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Abstract

Purpose: There has been little research into the use and efficacy of Mental Health First Aid across UK workplaces. The present study investigated the implementation of MHFA across six UK organisations, identifying key barriers and facilitators.

Design: Twenty-seven workplace representatives were recruited from six organisations through purposive sampling and took part in semi-structured interviews exploring their experiences of workplace MHFA. The data underwent thematic analysis, identifying key themes around implementation.

Findings: Implementation varied across organisations, including different reasons for initial interest in the programme, and variable ways that MHFA-trained employees operated post-training. Key barriers to successful implementation included negative attitudes around mental health, the perception that MHFA roles were onerous, and employees' reluctance to engage in the MHFA programme. Successful implementation was perceived to be based on individual qualities of MHFA instructors and good practice demonstrated by trained individuals in the workplace. The role of the inner organisational setting and employee characteristics were further highlighted as barriers and facilitators to effective implementation.

Research implications: MHFA is a complex intervention, presenting in different ways when implemented into complex workplace settings. As such, traditional evaluation methods may not be appropriate for gaining insights into its effectiveness. Future evaluations of workplace MHFA must consider the complexity of implementing and

operationalising this intervention in the workplace.

Originality: This study is the first to highlight the factors affecting successful implementation of MHFA across a range of UK workplaces.

Keywords: mental health first aid; mhfa; mental health; workplace mental health; qualitative research

Article classification: Research paper

Introduction

One trillion dollars are lost in productivity per year as a result of depression and anxiety (World Health Organization, 2019). Poor mental health among the workforce is estimated to cost UK employers between £33 billion and £42 billion annually (Stevenson and Farmer, 2017), incurred through increased absence, turnover, burnout and exhaustion (Mental Health Foundation/ Unum, n.d.). Mental health-related sickness absence is estimated to result in approximately 15.8 million working days being lost per year (Office for National Statistics, 2017), whilst further losses in productivity are attributed to presenteeism, when unwell individuals attend work but are unable to function effectively (Karanika-Murray and Biron, 2019, Department of Work & Pensions/ Department of Health, 2017). Beyond the economic losses incurred from sickness absences, absence from work due to mental health problems can result in personal costs to the individual themselves. Employment is central to identity and beneficial for mental health as it enhances confidence and self-esteem, offers coping strategies, enables the development of positive relationships, provides financial rewards, and lessens the risk of psychological distress (Thomas et al., 2019, Dunn et al., 2008, Waddell and Burton, 2006, Mental Health Foundation, 2012). This indicates that the workplace may be a helpful environment for facilitating recovery amongst those with mental health problems. Consequently, addressing mental health in the workplace is a priority for governments (Centers for Disease Control and Prevention, 2019, Office of Disability Employment Policy, Department of Industry Innovation and Science, Department of Work & Pensions/ Department of Health, 2017), regulatory and advisory bodies (Health and Safety Executive, Institution of Occupational Safety and Health, 2019, Safe Work Australia, 2019, National Institute for Health and Care Excellence (NICE), 2017, European Agency for Safety and Health at Work, 2011) and employers (Business in the Community, 2018,

Confederation of British Industry, 2018) and has led to a search for effective interventions to support mental well-being at work.

Mental Health First Aid

One intervention that has recently grown in popularity is Mental Health First Aid (MHFA) – an international training programme aiming to increase mental health literacy (Jorm et al., 1997), equipping individuals with the skills to recognise the signs and symptoms of mental health problems and crises and respond appropriately (MHFA England). MHFA has been described as an effective public health intervention, based on its ability to improve knowledge, attitudes and behaviours towards mental health problem (Morgan et al., 2018). It is increasingly being implemented into workplace settings, yet there is little evidence regarding the impact of MHFA in these contexts. The majority of workplace studies have addressed one particular setting and/or occupation, such as teachers (Evans et al., 2018, Kidger et al., 2016, Jorm et al., 2010), the healthcare sector (Moll et al., 2018) and the fire service (Moffitt et al., 2014). A scoping review found no evidence to suggest that MHFA training led to improvements in workplace management of mental health (Health and Safety Executive, 2018). A meta-analysis of seven workplace-based studies identified positive effects on the knowledge, stigma and helping behaviour of MHFA trained individuals, but only for up to six months following training (Morgan et al., 2018). In addition, challenges of the formal dedicated workplace role of MHFA trained individuals have also been identified in a recent Australian study, such as insufficient support and resourcing for the role (Bovopoulos et al., 2018).

Studies addressing the implementation, use and utility of the MHFA programme in workplaces in other national contexts have been lacking. In addition, little is known regarding how the success of the programme may be determined within workplaces; what the active ingredients of this intervention are; and what contextual factors are necessary to support effective implementation.

This paper presents interview data which specifically explores the implementation of MHFA in the workplace.

Aims

The aim was to investigate how MHFA had been implemented within different workplaces and identify the barriers to, and facilitators of successful implementation as perceived by a range of managers and employees within workplaces.

Methods

Ethical approval was obtained from the University of Nottingham Faculty of Medicine and Health Sciences ethics committee (REC ref: 14-1704). Semi-structured interviews were conducted between December 2017 and February 2018.

Sampling

Six organisations were selected using a sampling frame to ensure a range of

organisational characteristics were covered including sector, industry, and region of the UK (Table 1).

[Please insert Table 1 here]

Within each organisation, purposive sampling was used to recruit individuals for the interviews. Recruitment targeted a range of different employees including: those who had received MHFA training; employees with experiences of mental ill health; senior managers; line managers; health and safety representatives. A total of 27 interviews were conducted. The demographics of the participants are presented in Table 2.

[Please insert Table 2 here]

Procedure

Lead contacts in each of the organisations circulated information about the study and an invitation to participate to members of the workforce. In addition, the research team made direct telephone contact with individuals who had participated in an earlier study and who were willing to receive future correspondence.

The interview guide included questions on awareness, acceptance, and experiences of workplace MHFA, including the issue of receiving MHFA in the workplace. Interviews were conducted by MN and another member of the research team and discussed with AD periodically. Interviews were conducted either over the telephone (n= 22) or face-to-face

in interviewees' workplaces (n=5) and in locations where the interview could be conducted with minimal disturbance and where they felt comfortable to speak. Interviews lasted between 30 and 60 minutes each. All interviews were digitally recorded and transcribed, and the interviewer also made relevant written notes.

Data analysis

A thematic analysis approach was used, following the six steps described by Braun and Clarke (Braun and Clarke, 2006), due to its flexibility as a research tool and ability to generate rich insights into data. The analysis process involved transcribing the data and generating initial ideas. Coding the data for recurring ideas was done by MN, who then categorised these into potential themes. These themes were discussed and reviewed with CC. The themes were further refined by MN and CC and discussed with FN, AD and LT to gain consensus. Once themes had been established, the final stage of analysis took place with key examples from the data selected to convey the definitions of each theme, which involved all authors.

Results

A set of themes were identified from the data (Table 3), which are subsequently described and illustrated with selected quotations. The use of "X" within quotations replaces potentially identifiable information, such as names. Where the term "MHFAider" has been used, this refers to individuals trained in MHFA skills to attain a qualification from MHFA England that allows individuals to operate as first aiders in response to mental health issues.

[Please insert Table 3 here]

Implementation approaches

Reasons for initial interest in MHFA

This theme describes the range of reasons for organisations' initial interest and motivation in implementing MHFA.

MHFA was perceived to be something that could complement an existing strategy around mental health in the workplace by raising awareness and understanding about mental health among a wider group of employees. Furthermore, the MHFA package was appealing and seemed to provide a good fit to a perceived need, including responding to indicators of poor mental well-being within the workplace, such as high levels of mental health related sickness absences:

> *I think it was because of the lost time data - the amount of time that they lose people to having time off work with stress or any other kind of mental health problem. It's the numbers; the figures are quite high.* (M174, Org 3)

Some questioned the motivations of the organisations, suggesting that MHFA was being used due to its current popularity and without considering how MHFA should align with other strategies and policies on workplace health and wellbeing:

> *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…[MHFA] just seems to be another thing…* (M052, Org 4)

Others felt that organisations implemented MHFA as a way of showing that they were addressing workplace mental health issues but that, in fact, this meant that the organisation failed to tackle the work-related causes of employees' poor mental health and prioritise more preventative measures.

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

Attending MHFA training

Interviewees described a number of different ways in which employees were recruited to attend MHFA training and how they were assigned the role of MHFAider within the workplace. Participants described some of the challenges of attracting the 'right people' to take on the MHFAider role. Overall, the organisations' approaches to recruiting staff to attend the different types of training showed how MHFA was adapted by organisations to suit their perceived need and context. Some organisations targeted different types of employees with different types of MHFA courses:

> *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 then we do the half day course for our senior leadership team as well.* (M019, Org 5)

For some departments, MHFA training was implemented as mandatory training for all employees, whilst others allowed individuals to sign up on a voluntary basis. Mandatory training was supported by many due to beliefs that it would ensure increased awareness

of mental health across the workforce to maintain mental health for all members of the team:

> *I think it should be to everybody…Everyone in the team is part of the team. If [one member of a team is] not there, the machine effectively grinds to a halt or goes a bit slower.* (M177, Org 3).

However, others pointed out that mandatory training may not be effective for those who did not want to attend or had negative attitudes about mental health, highlighting the presence and impact of such individual attitudes:

> *I think that it would be wasted on other people that didn't want to be there…some people feel so strongly about the fact that you just have to be a man about things and you have to just suck it up that they'd probably get to the end of the course, it might not even have changed their opinion about it at all.* (M0183, Org 1).

It was generally agreed that individuals in leadership positions should attend courses as their management styles and behaviours were regarded as important factors in the well-being of their employees, and also because their attendance was perceived to be critical in getting others to attend:

> *If leadership push the message people start doing it. If leadership don't attend these sessions, it's all just word of mouth.* (M052, Org 4)

Others pointed out that freely allocating training places to anyone who was interested would not be beneficial in the long run. Instead, training places should be prioritised for those individuals who genuinely wanted to take on the role of MHFAider. Having a voluntary system of converting training attendance into a full MHFAider role with workplace responsibility was perceived to be unfair.

> *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 names so-and-so'.... they're not willing to put the training into practice.* (M0181, Org 4).

How MHFAiders operate

This theme highlighted variations in how MHFAiders operated within their organisations. Five sub-themes describe different aspects of their operationalisation, reflecting how the MHFAider role had been adapted to the organisational context.

a. *Engaging with colleagues who need support.*

There were differences in how MHFAiders engaged with people who might need their support. There were contrasting approaches of being reactive (waiting to be approached by colleagues in need of help) or proactive (approaching colleagues directly who they thought they might need help). Generally, it was expected that the MHFA trained person would wait to be formally approached by the person in need of support, but some organisations supported the idea of MHFAiders intervening even when they had not been approached directly:

> *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).

However, it was acknowledged that there may be less clarity over how the MHFAider should make that proactive approach:

> *If they're going to be trained to spot stuff, then yeah of course the approach would be delicate, I don't know [how] you'd go about that. I don't think there's a standard way.* (M187, Org 4).

b. Time and role commitment required.

Interviewees also raised the requirement of balancing MHFA duties with conducting their actual job role. Participants had different experiences of how well this balance was achieved, and this appeared to be partly due to the level of need for MHFA within the organisation. For some, the time commitment to providing MHFA to others was fairly minimal:

> *And really it doesn't require a great deal from us in terms of time and commitment because you never know some weeks I can have two or three conversations with people and other weeks go by and I have nothing. It's very unpredictable.* (M080, Org 2)

Whilst for others, commitment to the MHFAider role alongside their regular job was perceived to be too much. This was driven by the level of demand for MHFA as well as the job demands of the MHFAider's regular job role:

> *To be honest I do find that quite tough…it does mean that I work evenings and weekends and don't take lunch breaks and things like that…but the mental health (first aid) has made me feel more confident to deal with them.* (M082, Org 2).

Trying to balance the role alongside their job sometimes led to feelings that the MHFAider was not fulfilling MHFA responsibilities to the best of their abilities:

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).

In addition, the practicalities of particular job roles also presented challenges to fulfilling MHFAider duties, particularly for those with public-facing roles:

I also find it difficult because sometimes people will just come and talk to me, but reception's still happening…it's too public a place really (M080, Org 2).

c. *Boundaries and safety issues.*

One key area of concern regarding the MHFAider role regarded boundaries between the MHFAider and those requesting help. Some interviewees disclosed the potential risks of the MHFAider's role being misunderstood, including employees feeling they could keep requesting more and more time with the MHFAider:

They came across [the MHFAider] who was very interested and very sympathetic…so they were thinking 'oh well I'll just go and see the Mental Health First Aider and she will make me feel better and I can have coffee with her'…So we were talking about how to handle that because we're very clear with the volunteers that it's a signposting service and it's there for an acute moment. (M0188, Org 2)

Some situations were described where employees were contacting the MHFAider outside of work hours, and in a way that was intruding into their non-work time:

And 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)

It was also recognised that safety issues should be addressed, particularly if MHFAiders were meeting employees but no record of this was being kept due to confidentiality:

> *He'd asked me to go to his office. He had quite a few sort of personal issues. And we did get someone to cover reception. However, the girls were worried…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)

Thus the need to protect the person's confidentiality compromised full disclosure of the trained individual's whereabouts, which was potentially problematic.

d. *Support for MHFAiders*.

Within some organisations MHFAiders could join a dedicated network, comprising fully trained employees. MHFA networks had various functions, with one key purpose being to provide a forum for mutual support, especially in larger organisations.

> *…so we have the meetings to support them, just so that they don't feel out on a limb and we have some kind of check in with them that things are OK, that they're OK and everything.* (M188, Org 2).

The networks allowed trained members to share experiences and develop strategies for best practice and also to raise the profile of mental health more generally:

> *…we have a network of trained mental health first aiders already who provide support to the rest of the organisation, but they also work as champions* (M019, Org 5).

e. *Recording and monitoring.*

Some interviewees revealed that their organisations had formal systems in place, recording basic details of MHFA interactions. This enabled them to monitor and report back to the organisation about the number of people who had been helped, and gather evidence on the utility of the support service and variations in uptake across the organisation:

> *Recording some basic things might be useful so that you get some metrics to be able to demonstrate that this is a really good programme and it's worth doing. But that can't be down to any level whereby anybody could be identified.* (M191, Org 2).

However for others, the risk of breaching confidentiality discouraged them from recording any interactions between MHFAiders and employees. They also believed that employees would be put off using the service if they thought this would be monitored and recorded in some way:

> *I wasn't going to go and put it down anywhere, because of the risk of it leaking … if we did that and we did start recording things, I think that would discourage people from actually coming forward.* (M021, Org 3)

It was accepted that not all interactions may be captured through recordings, since some may not have considered that they were administering MHFA, but rather behaving as a supportive colleague. This highlights that the boundaries between the MHFA role and being a supportive colleague are often blurred. Some MHFA interactions were akin to natural conversations, which may not then be recorded:

> *I think it's a difficult one as well because 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…* (M168, Org 6)

There were few examples of how organisations were actively determining the programme's success, suggesting that strategies for collecting evidence around the effectiveness of the programme were not in place. Determining the success of the MHFA programme was perceived to be difficult. Moreover, even when success was believed to have been achieved, measuring this was challenging, due to the confidential nature of MHFA interactions and the inability to follow up what had happened after interactions:

> *...you won't know what the result is and you have no kind of right or responsibility in some of the cases to follow up and see where it went or whatever. You just did what you did in the moment.* (M189, Org 2)

Barriers to implementation and uptake

Attitudes to mental health

Negative attitudes regarding mental health were described as preventing full engagement by all employees with the MHFA training and support system. Interviewees suggested that these attitudes were prevalent amongst certain employees and this contributed to resistance to attend the MHFA training:

> *...[they] don't understand it, are 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.* (M183, Org 1)

Individual commitment required

The commitment required by employees to take on the MHFAider role was described by some as a barrier, suggesting that insufficient resources were provided by the

organisation to allow employees to complete both their regular job role and the MHFAider role. In addition, participants considered that the duration of the longer MHFA courses might discourage some employees from attending:

> *The thing is that quite a lot of our services are massively understaffed, and are struggling and things, so I don't know truthfully whether they'd be able to have two days away from work.* (M169, Org 6).

Being taken away from job responsibilities was also perceived to be a potential barrier to attending training, sometimes from the perspectives of managers:

> *I think probably the only resistance I'm aware of ... [was] 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.* (M085, Org 2).

The shorter course (formerly known as the "Adult MHFA Half Day" course and informally referred to as the "Lite" course by many) was recognised as being more amenable to busy workloads:

> *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.* (M080, Org 2).

However, others felt that this shorter course was not as useful as the longer courses:

> *...but 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).

In addition, the perceived ongoing responsibilities of being a MHFA trained individual in the workplace was sometimes regarded as onerous, further contributing to reluctance:

> *...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... it's almost like doing revision ... Because people will know X is qualified...actually I'm kind of more of a danger at that point unless I feel happy with what I've learnt.* (M186, Org 1)

Need to tailor approach

Some interviewees suggested that training content could have been made more specific to their particular workplace contexts, to take into account the types of employees and roles present. Adapting the training in this way may have made content more relatable and meaningful to the trainee:

> *I would have liked to have heard more experiences from colleagues who were working in similar roles to mine and how they do it... I'm sure we all would have had nuggets of wisdom to share with each other. So yeah I think you can't beat a live example really can you?* (M074, Org 2).

Reluctance to engage in MHFA

Interviewees discussed the realities of the MHFA programme operating within the workplace and disclosed occasions where employees were reluctant to seek help from MHFAiders. Sometimes the reluctance stemmed from MHFAiders themselves with regards to providing help and support within the work environment. The following sub-themes provided examples.

a. *Anonymity.*

Some interviewees described a reluctance amongst employees to use MHFAiders, a preference to speak to someone else, or seek other options within and outside the organisation due to desires to maintain anonymity. This reflected individuals' beliefs about the MHFA intervention and a lack of trust in the anonymity of the MHFA procedures:

> *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.* ((M080, Org 2).

> *I'd probably be happy with talking to the nurse, … [or]for instance the Samaritans have got a phone number you can talk to …you're not looking in someone's eyes sort of thing but you can speak to them.* (M177, Org 3)

b. Adding to work pressures.

Furthermore, it was suggested that employees were conscious of workplace time pressures and concerned about putting added pressure on MHFAiders. This may have reflected concern over the available resources provided by the organisation for the MHFA role. This also hindered seeking help from a MHFA-trained person, whilst also putting pressure on the MHFAider themselves:

> *I wouldn't want to during working hours go to somebody else who was working … 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).

Facilitators to implementation and uptake

Perceived usefulness/impact

Personal experiences of positive interventions by MHFAiders were shared, further indicating situations where perceived good practice had been demonstrated by trained individuals and highlighting the importance of monitoring and feedback regarding the MHFA programme:

> *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.' ... 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).

Others recognised that there had been a change in culture within the organisation, including improved 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).

In addition, MHFA was perceived to be a programme that could extend knowledge and confidence in supporting colleagues. Some interviewees recognised a difference in the way in which situations had been handled following MHFA training:

> *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 supported, plans have been put in place at the level of understanding about what the person is managing* (M188, Org 2).

Role of the instructors

Positive experiences of the training were attributed to the instructor who had delivered the session, with interviewees acknowledging favourable characteristics such as enthusiasm, passion and approachability:

> *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).

Moreover, instructors sharing their own lived experiences was also appreciated:

> *I didn't realise but on the day two of it, one of the ladies told us her personal story... 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).

In addition, the format of the session was also acknowledged as engaging when then was dynamic content:

> *... it was an engaging discussion where people would bounce off one another, share their experiences. And I think that definitely made it more engaging because, well, I would have switched off if I was just there writing things down on a piece of paper".* (M184, Org 1).

In contrast, one participant had found their instructor difficult to engage with and had been discouraged to challenge the information that was presented during the MHFA training:

> *...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… 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).

Clearly, the variability in instructor characteristics and approaches served to be either a barrier or facilitator to effective engagement of trainees.

Discussion

The study demonstrated multiple variations regarding how the MHFA programme had been introduced and embedded into different organisations, including perceived motivations for introducing MHFA, approaches to offering training opportunities to employees, and operationalisation of the programme in the workplace post-training. The reason for organisations' initial interest in the MHFA included MHFA aligning with the needs of the organisations and the popularity of the programme amongst other organisations.

Some commonalities between organisations were identified, for example the development of MHFA networks, which offered a community for training members. There was also general agreement amongst interviewees that leadership staff should attend training to encourage other members to engage with the intervention. The importance of leadership buy-in and the formation of networks was also emphasised in an Australian study (Bovopoulos et al., 2018) exploring MHFAOs in Australian workplaces. Attracting the right people to attend the training and then to take on the MHFAider role, was also highlighted as a priority by participants in the present study. This emphasises the importance of connecting with managers and employees to

effectively involve them in the process of implementation.

Amongst the different approaches that were identified in the present study, the issue of establishing boundaries regarding the MHFAider role became a cause for concern for some interviewees. In response, one organisation had to develop their own guidance around this, suggesting that it was either not covered in the training session, or was not adequately understood. According to Grossman and Salas (Grossman and Salas, 2011), scenarios which are used during training sessions should endeavour to include features of the actual workplace to improve the transferability of trained competencies. Following the publication of a key report (Narayanasamy et al., 2018) investigating workplace MHFA, both the Institution of Occupational Safety and Health (IOSH) and MHFA England have issued guidance and recommendations around the integration of MHFAiders in the workplace, addressing the importance of maintaining boundaries (MHFA England, 2019, Institution of Occupational Safety and Health, 2018).

In this present study, the main barriers to implementation and uptake of MHFA were negative attitudes to mental health within the organisation, the need for training to offer more applicability toward specific workplace contexts, hesitancy of individual employees to commit to the MHFAider role, and reluctance of employees to use the MHFAiders. These highlight the importance of the appropriate resourcing of the post-training MHFA roles, and of the knowledge and beliefs of employees that should be taken into account when implementing MHFA. Ensuring that there are sufficient resources to support the MHFA roles after the training course may be overlooked by some organisations implementing MHFA as a ‘quick fix’.

The facilitators identified in this study emphasise two key factors. First, the characteristics of the MHFA instructor providing training was critical, reflecting the importance of external change agents in engaging trainees. Second, the importance of providing feedback on the intervention, and sharing successful stories of noticeable impact where good practice had been demonstrated by MHFAiders led to enthusiasm and higher engagement for the intervention. The problem is that these may not be universally experienced and it may be difficult to generalise and replicate the core ingredients for success and also measure perceived success.

Interventions to address health issues are acknowledged as being complex (Moore et al., 2015) and the workplace environment is recognised as an important setting for interventions focussing on health promotion and ill-health prevention (Fitzgerald et al., 2016). However, workplaces may prove challenging settings for implementing and evaluating complex interventions due to the fact that they vary significantly across factors such as size, organisational structure and history and culture (Mackenzie et al., 2018). Clearly, as a programme which encompasses several interacting components, MHFA should be understood to be a complex intervention (Moore et al., 2015, Medical Research Council, 2006), which may not operate in a standardised way given the diversity of workplaces and workforces. Added to that complexity is the variable ways in which MHFA interactions are conducted, with more informal conversations difficult to distinguish as being demonstrative of skills being used. Therefore, evaluations of MHFA need to assess and control for such multiple variations in how it is implemented and operationalised. Developing measures of intervention fidelity may be one approach to overcoming this challenge (Gearing et al., 2011). However, traditional ways of

evaluating the MHFA intervention are likely to be inadequate in generating valid evidence concerning its effectiveness. MHFA is a complex intervention, and when implemented into complex workplace settings, it is adapted to that context and unfolds and is operationalised in many different ways.

The effectiveness of complex interventions may be difficult to demonstrate when they are rolled-out to different contexts and as such, it is crucial that all factors which may affect implementation are comprehensively investigated across a range of workplaces (Mackenzie et al., 2018). This may include contextual factors such as workplace structures and cultures as well as individual characteristics of key workplace stakeholders (Fitzgerald et al., 2016, Weiner et al., 2009). The findings of this present study suggest that this is particularly important given the varied ways in which MHFA had been embraced, resisted, maintained and monitored within and across workplaces. In healthcare, the use of realist evaluation and dynamic logic models have been recommended for evaluating such complex interventions in complex settings (Fletcher et al., 2016, Ling, 2012, Mills et al., 2019). The Medical Research Council guidance (Moore et al., 2015) recommend the use of process evaluation to investigate how an intervention has been delivered. This supports the assessment of how the intervention has been adapted to work in different contexts, such as multiple workplaces, and the extent to which such changes have caused intervention fidelity to be compromised. Process evaluations require full understanding and agreement over the intervention, including how it is intended to work (Moore et al., 2015). Thus within the MHFA programme, areas where there is confusion such as around the role remit of the MHFAider, would need to be clarified and operationalised before such evaluations could take place.

Limitations

The interview study was conducted on individuals who were based in UK organisations and who had an interest in MHFA. Data was based on insights provided by individuals, rather than organisational perspectives.

Conclusions

This study identified extensive variations in how MHFA has been implemented and operationalised in organisations, as well as key barriers and facilitators to effective implementation. Such barriers and facilitators were related to aspects of the inner organisational setting and employee characteristics. Effective implementation was compromised by negative attitudes towards mental health; a lack of resources provided by the organisation to fulfil MHFA roles and monitor the programme effectively; and employee reluctance to engage in MHFA. Facilitators were largely based on positive attitudes and approaches undertaken by instructors and trained members, though these elements did not appear to be easily measurable. Organisations choosing to implement MHFA training need to ensure that the MHFA roles are adequately defined and resourced. This should include specified hours of operation, clear role remit, clarity around both reactive and proactive approaches to assisting someone in need, establishing measurable points to assess use and utility of the programme, and developing support and safeguarding mechanisms for trained members. Organisations should also consider how this intervention fits alongside other workplace mental health interventions which take a more preventative approach. Process evaluation may be appropriate to assess effectiveness, but only when all aspects of the MHFA programme, including what the actual role of the MHFAider involves in the workplace and what it is intended to achieve, are developed, agreed, and operationalised.

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Tables

Table 1: Organisational characteristics of the six organisations

Organisation	Sector	Region of lead contact	Industry of organisation	Number of interviewees recruited
1	Public	Northern England	Media/Broadcasting/ Communications	5
2	Public	Northern England	Higher Education	9
3	Private	Northern England	Construction and rail	3
4	Private	West Midlands	Accountancy/ Finance	5
5	Non-profit making/ third sector	Greater London	Research	1
6	Non-profit making/ third sector	Greater London	Mental health	4

Table 2: Demographics of participants

Characteristics of interviewees	Total number
Had received some form of MHFA training	23
Had not received MHFA training	4
Were MHFA coordinators for their organisations	4
Had received help and support from a MHFA trained colleague	3

Table 3: Themes and sub-themes following thematic analysis

Research question	Themes and sub-themes
Implementation approaches	1. Reasons for initial interest in MHFA 2. Attending MHFA training 3. How MHFAiders operate *a. Engaging with colleagues who need support* *b. Time and role commitment required* *c. Boundaries and safety issues* *d. Support for MHFAiders* *e. Recording and monitoring*
Barriers to implementation and uptake	1. Attitudes to mental health 2. Individual commitment required 3. Need to tailor approach 4. Reluctance to engage in MHFA *a. Anonymity* *b.Adding to work pressures*
Facilitators to implementation and uptake	1. Perceived usefulness/ impact 2. Role of the instructors