happen at all.

Table 7. Anticipated outcomes of MHFA training

Variables (n=139)	**Yes**	**Not sure**	**No**
Increased understanding of MH issues	139	0	0
Increased confidence around MH issues	137	2	0
Increased MH conversations	134	4	1
Decreased stigma	131	3	5
Trained members helping another employee	122	6	11
Increased help-seeking behaviour	122	9	8
Improved signposting procedures	119	10	10
Improved wellbeing among employees	119	9	11
Comfortable reporting MH problems	115	14	10
Increased workplace initiatives	103	16	20
Helping others other than colleagues	100	18	21
Plans for further training	101	24	14
Increased personal MH disclosures	89	28	22
Organisation changes and interventions	82	29	28
Participation in national MH events	81	32	26
Reduced mental health absences	71	40	28
Reduced litigation risk	25	80	34
Average total anticipated outcome	28.07 (4.82)		

As illustrated in Table 8, most employees were not sure whether a reduced litigation risk would be or was affected by MHFA training in the workplace. In addition, there was an increase in uncertainty post-training regarding whether the following outcomes transpired as a result of training: comfortable reporting of mental health problems, increased personal mental health disclosures, reduced mental health absences, improved wellbeing among employees, decreased stigma, and increased help-seeking behaviour.

While a large majority of respondents anticipated that acquired skills would allow members to provide help to another member of the workforce (Table 7), the number of respondents that felt that this had actually happened post-training was much lower (Table 8). However, as shown in Table 8, this still constituted a majority. A higher number of respondents indicated that trained members had not actually used their skills to help an employee than had anticipated that such help would not be provided.

Regarding the potential effect of increased understanding of mental health issues, all respondents anticipated that this would happen as a result of training (Table 7). Table 8 shows that the majority of respondents agreed that this had happened following training.

The survey explored respondents' views around whether they anticipated that mental-health-related absences would reduce as a result of having MHFA-trained members in the workplace. Table 7 shows that over half of the respondents did anticipate that this would happen. However, the majority of respondents were not sure whether this had happened as a result of training (Table 8).

Survey data suggested that a large majority of respondents anticipated that training would enable their organisation to improve signposting procedures (Table 7). While a large majority of respondents agreed that this had actually happened post-training, the figure had reduced somewhat (Table 8). However, it is also important to take into account that some of the respondents felt that this aspect was at the planning stage, suggesting that the organisation was intending to achieve this.

Table 7 indicates that a large number of respondents did anticipate that training would bring about improved wellbeing among employees. Table 8 suggests that nearly half of respondents were not sure whether this had happened as a result of training. However, over a third of respondents agreed that employees' wellbeing had improved.

Table 8. Actual perceived outcomes of MHFA training

Variables (n=139)	Yes/in planning	Not sure	No
Increased understanding of MH issues	127	7	5
Increased confidence around MH issues	123	10	6
Increased MH conversations	121	13	5
Improved signposting procedures	116	9	14
Increased workplace initiatives	110	14	15
Trained members helping another employee	109	16	14
Organisation changes and interventions	100	18	21
Participation in national MH events	95	27	17
Helping others other than colleagues	94	30	15
Plans for further training	91	31	17
Decreased stigma	89	43	7
Comfortable reporting MH problems	83	41	15
Increased help-seeking behaviour	82	52	5
Increased personal MH disclosures	74	52	13
Improved wellbeing among employees	63	65	11
Reduced mental health absences	21	92	26
Reduced litigation risk	17	110	12
Average total actual outcome	24.22 (6.10)		

3.2.2.10 Motivations for MHFA training

Respondents were asked about the main motivations and reasons for their organisation sending members of the workforce for MHFA training. The majority of respondents (*n*=45) indicated that they felt training had been organised in recognition of existing or potential mental health problems among members of their organisation (Table 9). Qualitative data showed there was consistent mention of mental health problems being the cause of sickness absence. Others mentioned that mental health issues were prevalent among the industry in which their organisation was based (Table 9). This may suggest that such respondents and/or the organisation expected MHFA training to have a positive impact in terms of improving mental health wellbeing. Other common reasons for training included MHFA being part of the overall organisational strategy to address wellbeing and welfare; being driven by someone's personal interest or experiences; recognising that training would enable support to be provided to someone that the organisation was in contact with; and also helping to increase awareness and knowledge around mental health issues.

Table 9. Main motivations and reasons for training

Main reason for training (n=139)	Frequency	%
Recognition of the impact (actual or potential) of mental health problems	45	32.4
Part of organisation's strategy/agenda for wellbeing/welfare	27	19.4
Personal experiences/interests/desires	20	14.4
Providing support to someone, eg staff, students, clients, public	15	10.8
Improve understanding/awareness/knowledge/ confidence around mental health	11	7.9
External factors, eg profile of mental health, statistics, government	9	6.5
Moral/right thing to do	7	5.0
Course-specific advantage, eg cost, content, trainer	4	2.9
Protection/litigation	1	0.7

In addition, respondents were invited to offer a second reason around motivations for training. These are captured in Table 10. This time, the majority of respondents indicated that they felt that MHFA training had been introduced to enable them to improve aspects such as skills, understanding and awareness. As with the first reasons/motivations specified, a high number of respondents still believed that MHFA training was being implemented because of the actual or potential impact of mental health problems, such as increased sickness absence, and/or recognised risk factors for that particular industry or workforce. Some respondents felt that MHFA was complementing or progressing other organisational strategies around mental health and wellbeing, while others indicated that implementation had been the result of individuals and/or departments endorsing it. A smaller number felt that MHFA training had been introduced as a tick-box exercise. 'None specified' was the third most common response category, suggesting that these respondents only wished to disclose one reason/motivation why they perceived their organisations had instigated MHFA training. It should be noted that 'Unclear' refers to comments that could not easily be interpreted by the researchers, as opposed to respondents specifying that motivations had not been made clear to them.

Table 10. Second motivations and reasons for training

Second reason for training (n=139)	Frequency	%
Improve skills, understanding, awareness, knowledge, recognition, conversations, culture and confidence around mental health issues	48	34.5
Recognition of the impact (actual or potential) of mental health problems	37	26.6
None specified	19	13.7
Part of organisation's strategy/agenda/ commitment/initiatives addressing wellbeing/ welfare	12	8.6
Endorsement of MHFA from someone/ department in the organisation/personal experience	10	7.2
Instigated by staff feedback/employee satisfaction	4	2.9
Tick-box exercise	3	2.2
Business sense/meeting targets	2	1.4
Unclear	2	1.4
Lack of current mental health resources/ support	1	0.7
Legal issues	1	0.7

3.2.2.11 Other mental health initiatives

Respondents were asked to indicate whether any other initiatives around mental health were present in their organisations. As shown in Table 11, the majority were either not sure, or specified that there were none. However, the next most common initiative mentioned was training programmes around mental health and suicide awareness. These are understood to be separate from the MHFA courses, since the question asked respondents to name any initiatives other than MHFA. These other training courses covered topics such as general mental health awareness, suicide-focused awareness, resilience, trauma, stress, mindfulness, self-harm, bereavement and courses targeted towards managers. Many respondents also suggested that their organisations offered onsite resources and services to help raise mental health awareness and provide information, as found via intranet links and/or support for those experiencing mental health problems, such as counselling services within the organisation. Fewer respondents mentioned external services that the organisation had links to, and that were thus accessible to members of the workforce. Some respondents also suggested that their organisations participated in international events such as World Mental Health Day and/or UK national initiatives such as Time to Change. For some, this included their organisation signing the Time to Change pledge, which involves employers making a commitment to address mental health in the workplace fairly (60). A smaller number of respondents named more general health and wellbeing support systems such as employee assistance programmes and occupational health pathways.

Table 11. Other mental health initiatives after training in organisations

Other initiatives	Frequency	%
None/not sure	52	37.4
Mental health/suicide awareness training/planned mental health training/workshops/sessions/online packages	34	24.5
On-site mental health resources/services/support, eg counselling, intranet resources	30	21.6
International/national events/initiatives/campaigns such as Time to Change	17	12.2
Mental health presentations/events/meetings	12	8.6
Employee assistance programme and/or similar	8	5.8
Mental health interest groups/networks	8	5.8
Connections to external mental-health-related services/organisations	7	5.0
Occupational health	3	2.2
Workplace mental health champions	3	2.2
Unclear	1	0.7

3.3 Discussion

3.3.1 Motivations for training

It was notable that the most common motivations for training, such as attending to learn how to provide support, were factors that could impact on the mental health of the members of the workforce, as opposed to, for example, personal development reasons. However, the survey data also indicated that there were some who believed the organisation pursued MHFA training as a tick-box exercise – that is, that their organisation signed up for MHFA training as a way of appearing to be doing something to address mental health issues in the workplace.

3.3.2 The training experience

The majority of respondents had undertaken some form of MHFA training, commonly the standard two-day course, and most did not have any improvements to suggest. For those who did, the majority cited specific issues with the course content, such as the need to include more practical elements, such as role play, in the training. Some trainees found there was not enough time to practise skills and/or see demonstrations of the practical application of MHFA within the session itself. The suggestion of refresher training was also made, indicating that respondents felt that the opportunity to update skills at some point would be beneficial. However, there was no indication as to when this should happen in relation to the main course, or what format this should take. There was, however, a suggestion that the standard two-day MHFA course become a blended format encompassing e-learning components as well as retaining some face-to-face aspects. The rationale behind this was that some organisations face difficulties in releasing staff for two days. Blended delivery could potentially reduce the cost of a standard training session too, though this was referred to in the survey data.

3.3.3 Post-training

Post-training, most respondents felt there had been an increased understanding of mental health issues, increased confidence around mental health issues and increased mental health conversations in their workplace. It seemed that mental health literacy (ie knowledge and beliefs around mental health issues), which is central to MHFA (24), may have been enhanced by training. However, there was a discrepancy in that a higher number of respondents had anticipated that these outcomes would happen than reported that they felt that these had actually happened. On the other hand, for some outcomes, respondents indicated that expectations had been exceeded, which was the case for 'Organisation changes and interventions', 'Participation in national mental health events' and 'Increased workplace initiatives'. Survey data suggested that a large majority of respondents anticipated that training would enable their organisation to improve signposting procedures. Although the figure for those who agreed this had happened post-training was somewhat reduced, this still constituted a large majority. According to their course content (12), MHFA courses teach the trainee to help the person being supported to access various forms of support; the survey data therefore suggests that most respondents felt that this skill had been attained and used.

For all other outcomes that respondents were asked to assess, the results indicated that compared to the number of respondents who had anticipated that these things would be achieved, fewer agreed that they had actually been achieved post-training. Moreover, there was more uncertainty around whether outcomes had actually been achieved, compared to those that had been anticipated. This was particularly the case for the outcomes of 'Comfortable reporting mental health problems', 'Increased personal mental health disclosures', 'Reduced mental health absences', 'Reduced litigation risk', 'Improved wellbeing among employees' and 'Increased help-seeking behaviour'. It may be that respondents were not privy to information that would enable them to know whether these things had been achieved in the organisation. For example, they may not have had access to sickness absence records, which may have enabled them to assess whether or not there had been reduced mental health absences after MHFA training had been introduced. This might reflect the research team's difficulty in ensuring that the questionnaire went to respondents who were able to provide definitive 'Yes' or 'No' answers. During promotion of the survey, details were often circulated by email to all employees within an organisation by someone who had seen an advertisement. This reduced the researchers' ability to specify beforehand whom the most appropriate person might be to complete the questionnaire, ie someone in a position to provide definitive answers to all questions, such as those around mental health absences.

Regarding using skills to help an employee, the survey data suggested 11 people did not expect training to result in providing help to an employee. Fourteen people then indicated that they did not feel that help had been provided to an employee post-training. This might suggest that the training did not always result in trained members feeling that they could provide help to an employee in need of support. However, where respondents indicated that trained members from their organisations did not provide help to another employee following training, this particular outcome cannot definitively be interpreted negatively; it may be the case that circumstances simply did not arise to warrant trained members using their skills to help someone.

For items that generated 'Not sure' responses regarding post-training outcomes (thus suggesting uncertainty over whether they had been achieved), this may further underline that such factors are difficult to measure. For example, for 'Increased personal mental health disclosures', respondents may not have been able to gauge the extent to which this had changed post-training. In contrast, items which generated more certainty (for example, 'Increased workplace initiatives') were more visible in the workplace, and therefore respondents felt able to more confidently assess whether or not they had happened post-training. Moreover, some items might be problematic. An example would be 'Reduced mental-health-related absences': while the assumption may be that reduced absences

are a desired outcome of MHFA training, arguably an increase could also in fact be positive, due to people feeling more comfortable in disclosing mental health issues as a reason for taking time off work. Such examples underline that expected outcomes of MHFA may be difficult to assess in practical terms and/or may not necessarily be known to all members of the workforce. This may be supported by the survey data around potential improvements that could be made, where it was suggested that there should be a system in place for organisations to follow up and monitor how MHFA has been implemented by trained members in the workplace. This suggests that monitoring of MHFA is not always done, and, as mentioned, this could be due to the difficulties in measuring all potential outcomes of MHFA training.

It is also important to note that when measuring actual perceived outcomes of MHFA training, some respondents felt that their organisations may not necessarily have achieved certain outcomes at the time of response, but were intending to do so. Certain aspects of the organisation may need to be taken into account when assessing longer-term impact, such as the budget in place to implement changes and make improvements, the size of the workforce, and the proportion of the workforce who have been trained and are potentially better placed to lead on these changes.

CHAPTER 4. INTERVIEW STUDY

4.1 Tool development

An interview schedule was developed that was informed by the literature, the research team and input from the expert panel. The final schedule focused on the following areas:

- experiences of training, providing and accessing/receiving MHFA
- perceived facilitators of and barriers to providing and accessing/receiving MHFA
- perceptions and experiences regarding the awareness, acceptability and uptake of MHFA within the workplace
- views and opinions regarding the content and active ingredients of MHFA
- views and opinions on how the impact of MHFA might best be measured.

The interview schedule was piloted with a member of the research team, an expert panel member and an individual from an organisation that participated in the questionnaire survey. Following feedback, the schedule was revised to improve clarity and include more focused questions aimed at those who had received MHFA help and support in the workplace. The final interview schedule can be found in Appendix 2.

4.2 Methods

Semi-structured interviews were carried out with people over a three-month period. Ethical approval was obtained from the University of Nottingham Faculty of Medicine and Health Sciences ethics committee on 08 May 2017 (REC ref: 14-1704).

4.2.1 Participant sample

We aimed to select six organisations that had participated in the questionnaire survey (see Chapter 3). These represented public, private and third sectors; organisations which had received training from the Client Experience Team; and organisations which had received training from independent instructors. The sample also took into account other characteristics such as the regional base of the primary contact established from the survey questionnaire study, the industry represented, the response rate for the survey questionnaire, and reported numbers of MHFA-trained members. We identified six primary choices and 12 reserves. The sampling frame is shown in Figure 7.

1. Organisation 1 should be from the public sector, and must have received training from the Client Experience Team.
2. Organisation 2 should be from the public sector, and must not have received training from the Client Experience Team.
3. Organisation 3 should be from the private sector, and must have received training from the Client Experience Team.
4. Organisation 4 should be from the private sector, and must not have received training from the Client Experience Team.
5. Organisation 5 should be non-profit-making and/or from the voluntary/third sector, and must have received training from the Client Experience Team.
6. Organisation 6 should be non-profit-making and/or from the voluntary/third sector, and must not have received training from the Client Experience Team.
7. All final organisations have to be among the top four organisations within that particular sector, in terms of having the highest reported number of MHFA-trained members, according to questionnaire survey data.

Figure 7. Sampling frame for selecting organisations

The lead contacts of the six primary organisations selected were contacted and provided with information about the interview study. If lead contacts were not available, survey respondents based in these organisations were contacted. One organisation did not respond at this stage, and thus a reserve organisation in the same sector was approached.

4.2.2 Procedure

Purposive sampling was used to recruit workplace stakeholders. Information about the interview study was sent to lead contacts who had been established during the survey questionnaire study. These lead contacts circulated an information sheet to members of the workforce. We aimed to recruit employees who had received MHFA training, employees who had experience of mental ill health, managers, line managers, health and safety representatives, and other individuals in the workplace who wished to talk about MHFA.

The lead contact for one organisation circulated information to all the workforce; lead contacts for the remaining five organisations sent the information to selected members whom they thought were more likely to be interested in participating, eg people listed on the mental health networks and/or those who were known to have received training. Those interested in participating contacted the study coordinator to express an interest. In order to maximise the response, direct contact was also made by the research team with individuals within these organisations who had taken part in the questionnaire survey. The option of a telephone or face-to-face interview was offered to prospective participants.

4.2.3 Data analysis

Interviews were transcribed and underwent thematic analysis (61), which involved data coding, identification of key themes and categorisation of these. Further transcripts were then analysed using these themes.

4.3 Results

A total of 27 individuals agreed to be interviewed across the six organisations. In five organisations, interviews were conducted by telephone (*n*=22) at a mutually convenient time. In the remaining organisation, interviews were carried out face to face, since all five interviewees were available in the same location and on the same day. All interviews lasted between 30 and 60 minutes. Figure 8 provides an overview of the characteristics of the interviewees.

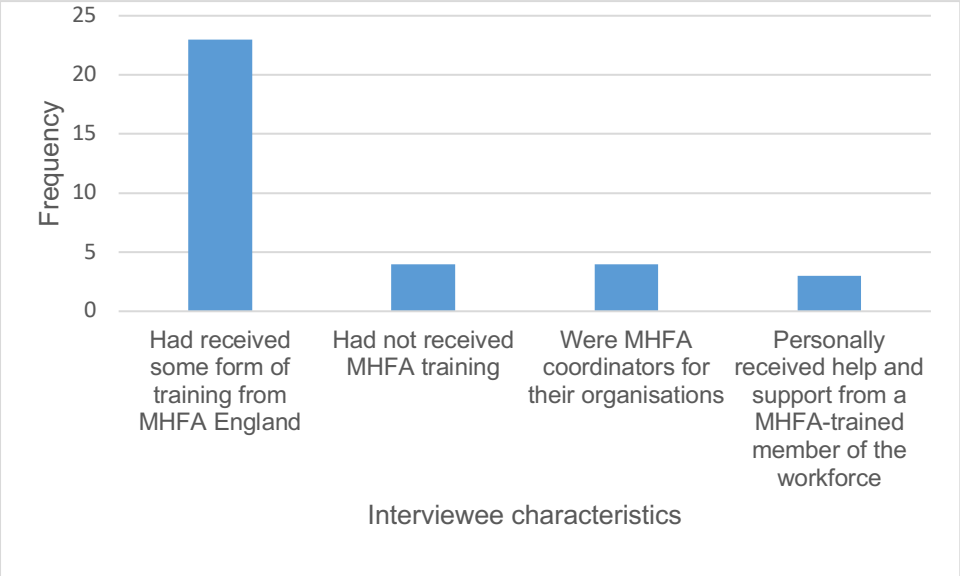


Figure 8. Overview of characteristics of interviewees

4.3.1 Organisation mini case studies

The six organisations are described in more detail in mini case studies below.

Organisation 1:

This organisation was within the public sector, in the media/broadcasting/communications industry, and had offices across the UK. The two-day standard Adult MHFA course was offered to all members. MHFA was introduced as part of the organisation's development of its agenda on mental health. The training was funded from a central budget. Uptake of training was optional, and places on courses were offered on a first-come, first-served basis. Initially, the waiting list was dealt with strategically to ensure that there was a good geographical spread of trained people. Training opportunities and the identities of the trained members were promoted on the organisation's website and intranet, at organisational events, and by word of mouth. MHFA-related information was also displayed on electronic display screens at some sites. The organisation also offered opportunities for trained members to refresh their knowledge on issues covered in the courses. In addition, an MHFA network was formed with all the MHFAiders, with further regional MHFA networks across the country. At the time of this report being published, training opportunities are continuing to be promoted within this organisation. Five people were interviewed from this organisation: the MHFA coordinator (who is also an MHFAider); three further MHFAiders (one of whom had also received MHFA in the organisation); and a line manager, who had not received training.

Organisation 2:

This organisation was a higher education institution. The two-day standard Adult MHFA course and the three-hour Adult Lite course were offered to members. The MHFA programme was introduced as a result of increased awareness of staff mental health and wellbeing. Some departments made MHFA training mandatory for all staff, while for others, uptake was optional. An MHFA network was formed for those who had undertaken the standard two-day MHFA Adult training. Network members were listed on a company website. Joining this network was optional. Specific departments had their own promotion strategies to make staff aware of who was trained, such as displaying posters of trained members and MHFA England certificates. However, the main way in which MHFAiders were accessed was through contacting those listed on the network. The network also functioned as a community for the MHFAiders, where experiences and other mental-health-related issues could be shared and discussed. At the time of this report being published, training opportunities continue to be promoted within this organisation. Nine people were interviewed from this organisation. These were the MHFA coordinator (who is also an MHFAider) and eight further MHFAiders (one of whom had also received MHFA in the organisation).

Organisation 3:

This organisation was a construction company that sits within the private sector, but works with partner organisations based on the nature of the projects undertaken. Therefore, some interviewees were recruited from both the construction company and partner organisations. Having undertaken MHFA training in another country, the MHFA coordinator was motivated to bring it to this company because of the mental health issues he felt were prevalent within the construction industry. The two-day standard Adult MHFA course and the three-hour Adult Lite course were offered to members. Promotion of the identities of the trained members was done via posters and electronic display screens. The organisation also ran an informal session, led by the occupational health nurse, to help trained members recap on relevant mental health issues. At the time of this report going to publication, it is unclear whether further MHFA training sessions will be planned. Three people were interviewed from this organisation. These were the MHFA coordinator, who had undertaken the MHFA training abroad; a member who had undertaken the three-hour MHFA Lite course; and a member who had not been trained, but had knowledge of the promotion of MHFA in the organisation.

Organisation 4:

This was a private sector organisation, situated within the accountancy and finance industry, which had offices across the country. Initially, only the standard two-day Adult MHFA course was offered to members of the workforce, but the three-hour MHFA Lite (Adult) course was later introduced. The organisation built mental health awareness into its agenda, including an online newsletter focusing on health and wellbeing news. Introducing MHFA training to the workforce was part of the approach to improving staff wellbeing. Promoting awareness of the trained members was done in various ways, with some strategies specific to particular offices across the country. These included photographs with contact details and a list of trained members on the website. An organisation mental health network existed, with smaller networks in certain regions. The purpose of these networks was to organise mental health events and raise awareness of mental health issues. Many of the MHFAiders were part of this network either pre- or post-training. Additionally, there was a system in place, facilitated by email, to match up people who needed help and support with an MHFAider. Employees in certain regions were not given the opportunity for training if it was decided that there were enough trained people present in these offices. Five people were interviewed from this organisation: three MHFAiders and two non-trained members who were part of the mental health network.

Organisation 5:

This organisation carried out research and was located within the third sector. This was the only organisation within the final six which offered all three Adult MHFA courses to the workforce (the standard two-day Adult MHFA course, the one-day Adult MHFA course and the three-hour MHFA Lite (Adult) course. MHFA was introduced to this organisation as part of its main strategy for supporting its workforce. Courses were offered between three and four times a year, and the organisation ensured that the uptake each time was the maximum number of delegates, which was 16. Places on the courses were allocated on a first-come, first-served basis. Trained members were dispersed across the organisation. The two-day Adult MHFA course was offered to everyone, while the one-day Adult MHFA course was offered to frontline managers and the three-hour MHFA Lite (Adult) course was for people in senior leadership positions. An MHFA network was formed for people who undertook the two-day course, and these MHFAiders were given some responsibility for promoting MHFA. In addition, MHFA was also promoted on the intranet. An emergency number was created for situations that required an MHFAider to be dispatched quickly. Other promotion strategies around making staff aware of trained members included posters. At the time of the publication of this report, the plan is to continue offering training opportunities to members of this organisation. The MHFA coordinator from this organisation was interviewed.

Organisation 6:

The final organisation, which had several offices around the country, sat in the third sector and focused on mental health. The standard two-day Adult MHFA course was offered to specific departments within the organisation. The manager of one particular department organised training for staff members because of their contact with vulnerable members of the public. Uptake of training was optional, but the majority of this team had completed training. Promoting awareness of trained members was largely through word of mouth and undertaken during organisational events. At the time of this report being published, MHFA training opportunities are routinely provided to teams within the organisation who are in contact with people who have diverse mental health problems. Three people were interviewed from this organisation, who were all MHFAiders within the same department.

These mini case studies are summarised in Table 12.

Table 12. Summary of mini case studies

Org	Sector	More than one base?	Region of lead contact	Type of work	MHFA coordinator present?	Types of training	Selection procedures used	Post-training	Main promotion strategies to identify trained members
1	Public	Yes	Northern England	Media/broadcasting/ communications	Yes	• Two-day standard training	• Open call • Optional	• MHFA network created • Opportunities to refresh knowledge	• Electronic screen • Website • Organisational events
2	Public	No	Northern England	Higher education	Yes	• Two-day standard training • Three-hour Lite training	• Open call • Optional; some departments mandatory	• MHFA network created	• Departmental diversity, eg posters and certificates displayed • Webpage
3	Private	No	Northern England	Construction and rail	Yes	• Two-day standard training	• Open call • Optional	• Opportunity to refresh knowledge	• Posters • Electronic screens
4	Private	Yes	West Midlands	Accountancy/finance	No	• Two-day standard training	• Open call • Optional • Some areas are no longer offered training as they have enough trained people	• Opportunity to join pre-existing mental health network • Email system for matching up trained people with individuals needing support	• Regional diversity, eg photographs in some offices; members listed on website
5	Non-profit-making/ third sector	No	Greater London	Research	Yes	• Two-day standard training • One-day course • Three-hour Lite course	• Open call • Optional	• MHFA network created	• Posters • Intranet • Dedicated email address • Emergency number • Mental health champions
6	Non-profit-making/ third sector	No	Greater London	Mental health	No	• Two-day standard training	• Offered to a specific department • Optional	• Specific accessories for trained members to wear at events to be identified	• Organisational events • Word of mouth

4.3.2 Thematic analysis

The qualitative data underwent thematic analysis, which involved coding the data for recurring ideas. The coding process consisted of highlighting incidences in the data, which provided insight into the organisation's approach to mental health in general, and then specifically how MHFA had been implemented and used in the organisation. These ideas were then categorised into themes, which are shown in Table 13. These themes are described and discussed with quotations to support the themes. The capitalised letter 'X' within a quotation replaces potentially identifiable information, such as the name of the organisation or the names of individuals. For each quotation, the participant's code and anonymised organisation are provided. We have also underlined specific parts of each quotation to highlight the themes identified.

Table 13. Main themes and sub-themes identified from thematic analysis of interview data

1. Why organisations do and do not take up MHFA
2. Why people do and do not attend MHFA training
3. Who should attend MHFA training?
4. Experiences and perceptions of MHFA training a. Intensity/duration of the course b. Format and content c. Attributes of the trainer d. Suggested improvements to training e. Refresher courses f. Providing feedback on training g. The impact of training
5. Promoting MHFA in the workplace
6. Accessing MHFA in the workplace
7. Delivering MHFA in the workplace a. Roles and responsibilities b. Boundaries and safety issues c. Examples of help and support provided d. MHFA networks e. Recording and/or monitoring the help and support provided f. Determining the success of MHFA within the organisation

1. Why organisations do and do not take up MHFA

Interviewees gave insights into why the organisation had chosen to introduce MHFA training to members of the workforce. The main reasons included fitting in with an overall organisational approach around mental health, an increased awareness and focus on the importance of staff mental wellbeing, and concerns over mental-health-related sickness absences:

> *… everybody thought it was fantastic and felt really equipped to support colleagues going forward. So it just seemed like it was the right time in terms of just starting this role and wanting to bring new initiatives in because we didn't really have enough going on already* (M025, Org 1).

Some interviewees had specific health and safety duties within the organisation and were instrumental in facilitating change as an extension of their existing roles:

> *Because as well as sort of health and safety advice in general, I've always had an interest in work-related stress and working around that. So as well as kind of general safety advice, as you would imagine, that was how I kind of got into [it]. The Mental Health First Aid was as a kind of extension of that work around work-related stress* (M188, Org 2).

In some cases, organisations had been looking for a course that could meet particular requirements, for example developing employees' awareness of mental health issues, one that involved peer support, and/or a practical and structured approach that all members of the workforce might feel comfortable with and able to use. MHFA seemed to meet their needs:

> *So I was kind of thrashing at trying to find something that we could use, and then appeared Mental Health First Aid. So obviously being a health and safety person I get the first aid idea, and I just thought this looks brilliant, this looks exactly what we need. What we want is to raise awareness, understanding, give people a sort of protocol to use almost so that – because a lot of, I mean the thing that I like about it is a lot of people are not comfortable having conversations. You know, we have a lot of people who would not describe themselves as 'people' people, if you see what I mean, and so it gave a structure for someone to use. And that was why I was like, wow, grab it with both hands* (M0188, Org 2).

Some organisations offered other training programmes around general mental health that were available to members of the workforce, whereas MHFA could specifically address crisis situations:

> *We also have mental health awareness courses as well, specifically for managers, and looking at how they can develop a culture of mental health and wellbeing within their teams, and support mental health and wellbeing on a day-to-day basis rather than just the emergency end of the spectrum* (M025, Org 1).

Some interviewees suggested that their organisation sought MHFA training to follow a trend, or to 'be seen' to be addressing mental health issues:

> *… like I say, over the last nine years as things changed so much and I'm not saying it's a tick-box exercise by any means necessary, but over the last few years we've put so much new, I don't want to say fad things out into the business, but it does seem that they are being overly conscious about every specific issue … It just seems to be another thing* (M052, Org 4).

In addition, some felt that interventions such as MHFA were being used to respond to individuals who had reached a crisis point, rather than the organisations identifying where they might prevent problems from arising by looking at underlying issues within the workplace:

> *So we end up needing a sticking plaster, as in 'I need a time out, I need some help' and going to someone. Whereas really we should be understanding more how people like bosses and colleagues and so on, how they behave and all this sort of thing, how that has an impact* (M177, Org 3).

Work cultures within organisations might not otherwise be challenged until it was too late:

> *I think because of the area of the business that people work within, I think it can be very highly pressured and stressful. So just as I started [working at the organisation], there was an email communication that had been sent around with regards to somebody from the X office who had gone on secondment to the [international] office and actually committed suicide on his first weekend there. And this guy had been dealing with depression and stress that no one was aware of* (M181, Org 4).

One interviewee suggested that although enthusiasm for MHFA was low within his organisation, he did feel that this might change in the future with growing general acknowledgement of mental health:

> *They weren't really particularly interested in doing it at that time. I think they will do once these things become more and more accepted. But we're only just getting into a position where people don't think that mental health is just you're crazy, you know what I mean? They'll realise that everybody's got mental health* (M021, Org 3).

And some interviewees perceived that stigma about mental health might be gradually reducing:

> *And also a lot of people in the past, not so much now, have kept it very undercover. It's been a very unspoken thing within the workplace* (M189, Org 2).

2. Why people do and do not attend MHFA training

Some interviewees indicated that their interest in MHFA originated from personal experiences, and wanting to help others who might be going through a similar situation:

> *I'd suffered from problems myself, and so I always thought if I can, and I like to think I'm a caring person, so if I can help somebody in any way possible, I'll probably go out of my way to try and help them. And I thought I wouldn't want anybody to go through whatever I went through* (M037, Org 4).

Other interviewees did not describe a specific interest originating from personal experience; rather, they stated that their personality traits – or altruistic reasons – encouraged them to pursue training:

> *I've not really got any past experience in mental health; I am a professional coach. I've had training in coaching, and I think it's just my nature really. And probably because of the jobs I've had – I've been frontline – you develop a way of talking and listening to people. And it just appealed to me* (M080, Org 2).

In some cases, interviewees perceived the course, which they did not have to fund themselves, to be relevant to their actual job role and their personal development:

> *One side of it is that I feel as though it's my duty to be quite well rounded as a safety adviser. And I suppose it's not just Mental Health First Aid, it's all types of training that I think can help me do my job. Plus we don't pay for it. I don't pay for it myself, so I think I should take what I can get. But then I think it also – so it helps me in my job, but it also helps me personally as well* (M183, Org 1).

Others cited the desire to gain or extend their knowledge and/or confidence in supporting others, including less commonly known health conditions:

> *I think my hopes for the training course were, like I said, to feel more confident in a situation where I would want to help someone but maybe didn't know what should be done. And I think I just was interested to find out more about things like psychosis and, you know, what to do if in sort of like more towards the extreme side of things* (M168, Org 6).

Staff might be selected to attend MHFA training, in some cases on the basis of their level of management responsibility or perceived level of need. For some organisations, different MHFA England courses were offered to different members of the workforce. More senior members might attend a less intensive course:

> *… so all of our Mental Health First Aiders are fully qualified on the two-day course. We also run the one-day mental health awareness course for people who are frontline managers and people who just need to have that awareness raising, and then we do the half-day course for our senior leadership team as well* (M019, Org 5).

Some interviewees thought that there should be greater representation of certain characteristics or groups of employees, with a greater spread and balance of gender, seniority and job types:

> *… they're all office based, either administrative roles or one of the safety advisers, QS, quantity surveyor. So they're office based, which is why I say what we really want is a spread across. It would have been great to have had a couple of site supervisors as well, or even some lads who are on the tools, you know, chippies or something* (M021, Org 3).

> *There were some people who were very senior. There was definitely what we would call a level four, so that's one off the top level. But most of them were level ones, twos and threes … There was about 20 people there, mainly female; in fact, I think I was one of only two men in the room* (M037, Org 4).

In some organisations the training opportunities were open to everyone. Interviewees spoke about how members of the workforce had been made aware of the opportunities around MHFA training. The most common way in which this was done was via email, although websites and intranet systems were also used:

> *An email came out to the whole office saying all right, we're doing this, anybody want to get involved, just email* (M037, Org 4).

Some interviewees discussed how the perceived responsibilities of an MHFAider might explain how people might be reluctant to attend training:

> *… but it's coming out at the other end and saying, you know, I've been given a responsibility here and I actually need to in fact walk away with notes, work through them, understand them, there has to be, it's almost like doing revision … Because people will know X is qualified, oh, X has been on this, actually I'm kind of more of a danger at that point unless I feel happy with what I've learnt* (M186, Org 1).

Interviewees spoke about perceived barriers and resistance among members of the workforce, and the organisation as a whole, which prevented training opportunities from being taken up. Among these were time pressures and heavy workloads, which might put people off attending the standard two-day course in particular:

> *… but I think also everybody we talk to is always so busy, you know? I haven't got time for this, I haven't got time for that, offering them a Lite course. You might get more people to sign up for it because they're not having to give up two full days* (M080, Org 2).

Another barrier might be their manager:

> *I think probably the only resistance I'm aware of, and I suppose it wasn't really resistance, but just more concern that my boss had about what the effects would be and whether that would take away from what I'm meant to be here doing type thing. But I think that was more just a lack of understanding on that account, and I think once she understood that, she was fine about it* (M085, Org 2).

A busy schedule did not necessarily mean that employees did not wish to undertake the training – they might be protecting their own mental health:

> *I've got to balance my personal life against my work life. And I don't take work home with me anymore, so therefore I try and fit in everything I can during my working hours. There's only so much I can do* (M186, Org 1).

However, there were also people who thought that particular attitudes were prevalent among certain members of the workforce, which contributed to resistance:

> *… the ones who talk about snowflake generations and all of that kind of stuff – in my day we just got on with it, you know, that whole thing. So they're the kind of quite classic, I suppose…people who don't see anything wrong with using derogatory terms, they think people should man up, they think people should just get on with and pull themselves together kind of thing* (M188, Org 2).

And some suggested that they might change these attitudes through attending the training:

> *[It's] very like we're men and mental health is just not a thing: stiff upper lip and all that. There are people in the business that do think like that. And I think if you asked, if they were told that they had to attend the course, it might be different* (M183, Org 1).

However, one interviewee suggested that the non-mandatory element of the training at their organisation mitigated against barriers and resistance:

> *I would say there wouldn't be resistance from the individuals because they volunteer. And they say they want to do it, which is why we always end up with a waiting list and the courses will run for years to clear that backlog* (M185, Org 1).

In addition, barriers and resistance were discussed in terms of the level of support people had received from managers and colleagues to attend training, for example arranging cover:

> *She was quite supportive on that one. I think the issue for her is always if I'm away, they have problems with somebody to cover the reception desk. Because other members of the team are fine, they're a really good team, but they don't like doing reception. So it's always a bit of an issue … other courses I've applied to go on I've had to postpone because we haven't got reception cover* (M080, Org 2).

Managers might be cautious about people with a mental health history attending the training:

> *And of course you had to fill in a form if you wanted to go on the network after you'd done the training, and it obviously flagged up that I'd had quite a serious condition. So they did call me back and have a chat and say, you know, 'Do you think this might be too much for you?' And we just had a chat. And I said, 'Oh no, it's fine.' And they said, 'Oh well, yeah, if you're happy to go ahead'* (M077, Org 2).

Organisations might restrict the number of places available. For Organisation 4, with offices across the country, the two-day courses were no longer offered in some regions:

> *One thing that I don't agree with that X are doing is they've capped the number of people who can do the full two-day course. So there's a quota within the office of how many people they will put through* (M181, Org 4).

Other organisations, on the other hand, might perceive that the longer course was a better long-term investment:

> *I think that when it was put forward to us, it had already been decided that we should go on the two-day – you know, if we were going to do it, we should do it well and get all of the information, so yeah. But I was aware that there were shorter ones available … Personally I definitely would have gone for the two-day anyway* (M168, Org 6).

3. Who should attend MHFA training?

Some interviewees indicated that only those members of the workforce who freely chose to attend MHFA training should do so. An interviewee from Organisation 1 felt that the non-mandatory element of enrolment onto the course was helpful:

> *Everyone was very enthusiastic throughout the course … But I suppose the people that were on that course were people that have generally volunteered to be on that course, rather than people that have been asked to go on that course, or told to go on that course* (M183, Org 1).

However, others thought that people in a crisis might receive more prompt support if all staff had attended training:

> *The information is there, but they weren't in a situation where they could spend time looking it up … I just think if everybody had the training, you know, hopefully then there would be times when somebody would ask something and it would just trigger, oh yes, I know how to deal with this, rather than floundering really* (M080, Org 2).

Many interviewees believed that MHFA training should be mandatory for all members of the workforce, comparing it to physical first aid.

> *I think it should be compulsory, yeah. It's like first aid, you know, you could save somebody's life, couldn't you, if you know what to do. Or you could do harm. And I don't think it should be any different really* (M074, Org 2).

Others suggested that there may be opportunities to make the Lite MHFA Adult course mandatory or initially offered on a wider scale, before recruiting to the longer courses.

Interviewees did not necessarily feel that those who had experienced mental health problems themselves should be given priority:

> *I found that a lot of people that were on the course were there because of their own mental health problems. And while that's really good, it almost became a bit of a storytelling afternoon. Which I can appreciate why that would encourage people, but it would have been better in my opinion to have more of a mix. If for example as a manager you know that somebody, you can see potential for them to be good at something like that, then perhaps it could come from the manager maybe putting their objectives to find out more about it, maybe do the training* (M174, Org 3).

Getting members of the workforce who were in higher positions, such as managers and partners, to help in attending or promoting MHFA was also seen as an area that needed attention:

> *… if leadership push the message, people start doing it. If leadership don't attend these [MHFA] sessions, it's all just word of mouth, and the only way that this will become a prominent thing is when people like myself, God forbid if I'm still there and I am at the top of the chain and can start making these changes myself* (M052, Org 4).

Others argued that priority should be given to those who were willing to take an active role in MHFA following the training:

> *There are people who have done the course who aren't happy for somebody just to rock up to their desk and say, 'Hi, my name's so-and-so; I'd really like to have a chat and a coffee about something which is on my mind', so some of those people are taking up the slots that have been allocated for the training and they're not willing to put the training into practice* (M181, Org 4).

4. Experiences and perceptions of MHFA training

The aftermath of training was explored to ascertain what happened to members who had undertaken training. Interviewees provided details about the types of MHFA England courses that had been

offered to the workforce, as well as which one(s) they had attended. Some interviewees were able to identify the funding source which allowed them to attend, and also how often the courses were run.

4a Intensity/duration of the course

The interviewees from Organisation 6 all worked within the same team, and had only been offered the standard two-day training course. However, this was deemed as a positive thing:

> *I think that when it was put forward to us, it had already been decided that we should go on the two-day, you know – if we were going to do it, we should do it well and get all of the information, so yeah. But I was aware that there were shorter ones available … Personally I definitely would have gone for the two-day anyway* (M168, Org 6).

Some felt that attending the same level of training led to greater consistency:

> *… we set out doing the two-day one – that seems to work, people like it. I don't know, maybe we'd look at the other options further down the line. But at the moment, for consistency, I think it's nice that everyone's had the same level of training* (M025, Org 1).

Both the standard two-day course and the Lite course were offered to the members of Organisations 2, 3 and 4. Most people were keen to attend the standard two-day training and thought that the Lite course would not offer a sufficient level of learning:

> *… the Lite course is now also offered as well. But it seems almost pointless. If you're going to learn a little bit, learn the lot* (M037, Org 4).

However, the Lite course was perceived as a good first step, particularly if allocating time away from work was a concern:

> *I think the time commitment might have a bearing on some people, so get them into the Lite course first. And there will be some, I'm sure, from that who would want to do more, and other people might feel that that was sufficient for them* (M0080, Org 2).

4b Format and content of the course

Interviewees were also keen to highlight the way in which topics had been presented:

> *… case studies, videos, this, that and the other, we as a group would discuss issues that, you know, friends, loved ones, colleagues, even people in the room have experienced themselves – that in itself, I feel, broke down a barrier in that room for people to then understand that we have to keep an eye out for one another* (M052, Org 4).

> *The course and the handbook didn't spend a lot of time telling you stuff you already knew. It was much more hands on. In this situation maybe do this, do that. If somebody's suicidal, don't worry about asking them if they're feeling suicidal, it's at the forefront of their mind, they're not going to be embarrassed by you saying it, or think you're a terrible person or whatever* (M189, Org 2).

Aspects of the course which worked well were identified. Course presentations, resources and practical exercises were viewed positively:

> *I like the range between information on the PowerPoint slides, and we had a couple of booklets that we were able to refer to. There was some role play and some*

> *discussion. There was a bit of writing. And I think that mixture meant that it felt quite engaging throughout the day* (M182, Org 6).

> *I enjoyed all the practical exercises. And I suppose the one that really sticks in my mind is, I presume, are they all the same, I don't know, but she used a piece of paper to talk into our ears to make us understand what it would be like if you suffered with psychosis and you're hearing voices. That was really difficult to go through. So, yeah, the practice side of it was great* (M183, Org 1).

Knowledge gained often exceeded expectations:

> *I got a lot of knowledge about things that I would have never even considered. That was huge. The huge amount of resource that I've now got because of that training is phenomenal* (M037, Org 4).

Interviewees also described how the training allowed more challenging issues to be discussed:

> *I thought it was really good training. I thought it was practical. I thought it took the fear out of stuff. Because to me something like psychosis or self-harm or talking about suicide, it's quite scary in some ways. And it was a safe place to do it and it was done in a supportive manner* (M189, Org 2).

The group face-to-face interactive format was particularly favoured, providing opportunities for people to contribute and to feel comfortable in discussing personal experiences:

> *I think once you start speaking about an issue and people have their opinions, it opens up more. I think in the group that we had, because everybody had their own personal experiences, I think it was good to know that everybody's got – it just put into reality that everybody's got a different story. Which I think can be quite useful if someone goes in there a bit wary; it kind of makes you feel like you're not on your own. Which I don't think you would get that if you had it in a different format. I think over the phone people would perhaps be a bit shy to share and obviously online you probably wouldn't get that opportunity* (M174, Org 3).

4c Attributes of the trainer

Perspectives around the instructor/trainer were offered. Many interviewees reflected positively on the person or people who had run the sessions. Interviewees spoke about instructors' high levels of knowledge and passion and how this had helped attendees to contribute to the sessions:

> *Definitely the trainer itself, she was fantastic. She knew an awful lot about what she was doing and she wasn't just informed, she was excited, and you could tell that she enjoyed what she did and she was passionate about it, which I think made the whole process a lot easier, because people weren't afraid to ask questions* (M184, Org 1).

In addition, interviewees appreciated the personal experiences that instructors shared:

> *There were two ladies that delivered the training. And I didn't realise but on the day two of it, one of the ladies told us her personal story. And I just thought that that was brilliant and I thought it really brought the training to life and, you know, it's always more interesting when you've got someone there that's experienced something* (M168, Org 6).

However, not all felt that the instructors had the required level of knowledge:

> *… that lady came out and presented some stats and figures and when questioned she didn't know what she was talking about – because she couldn't explain as to whether that was right or not, she just basically said, 'Well, this is my slide deck.' And*

> *to a room of people who have got questions and are intrigued, you may as well have just sent us the slide deck* (M052, Org 4).

Some respondents felt that the instructors lacked compassion and sensitivity for attendees who themselves had experienced mental health problems:

> *One of my diagnoses is bulimia. And so we were talking about that diagnosis, and he asked everyone, 'Oh, how would you describe someone with an eating disorder? How would you describe someone with bulimia, etc.?' Everyone sat round me saying things like, oh, like attention seeking, all of these sorts of things. Like poor appearance, bad teeth, smelly breath, all of these things. I didn't really feel like I then wanted to put my hand up and be like, oh, that's me* (M182, Org 6).

4d Suggested improvements to MHFA training

There were suggestions as to how to improve MHFA England course content. For some, even the two- day course felt too superficial:

> *I did think it was very compressed into the two days … I suppose the only way it could be improved is by having greater depth into the set subjects – you know, spending more time on the types of mental health. So you could maybe recognise it in your work colleagues a little bit better. But for what it is, I think it's a very good course* (M077, Org 2).

Other areas of improvement included identifying mental health topics and areas that interviewees felt members of the organisation should be trained in. These were potentially areas that interviewees did not feel had been covered adequately, or at all, by the MHFA courses they had attended, including better training in or understanding of signposting and men's mental health:

> *I think one thing that I would change would be how we look at men's mental health outside of the training. Because obviously we're such a male-dominated organisation, and the most at risk of depression and committing suicide is [males], is it 30- to 50-year-old?* (M174, Org 3).

4e Refresher courses

Another common area of improvement suggested was for some sort of refresher course, which would enable trained members to revisit topics and update their skills, and put MHFA on a par with physical first aid:

> *The only thing that I'd quite like is for there to be a process for refreshing, in the same way there is for being a physical. So I'm a physical first aider and it's on the system, then every three years you have to do a refresher. And it just gives you that confidence that you're still, you haven't gone rusty, especially if maybe you haven't encountered many situations* (M082, Org 2).

This could be a shorter course – eg one day every two years – but more focused:

> *I think it would be good to get some sort of refresher training so far down the line and taking on board the type of experiences that all the network members have dealt with … and try and make it more specific to the more common issues that we deal with really* (M080, Org 2).

4f Providing feedback on training

The majority of interviewees indicated that a feedback opportunity about the training had been given to them, in most cases actioned by MHFA England. Organisational strategies varied from formal

methods to more informal anecdotal feedback. Some interviewees felt that they would like further opportunities from the organisation to give feedback. However, opportunities might not always be taken up:

> *The [organisation's training department] generally send out a survey a few at a time after the event. I don't know what the uptake of that is. Largely because people are like, 'Well, actually, it was two months ago now and I couldn't be bothered to fill the form out'* (M185, Org 1).

4g The impact of training

Interviewees described notable changes that had happened after training had taken place. These varied from changes within the trained person – for example, increased confidence – to wider changes across the organisation.

Some interviewees reflected on how situations had arisen before and after training, and compared how these had been handled differently. Some now felt less concerned that they were going to make a situation worse, or accepted their limits and knew where to refer people on to:

> *I feel a lot more confident in [signposting] now. When I encountered the first one, it was actually prior to my training, so it was a little bit, yeah, I was upset actually because I didn't know. I couldn't do it* (M075, Org 2).

> *And if someone's threatening to take their life or something like that, that's maybe something that I would feel a lot more comfortable [with]. Hopefully that will never happen, but if I was in that situation and someone was in that situation, then I think because of the training I would feel a lot more confident to deal with that situation, yeah* (M168, Org 6).

In some cases, interviewees believed that these differences were a result of MHFA training.

> *And I think the biggest impact was seeing how it was dealt with this time, which must be I think five years after that initial, the awful one basically, maybe four years, something like that, or yeah maybe four years, and so there was a recurrence of the issue. And so the person had to take some time off work. But the difference this time, their manager had completed the two-day training. And they're now back in work in a way that I would never have expected them, and to be able to come back, they've been supportive, they've been supported, plans have been put in place at the level of understanding about what the person is managing and, you know, it's just remarkable* (M188, Org 2).

> *… before he came to me he was in the police shooting people. He was armed response and did a lot of VIP protection. And so he's a very – imagine your typical bruiser rugby player, six-foot-four-type individual. No, I don't think this came from anything from HR or management. This I think was purely the fact that he had done the course and he had an awareness of mental health, definitely* (M191, Org 2).

Some interviewees commented on a change in culture within the organisation, such as improved language and responses, and enhanced passion and enthusiasm around mental health issues:

> *… having that group of people … who basically put their hands up and said I'm interested in mental health and I'm interested in helping people who might have an issue of whatever magnitude, suddenly means it's a bit more in the open* (M185, Org 1).

One interviewee discussed how MHFA training at her organisation had removed the barriers around hierarchical relationships:

> *I have felt that [the people] I can support in that way have been much more senior than me. But they recognise that coming from a place of support as opposed to just*

> *someone junior asking about the problems that someone really senior might have. It doesn't come across like that, which is I think positive* (M182, Org 6).

However, it was also accepted that in some cases, changes could not definitively be attributed solely to MHFA training:

> *This is going to sound a bit big-headed, but I feel like without that course I'd have done equally as well. I just feel like I am that kind of person. I'm quite empathetic and I just take people's vibes on quite quickly and go from there really* (M052, Org 4).

5. Promoting MHFA in the workplace

Interviewees described how MHFA-trained members of the organisation were made known to other members of the workforce. The most common methods were posters, lists of trained members being displayed, and websites, including intranet systems. However, the latter depended on individuals knowing that the information was there:

> *… and we put all of our safety information on there about everything, and we have mental health pages on there as well. So, one of the things that's included on those pages is the contact list of all the Mental Health First Aiders within the X. So as long as we make sure that people know that that's there, then they know that they can get in touch with people* (M183, Org 1).

One interviewee who had not received training reported that posters had actually caught his attention. When posters were used to promote the MHFAiders, these were often displayed in communal places where employees gathered, such as lunch areas. However, more discreet locations might be more beneficial for those who were concerned about stigma or confidentiality:

> *They're in the toilets in our office. I think it's a bit more subtle. If you're going to jot the number down, no one has to see you do it* (M174, Org 3).

And it was important to keep information up to date, indicating that more than one strategy was needed to publicise trained members:

> *Because of the number of people that are continually being trained up, the list is out of date pretty much as soon as it's displayed, so we also have a lot of information on our site, our safety site. So we have a website* (M183, Org 1).

Some interviewees indicated that their organisation's promotion strategies were not enough to make members of the workforce aware of who the trained people were. Visible markers, such as lanyards and badges, might be used to indicate who was trained.

> *I think that we should be given sparkly badges. Something that's quite visible, because I think sometimes if you are in emotional distress, you don't want to have to be looking stuff up on the computer, and maybe you need something that's a bit more visual* (M168, Org 6).

Others questioned whether people would feel comfortable in approaching trained members in this way:

> *Because it's good to know that people are Mental Health First Aid trained and you kind of see it and identify that, but also people who might shy away from it: if they walk up to someone with this lanyard on and then start talking in a hushed tone and then maybe they disappear off somewhere else. I'm guilty of it myself* (M184, Org 1).

Larger organisations often held events at which attempts were made to raise awareness about the MHFAiders available in the workforce:

> *I think it might have been in the programme as well. It basically said like if you're feeling unwell, if you need someone to talk to, if you feel like you need a bit of support or if you're feeling a bit anxious, if you feel comfortable the people who have the red sashes on, that's their own job for the day. So you feel like you can approach them, and they have a quiet room* (M182, Org 6).

Interviewees from Organisation 6 suggested that there were currently insufficient strategies to publicise MHFA at their organisation:

> *But I don't think any of them are really aware that we did the course, truthfully … It's not widely advertised that if you do need to speak to somebody … I wouldn't say anyone else knows except for the people who sit all in the same room* (M169, Org 6).

Even the use of a range of strategies may still not reach everyone:

> *In our department, we have a lot of things on our webpages for staff. We have a lot of publicity material around the building. There's two of us in the department, coincidentally, who are part of the mental health network. And we have our information up, our photographs, our profiles, etc., so that people can see that. But it still surprises me when talking to people from around the campus that not everybody is aware that it's available* (M080, Org 2).

Four of the interviewees had not been trained in MHFA skills, and so the extent of their awareness of how MHFA was implemented and used in their organisations was explored. Not all were aware of MHFA:

> *I honestly haven't really heard of it. It's something that I've not really come across before; certainly not from just kind of passively being here … I'm getting to hear of different things, like mentoring, but not the first aid thing, I haven't. I didn't know it existed* (M187, Org 4).

Another area of improvement consistently identified was around ways to enhance promotion of MHFA-trained members within the organisation:

> *… I think that raising the awareness of who'd actually done it, even if nobody ever contacts them in relation to that, I think would be quite useful. But it's something that the whole organisation should be shouting about really, and encouraging, so, yeah, I would probably say it would be better* (M169, Org 6).

Interviewees highlighted that MHFAiders could, or should, be advertised in a similar manner to physical first aiders, and thus more easily accepted as routine:

> *… basically you have a list of 'normal' first aiders – you know, physical first aiders – and that's stuck to the wall in the staff tearoom. Next to it is the one from the Mental Health First Aiders … that's what the culture is that we're looking for that people have an awareness of; obviously it's just very much normalised in the workplace* (M188, Org 2).

Others suggested that information about MHFA and MHFAiders should be included in staff induction packs.

Interviewees also considered that better promotion of MHFA might help those who did not feel comfortable using the current strategies in place:

> *Ultimately, if they're experiencing difficulties with their mental health, then in all likelihood they're going to end up having to speak to their senior manager or their own line manager at some point. But maybe if they had the option and they knew that there was somebody that they could start that conversation with, who had done the*

mental health first aid course, and who would maybe be able to signpost them to a service that may be useful, and they were more comfortable doing that (M169: Org 6).

In some organisations, trained members took it upon themselves to promote training opportunities via word of mouth:

[MHFAiders] also work as champions. And so they'll talk about the training and about what it means to be a Mental Health First Aider (M019, Org 5).

6. Accessing MHFA in the workplace

The interviewees spoke about how people who had been trained in MHFA skills could be accessed within the organisation. Some organisations had formal systems in place for accessing members, such as networks and lists of trained members on websites.

So on the mental health pages on X there is access to this one particular person who deals with it, so they would then contact that person and they will have a list of first aid(ers) to kind of match up people. Kind of like a really weird dating [service] (M181, Org 4).

However, accessing trained members outside these formal approaches might be preferred:

The person that approached me first of all … asked to speak to me about something completely unrelated, and then when we sat down to talk about it he just immediately said, 'Is anything I say to you in confidence?' And I said, 'Yeah, absolutely.' … He made sure he was happy that it was, and then started to talk to me about what his problem was (M021, Org 3).

Some might prefer to seek support from someone they already knew and trusted. On the other hand, it was also perceived to be helpful to have trained members spread across the organisation, to ensure that people in need of help and support could contact someone whom they did not know if they wished:

We put them on a list, which means that their contact details and their location is listed. So if anybody wants to find one, they just pull them off the list and they don't have to talk to somebody that they already know; they can pick somebody at random in their building or a different building, for instance (M185, Org 1).

Similarly, another interviewee, who was an MHFAider, explained that she had passed on information about other trained members to an individual, as the person had not felt comfortable talking with her:

I've had somebody who knows I'm on the network who clearly feels she knows me too well and doesn't feel comfortable talking to me, but she's asked me how she can contact someone else, which I thought was an interesting twist really. She asked me where the information was and who the people were and how she could find out about who they were. Well, on the website we all have our photographs and our names and then they can follow the link to our profiles. So obviously I pointed her in that direction (M080, Org 2).

Some interviewees indicated concerns about pursuing support from MHFAiders who might be too 'close' to the individual, and risks to confidentiality:

I think the fact that we've got within the organisation an occupational nurse that comes in, I would probably, if I ended up in a situation that I couldn't speak to a colleague, I would probably go and see them as a starter for 10, probably more so

> *than some of the people who've identified as a Mental Health First Aider … I know like for instance the Samaritans have got a phone number you can talk to and things like that. Those sort of things where it's – you're not looking in someone's eyes sort of thing, but you can speak to them* (M177, Org 3).

> *I still personally wouldn't want to advertise if I was feeling a certain way. I'd want to talk to somebody confidentially, not send an all-staff email and say, 'Listen everybody, I've got this'* (M185, Org 1).

In contrast, interviewees from Organisation 6 suggested that because their work focus is mental health, people were likely to be more willing to seek help from colleagues.

There were also discussions around whether trained members would be approached by someone requiring help or vice versa, and what would be preferred:

> *So we ask people to do it in both directions. So to be on the lookout for anybody that might seem like they're particularly stressed, distressed or in some kind of crisis or having a difficult time. I think more often than not it's the individual that would approach the Mental Health First Aiders* (M025, Org 1).

In some cases, MHFAiders' usual work duties were located in a public area, which might deter approaches:

> *I also find it difficult because sometimes people will just come and talk to me, but reception's still happening. And there is always an opportunity to say to them, 'Would you like to go somewhere a little bit quieter and talk to me?' But it's too public a place really, I think* (M080, Org 2).

Other organisational issues could hinder the success of MHFA. These included work and time pressures, lack of resources, lack of support from those in higher positions, unhelpful attitudes towards mental health issues, and a lack of clarity over whose responsibility MHFA is:

> *I think part of that is because everyone is so busy, and they feel, like I would be the same, I wouldn't want to during working hours go to somebody else who was working because I'd know that … they'll then be half an hour behind on everything they're trying to do. So I think the work pressure side of it comes in* (M082, Org 2).

7. Delivering MHFA in the workplace

7a Roles and responsibilities

Since many of the interviewees had themselves been trained, they were able to explain what they had been taught about the role on the course. This included the fact that being trained did not make the person a mental health professional, and that largely the role encompassed talking, listening and signposting appropriately:

> *… because it was made very clear that you're not supposed to be a counsellor, you're just supposed to be a middle person to redirect and let people know the available facilities* (M174, Org 3).

One interviewee also reflected on a key point that she had learnt from the training regarding interactions with people. Here the interviewee describes the point of knowing when the interaction can no longer be regarded as an informal chat, but rather warrants a more formal approach where the trained person would indicate workplace policies – however, this 'point' had to be assumed:

> *I don't know because it's never happened to me, but she said, 'Oh, there's a point where you just know that it's more serious, and things are not going to be sorted just by a little chat', and that's when you would start saying, 'Well, this is what the university offers and there's this, there's the phone line that you can ring, and I assume it would be quite an obvious point, you would just know* (M077, Org 2).

Interviewees provided their perspectives around their own personal role as a trained person within the organisation. The nature of the support given was emphasised, in particular acting as a 'sounding board' and signposting where necessary, highlighting how MHFA-trained individuals were different to professional support systems:

> *But again, signposting and being somebody there who isn't official to maybe help just reflect back to them and help them, a bit of a sounding board. Rather than going around in their head too many times in circles* (M189, Org 2).

One interviewee from Organisation 6 suggested that defining the role of the MHFAider was difficult, particularly in her organisation, which focuses on mental health. She believed that only in certain situations would it become clearer when one was acting in an 'MHFAider' mode:

> *I think some people, being a Mental Health First Aider and just being a friend and someone that's able to listen sort of starts merging in some respects. I guess it would only be if you really were in a sort of an extreme situation that you would consciously think to yourself, right, you know, this is what I need to do in this situation* (M168, Org 6).

For others, the role was also about advocating mental health more generally, rather than only providing help and support:

> *I think a significant part of the role is about just keeping the profile of the mental health agenda reasonably high and normalising discussions about it. I don't think all the time for me it's necessarily about having those one-to-ones, though it can be* (M189, Org 2).

Insights were also provided around how a trained member balanced their roles and responsibilities around this position with those associated with their actual job within the organisation. Some reported that their role did not require a great deal of management, although it could be very unpredictable. However, others found the role more difficult to manage and promote:

> [On doing work around promoting MHFA:] *So I am happy, but I am also unhappy, and I think there's more to be done. It's just finding the time alongside my real job* (M037, Org 4).

Some had duties that were difficult to leave at short notice:

> *I find it difficult because I know people are reluctant to cover … it's too public a place really, I think. But, equally, trying to get someone to cover at a moment's notice is just so hard* (M080, Org 2).

7b Boundaries and safety issues

As well as general indications as to what the role of the MHFA-trained member entailed, there was also an awareness of what the remit of that role was, and where the limitations were, such as keeping the role strictly within work hours:

> *And [there have been] a few situations where people have given personal contact details, and somebody's phoning them in the middle of the night and it's got completely out of hand. So myself and a colleague are just in the process of*

> *developing some guidance around boundaries for the Mental Health First Aiders* (M025, Org 1).

Maintaining the personal safety of the MHFAider was also raised, particularly when balancing the need for confidentiality, and was suggested as an area that should be covered in training:

> *He'd asked me to go to his office. He had quite a few sort of personal issues. However, the girls were worried because they didn't know where I was. And I said I was on mental health work and that was enough for me, but they were concerned because if anything had happened they didn't know where I was. And I said I can't tell you where I am because it's confidential* (M080, Org 2).

7c Examples of help and support provided

Interviewees described incidences where MHFA had been sought and/or provided, providing insights into MHFA in action. The use of skills and delivery of MHFA were discussed, with interviewees describing how they had put their training into practice. This often entailed having a conversation with the person in need of help, and signposting to further support:

> *Last summer we had a student who had a panic attack during an assessed presentation, and I was able to be aware that the other staff member was quite distressed by this and trying to talk to them about it afterwards, just having like a debrief* (M082, Org 2).

Signposting might be to another MHFAider:

> *… but she's asked me how she can contact someone else, which I thought was an interesting twist really … So obviously I pointed her in that direction … I wasn't the right person for her and that's fine. If my help was helping her to find someone else, then so be it* (M080, Org 2).

Some interviewees considered that MHFA had been administered even when the trained person had not been directly or formally approached:

> *I've never been approached as a Mental Health First Aider, but then that's not to say that I haven't dealt with members of my team who've had issues. And because I understand the process and I can kind of understand where they are, but then my role, I suppose, from 2011 until 2015, I was dealing with, well I still do, but dealing with giving advice* (M185, Org 1).

Interactions with people about mental health might take place in an informal way:

> *Sometimes it just develops from an ordinary conversation that you suddenly find yourself listening to things – you know, a different kind of conversation takes a different turn* (M080, Org 2).

One interviewee explained that they had been approached by an individual's manager as opposed to the actual person requiring help and support:

> *So it's kind of about normalising it, but I've also had managers flag up when some people are struggling with various things and they've said is it OK to suggest that they maybe go for a coffee with you at some point. And you say, 'Yeah, absolutely, no problem'* (M189, Org 2).

For some interviewees, the informal manner in which some interactions took place made it harder to attribute their intervention to the MHFA skills they had acquired:

> *I mean, it's someone that I would have probably had a similar conversation with anyway. And actually he was nowhere near approaching crisis or anything like that … So it was after a bereavement. It was probably a very similar conversation to what I'd have had anyway with him* (M166, Org 6).

Interviewees gave examples of how MHFAiders had been able to manage employees who had become very agitated; indeed, this had been the case for one of the interviewees:

> *I was having a bit of a panic attack and just venting all my worries to him in a little meeting room, and then he was like, 'Right, we're going for a walk.' And we did discuss it, but he was also very good at just kind of – he knew that I needed to just get out there and just burn some energy off and just sort of get some fresh air and breathe properly and that was really good* (M184, Org 1).

In the following example, an MHFAider had been formally asked to help:

> *I had a colleague in a different department who was talking at the meeting the other day about how she'd approached somebody who came into her office having a full-blown panic attack and who'd then started also self-harming. And she'd been called because she was the Mental Health First Aider in the department and over a 40-minute period she managed to get him to calm down and resolve the situation* (M189, Org 2).

Advice and support might be extended indirectly to others outside the workplace, eg family members. This MHFAider had been approached by someone in the workplace who was seeking advice about his daughter, who was struggling with her mental health:

> *And he said, 'What can I do? What do you suggest?' So I just referred him to a few of the websites, Living Life to the Full and things like that, as a place to go to get a bit more information that might help him. Because there was no guarantee that that would happen when she finished, but I thought that might be a useful place for him to get more information* (M183, Org 1).

Other interviewees recalled using their skills with individuals outside the workplace:

> *And she got on and she sat in front and she was twitching violently. And she was really upset and you could see that she just was not right. The guy sat directly in front of her tried to address her and talk to her, and she wasn't really responsive. I was sat in the row behind her. So I just thought she can't see me, maybe she will engage because she doesn't feel as vulnerable. And she did and, you know, I talked to her through the gap in the seat, which is not the most effective technique, but for her it worked* (M052, Org 2).

Other ways of providing help and support included searching for and/or providing information if the MHFAider was unable to give it immediately:

> *And I just said to him, 'I will need to go away and find this out for you and I will let you know as soon as I've got some information.' Because there was no point in me doing [anything] other I think, but I think the fact that somebody who could just take charge of it was enough for him at that point. I don't think he expected me to have all the answers straightaway* (M80, Org 2).

Another interviewee had become ill in 2017 and was signed off work due to mental health problems. He described his return to work with the support of his manager, who was an MHFAider. Initially, he spoke about the contact that was maintained during his time off work:

> *[My manager] used to send me a text and ask, 'How are you feeling, do you fancy a chat?' And most of the time it would be, 'Yeah, I'll have a chat with you.' Occasionally it was, 'No, I don't want to talk to anybody at the moment', and that was always fine.*

> *He said, 'Fine, OK, sorry you're having a bit of a tough patch, but keep in touch'* (M191, Org 2).

This interviewee then described how his manager had made adjustments to his workplace so that he did not have to return to work in a busy open-plan office:

> *So [my manager] came up with a plan, and he said, 'OK right, there's what they call the reflection room. It's a little tiny office at the end of the corridor. No one uses it.' He said, 'Do you want to move into there?' I said, 'Oh, that would be good, yeah, if I could move.' He said, 'Yeah, we can just move your office into there'* (M191, Org 2).

7d MHFA networks

Most of the organisations had a 'network' of MHFAiders, which in some cases had developed as a result of having trained members on the workforce; otherwise, there was a risk that the training might not be acted upon:

> *We have a mental health network now, which is basically all of the Mental Health First Aiders. So I didn't want it to be just go on a training course and then off you go back to your respective parts of the business, and you forget about it over time. So we've got, and this is still very much evolving now, but we have an email distribution list for everybody, just starting a newsletter for everyone* (M025, Org 1).

Joining the network of MHFAiders was voluntary, which was generally supported in that members were more likely to be motivated:

> *I like the fact that it works with it being voluntary, because then you only get people who really want to do it who are doing it. And there is that aspect to it where, you know, no one is going to be doing this other than they actually feel that it's a good idea and they will, you know, they can see it's a good idea* (M188, Org 2).

This interviewee had joined a network to challenge existing perceptions in the workforce:

> *And part of it was, no, I want to do that so that people can see that there's somebody in security that you can talk to, so I wonder what they're like, you know, because security tend to be viewed as just knuckle-grazing thugs. And I thought, no, and if I can be on there and talk to people, that will be really good* (M191, Org 2).

The MHFA coordinator from Organisation 2 clarified what she felt the responsibilities were of MHFAiders who had not joined the network. These trained individuals would not be listed on the website as visible trained members. In Organisations 1, 2 and 5, the MHFA networks could only be joined by people who had undertaken the two-day standard training. Organisation 4 already had a network in existence prior to MHFA training being introduced to the organisation, serving as a group for people with an interest in mental health issues.

Organisations 1 and 4 had an overall national network, and then smaller local networks across regional offices. This could facilitate the sharing of information and resources.

As well as being a way of accessing MHFAiders, the networks also had other functions, such as mutual support, providing information and championing the service:

> *… so I wouldn't say it's further training, it's just recapping, and we discuss certain specific areas – like, I mean, next week I think it's people who have had some sort of abuse … And they did offer a meeting on suicide and how to deal with it in the workplace. So it's just like extra bits of information, and people discuss what cases,*

> *not specifically, but what's happened that month, and if there's anything, any other business really* (M077, Org 2).

In Organisation 1, one MHFAider had set up a workplace peer-support group following training to enable employees to discuss their mental health experiences:

> *… that's been really good, because we have all sorts of people from all walks of life come in. And you can have nothing in common at all, but we can all sit and talk of our experiences of mental health. And I think people are benefiting from it. And it's just really nice to help people and reassure them* (M184, Org 1).

7e Recording and/or monitoring the help and support provided

Formal recording procedures regarding interactions between trained members and those being helped and supported were used in some organisations, although details might be limited because of concerns about confidentiality:

> *We ask our Mental Health First Aiders just about an e-form, which is essentially just the Mental Health First Aider's name, the department that the person comes from and the nature of why they were having the conversation and any signposting advice they gave. There's an option for them to give a name if they think that's appropriate and if they think it might be an ongoing thing, but it remains completely confidential and accessible only by the Mental Health First Aider* (M019, Org 5).

Others used less formal methods:

> *… but we also have an informal recording kind of form, which is for when you might notice someone in distress and just have a chat with them or you're having coffee and things come up and you just start using your skills a bit more informally* (M019, Org 5).

This person's account highlights the challenges of capturing all MHFA interactions, since some people may not be conscious that they are giving MHFA:

> *We are asked that if we have to use our training within the business that we provide some sort of information about where we've used that and how we've used it back to X team. So that is captured. But I think some people will probably use it and not realise they've used it. I've used it but not for people in the business* (M083, Org 1).

The MHFA coordinator from Organisation 2 had directed the MHFAiders who were listed on the network to formally record their interactions, whereas those not listed were not obliged to.

The risk of breaching confidentiality was highlighted by several interviewees. In addition, some felt that the requirement to record interactions might discourage people from seeking help from trained members:

> *I wasn't going to go and put it down anywhere, because of the risk of it leaking, as it were. And we don't have a system, we don't have any system – well, we've got a database where if somebody has an accident or an injury, all that information goes on there, and any investigation goes on there. But we don't have the same thing for anybody who's raised a mental health issue … If we did that and we did start recording things, I think that would discourage people from actually coming forward* (M021, Org 3).

Another interviewee explained why people might be reluctant to have details recorded:

> *No, it's completely anonymous. So I would never write down anything unless I was formally told I had to … [I] think people are scared of management using it as a stick to beat them with* (M037, Org 4).

Written records were not necessarily the best format for capturing details around how MHFAiders had used their skills:

> *I struggle with forms, completing forms, because I just don't particularly enjoy completing the forms, and I don't feel like I can write it all down. I wouldn't outline every time I've used the training on a form, because I just think I haven't got the time for this. I'd rather sit in a room, I think, with a group of people and share how I've used it and when I've used it, and am I still using it?* (M183, Org 1).

On the other hand, the idea of recording interactions might have practical benefits for one interviewee:

> *… but for my own peace of mind, my own, you know, obviously you don't want to find you're having the same conversation with somebody that you had a year ago and you'd completely forgotten* (M074, Org 2).

The benefits of keeping records of interactions helped to identify how MHFA was being used. Sharing selected details and accounts of interactions also facilitated sharing of best practice and enabled interventions to be evaluated:

> *And discuss how they responded and what the situation [was], what could be done differently or not* (M189, Org 2).

Some interviewees considered that MHFA interactions should not be subjected to the same standards as physical first aid, but others disagreed:

> *I suppose another point that's just coming into my mind talking about it, in a physical health sense, whenever there's any kind of first aid there needs to be a record of it, doesn't there? So given that we are supposed to be combating stigma, you could argue that you should have the exact same requirements around Mental Health First Aid* (M166, Org 6).

MHFAiders might feel it an unnecessary intrusion to ask too many details about the outcomes of their interactions:

> *[He] didn't go into any details, so I didn't ask him for any details, and he didn't say, 'Yes, I'm OK because I've been having counselling or CBT', or taking whatever antidepressant or whatever, or been to the doctors or whatever. I didn't enquire about that, just asked him was he OK? He said yeah, so OK. He's a big boy; he'll tell me if he's not or if he needs anything* (M021, Org 3).

7f Determining the success of MHFA within the organisation

Determining success was perceived as a challenge, as measuring effectiveness was a complex task given the nature of MHFA and mental health.

Although interviewees generally supported the provision of MHFA in the workplace, it seemed there were few objective methods used by organisations to demonstrate its specific success in managing employees' mental health problems.

Evaluation was largely anecdotal based on experiences of individual cases:

> *I think the fact that that girl I spoke about earlier came to me and asked if I was OK is to me an indicator that it was successful. Because it just made me think: if I was in a*

> *sticky situation, for me personally if she'd have done that it would have been like an opening to share something, I think* (M174, Org 3).

There was uncertainty as to how individual change could be measured:

> *You need real-time feedback from people who've actually had that interaction with a Mental Health First Aider, which I actually don't know myself who has. So I suppose it's getting feedback … And I suppose it would be looking at that data and seeing if there's been any positive changes since Mental Health First Aiders have come in* (M085, Org 2).

General markers such as staff engagement and health and wellbeing could be used to demonstrate success:

> *From a personal success point I would say if – I mean, I don't know if you know the happiness [test], I think we should start doing sort of a happiness test in the office to see how happy people are, sort of anonymous* (M037, Org 4).

Sickness absence monitoring could be used in the same way:

> *You could look at actually how many people are off sick with mental health – because you could argue that were my department to have been much better, they might have recognised the signs that I was struggling long before it became at the point where actually I couldn't work anymore* (M191, Org 2).

However, there was perceived to be a potential difficulty in relying on reduced sickness absence data, if sickness absence was given to the person to give them the time and opportunity to access further support.

Organisations might consider measuring the number of people who had engaged with trained people, and the times and numbers of interactions:

> *I think more questionnaires and asking people if they've sought help from someone because they're a first aider would be a good way of assessing it* (M168, Org 6).

Other interviewees made the distinction as to what the organisation, as opposed to them personally, might regard as a sign of success:

> *Look, I work for a financial services firm. They are going to look at sick days. That's all they're going to look at. They're going to look at how much time that we've saved and then they're going to put it into a monetary figure and then they're going to tell us how well we've done at the end of the year with regards to time saved on holidays. That's it – essentially, that's all they'll look at … But I'd just like some way of dipping a finger in the water to see – have these conversations been heard and how have they been? Have people been better who have had these conversations? Do they feel better supported if they have had these conversations? Can they fill out a little survey for us to see how we've done?* (M052, Org 4).

In addition, although improved situations were capable of being recognised, interviewees suggested that these were not necessarily measurable or easily attributable to MHFA:

> *I think it's a difficult one as well, because like I said to you, I think [for] some people, being a Mental Health First Aider and just being a friend and someone that's able to listen sort of starts merging in some respects* (M168, Org 6).

There was also the issue of confidentiality, which was recognised as making it difficult to obtain data:

> *I don't really know, because it's not a statistic that we receive in the network. So it is kept quite confidential for anyone who has approached either the X scheme or an individual directly* (M181, Org 4).

Effectiveness and success were also acknowledged as difficult to determine, because it wasn't always possible to establish or follow up what had happened following interactions:

> *… because I suppose, you know, sometimes, when you feel like it's a bit open-ended and you don't know if you have said the right things, or you haven't said the right things…You know, did I do the right thing? And it sometimes can be difficult to know, really* (M182, Org 6).

4.4 Discussion

4.4.1 Motivations for training

The perceived organisational motivations articulated for implementing MHFA training supported the survey data around wanting to address staff wellbeing. However, as with the survey data, there were some negative perceptions around organisational motivations. For example, one person believed that staff wellbeing was not the priority for his organisation in embarking on MHFA training, while another felt that MHFA was introduced as a way to address arising mental health problems rather than as a preventative measure. Although many organisations were motivated to take steps to increase the wellbeing of their staff, the underlying major drive was to have a productive workforce. Organisations need to believe that there is an association between these two aspirations.

4.4.2 The training experience

The MHFA training experience was largely positive, with credit given to course coverage, and instructors described as passionate and engaging. Where negative experiences were discussed, this was mainly due to individual approaches taken by some instructors, which limited the engagement of the interviewees in their training session. The length of the two-day standard course was one area where potential improvement was identified, although there were some conflicting messages around this. For example, while interviewees described the need for the course to be longer to prevent content from being compressed and trainees from becoming too tired, other interviewees also felt that some resistance to training was due to the two-day commitment proving lengthy amid other work responsibilities. Managers were particularly concerned about releasing staff to attend for this reason. Notably, one interviewee who had not received MHFA training said that his busy work schedule was a key reason why he had not attended. These conflicting opinions around course length suggest that a compromise should be sought that would enable managers to comfortably release staff for training, while also having the courses structured along a timeframe that would mitigate against content being rushed. Issues with course length had also been identified from the survey data, suggesting that it is a priority. The interview data also suggested that having more managers attending training could allow a compromise to be reached, since managers may be more inclined to support initiatives in which they themselves are directly involved.

Course content was also a topic of interest. While the survey data suggested that respondents desired more practical elements, many interviewees highlighted that these had been present in their training sessions, and regarded them positively. This included a practical exercise which aimed to provide insight into what it was like for a person to experience hearing voices. The diversity of content, such as PowerPoint slides, group discussions and course materials, was perceived to be positive. However, one interviewee felt that her course became a 'storytelling' session due to the high number of attendees who disclosed personal experiences, rather than a training programme. Others disclosed personal experiences within training sessions, as highlighted by another interviewee who suggested that she had been upset by the negative stereotypes about her own mental health condition that were being discussed. Having attendees from across the organisation, particularly the larger ones, was believed to be preferable, since it enabled trained people to be spread across

different departments and different sites. Practically, it also meant that individuals could have the option of seeking help from someone whom they did not know or see every day.

Other course-related issues that emerged from the interview data included support for making the Lite MHFA Adult course mandatory for workplaces, with a preference for keeping the longer courses voluntary. There was also a desire for refresher training to be made available, which was consistent with the survey data. One organisation had organised its own refresher sessions, working with the instructor who had provided the original training, and reported that take-up of this had been positive. The consensus was that refresher training would enable knowledge and skills to be updated, particularly in light of trained individuals having real-life experiences to reflect on by that stage. MHFA England are currently in the process of piloting a new half-day Adult MHFA Refresher course, which is aimed at people who have attended either the Adult MHFA two-day or the Adult MHFA one-day course (62). This is currently being piloted with instructors, who will provide feedback to help with product development.

4.4.3 Post-training

4.4.3.1 Feedback

Interviewees also specified that they would like further feedback opportunities post-training. Beyond reviewing the actual training experience, respondents felt that further feedback around the actual interactions and experiences people had had when using MHFA in the workplace, notably in the delivery, was needed. This may indicate that there is a need for a system to be in place within the organisation to allow monitoring of MHFA. This issue had been identified in the survey also. Feedback mechanisms could be instigated by the organisation, potentially with the support of MHFA England, since both could benefit from this knowledge.

4.4.3.2 Roles and responsibilities of trained people

Most interviewees had clarity over the roles and responsibilities of the trained person, most notably that they were not a mental health professional, the importance of the signposting aspect and the limitations of the role. Interestingly, those who had not received training still had an awareness of the types of support that a trained person could provide. However, expectations of the responsibilities of the trained person within the workplace varied widely across organisations. Some organisations expected their trained members (largely those who had attended the standard two-day course, and were therefore MHFAiders) to join a network within the workplace. This network was often then a formal way in which individuals could identify and access MHFAiders, thus promoting these individuals as ‘visible’ trained members. One organisation expected their MHFAiders to champion the programme across the business, as well as providing help and support to those who required it. For other organisations, being an identifiable trained person in the workplace was voluntary, though interviewees from these workplaces did want to become visible.

In one case, an MHFAider reported how they had supported staff who were more senior than them. This raises an interesting point as to whether, and how, the seniority of staff impacts on the delivery and uptake of MHFA in the workplace, and the extent to which stigma and/or power relationships might affect its success.

Of most importance was that significant issues were identified around the lack of clarity around boundaries. There were examples given of individuals who had been supported and became attached to the trained person and in one instance contacted them outside work. There was concern that this took advantage of the trained person. In one organisation, this had led the MHFA coordinator to develop specific guidelines, while in another the MHFA coordinator said that there had been

discussions around how to deal with such situations. Clarity around roles, responsibilities and remits should be operationalised by the organisation beyond the initial guidance provided by MHFA England, and should directly acknowledge the potential risks to MHFAiders.

4.4.3.3 Identifying trained people

Although the survey data suggested that many individuals were able to identify MHFA-trained people within their organisations, the interview data indicated that this varied across different workplaces. Generally, there seemed to be clearer systems in place for larger organisations. Formal systems for accessing MHFA-trained individuals seemed beneficial, but without promotion and clarity, the awareness of MHFA was limited. Posters, intranet systems and MHFA networks were used for raising awareness about MHFA, though a combination of strategies seemed more successful than relying on just one.

4.4.3.4 Measuring impact and success

The interview data suggested that there were challenges in relation to assessing the impact and success around MHFA within the organisations. This was largely because of the informal ways in which help and support was given, even to the extent that the trained person did not necessarily reveal their trained status. It should be noted that in these situations, they were not being approached as someone who had been trained in MHFA skills. Through the interview data, snapshots of MHFA in action were captured, and many commented that intervening as a trained person often arose from initially talking about something unrelated. Consequently, MHFA was not always provided on the basis of the person going through formal approaches to access the trained person. Notably, one interviewee commented that she found it hard to differentiate between being an MHFAider and being a friend – similarly, Organisation 6 interviewees highlighted that they perceived their workplace to differ from other organisations, since as a mental health charity, this was at the forefront of everything they did. This therefore made it particularly hard to identify when they were giving MHFAider support. This blurring of boundaries also made the issue of evaluation problematic.

On the other hand, there were also clear examples offered by interviewees where they had identified responding to individuals and attributed this to being a trained person. Interviewees spoke about how they felt MHFA skills had been employed, with some even going as far as making comparisons to how similar situations had been handled less well before training. MHFA support ranged from holding conversations to providing information and signposting. In addition, three interviewees were able to provide details of having been personally supported by an MHFAider. In these cases, MHFA had been administered through conversations (verbal and texting), taking the person out of the workplace and planning a return to work; these were perceived as positive experiences. As well as insights into how well MHFA had been given and received, interviewees commented on notable changes in their confidence in dealing with situations and on the wider changes in their workplace culture, which included achieving an environment where mental health issues could be discussed more openly.

Yet, beyond offering personal perceptions, it was recognised that there were limited strategies for measuring impact and determining success. Interviewees commented that this was further challenged by the fact that there were fewer opportunities to follow up on what had happened to the person once MHFA had been given. It was also acknowledged that there may be differences between the organisation and individuals themselves regarding their perceptions of what would constitute success. While mental-health-related sickness absences were seen as a potential way in which to assess the

effectiveness of MHFA, one interviewee noted that an increase would not necessarily indicate failure, since the person may be taking time off to receive further support.

The interview data suggested that impact relating directly to MHFA-related interactions could best be assessed where there is a formal system for recording the use of MHFA (delivering and receiving). Some organisations had already implemented this, but where it was not mandatory, interviewees did raise concerns over potential breaches of confidentiality. In addition, although some interviewees worried that mandatory recording of conversations might dissuade individuals from seeking help from trained people, others suggested that anonymous recording, with the consent of the person being assisted, may be acceptable. Where recording of interactions was taking place, this allowed the organisation to monitor the MHFA in several ways – for example, what problems were being addressed, what approaches were taken, the outcome of the interaction and what further training needs were required. It may be the case that it is simply not feasible to measure the impact of MHFA through the end user, and that other, surrogate outcomes, such as managerial and/or organisational developments and improvements, are more achievable.

On the surface, it seemed that we did not recruit as many individuals in the workplace who had received MHFA from trained members as we would have liked to. However, we found in the interviews that in some cases, trained members were also individuals who had themselves received support from another trained person. Therefore, the two groups were not necessarily mutually exclusive, and we were able to collect some perspectives from those who had received MHFA. With hindsight, we would have changed our methodology to employ a specific recruitment strategy to increase participation of individuals who had received MHFA. In addition, it should be acknowledged that those with little or no knowledge of mental health issues may be more satisfied with, and less critical of, MHFA training than professionals with experience in this field.

4.4.3.5 MHFA networks/communities

MHFA networks were a common way in which trained people could join a community. The creation of MHFA networks enabled a formal system to exist by which individuals in the workplace could identify and access trained individuals. Moreover, the MHFA networks were also seen as ways in which trained individuals could connect with each other, share experiences, identify best practice for using MHFA skills, submit problems, promote future MHFA training opportunities, raise awareness about mental health more generally, and receive further training and education around particular issues. In our study, the larger organisations with several sites had one major network, with smaller networks in localities. Connections were maintained through email and by telephone, while smaller networks had regular face-to-face meetings. Given the range of network activities that were identified by interviewees, introducing MHFA networks may offer another way in which the MHFA programme within an organisation could be monitored.

CHAPTER 5. KEY CONCLUSIONS AND RECOMMENDATIONS

5.1 Key conclusions

The findings should be understood in the context of the study, which collected data from organisations and individuals with an interest in MHFA, many of whom had received MHFA training. Our aim was to gain insight into how MHFA had been implemented and used across different organisations. Therefore, we recognise that the views expressed may, to some extent, be polarised, as we did not recruit from organisations that did not have MHFA training.

MHFA is one strategy for addressing mental health issues

MHFA appeared to be a useful 'vehicle' for raising awareness around mental health issues, but we cannot ascertain whether it is the best or only means of doing so or indeed whether it is cost-effective. As identified by the scoping review, survey and interview data, other initiatives are available to organisations that are being used, either alone or in conjunction with MHFA training. Interviewees also identified other strategies and approaches used by their organisations to raise awareness and promote mental health. Some of these on the surface appear to cost considerably less than MHFA, but there is also little, if any, evidence about their effectiveness either. It could also be argued that as MHFA trainers are not required to be mental health professionals, this in itself should make for a more cost-effective delivery.

Clearly, there were expectations about what MHFA training might have achieved, and based on the perceptions of individuals we surveyed and spoke to, some of these expectations were met. Certainly, individuals within the organisations from which we recruited believed that MHFA training had increased their confidence, understanding and awareness, as well as having enabled them to deal with situations where they needed to provide support. Many survey respondents felt that signposting in their organisation had improved following MHFA training, and it was a skill that interviewees referred to when they gave practical examples of providing MHFA. Notably, one interviewee suggested that he had struggled with signposting prior to training, and believed that it had improved after finishing the course. However, others could not confidently attribute their ability to deal with situations solely to the MHFA training they had received.

It is important to note that some individuals believed MHFA training had been introduced into their organisation as a tick-box exercise in order to give the impression of taking mental health seriously. One interviewee suggested that MHFA was part of the organisation's preoccupation with topical issues, suggesting that it was not necessarily being implemented as a service to address the mental health needs of the workforce. Thus, some believed that the training could be used to give a false impression that mental health issues were being dealt with by their organisation. One of the limitations of MHFA is that it does not in itself tackle any underlying issues within the organisation that may be contributing to the mental health problems of employees, such as workplace culture, stigma, work organisation or job design. Such issues may in turn impact on the uptake of MHFA in the workplace.

The active ingredients of workplace MHFA

This research enabled us to gain some insight into the elements of MHFA implementation that were perceived to contribute to its success within an organisation. It seemed that having clear visions and rationales for introducing and progressing the programme was helpful. Managerial support was believed to be vital in making training more accessible, although this could still be challenging, particularly in approving time to attend the standard two-day MHFA course.

Having individuals who were motivated and enthusiastic MHFA coordinators was advocated as being one of the most important ingredients to encourage members of the workplace to support MHFA. The MHFA coordinator was often the person who had championed the training programme and convinced the organisation to introduce training to staff. Post-training, the coordinator also provided support to those who had been trained, dealt with any issues and concerns, and led MHFA networks. Clear systems for promoting the identity of and accessing trained members were also viewed as facilitating success, as well as the need to be consistent across the organisation.

Mandatory recording of formal MHFA interactions (ie where the trained person has been intentionally sought as an individual with MHFA skills, or has made clear their status as someone who has been trained) provided a method in some organisations for monitoring the delivery and receipt of MHFA in the workplace. This was conducted through online forms and databases. The collection of anonymised, basic data around the presenting problem, the approaches taken and the immediate outcome was considered by participants to be appropriate, with the assurance that confidentiality would not be breached. However, it was also recognised by participants that it may not be possible or feasible to record informal interactions. This suggests that it may not be possible to measure the impact of MHFA from the perspective of the employee or end user. Data collected from the survey and interviews indicated that workplaces do not have adequate or reliable measurement methods, with some relying on surrogate measures, such as sickness absence, or anecdotal feedback, with many unclear as to how they might approach this.

Finally, a ‘community’ of trained members – namely, an MHFA network – was identified as allowing experiences to be shared and problem-solving to take place, suggesting that this may help MHFA to work well. Participants perceived such networks to be a support system where they could discuss MHFA interactions and assess how they might have done things differently. In addition, the networks also supported members’ involvement in other endeavours related to mental health, such as raising awareness. Moreover, the existence of a network provided some organisations with a formal way of accessing trained members.

Barriers to MHFA success within organisations

One of the fundamental issues raised was around the measurement of impact and success. A key challenge identified is that MHFA ‘in action’ can include informal conversations, and some interviewees noted instances when it was difficult to fully ascertain whether they were intervening as a trained person or as a colleague or friend; evaluation is therefore potentially problematic. One interviewee commented that trained members may even be using their skills without realising it. The lack of opportunities for trained members to follow up on what had happened to the person further limited opportunities to assess the impact of MHFA. Poppy Jaman, the former CEO of MHFA England, recognised this issue and has previously stated that traditional scientific methods of evaluation may not easily capture the effectiveness of MHFA interactions (63). However, moving forward, it would seem that this needs to be addressed.

In organisations where MHFA was perceived as not being successful, or was limited, there were barriers identified around work and time pressures. These included reservations regarding the time needed for staff to attend the standard two-day MHFA training course, concerns about how responsibilities may be too onerous and difficulties faced by individuals in balancing the MHFA role with their actual job role. A particular area of concern was the issue of establishing boundaries as an MHFA-trained person; in some instances, there were no boundaries or safeguards in place. Interviewees provided examples where individuals were seen to have become overdependent on the trained person, including one situation where the MHFAider had been contacted in the middle of the night. This is an area which needs much more attention given the potential risks to the trained MHFA person.

Weak or inconsistent strategies around identifying trained members and promoting MHFA generally appeared to result in a lack of knowledge as to how to access and use the service. This may be another potential barrier to MHFA success. Such inconsistent and/or weak promotion of the identities of trained members also meant that some members of the workforce did not know whether they could access further MHFA training opportunities. For some organisations, department or site-specific promotion strategies around making staff aware of who had been trained had been initiated by trained people themselves, rather than by management. Although this had been successful, it was sometimes perceived to be an added pressure for those who had been trained.

MHFA England course-specific issues

The duration of the standard two-day course was an issue, particularly for managers and those who had undertaken training. While there was reluctance from management to release staff for two consecutive days, some participants felt that two days was insufficient to adequately cover content, and was tiring. It was suggested that a blended training package comprising both face-to-face and e-learning elements may be appropriate, as may having the course run over a longer period of time. If the latter was the case, running the course over a number of weeks, rather than over consecutive days of the same week, might be more realistic from managers' perspectives.

Refresher training was consistently mentioned as a potentially helpful resource for enabling knowledge and skills to be updated. Study participants felt that refresher training would be particularly worthwhile in instances where there had been limited opportunities to use their skills in the workplace. Likewise, even when skills had been used, refresher training was seen as an opportunity for these experiences to be discussed and for shared learning to be of value.

The need for evaluative feedback opportunities within the workplace was also highlighted by several participants. This would provide the organisation with perspectives around the actual training experience itself, as well as the implementation of MHFA skills. Organisations could liaise with MHFA England on this, and both would potentially benefit from such feedback.

5.2 Key recommendations

Key recommendations are summarised in Tables 14 and 15. Table 14 presents overall recommendations around MHFA, while Table 15 specifies recommendations specific to the MHFA course.

Table 14. Overall key recommendations

Overall recommendations	Details
1. Further research into and evaluation of the effectiveness and cost-effectiveness of MHFA training	- More research, potentially further feasibility work, is needed to evaluate the effectiveness of this intervention, before its impact and success can be determined. - There is a need to recognise that MHFA is the most well-known intervention for addressing mental health needs, but there are other interventions which need evaluation.
2. Clear definition of the trained person's role within the organisation, with guidelines around the role, boundaries and safeguarding procedures	- A formal MHFA coordinator should be appointed within the workplace to oversee the MHFA programme and provide ongoing support to members who have undergone training. - Guidelines should be formulated and disseminated within organisations to define the role of the trained person (ie MHFAiders, champions, and individuals who have attended Lite MHFA training), and the role should be operationalised so that limitations are highlighted, eg availability. - Safeguarding procedures should be in place, eg debriefing sessions for trained people to discuss MHFA experiences/interactions.

Table 15. Specific recommendations for MHFA courses

Specific recommendations for MHFA courses	Details
1. Further opportunities to evaluate courses	- Provision of more evaluation opportunities at different time points post-training. This could be done collaboratively between MHFA England and individual organisations.
2. Review of the standard Adult MHFA two-day course	- Review of length, format (which may need adapting to suit workloads and gain support from managers, eg a blended format comprising face-to-face and e-learning elements) and content (including whether more practical elements such as role play should be considered).
3. Refresher training	- A refresher course could be offered to trained members to enable them to refresh their skills, knowledge and awareness. - Format, content and length should be determined through feedback from trained members.

5.3 Limitations

There are acknowledged limitations to the MENTOR study, most notably:

- All data was collected from UK-based organisations and individuals who had an interest in MHFA, and therefore our sample could be regarded as biased.
- Data was based on individual perspectives as opposed to those of the organisations, and although survey respondents may have responded on behalf of their organisations, we cannot make the assumption that this is what was actually done.
- Regarding the survey, we were unable to determine how many organisations had received training from the MHFA Client Experience Team. This may have limited our analysis, since we were unable to examine potential differences between organisations trained by the Client Experience Team and independent instructors.
- We also acknowledge that we received many 'Not sure' responses in the survey, highlighting that survey respondents may not have been in possession of the information which would have enabled them to provide definitive responses. On the other hand, 'Not sure' responses may indicate that MHFA-related information was available within the workplace, which in itself is an important finding.
- We were unable to recruit as many individuals who had received MHFA in the workplace as we would have liked; recruiting more individuals would have provided further insights.

Nevertheless, the MENTOR study was the first to investigate the implementation, use and utility of MHFA across different organisations from the perspectives of their staff. Individuals were open and many were willing to provide detailed insights into a whole range of their experiences around mental health in the workplace, including personal experiences of mental ill health. There is no doubt that the profile of mental health issues in the workplace has improved significantly over recent years; however, there is still much work to be done to ensure that what is being implemented is effective and cost-effective.

APPENDIX 1: Scoping review table

Organisation	Name	Type	Location	Objectives	Summary of content	Maximum no. of delegates	Cost	Duration	Website link
MHFA England	Adult MHFA Two Day	Face to face	At a centre for individuals. In-house available for organisations	To provide an understanding of mental health issues and practical training in order to become a Mental Health First Aider	An in-depth understanding of mental health and factors that can affect wellbeing Mental health issues covered include depression in the workplace, bipolar disorder, suicide and self-harm, anxiety disorders, psychosis and schizophrenia, alcohol and drugs, crisis after traumatic events, and eating disorders Practical skills to spot triggers and signs of mental health issues Confidence to step in, reassure and support someone in distress Enhanced interpersonal skills such as non-judgmental listening Knowledge to help someone recover their health by guiding them to further support	16	£300 pp (recommended price) but costs can vary depending on location and instructor. Occasionally, some instructors can access local funding to offer discounted places	Two days	https://mhfaengland.org/organisations/workplace/2-day/ https://mhfaengland.org/individuals/adult/2-day/
MHFA England	Adult MHFA One Day	Face to face	At a centre for individuals. In-house available for organisations	To provide awareness of mental health and provide training in order to become a mental health champion	An understanding of common mental health issues Mental health issues covered include mental health and stress in the workplace, depression, anxiety disorders, eating disorders, self-harm, psychosis, alcohol, and drugs Knowledge and confidence to advocate for mental health awareness Ability to spot signs of mental ill health Skills to support positive wellbeing	16	£200 pp (recommended price) but costs can vary depending on location and instructor. Occasionally, some instructors can access local funding to offer discounted places	One day	https://mhfaengland.org/organisations/workplace/1-day/ https://mhfaengland.org/individuals/adult/1-day/
MHFA England	Adult MHFA Lite course	Face to face	At a centre for individuals. In-house available for organisations	To provide an introductory session to raise awareness of mental health	An understanding of mental health and emotional wellbeing, and how to challenge stigma A basic knowledge of some common mental health issues (depression, anxiety disorders, psychosis and schizophrenia, bipolar disorder, eating disorders, mental health and risk, suicide and self-harm) An introduction to looking after own mental health Confidence to interact with and support someone in distress or experiencing a mental health issue	25	£75 pp (recommended price) but costs can vary depending on location and instructor. Occasionally, some instructors can access local funding to offer	Half a day	https://mhfaengland.org/organisations/workplace/half-day/

					□ Insight into the two-day course and the benefits of becoming a Mental Health First Aider □ Helpful resources and statistics		discounted places		
MHFA England	Armed Forces MHFA Two Day	Face to face	At a centre for individuals. In-house available for organisations	For everyone in the Armed Forces community: serving personnel, veterans, their families and support organisations – training gives people the skills to: stop a preventable health issue from escalating by spotting and addressing early; know how and where to access treatment if needed for a faster recovery; help self, colleagues and family to be healthy; and minimise the impact of mental ill health on work and life	□ An in-depth understanding of mental health and the factors that affect wellbeing for the Armed Forces community □ Mental health issues covered include violence, depression, anxiety disorders, suicide and self-harm, psychosis, vicarious trauma and burnout, alcohol and drugs, post-traumatic stress disorder, and impact of trauma □ Practical skills to spot triggers and signs of mental health issues □ Confidence to step in, reassure and support someone in distress □ Enhanced interpersonal skills such as non-judgmental listening □ Knowledge to help someone recover by guiding them to further support	16	□ £300 pp (recommended price) but costs can vary depending on location and instructor. Occasionally, some instructors can access local funding to offer discounted places	Two days	https://mhfaengland.org/individuals/armed-forces/2-day/
Rethink Mental Illness	Mental Health Awareness E-learning	Online	Online	To enable participants to become familiar with the signs, symptoms and possible causes of the most common mental illnesses, and the various treatments used. Covers diversity issues, stigma, discrimination and recovery	□ An understanding of the terms 'mental health' and 'mental illness' □ Learn about the characteristics of some typical mental illnesses □ An understanding of support available for people with mental health problems □ An understanding of what is meant by the Recovery approach □ An awareness of the impact of stigma and discrimination	n/a	□ Computer licences range from £25 to £35 pp depending on the number purchased and any discretionary discounted rates	45 minutes to one hour	https://rethink.org/services-groups/mental-health-training
Rethink Mental Illness	Mental Health Awareness	Face to face	At a centre for individuals. In-house available for organisations	To shift the perspective on mental health issues; to help attendees to understand the impact they have and how to approach conversations with people who may be suffering from a mental illness	□ A better understanding of mental health and mental illness □ An understanding of the effects of stigma and discrimination □ A basic understanding of both common mental health conditions (stress, anxiety, depression) and less common mental health conditions, eg schizophrenia □ An understanding of how mental illness can manifest itself in day-to-day interactions □ Confidence to hold a short conversation with someone affected by a mental health problem who may be communicating their needs in complex ways	20	□ Free, open courses for individuals who live, study or volunteer in the London Boroughs of Camden or Islington; for other locations, cost is dependent on organisation	One day or half a day	https://www.rethink.org/services-groups/mental-health-training?gclid=CPqXnYvk09MCFdTNGwodEfkDqg

					□ An understanding of how stress can impact on mental health □ Key sources of information on mental health		type and course length		
Rethink Mental Illness	Mental Health in the Workplace for Managers	Face to face	At a centre for individuals. In-house available for organisations	To shift the perspective on mental health issues; understand the impact; and equip managers to respond appropriately and confidently to mental illness in the workplace, in line with relevant legislation	□ A better understanding of mental health, mental illness and stigma □ A basic understanding of both common mental health conditions (stress, anxiety disorders, depression) and less common mental health conditions, eg schizophrenia □ An understanding of the prevalence and causes of mental ill health in the workplace □ An understanding of how mental illness can manifest itself in day-to-day interactions within the workplace □ An understanding of how changes in behaviour can suggest a possible mental health condition, and ways of responding to this □ Greater confidence in holding a conversation with a staff member who may be affected by a mental health problem and in handling the outcomes □ A better understanding of the legal frameworks managers need to be aware of in the workplace when dealing with mental health □ Key sources of information on supporting mental health in the workplace, including Wellness and Recovery Action Plans (WRAPs)	20	□ Cost depends on location and organisation type and course length	One day or half a day	https://www.rethink.org/services-groups/mental-health-training?gclid=CPqXnYvk09MCFdTNGwodEfkDqg
Rethink Mental Illness	Wellbeing, Mindfulness and Resilience	Face to face	At a centre for individuals. In-house available for organisations	To address the misconceptions around the words wellbeing, mindfulness and resilience	□ Fostering a reflective and adaptive approach in relation to own wellbeing □ Understanding the meaning of 'wellbeing', 'mindfulness' and 'resilience' □ Understanding how the body and mind can respond to stress □ Exploring methods of managing stress □ Practising a mindfulness technique □ Exploring resilience strategies to manage change and difficulties in the longer term	20	□ Cost depends on location and organisation type and course length	One day or half a day	https://www.rethink.org/services-groups/mental-health-training?gclid=CPqXnYvk09MCFdTNGwodEfkDqg
Mind	Mental Health Awareness Training	Face to face	At a centre for individuals. In-house available for organisations	To raise awareness of mental health; to understand and recognise the causes, symptoms and support options for a range of common and less common mental health problems	□ An understanding of mental health and mental distress □ Different models of mental health – medical/biological or psychological and social □ How race, culture and gender impact on our experience of mental health □ Common versus severe mental health conditions: neurosis or psychosis?	□ Centre course size is 16, but small group bookings are limited to three per company □ In-house training is available for	□ £219 + VAT pp. Discount available for early booking and local Mind locations □ From £1,495 + VAT for in-house	One day (organisations can choose duration)	https://www.mind.org.uk/workplace/training-consultancy/upcoming-courses/mental-health-awareness/?ctaId=/workplac

					□ Personality disorders: general features, causes, treatment and support □ The common mental health conditions: signs and symptoms, causes, treatment, and support □ The less common mental health conditions: signs and symptoms, causes, treatment, and support of bipolar disorder and schizophrenia	larger groups of 14–16	organisation group training □ Reduced rates for charity and statutory bodies		e/training-consultancy/courses-for-anyone/courses-for-anyone/mha-training/
Mind	Mental Health and How to Support Someone Training	Face to face	At a centre for individuals. In-house available for organisations	Practical and interactive course to explore what non-specialists can do to help make people in distress feel safe, supported and understood. Provides awareness for individuals who work/live alongside someone who experiences a mental health problem	□ How to use basic listening skills to build rapport, promote trust and encourage openness □ Skills to help someone manage their anxiety and low mood □ The importance of promoting wellbeing and good health □ Talking with someone about the pros and cons of psychiatric medication □ How to briefly assess risk (and what your options are when someone poses a risk to themselves or others) □ How to respond sensitively and effectively in a crisis □ How to help someone experiencing the extreme highs and lows associated with bipolar disorder □ How to interact confidently and sensitively with someone experiencing psychosis	□ Centre course size is 16, but small group bookings are limited to three per company □ In-house training is available for larger groups of 14–16	□ £219 + VAT pp. Discount available for early booking and local Mind locations □ From £1,495 + VAT for in-house organisation group training. Reduced rates for charity and statutory bodies	One day (organisations can choose duration)	https://www.mind.org.uk/workplace/training-consultancy/upcoming-courses/mh-and-how-to-support-someone/?ctaId=/workplace/training-consultancy/courses-for-anyone/courses-for-anyone/mh-how-to-support/
Mind	Managing Mental Health at Work Training	Face to face	At a centre for individuals. In-house available for organisations	Learn how to recognise when a staff member is struggling. Learn how to support them professionally	□ The different models of mental health □ How mental illnesses are diagnosed □ The causes, signs and symptoms, and treatment and support options that relate to stress, anxiety and depression □ What organisations are expected to do for employees who are stressed, anxious or depressed □ What individuals are expected to do for themselves □ What to do if the problem worsens □ Appropriate language and topics for one-to-one meetings with staff who are struggling	□ Centre course size is 16, but small group bookings are limited to three per company □ In-house training is available for larger groups of 14–16	□ £219 + VAT pp. Discount available for early booking and local Mind locations □ From £1,495 + VAT for in-house organisation group training. Reduced rates for charity and statutory bodies	One day (organisations can choose duration)	https://www.mind.org.uk/workplace/training-consultancy/upcoming-courses/managing-mental-health-at-work/?ctaId=/workplace/training-consultancy/courses-for-anyone/courses-for-anyone/managing-mental-health-at-work/
Mind Matters	Training for Managers in Mental Health	Face to face	At a centre for individuals. In-house available for	To train all managers in the need to be aware of their own mental health and wellbeing, along	□ How to identify signs of poor mental health □ Have a conversation with their staff members about mental health □ Prevent someone going off sick	20	□ £100 pp. Full day courses for organisation= £900	One day	http://www.mindmatterstraining.co.uk/mental-health-training/trainin

			organisations	with those whom they support	□ How to provide an early return to work that prevents someone going back on sick leave □ How to adopt and ensure best practices in the workplace □ Signposting support services		□ 10% discount for multiple bookings		g-for-managers-in-mental-health/
Mindful Employer	Being a Mindful Manager – Mental Health Awareness for Managers	Face to face	In-house	Workshop focuses on stress, anxiety, depression and bipolar disorder; the impact on the workplace; having conversations with staff; supporting presence; and managing absence	□ Overview of mental health and work – financial costs, workplace culture, government initiatives □ What is mental ill health? □ Anxiety, depression and bipolar disorder (including treatment and recovery) and can cover other conditions if required □ Identifying signs in the workplace □ Having conversations about mental health and how to respond to distress □ Case studies – linked to the themes of supporting presence in work and managing absence □ Signposts to further support	15	Information not available on website	Three hours	http://www.mindfulemployer.net/files/8614/3193/9503/Being_a_Mindful_Manager_-_aims__outline.pdf
Mindful Employer	Being Aware – Mental Health Awareness for Staff	Face to face	In-house	To increase awareness of mental health conditions for frontline staff or anyone with little or no knowledge of mental health conditions	□ An in-depth overview of common mental health conditions such as depression and anxiety and more severe ones such as psychosis, schizophrenia, personality disorder and bipolar disorder □ Causes, coping mechanisms and helping people in distress	15	Information not available on website	Three hours	http://www.mindfulemployer.net/awareness/
Mindful Employer	Keeping Well at Work	Face to face	In-house	To teach practical tools to maintain and increase wellbeing from both an organisational and individual perspective	□ Introducing practical tools, including the internationally acknowledged Wellness Recovery Action Planning (WRAP) approach, mindfulness and Five Ways to Wellbeing □ How to help people maintain their wellbeing (from both organisational and individual perspectives) □ Identifying if that level of wellbeing drops and what can be done to help □ Developing the themes first introduced in our Being Resilient workshop	15	Information not available on website	Three hours	http://www.mindfulemployer.net/awareness/
Health Assured	Mental Health Awareness	Face to face	In-house	To give employers or employees knowledge of and insight into how to identify, understand and help individuals who may be developing mental health issues	The workshop can be tailored to an organisation's needs, with the following as a guideline of content: □ Understanding the importance of mental health in the workplace □ Attitudes and stigmas □ Knowledge and awareness of common mental health issues (depression, anxiety, individuals feeling suicidal, people experiencing psychosis) □ The five steps in supporting individuals □ Action planning	Information not available on website	Information not available on website	Information not available on website	https://www.healthassured.org/trauma-management/workshops/

Health Assured	Stress Management	Face to face	In-house	To help educate both employees and managers about stress and how to recognise key signs in the workplace	□ Normalisation of stress and explanation □ Recognition of symptoms and triggers of stress in both managers and employees □ Managing wellbeing at work (self-evaluation, process, creating the right culture) □ Intervention, coping and personal resilience (services available and how to access; management referral and supporting employees)	Information not available on website	Information not available on website	Information not available on website	https://www.healthassured.org/trauma-management/workshops/
Health Assured	Resilience at Work	Face to face	In-house		□ What does it really mean to be resilient? □ Exploring the working environment and approach to work (recognition of beneficial and healthy pressure and the difference of stress) □ Awareness of resilience (recognise how you react under pressure; be aware of your stressful operating patterns) □ Manage the situation (recognise the impact on you when your resilience is low; learn techniques to manage pressure and improve resilience)	Information not available on website	Information not available on website	Information not available on website	https://www.healthassured.org/trauma-management/workshops/
Health Assured	Mindfulness	Face to face	In-house		□ Mindfulness and common misconceptions □ Attitudes and stigmas □ How mindfulness can be useful when experiencing stress, relationship breakdown and other factors □ How to be proactive before daily life becomes overwhelming □ Putting it into practice (cognitive exercise; breathing techniques; making plans) □ Maintaining a balance in life	Information not available on website	Information not available on website	Information not available on website	https://www.healthassured.org/trauma-management/workshops/
Remploy Advisory Services	Mental Wellbeing in the Workplace	Face to face	In-house	To discuss mental wellbeing in the workplace; to explore different approaches to mental health, common mental health conditions and the impact of stress and wellbeing on performance; and to provide delegates with the confidence and tools to approach, support and manage mental wellbeing in the workplace	□ What is mental health? □ Models of mental wellbeing □ Common mental health conditions □ Stress, mental wellbeing, pressure and performance □ Supporting mental wellbeing in the workplace: creating a supportive climate, and having helpful conversations, practical tools and solutions □ Workplace adjustments and the Equality Act (2010) □ Action planning and case studies □ Where and how to access support services	12	□ £1,100 + VAT per day for up to 12 delegates □ £600 + VAT per half-day course (overview version of day course)	One day or half a day	http://information.remploy.co.uk/acton/attachment/12273/f-030b/1/-/-/-/-/Training%20Mental%20wellbeing%20in%20the%20workplace.pdf?sid=TV2:dTIUfBhJW
Online Care Courses	Mental Health Awareness E-learning	Online	Online	To increase awareness, reduce stigma and enable participants or individuals to support	□ What is mental health? □ Different mental health disorders □ Signs and symptoms	n/a	□ £4.99 for an individual □ For groups and	Two hours	http://www.online-care-courses.co.uk/care-

				someone with mental health issues	□ Responding to a suspected mental health disorder □ Referring a patient □ Providing care and support □ Awareness of discrimination and social stigma □ Types of medication and effects		organisations will depend on the number of computer licences purchased □ Pay monthly prices are from 99p per person. Pay as you go are from £1.49 per course (for 5,000+)		training/online-mental-health-awareness-training-courses.php
Mates in Mind	Module 3 Mental Health First Aid for Construction	Face to face	Currently undergoing piloting and more details will be released when launched	To provide awareness of mental health and provide training in order to become a mental health champion	□ Increasing understanding of mental health issues in the workplace □ How to deal with mental health 'incidents' □ Enabling supervisors and managers to become a Mental Health First Aid champion □ Providing signposting materials □ Supporting champions to promote/campaign for positive mental health and develop their own approaches to tackle mental ill health in the workplace	Currently undergoing piloting and more details will be released when it is launched	Currently undergoing piloting and more details will be released when it is launched	Two days	https://www.matesinmind.org/awareness-and-education.html
Mates in Mind	Module 2 Mental Ill Health Awareness: for foremen, supervisors and managers	Face to face	Currently undergoing piloting and more details will be released when launched	To provide better awareness and support for supervisors and line managers	□ Awareness of mental health issues in construction workers □ Educating foremen, supervisors and managers to identify signs of mental ill health □ Enabling foremen, supervisors and managers to support their staff who are experiencing mental ill health	Currently undergoing piloting and more details will be released when it is launched	Currently undergoing piloting and more details will be released when it is launched	Half a day	https://www.matesinmind.org/awareness-and-education.html
Mates in Mind	Module 1 Mental health awareness	Face to face	Currently undergoing piloting and more details will be released when launched	To create general awareness and understanding of the issues in construction workers and managers	□ Awareness of mental health issues in construction workers □ Addressing stigma and increasing understanding □ Enabling conversations into mental health in the workplace	Currently undergoing piloting and more details will be released when it is launched in September	Currently undergoing piloting and more details will be released when it is launched	45 minutes	https://www.matesinmind.org/awareness-and-education.html
Business Disability Forum	Non-visible Disabilities: Neurodiversity	Face to face	At centre	To provide understanding along with the tools and skills to be confident in	□ Understanding the differences between mental health conditions and conditions such as autism and dyslexia □ Learn employers can reduce barriers that	Information not available on website	□ £200 + VAT for members and partners	Half a day	http://www.businessdisabilityforum.org.uk/networking-and-

	and Mental Health			delivering adjustments that work for individuals, teams and the business. Designed for diversity and inclusion for professionals, employee relations, HR and equality managers	employees with a variety of non-visible disabilities may face in the workplace □ Support line managers in identifying when an employee with a non-visible disability may require an adjustment but would prefer not to share detailed information about their disability		□ £250 + VAT for non-members □ Partners are entitled to one free place per workshop on a first-come, first-served basis		events/our-latest-events/non-visible-disabilities-neurodiversity-and-mental-health/
Mental Health Foundation	Healthcare and Workplace: Mindfulness Training	Online but face to face can also be arranged	Online	To enable workplaces to provide mindfulness training to staff or patients To reduce stress, depression, anxiety, fatigue and work-related rumination, and to improve sleep quality in staff and patients	□ Learning the key concepts of Mindfulness-Based Cognitive Therapy (MBCT) □ Paying attention to thoughts and feelings in order to manage difficult situations and make wise choices □ Learning how to use these skills in home and work lives	n/a	□ £30	Four weeks	https://www.mentalhealth.org.uk/projects/online-mindfulness-training-workplace
Anxiety UK	Anxiety UK Training: Workplace Training	Face to face	In-house	To train staff members how to listen, talk and work with clients with an anxiety disorder. To improve staff and beneficiaries' wellbeing, improve productivity, create a healthy working environment and reduce absences. To align with current government policy by receiving an endorsement from a respected mental health charity	□ Understanding and recognising how anxiety affects the mind and body for when colleagues, employees or pupils are struggling with their mental health □ Different types of anxiety and ways to manage anxiety at home and in the workplace/school □ Workplace-based training also includes how to discuss mental health with a manager or supervisee and how your organisation as a whole can be positive mental health ambassadors The core training packages include: □ Stress and anxiety in the workplace for staff □ Stress and anxiety in the workplace for managers □ Stress and anxiety in schools for teachers □ Stress and anxiety in schools for pupils □ Understanding and supporting panic attacks	20	□ Group price £500 for half a day, £800 for full day □ Discounts for smaller organisations	One day or half a day	https://www.anxietyuk.org.uk/for-professionals/training-packages/
New Leaf Health	Workplace Wellbeing Coordinators	Face to face	At centre	To enhance theory and evidence-based knowledge of the management of health and wellbeing at work by developing a workplace wellbeing strategy and policy development. To learn to create a positive	□ Definition of wellbeing □ Understanding health promotions: models, ethics, values and behaviours □ Lifestyle and behaviour change □ Reviewing and producing your workplace programme vision, values, ethics and behaviours □ Understanding the theory and processes around behaviour change	Information not available on website	□ £295 + VAT pp	One day	https://www.newleafhealth.co.uk/workplace-wellbeing-coordinators-course/

				environment for a health and wellbeing programme to be effective and be able to plan, implement and evaluate the wellbeing strategy effectively	□ Assess research, plan and deliver evidence-based programmes □ Making a business case for a workplace health programme □ The evidence of effective workplace wellbeing – reviewing relevant national, empirical evidence and how to assess it □ How to undertake gap analysis on wellbeing □ How to complete a wellbeing needs assessment – needs assessment questionnaires and focus groups, biometrics and staff surveys □ Wellbeing mapping and proofing of staff-related policies – mapping existing company wellbeing provision/policies and looking at competitors' wellbeing activities □ How to link wellbeing strategy to business aims and embed analytical practices that ensure a return on time and investment □ Acquiring senior management buy-in – needs and drivers of the board, stakeholders (decision makers), produce a reasoned argument, benefits, timeline, performance indicators, targets, investment □ Strategy production – linking your strategy aims to effective wellbeing activities □ Wellbeing topics: stress, musculoskeletal health, smoking, alcohol and substance misuse, obesity □ Considering different approaches and interventions and developing ideas for your company wellbeing programme □ Choosing which wellbeing activities are right for your organisation: induction, return to work, PDP, wellbeing calendar □ Recruiting, training and supporting Wellbeing Champions □ Identifying influence at a local level □ Developing a communications plan □ Helping to implement a robust evaluation process by identifying what success looks like and considering who and how the data will be used				
New Leaf Health	Managing Mental Health for Line Managers	Face to face	At centre or in-house	To introduce line managers to the signs and symptoms of mental ill health and equip them with the knowledge and skills they need to create	Introducing mental health: □ Exploration of attitudes towards mental health stigma, using high-profile public figures who have shared their own mental health struggles □ Learning to recognise the signs and symptoms of mental illness □ Learning appropriate intervention approaches	Information not available on website	□ £50 pp	Three hours	https://www.newleafhealth.co.uk/mental-health-courses-for-line-managers/

				a healthier, more productive workplace	□ Examining resilience Pressure and resilience: □ Using the Health and Safety Executive's Management Standards Model to assess workplace stress by building up a picture of the demands, control, support, relationship, roles and changes in their own working environments □ Formulating an action plan to proactively improve mental wellbeing in own specific workplace Relationship management: □ Using effective relationship management and emotional intelligence to embed learning □ Using a four-part model and practical role play to improve self-awareness, self-management and awareness of others				
LivingWorks Education	ASIST (Applied Suicide Intervention Skills Training)	Face to face	At a centre for individuals. In-house available for organisations	To teach 'suicide first aid skills' including recognising when someone may have thoughts of suicide and to work with them to create a plan that will support their immediate safety	□ Understanding the ways that personal and societal attitudes affect views on suicide and interventions □ Providing guidance and suicide first aid to a person while meeting safety needs □ Identifying key elements of an effective suicide safety plan and the actions required to implement it □ Appreciating the value of improving and integrating suicide prevention resources in the community at large □ Recognise other important aspects of suicide prevention including life promotion and self-care	30	Cost depends on location and organisation type	Two days	https://www.livingworks.net/programs/asist/
LivingWorks Education	Suicide to Hope	Face to face	At a centre for individuals. In-house available for organisations	To provide a sequel to suicide first-aid training that complements and enhances management, treatment and therapy by framing within a recovery and growth perspective. To aid recovery and growth in persons with previous suicide experiences who are currently safe	□ Reflecting on own qualities as helpers – beliefs, values and attitudes – and how these impact on the effectiveness of their work □ Describing key features of a hope-oriented, recovery and growth approach to suicide □ Understanding a framework for finding and exploring recovery and growth opportunities in suicide experiences □ Applying a Pathway to Hope (PaTH) model for setting and working towards recovery and growth goals	24	Cost depends on location and organisation type	One day	https://www.livingworks.net/programs/safetalk/
LivingWorks Education	SafeTALK	Face to face	At a centre for individuals. In-house available for	To provide awareness training which enables participants to become a suicide-alert helper	□ Noticing and responding to situations where suicide thoughts might be present □ Recognising that invitations for help are often overlooked	30	Cost depends on location and organisation type	Half a day	https://www.livingworks.net/programs/safetalk/

			organisations		□ Moving beyond the common tendency to miss, dismiss and avoid suicide □ Applying the TALK steps: Tell, Ask, Listen and KeepSafe □ Knowing community resources and how to connect someone with thoughts of suicide to them for further help				
The Association for Psychological Therapies	Suicide-risk Assessment and Management	Face to face	In-house	To be able to spot those who are at risk, to manage the risk and to intervene to help people build a rewarding life long-term using the DICES model	□ To illustrate the importance of helping people who are so distressed that they are thinking of ending their lives □ To change the perception of suicide from something that appears worrisome to something where there is a clear opportunity to make a great impact □ To be able to 'spot' people who are at risk of suicide and to engage with them □ To know how professionals can be 'set up' as a focus for hope, and appreciate the danger if this hope is thwarted □ To be able to manage suicide risk – that is, to keep the person safe while effective treatment is provided □ To provide a simple non-intrusive measure of progress while at the same time monitoring risk □ To be aware of 'false dawns' and how dangerous they can be □ To be able to enjoy the rewards – and handle the stresses – of working with suicide	15	□ £3,050 + VAT for up to 15 people	Two days	http://www.apt.ac/suicide-prevention-training.html#suicide-risk
Samaritans	Conversations with Vulnerable People	Face to face	In-house and 'open' courses	To enable staff to build rapport, alleviate distress, and de-escalate anger and aggression with vulnerable customers and colleagues using the 'Samaritans Listening Wheel' model	□ Understanding difficult feelings and circumstances, eg anger, aggression, bereavement and loss □ Effective listening tools and techniques □ Appropriate responses to sensitive subjects □ Defusing difficult conversations □ Ending conversations effectively □ Support for customers and staff	Information not available on website	Discounts available for multiple bookings	One day	https://www.samaritans.org/sites/default/files/kcfinder/branches/branch-96/files/WPT%20Directory_Final%20web.pdf
Samaritans	Managing Suicidal Conversations	Face to face	In-house and 'open' courses	To enable staff to confidently approach or speak to somebody with suicidal feelings, and to minimise the impact on staff's own emotional wellbeing	□ Dispelling myths about suicide – understanding and acknowledging suicidal feelings □ Understanding how talking about suicidal feelings can be beneficial □ Recognising signs of distress and suicidal thoughts □ How to approach someone who appears suicidal	Information not available on website	Discounts available for multiple bookings	One day	https://www.samaritans.org/sites/default/files/kcfinder/branches/branch-96/files/WPT%20Directory_Final%20web.pdf

					□ Enabling staff to make informed decisions when dealing with people □ How to refer someone who is feeling suicidal to Samaritans or medical services for support □ How to use support to minimise the impact on your own emotional wellbeing				
Samaritans	Building Resilience and Wellbeing	Face to face	In-house and 'open' courses	Designed for organisations/ workplaces to promote emotional health and resilience, and to encourage self-awareness and emotional literacy	□ Understanding emotional health and resilience □ Tools to consider your own emotional state at work □ Understanding difficult circumstances and recognising signs of stress □ Enabling staff to make informed decisions when dealing with vulnerable employees or customers □ Strategies for building emotional resilience – developing an action plan to improve personal resilience □ Techniques for managing our own thoughts □ Helping remove stigmatising attitudes to those experiencing emotional issues	Information not available on website	Discounts available for multiple bookings	One day	https://www.samaritans.org/sites/default/files/kcfinder/branches/branch-96/files/WPT%20Directory_Final%20web.pdf
Samaritans	Working with People who Self-Harm	Face to face	In-house and 'open' courses	Designed for all types of organisations and personnel who come into contact with individuals who self-harm	□ Recognising what self-harm is and responding appropriately □ Explaining some of the reasons why people self-harm and reducing stigmatising attitudes □ Using effective listening tools and techniques to acknowledge difficult feelings and circumstances □ Learning how to end conversations sensitively and professionally □ Learning how to use support effectively □ Enabling staff to make informed decisions when dealing with vulnerable employees or customers	Information not available on website	Discounts available for multiple bookings	One day	https://www.samaritans.org/sites/default/files/kcfinder/branches/branch-96/files/WPT%20Directory_Final%20web.pdf
Suicide-Safer London and the International City & Guilds Approved Centre 'Train on the Tracks'	Suicide First Aid through Understanding Suicide Intervention	Face to face	In-house	To teach the theory and practice of suicide intervention skills applicable in any professional or personal setting	□ The impact and value of personal and professional experience with suicide □ Barriers that prevent people with thoughts of suicide seeking help □ Prevalence of suicide thoughts and behaviours □ Population-based approach to suicide prevention □ The Signs of Suicide and the Suicide-Safety Guide □ Understanding approaches and process of suicide intervention including desired outcomes □ Understanding the importance of self-reflection and personal impact when working with suicide and people at risk □ Partnership working and community resources	16	□ £235 + VAT for up to 16 people	Half a day	http://trainonthetracks.com/understanding-suicide-intervention-city-guilds-endorsed

Papyrus: Prevention of Young Suicide	Introduction to Suicide Prevention: Suicide Awareness	Face to face	Information not available on website Bespoke training options available	To invite participants to have an open and honest talk about suicide. To increase awareness of the prevalence of young suicide (under 35 years) and aim to break the stigma and taboo surrounding suicide. Can deliver tailor-made bespoke sessions for organisations in contact with young people and young adults throughout their working day	□ Challenging the stigma and taboo surrounding suicide □ Increasing participants' awareness of myths and facts surrounding suicide □ Increasing participants' awareness of the sensitivity of language when talking about suicide □ Increasing participants' understanding of why a person may consider suicide □ Increasing personal commitment to and action in suicide prevention □ Supporting the spread of training opportunities and networking activities	20	□ £25 pp or £220 for a group booking	60–90 minutes	Link no longer available
Papyrus: Prevention of Young Suicide	Identifying and Talking about Suicide	Face to face	Information not available on website Bespoke training options available	To improve suicide alertness among staff, teaching them how to identify a person at risk and respond effectively to aid safety. Designed for professionals who come into regular contact with young people (under 35 years) but aren't necessarily a long-term caregiver	□ Discussions around knowledge of suicide □ Exploring and understanding of invitations a person at risk of suicide may give □ Providing clear and practical information on how to explore suicide and respond appropriately □ Considering 'real life' scenarios □ Concluding with an emphasis on the importance of self-care	15	□ £55 pp or £410 for a group booking	Half a day	Link no longer available
Storm	Self-Harm Mitigation	Face to face	Information not available on website	To provide participants with the skills to mitigate self-harm and with coping/self-help strategies	The complete course includes the following modules: □ Suicide prevention – assessment of risk □ Suicide prevention – safety planning □ Suicide prevention – problem solving □ Suicide prevention – future safety planning □ Self-injury mitigation – assessment of risk □ Self-injury mitigation – safety planning There is also the option to include a module on: □ Suicide postvention	Information not available on website	Information not available on website	Three days (6–7 modules), two days (3–4 modules) or one day (2 modules)	Link no longer available
Storm	Suicide Prevention Skills	Face to face	Information not available on website	To provide participants with the skills to prevent suicide and with coping/self-help strategies	The complete course includes the following modules: □ Suicide prevention – assessment of risk □ Suicide prevention – safety planning □ Suicide prevention – problem solving □ Suicide prevention – future safety planning There is also the option to include modules on:	Information not available on website	Information not available on website	Three days (6–7 modules), two days (3–4 modules) or one day (2 modules)	Link no longer available

					□ Suicide postvention □ Self-harm				
Storm	Suicide Postvention Skills	Face to face	Information not available on website	To enhance participants' understanding of postvention in the context of the workplace	□ How suicide impacts on the lives of others – in particular, how the 'work community' (eg customers, suppliers, service users) and the wider community can be affected by the suicide of a colleague/service user/customer/supplier □ How to identify individuals who may need specialist help □ How to build rapport and safety plans as part of a strategic postvention approach □ Developing an understanding of grief, including prolonged and complex grief □ Promoting a positive and enabling approach □ Postvention planning, including short-term and continued support for staff (and service users), identifying those at risk, and safety planning	Information not available on website	Information not available on website	Three days (6–7 modules), two days (3–4 modules) or one day (2 modules)	Link no longer available

APPENDIX 2: Interview schedule

INTERVIEW SCHEDULE

Introduction: *Thank you for taking the time to meet with/talk to me today. Do you have any questions before we start?*

This organisation has been identified as having at least one member of staff who has been trained in Mental Health First Aid by MHFA England. We would like to explore your perspectives on and experiences of Mental Health First Aid in the workplace. There are no right or wrong answers and you don't have to answer any questions that you don't feel comfortable with. The interview shouldn't last longer than an hour and will be recorded using a digital recorder, with your permission.

♦ **Characteristics of the organisation**
1. **How would you describe the type of work undertaken by this organisation?** 2. **What procedures are you aware of within this organisation for addressing the mental health and wellbeing of the workforce?** > Health and safety policies – do these include mental health support? > Sickness absence policies > Occupational health provision; appointments > Employee assistance; counselling > Encouraging and developing conversations/open conversations > Strategies for enhancing the mental health/wellbeing of the workforce > Making information/resources and support accessible; signposting > Mental health at work plans; people management – support, safety, wellbeing, training > Staff questionnaires to measure/monitor mental health > Were these put in place pre or post MHFA training?
♦ **Characteristics of participant**
1. **What is your specific job role in the organisation? What type of work do you undertake?** 2. **To what extent are you involved in workplace health/mental health?** > Role; responsibilities relating to this; personal interest in mental health? > How do you feel about this role/responsibility? > (If the person has health/mental health responsibilities) Have you received training to help you in this role? (This might lead on to questions around MHFA as below)
♦ **Mental Health First Aid training**
1. **To your knowledge, how often are staff trained in Mental Health First Aid?** > Who provides this training? Eg MHFA England directly, or another organisation licensed to offer the course > Does this workplace offer training opportunities regularly, or was it a one-off? > Where does the training take place? 2. **Have you specifically received Mental Health First Aid training?** > (If yes) Please describe the process by which you were able to receive this training. Eg personal request; personal motivations for seeking/attending; selection process and opinions about this; funding > (If no) Are you aware of the process by which people are able to receive the training? Eg is it based on requests? Selection process and opinions about this; funding

3. **What are your opinions about Mental Health First Aid training for this organisation/members of this organisation?**
   > Organisation's motivations for receiving training
   > Type(s) of training undertaken and by whom (eg role of the person trained; which department do they sit in)
   > Appropriateness/applicability to the organisation/workplace
   > Content; format; limitations; strengths; improvements; cost-effectiveness; accessibility of training; expected and unexpected outcomes of training
   > Organisational strategies for implementing MHFA
4. **What feedback channels, if any, exist to evaluate the MHFA training experience?**
   > Provided by MHFA England *and* organisation?
   > Post-training time period for feedback, eg immediately, 6 months, 12 months?
   > What feedback is invited?

♦ **The impact/effect of having Mental Health First Aiders/champions/people who have been trained, and the provision of MHFA in the workplace**

1. **How would you define Mental Health First Aid in this organisation?**
   > What do you understand it to be generally, and in the context of this organisation?
2. **To what extent are members of the workforce aware that there is someone/are people trained in Mental Health First Aid?**
   > How are people made aware that trained members are available?
   > What information on Mental Health First Aid provision has been provided within the organisation? What strategies have been used? Promotion of MHFA skills
   > Is there anything further that could be done to increase awareness?
3. **How do people access Mental Health First Aid? Ie the help/assistance provided by someone trained in Mental Health First Aid skills**
   > Is there a formal system in place?
4. **To your knowledge, have people in the workplace ever been supported by people trained in Mental Health First Aid skills?**
   > Did they actively seek help?
   > Was the person in need of help approached? How?
   > Anonymised examples? What mental health issues/problems were addressed and how?
   > Is use of MHFA recorded? How? What details are recorded?

♦ **<u>People who have received assistance from someone trained in MHFA skills</u>**

I understand that you have received support from someone trained. Could you tell me some more about your experience?

> If you feel comfortable to discuss, what mental health issues/experiences were you going through?

> How did you access help? Did you actively seek this, or were you approached by a trained individual?

> How do you feel about the way in which MHFA was accessed/offered/given?

> Were you assisted by the organisation in any other way?

> How do you feel about this approach/these approaches?

> Could anything have improved your experience?

> Was your experience recorded by the organisation in any way?

> Were you able to give feedback in any way regarding your experience of receiving assistance from a trained member?

> Has your experience affected your perception/understanding of MHFA in any way?

5. **Have there been any organisation changes/responses following MHFA training of members of staff/the workforce? How do you know?**

6. **To what extent do you think that Mental Health First Aid (ie the presence of people trained in these skills and any organisational changes that have arisen from this) is accepted by people in your organisation?**
   > What indications are there of acceptance?
7. **What feedback channels, if any, exist to evaluate MHFA impact?**
   > What kind of feedback is invited?
   > When?
   > What do you feel is important to take into account when thinking about MHFA impact?
8. **What do you consider to be indicative of the effectiveness of having people trained in Mental Health First Aid in your organisation?**
   > Are there ways in which this is/can be monitored?
   > Are there ways in which this is/can be measured?
   > Is cost-effectiveness of MHFA in your workplace determined? How?
9. **To what extent do you think that Mental Health First Aid has been a success in your organisation?**
   > What works well, and why?
   > Is there anything that has limited/prevented the success of MHFA in your organisation?
10. **How would you feel if MHFA training was made mandatory in workplaces?**

♦ **Experiences and perceptions of other workplace mental health and education/training programmes**

1. **Has your organisation used any other training programmes/education/courses around mental health and work and/or suicide awareness?**
   > Name of course; provider; accessibility; in-house/external; content; length; cost
   > Topics covered, eg resilience training, stress management, conflict management, mind training
   > Initiatives that don't fall under 'training programmes', eg Time to Change pledges
   > How have these been implemented and used by the organisation? What strategies have been used?
   > What are your opinions of these other programmes/education initiatives/courses?
   > How do these compare with MHFA training programmes in terms of accessibility; provided in-house/external; content; length; cost

2. **Are there any other areas/aspects that you feel that your organisation should be trained in regarding mental health and wellbeing and/or suicide awareness?**
   > What are these and why?
   > Could these be covered by existing training programmes (eg MHFA England courses)?

Closing: *Is there anything else that you would like to add? Many thanks for your time.*

N.B. These questions (>) were prompts to be used as required by the interviewer(s).

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