



Mental Health First Aid Canada Pilot Evaluation (September 2007 to September 2008) Report: December 2008

PREPARED BY:

INFORMATION MANAGEMENT, ALBERTA HEALTH SERVICES – ALBERTA MENTAL HEALTH, DECEMBER 2008

SUMMARY OF RESULTS

A comprehensive evaluation plan has been developed for the Mental Health First Aid (MHFA) Canada program. One component of the overall plan is to assess the immediate impact of the 12-hour course on participants. Key areas for assessment include mental health literacy; stigmatizing attitudes towards mental health problems; and knowledge, skills and confidence in managing mental health problems.

The following report describes an assessment of instructor trainees, who completed the 12-hour course as part of their five-day instructor training. This sample of 199 instructor trainees entered the course already having some combination of education, training and work experience in the mental health field. This characteristic produced a skewed sample relative to typical participants in the 12-hour course, who tend to be members of the general public and not likewise educated and experienced in mental health. Despite the level of "pre-course readiness" in the instructor trainee sample, pre/post testing demonstrated impressive results, as summarized below. These results suggest that non-trained participants in the 12-hour courses may demonstrate even greater change in the desired direction, as a result of completing the MHFA Canada program.

↓ STIGMATIZING ATTITUDES

Prior to completing the MHFA Canada 12-hour course, instructor trainees expressed relatively low social distance (indicating little stigma). Even so, social distance decreased among this sample following the course, indicating that instructor trainees were more willing to interact with, or befriend, someone with a mental health problem following the course.

↑ KNOWLEDGE

BELIEFS ABOUT TREATMENTS: Treatment beliefs became significantly more concordant with those of mental health experts from pre-course to post-course.

SYMPTOM RECOGNITION:

- Instructor trainees demonstrated increased ability to recognize symptoms of depression described in a vignette.
- They showed significantly increased ability to recognize symptoms of mental health problems in a family member.
- There was little change in the ability to recognize symptoms in themselves.
- Immediately following the course, they were more likely to report having had contact with someone with a mental health problem in the six months prior to course.

CONFIDENCE: Instructor trainees were significantly more likely to report feeling confident in helping someone with a mental health problem, after completing the course.

GENERAL KNOWLEDGE: Instructor trainees demonstrated a significant increase in their general mental health knowledge from pre-course to post-course.

↑ SKILLS

Instructor trainees significantly increased in their knowledge of relevant mental health first aid skills from pre-course to post-course.

COURSE SATISFACTION

Instructor trainees' satisfaction with the 12-hour course ranged from 81.7% (ease of registering for the program) to 99.5% (appropriateness of the size of the group).

INTRODUCTION

The MHFA Canada program teaches Canadians to recognize and help themselves or others if they are developing a mental health problem or in a mental health crisis. The program was developed in Australia and was introduced in Canada in 2006.

MHFA Canada aims to improve mental health literacy, and to provide the skills and knowledge to help people better manage potential or developing mental health problems in themselves, a family member, a friend or a colleague. It teaches people to recognize the signs and symptoms of mental health problems, provide initial help, and guide a person towards appropriate professional help.

The course is delivered by certified MHFA Canada instructors and covers the following topics: What is meant by mental health and mental illness/mental health problems; signs and symptoms of common mental health problems and crisis situations; a basic five-step model to provide mental health first aid; information about effective interventions and treatments; and how to access professional help.

Through the five-step model, mental health first aiders are taught to assess the risk of suicide or harm, listen non-judgmentally, give reassurance and information, encourage the person to get appropriate professional help, and encourage self-help strategies.

Two national Master Facilitators conduct intensive five-day instructor training and provide ongoing support to instructors, who then teach 12-hour courses to the general public.

EVALUATION OVERVIEW

The purpose of the current phase of the evaluation was to demonstrate the short-term effectiveness of the MHFA Canada 12-hour course in meeting its objectives. The first two days of the five-day instructor training parallel the 12-hour course these instructors later teach to the general public. These circumstances presented an opportunity to pilot-test evaluation questionnaires that were developed for the general public. Therefore, prior to implementing the evaluation for the general public, who complete 12-hour courses across Canada, the questionnaires were pilot-tested among instructor trainees.

From September 2007 to September 2008, all individuals entering five-day instructor training were asked to complete a pre-course questionnaire (Appendix A), a post-course questionnaire (Appendix B), and an immediate feedback sheet (Appendix C). The pre- and post-questionnaires assessed the instructor trainees' knowledge, skills and attitudes before and after the 12-hour (two-day) course. The immediate feedback sheet assessed their satisfaction with the 12-hour course.

Consistent with evaluation of the MHFA program in Australia, the MHFA Canada evaluation incorporated the Kirkpatrick four-level model for assessing the effects of training programs. Levels include *Reaction*, i.e., participant satisfaction, which may influence the degree of learning that occurs; *Learning*, i.e., knowledge acquired, skills improved, and attitudes changed due to the program; *Behaviour*, i.e., the extent to which participants change their behaviour due to the training; and, *Results*, i.e., longer-term outcomes relevant to the training program. In the MHFA Canada evaluation, results would include improved mental health literacy in Canadian society, increased community capacity for managing mental health problems, etc. (Kirkpatrick, 1996).

As described earlier, the purpose of the current phase of the evaluation was to demonstrate the short-term effectiveness of the MHFA Canada 12-hour course. Short-term effectiveness includes the first two levels of the Kirkpatrick model, i.e., reaction and learning. While behaviour change is not typically tested in the short-term, some indirect assessment of behaviour change is included in the current analysis.

To evaluate the learning that occurs among individuals as a result of completing the MHFA Canada 12-hour course, the course was assessed in terms of its effectiveness in reducing stigma among instructor trainees (i.e., changed attitudes), increasing instructor trainees' ability to recognize the signs and symptoms of mental health problems in themselves and others (i.e., knowledge and skills), and increasing their knowledge and skills to provide initial help and guide a person towards appropriate professional help (i.e., knowledge and skills).

Response rates were very high: Of the first 73 individuals entering instructor training who were asked to participate in the evaluation, 72 completed all three questionnaires. Class sizes were unavailable for the remaining 127 instructor trainees who completed the questionnaires so response rates for the total sample of 199 cannot be calculated. Based on the first portion of the sample, however, it is reasonable to suggest that the final response rate was high.

SAMPLE

Most of the instructor trainees participating in this pilot evaluation were female (79%), and between the ages of 26 and 54 (83%). Nearly 87% had a diploma, Bachelor or graduate degree, and the vast majority (83%) had previous training, learning or knowledge about mental health problems. Most (62%) indicated that they pursued MHFA Canada instructor training out of professional interest or on behalf of their employer.

LIMITATIONS:

Due to the sample's high level of education and experience in mental health and mental health problems, all data for this pilot study are skewed. Instructor trainees enter the 12-hour course (of their five-day training) with a much higher level of knowledge and skills in mental health problems than would be expected amongst the general public, for whom the evaluation questionnaires were developed. Hence, post-course scores for the instructor trainees demonstrate less change than would be expected among the general public, who more typically take the MHFA Canada course as an introduction to these topics. The following results should be interpreted within this context.

RESULTS: ATTITUDES

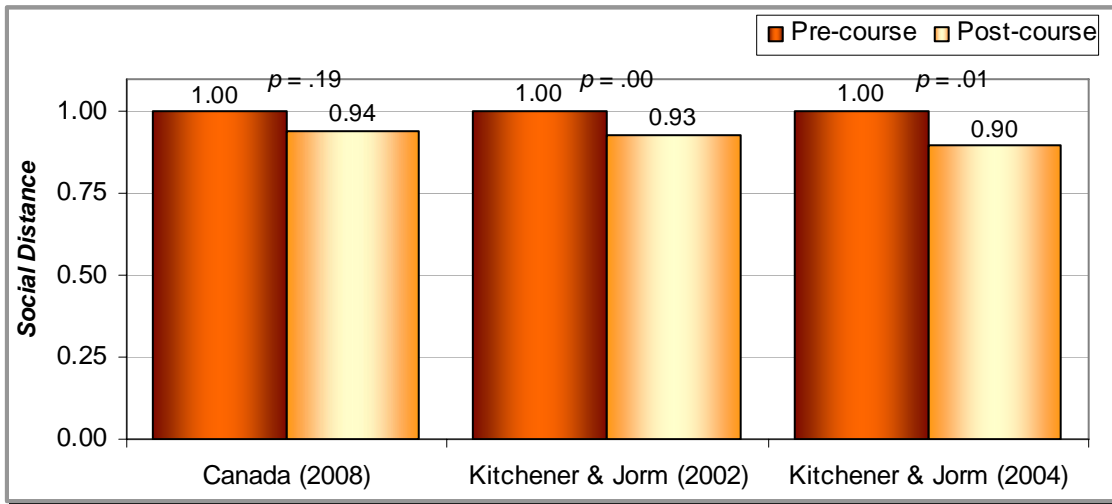
Stigmatizing attitudes were measured by items related to social distance, using a vignette describing Mary, a fictitious individual with depression (Jorm, Korten, Jacomb, Christensen, Rodgers & Pollitt, 1997). Instructor trainees participating in the evaluation were asked to rate their degree of willingness to move next door to Mary, spend an evening socializing with Mary, make friends with her, work closely with her, and have her marry into their family. Responses were provided on a three-point scale: definitely willing, probably willing, or definitely unwilling. Responses in the desired direction for each these five items were summed, so that 1 represents the lowest possible social distance, and 5 represents the greatest possible social distance. Prior to completing the MHFA Canada 12-hour course, instructor trainees expressed relatively low social distance ($M = 1.29$, $SD = 1.23$). Even so, social distance decreased among this sample following the 12-hour course ($M = 1.21$, $SD = 1.23$). This difference was not significant ($p = .19$).

The same vignette was originally used in Kitchener and Jorm's (2002) evaluation of change in social distance among a sample of 166 members of the general public after taking the Australian version of the 12-hour MHFA Canada course. Ratings on the social distance items showed significant change ($p = .00$) from pre-course ($M = 8.05$, $SD = 2.47$) to post-course ($M = 7.48$, $SD = 2.36$; Kitchener & Jorm, 2002). Kitchener and Jorm (2004) also report an evaluation of MHFA courses offered to employees in various health and community services departments of the Australian government. Participants' ratings again showed significant change ($p = .01$) from pre-course ($M = 8.74$, $SD = 2.80$) to post-course ($M = 7.86$, $SD = 2.50$; Kitchener & Jorm, 2004).

Equalizing the scoring scales of the current evaluation with those of the Kitchener and Jorm (2002, 2004) studies enables more direct comparisons. Interpretations must be made in the context of the distinct populations under comparison; the current sample of instructor trainees would not be expected to demonstrate the degree of change pre-course to post-course of Kitchener and Jorm's samples of

typical 12-hour course participants. Though attitudes among the current sample were very positive (indicating little stigma) pre-course, the change in stigmatizing attitudes following the MHFA Canada course was similar to that reported by Kitchener and Jorm amongst samples not likewise skewed (see Chart 1.0). *Note: Lower ratings represent more positive attitudes, in that respondents indicate they are comfortable with less social distance from an individual with a mental health problem.*

CHART 1.0. CHANGE IN STIGMATIZING ATTITUDES FOLLOWING TRAINING IN MHFA

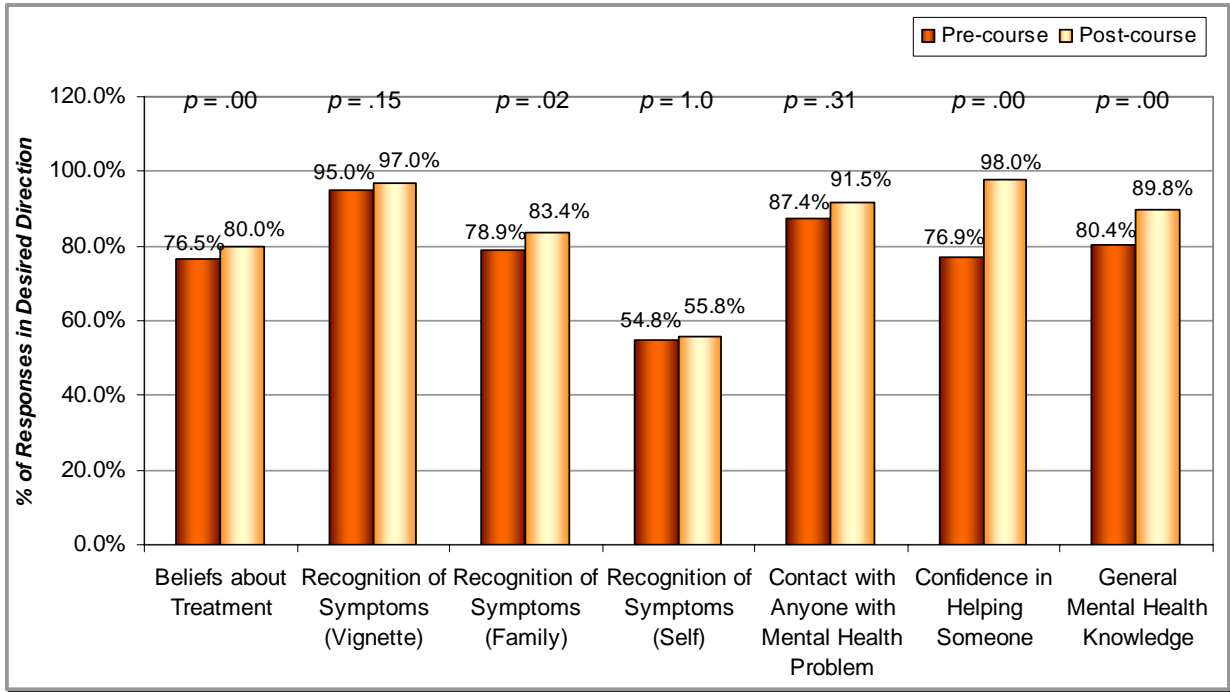


RESULTS: KNOWLEDGE

Knowledge of mental health and mental health problems among the current sample of instructor trainees was measured pre- and post-course by items that were grouped into several categories. Assessment of knowledge included items that determined the degree of concordance between instructor trainees’ treatment beliefs and those of mental health experts, instructor trainees’ ability to recognize symptoms in themselves or others, their level of confidence in providing help for a mental health problem, and their general knowledge about mental health and mental health problems.

Though the current sample of instructor trainees entered the MHFA Canada 12-courses with high levels of education and experience in mental health and mental health problems, the level of knowledge specific to MHFA Canada training showed significant change in a number of areas (see Chart 2.0). All areas of knowledge that were measured showed some improvement (see Chart 2.0). The greatest change was demonstrated in instructor trainees’ confidence in helping someone with a mental health problem, while the least change was demonstrated in their ability to recognize symptoms of mental health problems in themselves.

CHART 2.0. CHANGE IN KNOWLEDGE FOLLOWING MHFA CANADA 12-HOUR COURSE



BELIEFS ABOUT TREATMENTS: One of the prompts for the development of the original MHFA program was a 2003-2004 Australian national survey of mental health literacy, which revealed that the general public differed from mental health experts in their beliefs about the causes of mental disorders and the most effective treatments (Jorm, Blewitt, Griffiths, Kitchener & Parslow, 2005). As such, the questionnaires developed for the Kitchener and Jorm (2002, 2004) evaluations and adapted for the current evaluation, include items that assess respondents' beliefs about the helpfulness or harmfulness of various treatments and actions potentially sought by an individual with a mental health problem.

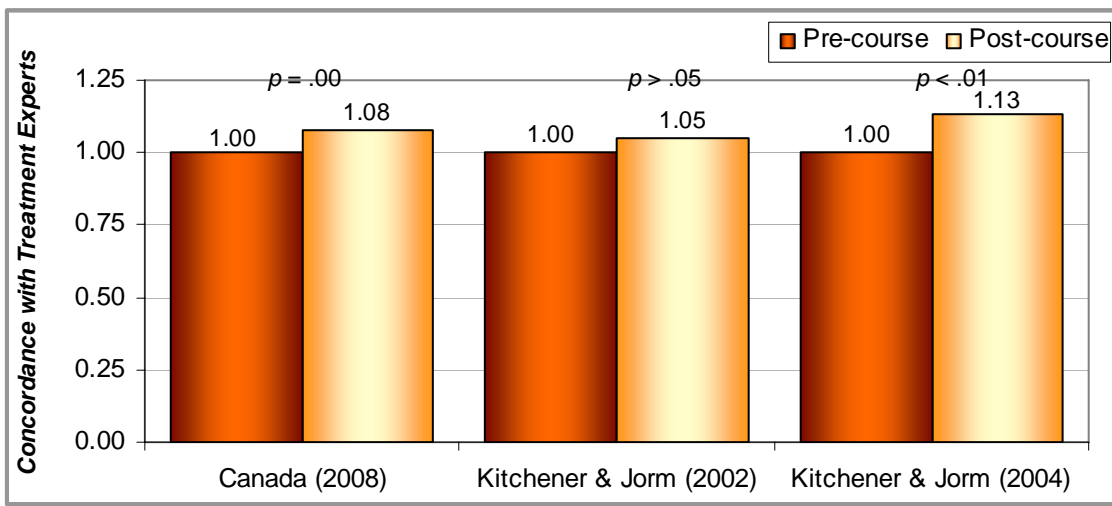
Accepted responses for the 22 items addressing treatment beliefs were summed for each instructor trainee. Values could range from 1 to 22, where 1 represents the lowest possible concordance with mental health experts. Treatment beliefs among this sample became significantly ($p = .00$) more concordant with experts from pre-course ($M = 15.18, SD = 3.44$) to post-course ($M = 16.38, SD = 3.18$).

This result is comparable to that reported by Kitchener and Jorm (2002), where members of the general public were significantly ($p < .01$) more likely to concur with mental health professionals after

completing the MHFA course (pre-course: $M = 79.65$, $SD = 25.01$; post-course: $M = 89.90$, $SD = 17.90$). The government department workplace sample evaluated by Kitchener and Jorm (2004), demonstrated a change in treatment belief concordance in the same direction pre-course ($M = 82.10$, $SD = 17.27$) to post-course ($M = 86.29$, $SD = 18.30$) though this change was not significant ($p > .05$).

Equalizing the scoring scales of the current evaluation with those of the Kitchener and Jorm (2002, 2004) studies once again enables more direct comparisons. As previously discussed, the current sample of instructor trainees would not be expected to demonstrate the degree of change pre-course to post-course of Kitchener and Jorm’s samples of typical 12-hour course participants. Though treatment beliefs among the current sample were already quite concordant with mental health treatment experts pre-course, the change towards even greater concordance following the MHFA Canada course was similar to that reported by Kitchener and Jorm amongst samples not likewise skewed (see Chart 3.0).

CHART 3.0. CHANGE IN TREATMENT BELIEFS FOLLOWING TRAINING IN MHFA



RECOGNITION OF SYMPTOMS: Instructor trainees participating in this evaluation were assessed on their ability to recognize symptoms of a mental health problem in themselves and in their family members or colleagues. Also assessed was instructor trainees’ ability to correctly identify symptoms of depression as presented in a vignette (previously described) and, related to symptom recognition, the number of people with mental health problems that they reported having contact with in the six months previous to the course. Six items addressed these areas of symptom recognition; correct responses for each instructor trainee were summed, so that values could range from 1 to 6, where 1 represents no ability

to recognize symptoms. As a group, there was not significant change ($p = .89$) in correct responses to these six items from pre-course ($M = 4.48$, $SD = 1.54$) to post-course ($M = 4.49$, $SD = 1.47$), although the direction of the change corresponds to results demonstrated by Kitchener and Jorm (2002, 2004). *Please note that the mode for this group of items was 6.0, indicating that the majority of the sample had perfect ability to recognize symptoms.* This result, combined with the relatively high standard deviation both pre- and post-course, suggests that while most instructor trainees had perfect symptom recognition ability (as measured by the questionnaires used for this evaluation), a sizeable portion had very poor ability. There were few instructor trainees between these two extremes.

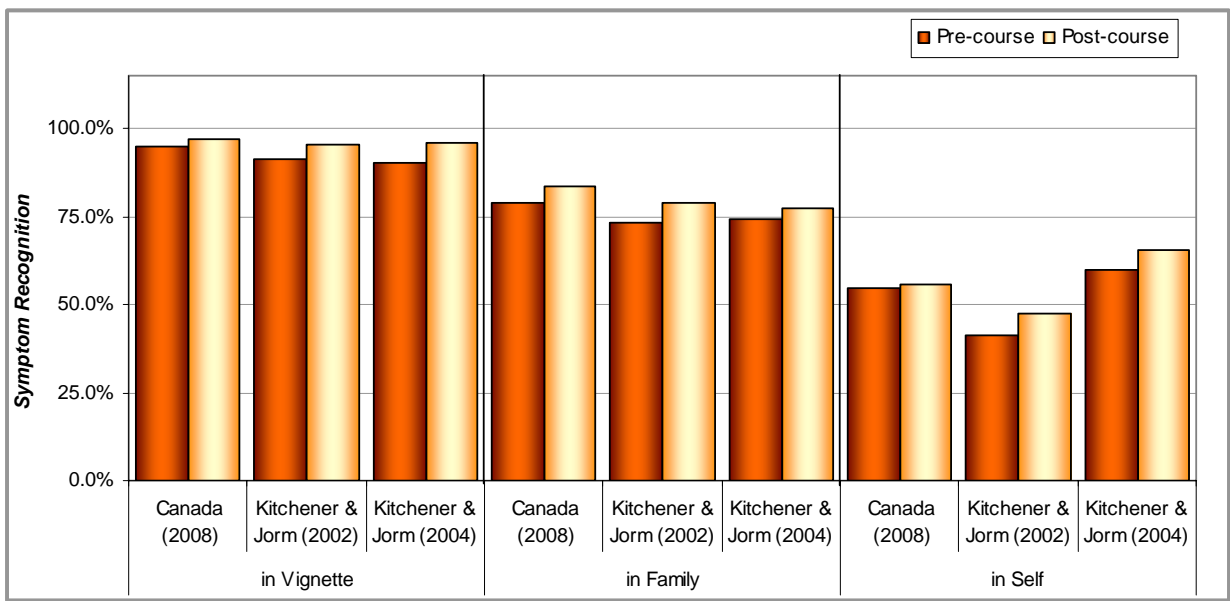
VIGNETTE: Pre-course, 95.0% of instructor trainees were able to correctly identify the mental health problem described in the vignette as depression. This did not change significantly ($p = .15$) at post-course (97.0%), presumably due to the sample's high level of familiarity with mental health problem symptoms and diagnoses prior to completing the MHFA Canada course. Even in samples that were not likewise skewed, Kitchener and Jorm (2002, 2004) did not demonstrate significant increases in correct identification of depression in this vignette among the general public (91.4% to 95.2%, $p = .27$; 2002) nor among government department employees (90.2% to 95.8%, $p > .05$; 2004) from pre-course to post-course.

FAMILY: The percentage of instructor trainees reporting recognition of a mental health problem in a family member significantly increased ($p = .02$) from 78.9% pre-course to 83.4% post-course in the current evaluation. This significant result was not likewise demonstrated by Kitchener and Jorm among the general public (73.4% to 79.0%, $p > .05$; 2002) or among government department employees (74.5% to 77.2%; $p > .05$; 2004).

CONTACT: Related to this measure are instructor trainees' reports of whether or not they had contact with anyone with a mental health problem in the six months prior to taking the course. In the current sample, 87.4% reported having had such contact when asked at pre-course. Immediately following the MHFA Canada course, this rate increased to 91.5% reporting having had such contact; this increase was not significant ($p = .31$). The rise in instructor trainees' contact frequency, retrospectively, with people with mental health problems may reflect improvement in their ability to recognize symptoms. It seems that instructor trainees learned to better identify individuals with mental health problems, which increased their reports of symptomatic individuals in their lives over the six months immediately previous to the MHFA Canada course. Comparable findings for this measure are unavailable, as the Kitchener and Jorm (2002, 2004) evaluations provide data at five and six months post-course rather than immediately post-course.

SELF: In order to maintain consistency with the Australian evaluations of MHFA training courses, instructor trainees participating in the current evaluation were assessed on their ability to recognize symptoms of mental health problems in themselves. This sample demonstrated little change, moving from 54.8% pre-course to 55.8% post-course ($p = 1.0$). Likewise, Kitchener and Jorm report non-significant improvements in recognition of symptoms (in self) from pre- to post-course for both the general public (41.4% to 47.4%, $p = .05$; 2002) and government department employees (60.0% to 65.5%, $p > .05$; 2004).

CHART 4.0. CHANGE IN SYMPTOM RECOGNITION FOLLOWING TRAINING IN MHFA



CONFIDENCE: Instructor trainees were asked how confident they felt in helping someone with a mental health problem prior to taking the MHFA Canada course: 76.9% of the sample reported feeling “moderately”, “quite” or “very” confident. A significant increase ($p = .00$) in this confidence was demonstrated following the course, where 98.0% of instructor trainees reported feeling one of these three levels of confidence relative to the other choices of feeling “not at all” or “a little” confident. Comparable findings for this measure are unavailable, as the Kitchener and Jorm (2002, 2004) evaluations did not provide data on confidence levels of participants immediately post-course.

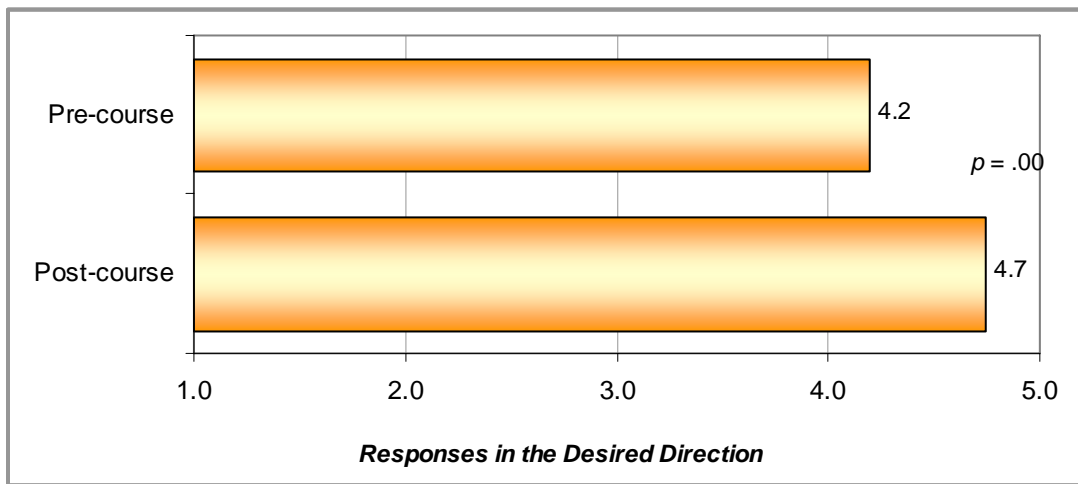
GENERAL KNOWLEDGE: Items that assessed the general knowledge of instructor trainees on mental health and mental health problems were included in the pre- and post-course questionnaires. All items were specific to information covered in the MHFA Canada course. Instructor trainees demonstrated a

significant ($p = .00$) increase in their general knowledge from pre-course ($M = 12.98$, $SD = 2.80$) to post-course ($M = 14.94$, $SD = 2.33$). Pre-course, 80.4% of trainees responded correctly to general knowledge items; post-course, this rate rose to 89.8%. The mean increased while the standard deviation decreased, indicating that participants scored more uniformly higher following the MHFA Canada course. Comparable findings for this measure are unavailable, as the Kitchener and Jorm (2002, 2004) evaluations do not report on the general knowledge items. Further, items are specific to each of the Australian and Canadian evaluations.

RESULTS: SKILLS

Skills were evaluated using several items that measured instructor trainees' knowledge of mental health first aid skills including their knowledge of the five-step model to provide mental health first aid, good listening skills, and the appropriate help to provide in specific circumstances. The current sample demonstrated a significant increase ($p = .00$) in their knowledge of relevant mental health first aid skills from pre-course ($M = 4.20$, $SD = 1.13$) to post-course ($M = 4.74$, $SD = 0.79$). Comparable reports of this measure are unavailable, as the Kitchener and Jorm (2002, 2004) evaluations do not report on the skill levels of their samples pre- and post-course.

CHART 5.0. CHANGE IN SKILLS FOLLOWING MHFA CANADA 12-HOUR COURSE



RESULTS: REACTION (SATISFACTION)

Typically, when participants in a training program have a positive response to the program, their likelihood of being motivated and interested to learn improves (Kirkpatrick, 1996). Areas of satisfaction that were assessed for the current evaluation include: Ease of registering for the program, comfort of the training facilities, balance between presentation and group participation, length of the program,

effectiveness of the audiovisual materials, helpfulness of the manual, applicability of the course content, appropriateness of the group size, and the consistency between the stated objectives of the course and its deliverables. Satisfaction with the MHFA Canada 12-hour course among this sample of instructor trainees was very high across all areas measured (see Charts 6.0 and 6.1).

CHART 6.0. SATISFACTION WITH MHFA CANADA 12-HOUR COURSE (CONTINUED)

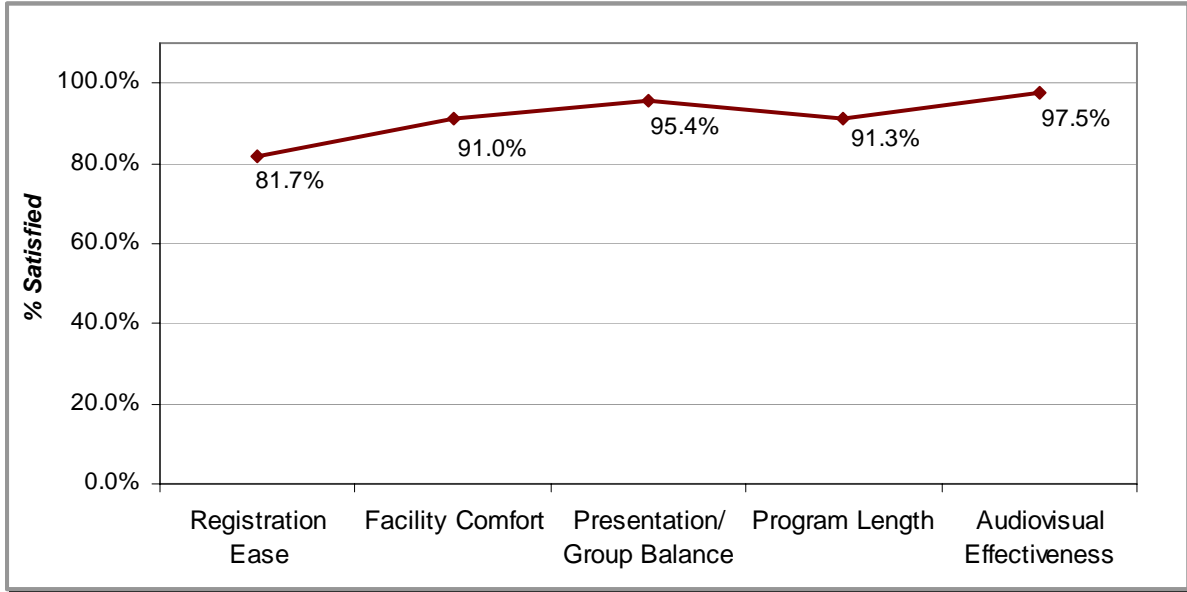
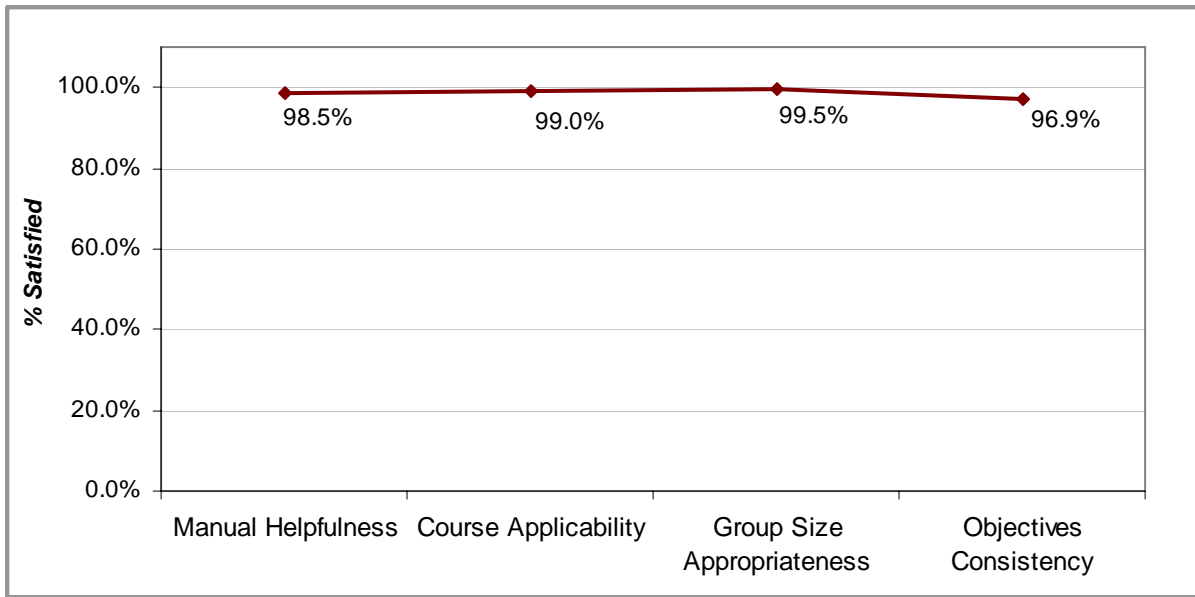


CHART 6.1. SATISFACTION WITH MHFA CANADA 12-HOUR COURSE



CONCLUSION

As described earlier, this sample was skewed in the desired direction prior to entering the MHFA Canada 12-hour course. However, even this skewed sample demonstrated change, often significantly, after completing the course. The decrease in stigmatizing attitudes following the course was significant. Instructor trainees were more willing to live next door to an individual with depression, more willing to socialize with her, befriend her, work with her or have her marry into their family. Instructor trainees came to hold treatment beliefs for mental health problems that were significantly more concordant with mental health experts, after completing the course. They demonstrated improved ability to recognize symptoms of mental health problems in themselves and others; the ability to do so among family members improved significantly. Their confidence in providing help to someone with mental health problems showed a significant increase following completion of the course, as did their general knowledge of mental health and mental health problems. This knowledge and confidence perhaps contributed to the significant increase in the skill level observed in this sample. Skill levels as measured included instructor trainees' knowledge of the five-step model to provide mental health first aid, good listening skills, and the appropriate help to provide in specific circumstances.

In context to the results shown among the samples evaluated by Kitchener and Jorm (2002, 2004) and described throughout this report, these favourable findings among a skewed sample clearly demonstrates the effectiveness of the MHFA Canada 12-hour course in all program objectives. Further, instructor trainees indicated a high level of satisfaction with the format, content, delivery, and applicability of the course.

RECOMMENDATIONS

It is recommended that the evaluation be expanded to participants in general public entering the MHFA Canada 12-hour course. Implementing the evaluation to participants will ensure that program administrators continue to contribute to the body of knowledge about MHFA evaluation that informs current and future providers of MHFA. Evaluation of participants on the measures described in this report will test assumptions about the benefits of the MHFA Canada program. Continued assessment of participant satisfaction and perception will also demonstrate a commitment to quality improvement in the ongoing design and refinement of the MHFA Canada program content and process. The positive results of the instructor trainee group suggest that even more positive results can be anticipated with typical participants of the MHFA Canada 12-hour courses.

REFERENCES

Jorm, A. F., Korten, A. E., Jacomb, P. A., Christensen, H., Rodgers, B., & Pollitt, P. (1997). "Mental health literacy": A survey of the public's ability to recognize mental disorders and their beliefs about the effectiveness of treatment. *Medical Journal of Australia*, 166: 182-186.

Jorm, A. F., Blewitt, K. A., Griffiths, K. M., Kitchener, B. A., & Parslow, R. A. (2005). Mental health first aid responses of the public: Results from an Australian national survey. *BioMed Central Psychiatry*, 5: 9.

Kitchener, B. A., & Jorm, A. F. (2002). Mental health first aid training for the public: Evaluation of effects on knowledge, attitudes and helping behavior. *BioMed Central Psychiatry*, 2: 10.

Kitchener, B. A., & Jorm, A. F. (2002). Mental health first aid training in a workplace setting: A randomized controlled trial. *BioMed Central Psychiatry*, 4: 23.

Kirkpatrick, D. L. (1996). Great ideas revisited: Revisiting Kirkpatrick's four-level model. *Training and Development*, January issue.



Mental Health First Aid Canada

Date: _____
Instructor: _____
Facility: _____

To determine the effectiveness of this program in meeting your needs and interests, we require your input. Your responses are confidential and anonymous unless you opt to provide your signature at the end of the form.

First, we would like to know about your experience with mental health problems in your everyday life.

- How knowledgeable are you today about mental health problems?
Not at all A little Moderately Quite Very
- How confident do you feel today in helping someone with a mental health problem?
Not at all A little Moderately Quite Very
- Have you yourself ever experienced a mental health problem?
Yes No
- Has anyone in your family ever experienced a mental health problem?
Yes No
- In the last 6 months, have you had contact with anyone with a mental health problem?
Yes No Don't know
- If "yes", how many people?
0-1 2-5 6-10 11-20 >20
- If "yes", did you offer help?
None A little Some Quite a bit A lot
- If "yes", what help did you offer?

The box below is a non-factual account of a person named Mary. Following the description are questions about how Mary has been lately.

Mary is 30 years old. She has been feeling unusually sad and miserable for the last few weeks. Even though she is tired all the time, she has trouble sleeping nearly every night. She doesn't feel like eating and has lost weight. She can't keep her mind on her work and puts off making any decisions. Even day-to-day tasks seem too much for her. This has come to the attention of her boss who is concerned about her lowered productivity.

- From the information given, what, if anything, is wrong with Mary?

- Do you think Mary needs professional help?
Yes No
- If Mary were to seek help from any of the following people, is it likely to be helpful, harmful or neither for her? (Please check one response for each line.)
 - Family physician
Helpful Harmful Neither
 - Pharmacist
Helpful Harmful Neither
 - Counsellor
Helpful Harmful Neither
 - Social worker
Helpful Harmful Neither
 - Telephone counselling service
Helpful Harmful Neither
 - Psychiatrist
Helpful Harmful Neither
 - Clinical psychologist
Helpful Harmful Neither
 - Close family
Helpful Harmful Neither
 - Close friends
Helpful Harmful Neither
 - Naturopath
Helpful Harmful Neither
 - Clergy, minister or priest
Helpful Harmful Neither
 - Deal with her problems on her own
Helpful Harmful Neither
- If Mary were to take one of the following medications, is it likely to be helpful, harmful or neither for her? (Check one response for each line.)
 - Vitamins and minerals
Helpful Harmful Neither
 - St John's wort
Helpful Harmful Neither
 - Pain relievers such as Tylenol, ibuprofen or codeine
Helpful Harmful Neither
 - Antidepressants
Helpful Harmful Neither
 - Antibiotics
Helpful Harmful Neither
 - Anti-psychotics
Helpful Harmful Neither

- g. Sedatives such as Valium
Helpful Harmful Neither
5. If Mary were to undertake any of the following, is it likely to be helpful, harmful or neither for her? (Please check one response for each line.)
- a. Becoming more physically active such as playing more sports, or doing more walking or gardening
Helpful Harmful Neither
- b. Reading about people with similar problems and how they have dealt with them
Helpful Harmful Neither
- c. Getting out and about more
Helpful Harmful Neither
- d. Taking courses on relaxation, stress management, meditation or yoga
Helpful Harmful Neither
- e. Cutting out alcohol altogether
Helpful Harmful Neither
- f. Engaging in counselling/ psychotherapy
Helpful Harmful Neither
- g. Undergoing hypnosis
Helpful Harmful Neither
- h. Being admitted to a psychiatric unit of a hospital
Helpful Harmful Neither
- i. Receiving electroconvulsive therapy (ECT)
Helpful Harmful Neither
- j. Having an occasional alcoholic drink to relax
Helpful Harmful Neither
- k. Following a special diet or avoiding certain foods
Helpful Harmful Neither
6. How willing would you be to:
- a. Move next door to Mary
Definitely Willing Probably Willing Definitely Unwilling
- b. Spend an evening socializing with Mary
Definitely Willing Probably Willing Definitely Unwilling
- c. Make friends with Mary
Definitely Willing Probably Willing Definitely Unwilling
- d. Have Mary start working closely with you on a job
Definitely Willing Probably Willing Definitely Unwilling
- e. Have Mary marry into your family
Definitely Willing Probably Willing Definitely Unwilling
7. Have you ever had a problem similar to Mary's?
Yes No
8. Has anyone in your family or close circle of friends ever had a problem similar to Mary's?
Yes No

Please indicate whether you agree or disagree with each of the following statements.

- Mental health problems are in general less disabling than physical health problems.
Agree Disagree
- 50% of people who have a mental health problem or substance dependency are likely to seek treatment.
Agree Disagree
- It is common for people to have a mixture of both anxiety and depression.
Agree Disagree
- A first-aider can distinguish a panic attack from a heart attack.
Agree Disagree
- If a person has a panic attack, the best way to help is to get them to jog on the spot.
Agree Disagree
- When someone has a traumatic experience, it is best to press him or her talk about it as soon as possible.
Agree Disagree
- Exercise can help relieve depression and anxiety.
Agree Disagree
- It is normal to move through the process of grieving a loss anywhere from a few days to a few years.
Agree Disagree
- A person who is depressed will often appear unkempt and speak in a slow, monotonous way.
Agree Disagree
- If you are suddenly able to do far more than usual and feel little need for sleep for several days, don't be concerned--enjoy the increased energy.
Agree Disagree
- A person is at less risk of suicide if someone they know has died by suicide.
Agree Disagree
- It is not a good idea to ask people if they are feeling suicidal in case you put the idea in their head.
Agree Disagree
- It is safe for women to drink up to nine standard alcoholic drinks a week on average.
Agree Disagree
- Some of the effects of cannabis use (e.g., lethargy, difficulty making decisions) mirror symptoms of depression.
Agree Disagree
- People who regularly use one drug are more likely to use other drugs, as well.
Agree Disagree

- 16. Schizophrenia is one of the most common mental health problems in Canada.
 Agree Disagree
- 17. A person who is experiencing acute psychosis is most often violent.
 Agree Disagree
- 18. It is best to agree with a psychotic person's delusions, so they don't get upset with you.
 Agree Disagree
- 19. Psychosis often begins in late adolescence/early adulthood. A major reason it may go un-diagnosed is that it involves behaviours common in this age group.
 Agree Disagree
- 20. People with eating disorders often have low self-esteem.
 Agree Disagree
- 21. Effective listeners are aware of their own feelings and thoughts.
 Agree Disagree
- 22. One of the best ways to help someone recover from a mental health problem is to encourage them to engage in self-help strategies.
 Agree Disagree

Now we need to ask some personal information, none of which can or will be used to identify you.

- 1. What is your gender?
 Male Female
- 2. In which age category do you belong?
 18-25 26-35 36-44 45-54 55+
- 3. What is the highest level of education you have completed?
 High School or Less
 Some College or University
 College Diploma or Bachelor's Degree
 Graduate Degree
 Other (please specify): _____
- 4. Have you had previous training, learning, or knowledge about mental health problems?
 Yes No
- 5. Do you belong to any of the following groups? (Please check all that apply.)
 User of mental health services
 Provider of mental health services
 Other health services provider (please specify area/discipline): _____
 None of the above

- 6. Which of the following BEST describes the sector in which you work or volunteer? (Please check one.)
 Education
 Business or corporate
 Health services
 Public safety
 Special interest or non-profit
 Other (please specify): _____
- 7. Why did you register for this course? (Please check one.)
 Personal interest
 Professional interest
 I was approached by my employer/ organization
 Other _____
- 8. How did you first hear about MHFA? (Please check one.)
 Employer/ volunteer organization
 Professional association
 Friends or family
 Internet search/ MHFA website
 MHFA course advertisements
 Conference/ trade show
 Other (please specify): _____
- 9. What is the length of this course?
 2 days 4 sessions

We welcome any additional comments or suggestions that will help us to serve you, based on your experiences with MHFA so far, e.g., the registration process.

Thank you!

*Please place this questionnaire **FACE-DOWN** on the table in front of you.*

 Signature (**Optional**)

POST-COURSE QUESTIONNAIRE



Mental Health First Aid Canada

Date: _____
 Instructor: _____
 Facility: _____

Like the other surveys you completed, your responses to this questionnaire are confidential and anonymous unless you opt to provide your signature at the end of the form. The information will be used to create categories of respondents, but it cannot and will not be used to identify you. The results will help to ensure that the MHFA program is effective in meeting your needs and interests.

- Was the material that the course covered new to you?
 Not at all Somewhat Very
- How easy was it to understand?
 Very easy Somewhat easy Very hard
- Was the content relevant for you?
 Not at all Somewhat Very
- Which topics were most beneficial:
 - Introduction to MHFA, mental health/illness
 Not at all Somewhat Very
 - Anxiety disorders
 Not at all Somewhat Very
 - Mood disorders
 Not at all Somewhat Very
 - Substance-related disorders
 Not at all Somewhat Very
 - Psychosis and related disorders
 Not at all Somewhat Very
 - Resources
 Not at all Somewhat Very
 - Other (Please specify): _____
 Not at all Somewhat Very
- Are there any other specific topics that you think should be included in the MHFA course?

- How knowledgeable are you today about mental health problems?
 Not at all A little Moderately Quite Very
- How confident do you feel today in helping someone with a mental health problem?
 Not at all A little Moderately Quite Very

- Have you yourself ever experienced a mental health problem?
 Yes No
- Has anyone in your family ever experienced a mental health problem?
 Yes No
- In the last 6 months, have you had contact with anyone with a mental health problem?
 Yes No Don't know
- If "yes", how many people?
 0-1 2-5 6-10 11-20 >20
- If "yes", did you offer help?
 None A little Some Quite a bit A lot
- If "yes", what help did you offer?

The box below is a non-factual account of a person named Mary. Following the description are questions about how Mary has been lately.

Mary is 30 years old. She has been feeling unusually sad and miserable for the last few weeks. Even though she is tired all the time, she has trouble sleeping nearly every night. She doesn't feel like eating and has lost weight. She can't keep her mind on her work and puts off making any decisions. Even day-to-day tasks seem too much for her. This has come to the attention of her boss who is concerned about her lowered productivity.

- From the information given, what, if anything, is wrong with Mary?

- Do you think Mary needs professional help?
 Yes No
- If Mary were to seek help from any of the following people, is it likely to be helpful, harmful or neither for her? (Please check one response for each line.)
 - Family physician
 Helpful Harmful Neither
 - Pharmacist
 Helpful Harmful Neither
 - Counsellor
 Helpful Harmful Neither
 - Social worker
 Helpful Harmful Neither
 - Telephone counselling service
 Helpful Harmful Neither
 - Psychiatrist
 Helpful Harmful Neither

- g. Clinical psychologist
Helpful Harmful Neither
 - h. Close family
Helpful Harmful Neither
 - i. Close friends
Helpful Harmful Neither
 - j. Naturopath
Helpful Harmful Neither
 - k. Clergy, minister or priest
Helpful Harmful Neither
 - l. Deal with her problems on her own
Helpful Harmful Neither
4. If Mary were to take one of the following medications, is it likely to be helpful, harmful or neither for her? (Please check one response for each line.)
- a. Vitamins and minerals
Helpful Harmful Neither
 - b. St John's wort
Helpful Harmful Neither
 - c. Pain relievers such as Tylenol, ibuprofen or codeine
Helpful Harmful Neither
 - d. Antidepressants
Helpful Harmful Neither
 - e. Antibiotics
Helpful Harmful Neither
 - f. Anti-psychotics
Helpful Harmful Neither
 - g. Sedatives such as Valium
Helpful Harmful Neither
5. If Mary were to undertake any of the following, is it likely to be helpful, harmful or neither for her? (Please check one response for each line.)
- a. Becoming more physically active such as playing more sports, or doing more walking or gardening
Helpful Harmful Neither
 - b. Reading about people with similar problems and how they have dealt with them
Helpful Harmful Neither
 - c. Getting out and about more
Helpful Harmful Neither
 - d. Taking courses on relaxation, stress management, meditation or yoga
Helpful Harmful Neither

- e. Cutting out alcohol altogether
Helpful Harmful Neither
 - f. Engaging in counselling/ psychotherapy
Helpful Harmful Neither
 - g. Undergoing hypnosis
Helpful Harmful Neither
 - h. Being admitted to a psychiatric unit of a hospital
Helpful Harmful Neither
 - i. Receiving electroconvulsive therapy (ECT)
Helpful Harmful Neither
 - j. Having an occasional alcoholic drink to relax
Helpful Harmful Neither
 - k. Following a special diet or avoiding certain foods
Helpful Harmful Neither
6. How willing would you be to:
- a. Move next door to Mary
Definitely Willing Probably Willing Definitely Unwilling
 - b. Spend an evening socializing with Mary
Definitely Willing Probably Willing Definitely Unwilling
 - c. Make friends with Mary
Definitely Willing Probably Willing Definitely Unwilling
 - d. Have Mary start working closely with you on a job
Definitely Willing Probably Willing Definitely Unwilling
 - e. Have Mary marry into your family
Definitely Willing Probably Willing Definitely Unwilling
7. Have you ever had a problem similar to Mary's?
Yes No
8. Has anyone in your family or close circle of friends ever had a problem similar to Mary's?
Yes No

Please indicate whether you agree or disagree with each of the following statements.

- 1. Mental health problems are in general less disabling than physical health problems.
Agree Disagree
- 2. 50% of people who have a mental health problem or substance dependency are likely to seek treatment.
Agree Disagree
- 3. It is common for people to have a mixture of both anxiety and depression.
Agree Disagree
- 4. A first-aider can distinguish a panic attack from a heart attack.
Agree Disagree

- 5. If a person has a panic attack, the best way to help is to get them to jog on the spot.
Agree Disagree
- 6. When someone has a traumatic experience, it is best to press him or her talk about it as soon as possible.
Agree Disagree
- 7. Exercise can help relieve depression and anxiety.
Agree Disagree
- 8. It is normal to move through the process of grieving a loss anywhere from a few days to a few years.
Agree Disagree
- 9. A person who is depressed will often appear unkempt and speak in a slow, monotonous way.
Agree Disagree
- 10. If you are suddenly able to do far more than usual and feel little need for sleep for several days, no need to worry--enjoy the increased energy.
Agree Disagree
- 11. A person is at less risk of suicide if someone they know has died by suicide.
Agree Disagree
- 12. It is not a good idea to ask people if they are feeling suicidal in case you put the idea in their head.
Agree Disagree
- 13. It is safe for women to drink up to nine standard alcoholic drinks a week on average.
Agree Disagree
- 14. Some of the effects of cannabis use (e.g., lethargy, difficulty making decisions) mirror symptoms of depression.
Agree Disagree
- 15. People who regularly use one drug are more likely to use other drugs, as well.
Agree Disagree
- 16. Schizophrenia is one of the most common mental health problems in Canada.
Agree Disagree
- 17. A person who is experiencing acute psychosis is most often violent.
Agree Disagree
- 18. It is best to agree with a psychotic person's delusions, so they don't get upset with you.
Agree Disagree
- 19. Psychosis often begins in late adolescence/early adulthood. A major reason it may go un-diagnosed is that it involves behaviours common in this age group.
Agree Disagree

- 20. People with eating disorders often have low self-esteem.
Agree Disagree
- 21. Effective listeners are aware of their own feelings and thoughts.
Agree Disagree
- 22. One of the best ways to help someone recover from a mental health problem is to encourage them to engage in self-help strategies.
Agree Disagree

We welcome any additional comments or suggestions that will help us to serve you.

You have finished! Thank you!

*Please place this questionnaire **FACE-DOWN** on the table in front of you.*

Signature (Optional)



Mental Health First Aid Canada

Date: _____
Instructor: _____
Facility: _____

Please provide your frank reactions and comments to this program, to help us best meet your needs and interests. Your responses are confidential and anonymous unless you opt to provide your signature at the end of the form.

Please check one response for each statement below. Space is provided to expand on your responses.

1. Registering for this program was straightforward and trouble-free.

Agree Disagree

2. The facilities were comfortable.

Agree Disagree

3. There was a good balance between presentation and participant/group involvement.

Agree Disagree

4. The length of the program was suitable.

Agree Disagree

5. The audiovisual aids were effective.

Agree Disagree

6. The manual will be helpful for me.

Agree Disagree

7. I will be able to apply much of the course material.

Agree Disagree

8. The size of the group was appropriate for efficient yet valuable discussions.

Agree Disagree

9. The course was consistent with stated objectives.

Agree Disagree

Following are statements about your instructor(s). If you had one instructor, complete Question (1) only. If you had two instructors, complete both Question (1) and (2). In all cases, please provide the name of each instructor you rate.

1. Instructor Name: _____
How do you rate this instructor:

- a. in maintaining a friendly and helpful attitude
Poor Fair Good Excellent
- b. in having good knowledge of the subject matter
Poor Fair Good Excellent
- c. in keeping the sessions lively and interesting
Poor Fair Good Excellent
- d. in using the audiovisual aids effectively
Poor Fair Good Excellent
- e. in being well-prepared
Poor Fair Good Excellent
- f. as an effective communicator
Poor Fair Good Excellent

2. Instructor Name: _____
How do you rate this instructor:

- a. in maintaining a friendly and helpful attitude
Poor Fair Good Excellent
- b. in having good knowledge of the subject matter
Poor Fair Good Excellent
- c. in keeping the sessions lively and interesting
Poor Fair Good Excellent
- d. in using the audiovisual aids effectively
Poor Fair Good Excellent
- e. in being well-prepared
Poor Fair Good Excellent
- f. as an effective communicator
Poor Fair Good Excellent

1. What would have made the sessions more effective?

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

Thank you!

Please place this questionnaire **FACE-DOWN** on the table in front of you.

Signature (**Optional**)