

Master's Thesis

The Mayor's Office of ThriveNYC Mental Health First Aid Training:

An Evaluation Proposal to Assess Program Effectiveness, Outcomes and Financial Viability.

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Abstract

The Mental Health First Aid (MHFA) Training program by ThriveNYC (2015) aims to increase the understanding of mental health, to teach trainees how to respond to signs of mental distress, to connect people in need to accessible options for care, and ultimately, to reduce the stigma associated with mental illness (ThriveNYC, 2020a).

The program has continued to expand over the past five years with a steady increase in the number of trainings administered (ThriveNYC, 2020a). However, this expansion does not seem to be supported by anything more than a primary evaluation of the program. Since its launch, publicly available internal evaluations of the MHFA program only highlight frequency data regarding the number of trainees who self-reported sharing or using the knowledge and/or the skills they gained to help others or themselves (NYC Open Data, 2020). There is no further evaluation into the behavioral impact on trainees, perceptions towards mental health or program fidelity. With a substantial portion of the budget allotted to the program, a thorough evaluation of the effectiveness and reach of its efforts is necessary to justify continued funding.

The purpose of this proposal is to facilitate a rigorous evaluation of ThriveNYC's MHFA program, by designing an evaluation plan that incorporates a process, short-term and mid-term outcome analysis. The evaluation proposal will aim to (1) develop an evaluation plan that has measurable goals and objectives and rigorous methods for evaluation; (2) create an instrument that measures the program's impact on behavior, knowledge and attitudes of trainees in relation to mental health awareness and crisis response; (3) develop a tool to measure the short-term and mid-term outcomes of the training program in relation to eliminating barriers to care; (4) create a plan to measure process goals of the program, including program inputs and fidelity.

This evaluation along with its recommendations will inform the further continuation or expansion of ThriveNYC's MHFA program.

Specific Aims

In response to the increasing prevalence of mental health related illnesses and stigma amongst New York City (NYC) residents, in 2015, the Mayor's Office of ThriveNYC launched a Mental Health First Aid Training program (ThriveNYC, 2020a). The purpose of this program is to equip the public with the skills necessary to identify and respond to signs of mental distress, and to connect people in need to appropriate care (ThriveNYC, 2020a). Simultaneously, by improving people's understanding of mental illness, it aims to reduce the existing stigmas against it (ThriveNYC, 2020a).

Since its introduction, the MHFA program has continued to expand across NYC, and has trained a total of 159,952 individuals. With the program growing, ThriveNYC began conducting evaluations on a quarterly basis starting from July 2019. However, these publicly available internal evaluations provide limited data on the extent of the program and its impact on trainees. The shared data simply indicates the number of individuals trained, the number of trainees who self-reported sharing or using the knowledge and/or the skills they gained to help others or themselves (NYC Open Data, 2020). These evaluations are unable to address the specific aims of the program without any items measuring what content was most useful, frequency of individuals using their training, what types of mental distress trainees encountered, what the outcomes of the encounters with those in distress were, and any reduction in mental health stigma. Questions like these are crucial to understanding the practical usability of the training as a mental health first aid response mechanism. Additionally, implementation and process specific questions that can help evaluate cost-effectiveness are crucial in determining the sustainability of the program.

To address these unanswered questions, this evaluation plan will include a measurement of behavioral, knowledge-based and attitudinal outcomes amongst trainees as well as evaluate the program itself by measuring process-level objectives, program fidelity, and reach. The intention of this proposal is to provide an alternate evaluation for ThriveNYC's MHFA training program. The proposal presents a program evaluation plan that would address existing limitations by measuring key behavioral, knowledge-based and attitudinal outcomes, process-level objectives, program fidelity, and reach. This would inform the overall effectiveness of the

MHFA program and its financial viability regarding its continuation or expansion. The following five aims will be addressed in this evaluation proposal:

1. To develop an evaluation plan that has measurable goals and objectives and rigorous methods for evaluation.
2. To create an instrument that measures the program's impact on behavior, knowledge and attitudes of trainees in relation to mental health awareness and crisis response.
3. To develop a tool to measure the short-term and mid-term impacts of the training program in relation to eliminating barriers to care.
4. To create a plan to measure process goals of the program, including program inputs and fidelity.

By designing a comprehensive plan that incorporates the aims mentioned above, this proposal will provide a framework to assess ThriveNYC's MHFA program effectiveness, short-term and mid-term outcomes, and financial viability. This key data is necessary to determine whether the MHFA program is achieving the goals it was designed for, whether its increases in funding are justified, and ultimately whether ThriveNYC should restructure or discontinue this program. Additionally, the results gained from these evaluations can help identify unmet needs or necessary changes that can inform the redesign of the MHFA program or its alternative.

Background and Significance

Mental Illness in the United States of America

Since long before the start of the COVID-19 pandemic, the United States (U.S.) has been struggling to address a growing mental health problem. In 2019, 18.57% of adults in the country reported experiencing a mental illness, which corresponds to 45 million Americans (Mental Health America, 2020). Four-point five percent of the population reported having a severe mental illness and 7.68% reported having a substance use disorder in the past year (Mental Health America, 2020). Between 2014 and 2018, the State of Mental Health in America report (Mental Health America, 2019) found that despite a small (0.12%) decrease in the number of American adults who have mental health problems, there was a simultaneous 0.27% increase in

reported adult suicidal ideation and a disconcerting 3.97% increase in the number of major depressive episodes reported by youth. By 2019, 10.3 million Americans were estimated to have had serious suicidal thoughts which was 450,000 more individuals than in the previous year (Mental Health America, 2020). Similarly, the number of youths who had reported experiencing at least one major depressive episode increased by 99,000 individuals, while the number of youths reporting a severe major depressive episode increased by 121,000 individuals between 2018 and 2019 (Mental Health America, 2020).

These rising prevalence rates stand in stark contrast to the depleted mental health resources and lack of awareness in the U.S. More than 26 million individuals who were experiencing a mental illness did not receive treatment for it (Mental Health America, 2020). Additionally, since 2011, there has been a steady increase in the number of adults with a mental illness who were not able to receive the treatment that they needed, with a total of 22.3% individuals in the U.S. being counted in 2019.

Unsurprisingly, these numbers escalated in the wake of the COVID-19 pandemic. In 2020, the percent of adults who reported experiencing a mental illness jumped to 19%, which brought the total number of Americans affected to 2 million more than the previous year (Mental Health America, 2021). Four-point thirty-four percent of adults reported having serious thoughts of suicide in 2020, which accounts for 460,000 more individuals than in 2019, with 23.6% of the population still not being able to receive treatment (Mental Health America, 2021). Mental health amongst youths also worsened with a 0.5% increase in the number of youths experiencing severe major depression from the last year, and only 27.3% of this demographic receive consistent treatment (Mental Health America, 2021). A greater number of youths between the ages of 11-17 years are actively looking for mental health related resources during the pandemic, and they also seem to be more at risk with individuals in their age group being more likely to score for moderate to severe symptoms of anxiety and depression than others (Mental Health America, 2021). This age group, especially LGBTQ+ youth, had the highest rates of suicidal ideation (Mental Health America, 2021).

Recent studies continue to alert us to this rising prevalence of mental illnesses as a consequence of the unique characteristics of this pandemic such as the economic recession, extreme isolation, and increased emotions of fear and uncertainty (Panchal et al., 2020). The need for assistance dealing with anxiety and depression increases substantially between January

and September 2020, with a 93% increase in the number of people taking the anxiety screen in comparison to 2019 (Mental Health America, 2021). Similarly, 534,784 individuals took a screening for depression, which was a 62% increase than in the previous year (Mental Health America, 2021). Similar patterns were seen amongst those with moderate to severe symptoms of depression and/or anxiety (Mental Health America, 2021). As could be expected, amongst those who screened for mental illnesses during this period, loneliness and isolation were the most common reported contributing factors (Mental Health America, 2021). With regards to demographic changes, findings show that people who identify as Asian or Pacific Islander are searching more for mental health resources than in previous years (Mental Health America, 2021).

These findings reiterate the enormous impact the global pandemic has had on the depleting state of mental health in the U.S. Not only are prevalence rates rising, but so are the calls for help. It is crucial that states can recognize this growing need and provide adequate resources to address it.

Mental Illness in New York City

The growing mental health burden in NYC has been documented and shared on the ThriveNYC dashboard as well as through a white paper focused on ‘Understanding New York City’s Mental Health Challenge’ (ThriveNYC, 2020b; NYC.gov, 2015). According to these reports, there is a growing problem of mental health and substance use related issues across the five boroughs. A minimum of one out of every five adult New Yorkers is expected to experience a mental health disorder in a given year. This is close to national estimates of nearly one in four US adults who are expected to suffer from a diagnosable mental disorder in a given year (Johns Hopkins Medicine, 2020). This data is based on self-reported estimates, which, with a stigmatized issue like mental health, can likely be an underestimation of its prevalence (Tourangeau and Yan, 2007). Among the younger New Yorkers, eight percent of public high school students in NYC have reported attempting suicide and approximately 73,000 students report feeling either sad or hopeless (ThriveNYC, 2020b).

Major depressive disorder is reported to be the biggest source of disability in NYC, with about eight percent of the adult population experiencing symptoms each month (ThriveNYC, 2020b). In line with national trends, in 2020 since the start of the Covid-19 pandemic, NYC

which was the epicenter of the pandemic in its early stages also witnessed an increase in prevalence of mental illnesses. According to the New York City Department of Health and Mental Hygiene, 44% of New Yorkers reported experiencing symptoms of anxiety due to COVID-19 and 36% reported having experienced symptoms of depression due to COVID-19 (NYC.gov, 2020).

Of the over half a million adults in NYC who are estimated to have depression, only 40% of these report receiving care, highlighting a gap between the recognition of mental health illness and accessing appropriate care (ThriveNYC, 2020b). As of 2019, there were 17 federally designated mental health care shortage areas across the city (ThriveNYC, 2019). This is even more amplified amongst communities of color. The percentage of people with depression who self-report receiving mental health treatment is highest for White New Yorkers (58.3%) as compared to Black (30.3%), Latinx (39.3%), and Asian American and Pacific Islander (38.2%) New Yorkers (ThriveNYC, 2020b). Systemic racism and prejudice continue to create roadblocks between communities of color and healthcare. A 2019 report found that White New Yorkers were more likely than Latinx New Yorkers to receive treatment for depression, while Asian and Pacific Islander adults cited systemic and linguistic barriers as the main reason for not being able to access mental health services in the city (ThriveNYC, 2019). These statistics underscore the disparities in mental health care and are further exacerbated by the impact of the pandemic. NYCDOH reports (2020) show that Latinx (49%) and Asian (45%) adults are more likely than white (34%) adults to report having lost their job or a reduction in hours and that Latinx (53%) adults are more likely than white (40%) adults to report feelings of financial stress (NYC.gov, 2020).

Stigma: A Barrier to Mental Health Care

Another factor to consider when trying to increase resources and acceptance of new mental health programs is the stigma associated with mental illness. A reluctance to access available mental health resources or even address mental health issues is often attributed to stigma. A systematic review of perceived barriers to mental health help-seeking found stigma and embarrassment to be the most prominent barriers across qualitative and quantitative studies (Gulliver, Griffiths, and Christensen, 2010). Interestingly, the findings also showed that

perceived stigma may have a greater influence on help-seeking on adults living in rural areas as opposed to urban areas (Gulliver, Griffiths and Christensen, 2010).

Another study highlighted stigma as the most common reason that prevented young people from reaching out and taking advantage of available mental health services (Molloy et al., 2020). Young people often prefer to receive help from friends or family over professionals due to negative attitudes that are associated with reaching out for help through treatments or other mental health services (Gulliver, Griffiths and Christensen, 2010). These patterns are also true of older populations. Older adults may hesitate to use mental health services due to the worries regarding community acceptance and perceptions (Sirey et al., 2014). In fact, older adults are 40% less likely to seek help relating to their mental health than younger populations (Substance Abuse and Mental Health Services Administration [SAMHSA], 2019).

Mental health stigma also presents itself differently across cultures. Sirey et al (2014) found cultural differences towards mental illness to be associated with greater experiences of shame and stigma within families, which in turn deters people from these cultures to engage in mental health treatments. These patterns vary across culture, some of which are less accepting of mental health resources than others. Older African American adults, for example, are less likely than their Caucasian counterparts to seek help for their mental health (Sirey et al., 2014). The reasons for this are often associated with a lack of trust stemming from years of discriminatory practices in medicine targeting Black communities (Sirey et al., 2014).

This research reiterates the importance of designing mental health interventions and resources that acknowledge resistance to help-seeking and actively aim to reduce stigma by removing barriers to mental health care.

Mental Health First Aid: Developments and Evaluations

Origins of MHFA

Mental Health First Aid Training (MHFA) was developed by Anthony J. Form and Betty A. Kitchener in Australia in 2001 (Mental Health First Aid USA, 2021) in response to the lack of first aid courses that address mental health. The training was developed using research done with Australian citizens. In discussing reasons for developing this training, they highlight three specific factors. First is the increased prevalence of mental disorders, which was described as "so

high that virtually everyone in the community [could] be expected to either develop a mental disorder themselves or to have close contact with someone who does” (Kitchener and Jorm, 2002). Second is low rates of mental health literacy; people’s inability to identify or know the differences between disorders or their lack of understanding of various treatment methods. The third reason is the negative impact of stigma associated with mental illness as an impediment to accessing help (Kitchener and Jorm, 2002). These reasons are all relevant in the United States as well as highlighted in the previous sections on mental health and stigma in the U.S.

The original MHFA training was a nine-hour course delivered in three three-hours sessions over three consecutive weeks and taught by the same instructor. The content was designed to teach trainees how to help those experiencing a mental crisis or those who were in an early stage of a mental health problem (Kitchener and Jorm, 2002). The training covered preparation for crises such as suicidal thoughts and behaviors, acute stress reaction, panic attacks and acute psychotic behavior, and mental health problems including depressive, anxiety and psychotic disorders (Kitchener and Jorm, 2002). Taking these critical areas into consideration, Kitchener and Jorm (2002) developed a five-step action plan to use in MHFA training:

1. Assess risk of suicide or harm
2. Listen non-judgmentally
3. Give reassurance and information
4. Encourage person to get appropriate professional help
5. Encourage self-help strategies

MHFA Evaluation

The evaluation process for the initial MHFA training included the first 210 participants who engaged in the public course (Kitchener and Jorm, 2002). An anonymous self-administered questionnaire was administered at the beginning of the first session (pre-test), end of the last session (post-test), and six months after the course was completed (follow-up) (See Table below for. The pre-test questionnaire included sociodemographic questions and a question about personal experiences with a mental health problem for themselves or if they knew someone who had. For all three questionnaires, the same subsequent sections were part of the survey. Evaluators asked about recent interactions with anyone who had mental health problems and if and how they engaged in assisting them. These following questions were asked: "*How*

confident do you feel in helping someone with a mental health problem?", with the answer options including "Not at all", "A little bit", "Moderately", "Quite a bit" and "Extremely" (Kitchener and Jorm, 2002). "In the last 6 months, have you had contact with anyone with a mental health problem?", with "Yes", "No" and "Don't know" as answer options (Kitchener and Jorm, 2002). If yes, they were also asked "How many people?". To assess the participants' experience with helping, they were asked "Have you offered any help", with "Not at all", "A little", "Some" and "A lot" as answer options, and "What type of help?", which was open-ended (Kitchener and Jorm, 2002).

The next section used components of the National Survey of Mental Health Literacy, which measures perceived attitudes and behaviors in hypothetical scenarios of mental health crises. Participants were randomly assigned to one of two vignettes, either about depression or schizophrenia, that would be repeated in the post-test and follow-up evaluation. The scores measured the extent to which participants agreed with health professionals about which intervention would be most useful in the presented case (Kitchener and Jorm, 2002). The next set of questions assessed social distance by asking how willing participants would be to engage in the following behaviors in reference to the vignette: *Move next door to Mary/John; Spend an evening socializing with Mary/John; Make friends with Mary/John; Have Mary/John start working closely with you on a job; Have Mary/John marry into your family*. The final section assessed personal experience with mental health concerns: "Have you ever had a problem similar to Mary's/John's?" and "Has anyone in your family or close circle of friends ever had a problem similar to Mary's/John's?" (Kitchener and Jorm, 2002). The last two final questions were not included in the post-test, but were assessed in the follow-up, because it was theorized that six months was the minimum time needed to start seeing the influence of the course in the participant's life.

Table 1. MHFA Evaluation Questions (Kitchener and Jorm, 2002)

MHFA 2002 - EVALUATION	
Pre-Test - At the beginning of the first session of the course	
Questions	Answer Options
<i>Opening Questions</i>	
1) Sociodemographic Questions (undisclosed)	
2) Have you ever experienced a mental health problem?	
3) Has anyone in you family experienced a mental health problem?	
4) How confident do you feel in helping someone with a mental health problem?	1. Not at all, 2. A little bit, 3. Moderately, 4. Quite a bit, 5. Extremely
5) In the last 6 months have you had contact with anyone with a mental health problem?	Yes/ No/ Don't know
If "yes" to 5:	
6) How many people?	
7) Have you offered any help	1. Not at all, 2 A little, 3. Some, 4. A lot
8) What type of help?	Blank lines were provided for a description
<i>Vignette Questions: Participants were randomly assigned a vignette of a person who had either major depression ("Mary") or schizophrenia ("John"). The follow questions were in reference to these vignettes</i>	
1) From the information given, what, if anything is wrong with Mary/John?	Open-ended question
2) Do you think Mary/John needs professional help?	Yes/No

<p>3) Rate the following list of people, treatments and actions that the person in the vignette might use in terms of how likely they are to be helpful, harmful or neither:</p> <ul style="list-style-type: none"> A typical GP or family doctor A chemist or pharmacist A counselor A social worker Telephone counseling services, e.g. Lifeline A psychiatrist A clinical psychologist Help from her/his close family Help from some close friends A naturopath or a herbalist The clergy, a minister or a priest Mary/John tries to deal with her/his problem on her/his own Vitamins and minerals St John's wort Pain relievers such as aspirin, codeine or panadol Antidepressants Antibiotics Sleeping pills Anti-psychotics Tranquillisers such as valium Becoming more physically active such as playing more sport, or doing a lot more walking or gardening Read about people with similar problems and how they have dealt with them Getting out and about more Courses on relaxation, stress management, meditation or yoga Cutting out alcohol altogether Counseling Cognitive-behavior therapy Psychotherapy Hypnosis Admission to the psychiatric ward of a hospital Electroconvulsive therapy (ECT) Having an occasional alcoholic drink to relax A special diet or avoiding certain foods 	<p>Scales were created showing the extent to which participants agreed with health professionals about which interventions would be useful</p>
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<i>Social Distance Questions</i>	
1) How willing would you be to move next door to Mary/John?	1. Definitely willing, 2. Probably willing, 3. Probably unwilling, 4. Definitely unwilling
2) How willing would you be to spend an evening socializing with Mary/John?	1. Definitely willing, 2. Probably willing, 3. Probably unwilling, 4. Definitely unwilling
3) How willing would you be to make friends with Mary/John?	1. Definitely willing, 2. Probably willing, 3. Probably unwilling, 4. Definitely unwilling
4) How willing would you be to have Mary/John start working closely with you on a job?	1. Definitely willing, 2. Probably willing, 3. Probably unwilling, 4. Definitely unwilling
5) How willing would you be to have Mary/John marry into your family?	1. Definitely willing, 2. Probably willing, 3. Probably unwilling, 4. Definitely unwilling
<i>Final Questions</i>	
1) Have you ever had a problem similar to Mary's/John's?	Yes/No
2) Has anyone in your family or close circle of friend ever had a problem similar to Mary's/John's?	Yes/No
Post-Test - At the end of the last session	
Questions	
<i>Vignette Question: Participants were given the same vignette that was randomly assigned at pre-test</i>	
<i>Social Distance Questions</i>	
<i>Final Questions</i>	
Follow-Up - Mailed questionnaire 6 months after completing the course	
Questions	
<i>General Questions (did not include sociodemographic questions)</i>	
<i>Vignette Question: Participants were given the same vignette that was randomly assigned at pre-test</i>	
<i>Social Distance Questions</i>	
<i>Final Questions</i>	

In analyzing the data from this sample, Kitchener and Jorm (2002) found that there was an increase in the number of people who reported having ever experienced a mental health problem themselves, from 41.4% in the pre-test to 47.4% in the post-test ($p=0.05$). Similarly,

there was an increase in the number of people who reported someone in their family having experienced problems with their mental health from 73.4% to 79.0% ($p=0.052$). However, neither of these findings were significant. For the vignette question, no improvement was noted in the post-test of the depression scenario option, but an improvement was seen in the schizophrenia example. There was no clear change in the beliefs of participants regarding how close their responses were to health professionals (Kitchener and Jorm, 2002). For social distance questions, those who had the schizophrenia example expressed greater social distance than those who had the depression example, however social distance decreased across both groups at post-test and increased a little at follow-up (Kitchener and Jorm, 2002). The results of the last section, which was measured at follow up, showed an increased confidence in providing help, and there was a non-significant trend towards providing multiple kinds of help but a non-significant decrease in the percent of participants who advised professional help (Kitchener and Jorm, 2002).

The data indicates that MHFA training was able to improve participant's ability to identify mental illnesses correctly, improve their beliefs regarding treatment to match those of health professionals, and decrease social distance, which is meant to measure stigmatizing attitudes (Kitchener and Jorm, 2002). However, most of these results were not statistically significant and furthermore, the use of hypothetical scenarios allows for biased self-reporting which may not always provide an accurate depiction of an individuals' attitudes and behaviors. This could make responses more vulnerable to social desirability biases. Ironically, participants were found to be less likely to advise others to seek professional help, which is contrary to one of the primary goals of the training, however this trend was non-significant. The researchers mention that an increase in participants reporting experiencing a mental health themselves or amongst family, could be attributed to the labelling of ordinary problems as mental disorders as a result of the training (Kitchener and Jorm, 2002).

MHFA Adaptations

After its first year, the MHFA program was extended from a 9-hour to a 12-hour training program based on initial feedback (Kitchener and Jorm, 2008). By 2005, there were MHFA instructors in every state and territory across Australia, each of whom met the MHFA instructor criteria (Kitchener and Jorm, 2008):

1. Good knowledge of mental health problems
2. Personal or professional experience with people with mental health problems
3. Good background knowledge of mental health and community services
4. Favorable attitudes towards people with mental health problems
5. Good teaching and communication skills
6. Good interpersonal skills
7. Good business plan or organizational support

A decentralized model to disseminate the MHFA training was developed that consists of three levels (Kitchener and Jorm, 2008). *Level 1* includes trainers of the instructors who train the MHFA instructors through a five-day training program. *Level 2* includes the instructors who provide the twelve-hour MHFA course to members of the public or workplace. *Level 3* includes the first aiders who assist those who are developing mental disorders or are in a crisis.

After a 2006 National Youth Mental Health Literacy Survey highlighted the lack of knowledge about mental health disorders and resources among young populations, a youth-focused fourteen-hour MHFA course was designed that includes modules on deliberate self-harm and eating disorders (Kitchener and Jorm, 2008). Additionally, in order to accommodate the cultural and linguistic diversity of the Australian population, the course was modified for different communities by working with local groups, including one for Aboriginal and Torres Strait Islanders, and the instructors were trained accordingly (Kitchener and Jorm, 2008).

Kitchener and Jorm (2008) then began adapting and disseminating this program to other countries including Hong Kong (2003), Scotland (2003), Canada (2004), Finland (2006), Singapore (2006), England (2007) and Ireland (2007). Examination of these programs has added to the evidence base for the MHFA program. One study revealed that participants who completed the MHFA training program had an increased ability to recognize mental disorders, maintained less social distance from those with mental disorders, shifted their beliefs about treatment closer to those held by professionals, increased confidence to help and the amount of help they provided to others (Kitchener and Jorm, 2006). All these changes were maintained by participants at the 6-month follow up mark.

Two other randomized control trials were conducted that showed the same results. Additionally, one study evaluated the mental health benefits of the course on the participant,

which was found to have positive effects (Kitchener and Jorm, 2004). However, a limitation in the evaluations was also identified, which was the inability to attain information from the person who received the first aid from a trainee. In an attempt to rectify this, Kitchener and Jorm conducted a qualitative study of those who administered the first aid, by asking them about the actions they took, and the report impact it had on the recipient (Kitchener and Jorm, 2005). Seventy-eight percent of the respondents reported that they administered mental health first aid and that in most of those cases they believed that the outcome of their actions were better than they would have been without the training (Kitchener and Jorm, 2005). These respondents also had higher confidence to respond, increased empathy and improved handling of crises (Kitchener and Jorm, 2005). Assessing the effectiveness of the first aid from the perspective of those receiving the first aid from MHFA trainees would be extremely hard to conduct due to issues with confidentiality, tracking and stigma. However, this qualitative study, although possibly biased as it depends on trainees' perception of the effectiveness of their own performance, still provides much needed insight regarding how the first aid is being delivered and received (Kitchener and Jorm, 2005). Further assessment of these aspects of the training are crucial in capturing the real-world applicability and benefits of the MHFA training.

MHFA was introduced in the US in 2007, and since then only a few of the programs have published evaluations (Mental Health First Aid USA, 2020). Most of these studies have found that, while the trainings were effective in increasing mental health literacy and trainees' confidence in approaching people experiencing a mental health crisis, there was no clear evidence of the effectiveness of the use MHFA in actually providing help or support to those on those being assisted by trainees (Kitchener & Jorm, 2002; Jorm, Kitchener, Sawyer, Scales and Cvetkovski, 2016; Kitchener & Jorm, 2008; Aakre, Lucksted and Browning-McNee, 2016; Lucksted, 2015).

Program Overview: MHFA in NYC

Program Description

Mental Health First Aid (MHFA) training was first introduced to communities in New York City (NYC), via the ThriveNYC initiative from the Mayor's office. First Lady Chirlane McCray and Mayor Bill de Blasio introduced this program the same year as they launched

ThriveNYC in 2015. The ThriveNYC initiative was created to address the gaps in mental health care in the city and to increase access to necessary resources. According to the ThriveNYC website, “a focus on programmatic oversight, coordinated evaluation, research and strategic partnerships” are central to its model (ThriveNYC, 2020a). The initiative’s core goals include the promotion of mental health amongst younger New Yorkers, reaching those with the highest need, strengthening crisis prevention and response, and eliminating barriers to care. In pursuit of this, the MHFA training program was launched to tackle stigma concerning mental health and to equip community members with the skills to identify and attend to mental health related crises (ThriveNYC, 2020a).

The Mental Health First Aid Training program is just one attempt by ThriveNYC to address the stigma associated with mental illness by increasing awareness and access to resources (ThriveNYC, 2019). It is defined as a way to “expand the mental health safety net for New Yorkers” (ThriveNYC, 2019). The training program was launched in partnership with the New York City Department of Health and Mental Hygiene. The program provides free, eight-hour training sessions that are offered throughout the week across all five boroughs of New York City (ThriveNYC, 2019). The training is offered in English, Mandarin and Spanish and can be requested via registration on the ThriveNYC website (ThriveNYC, 2019). These trainings are easy to register for and can be requested by any member of the New York City community. The training can be focused to capture the needs of specific audiences, including adults, youth, veterans, older adults, higher education and public safety officers and the LGBTQIA+ community (ThriveNYC, 2020a). Through this training, participants are expected to learn how to recognize a need for mental health assistance, be equipped to have a conversation about it and to know what resources and options are available to help individuals who require it (ThriveNYC, 2019).

Program Goals

The program’s mission page highlights the growing strain of stigma surrounding mental health and the association of stigma with lower levels of help-seeking behaviors, hope and self-esteem (Livingston and Boyd, 2010). According to the website, MHFA training tackles this stigma by increasing awareness and facilitating community members to identify and support

those who need help. The following learning objectives are defined by the MHFA training program: (ThriveNYC, 2020a):

- Build an understanding of mental health.
- Learn how to respond to signs of mental health need or substance misuse.
- Understand how to connect people in need to care.
- Learn how to support people in crisis.

While these objectives provide a better understanding of the mission of the MHFA program, they are neither specific nor measurable. There are neither defined outcome objectives regarding behavioral, knowledge-based or attitudinal outcomes, nor any mention of process level goals that would track and ensure the fidelity of the program.

The program website also mentions the use of an evidence-driven approach for its design and implementation (ThriveNYC, 2020a). The findings from the studies used to inform the design of ThriveNYC's MHFA program showed that the trainings were able to prepare trainees to recognize distress, make connections to care and exhibit improved mental well-being themselves (ThriveNYC, 2019). However, only one study is cited as a reference for the program's effectiveness, a systematic review and meta-analysis of 18 MHFA programs, of which only three studies evaluated variations of the MHFA program in the U.S. (Morgan, Ross & Reavley, 2018). The three US studies included in the meta-analysis all used samples of professionals who were previously trained in some form of mentoring or emergency response, which is not representative of the average US citizen who likely would not have any relevant experience prior to participating in ThriveNYC's program (Lipson, Speer, Brunwasser, Hahn & Eisenberg, 2014; Mohatt, Boeckmann, Winkel, Mohatt & Shore, 2017; Rose, Leitch, Collins, Frey, & Osteen, 2017).

Furthermore, stigma associated with mental health is a commonly cited barrier to positive mental health and access to care, and one that is frequently raised on the ThriveNYC and MHFA websites. While stigma is known to negatively impact mental health, no data or information regarding the extent of this stigma in NYC is provided to distinguish it as a unique burden (Knaak, Mantler & Szeto, 2017; ThriveNYC, 2020a). Last year, the Manhattan Institute went so far as to call out political leaders, including Mayor Bill de Blasio, for taking on stigma merely as a "safe route" to address psychiatric illnesses, given that these interventions can often be "easy

on the budget” in comparison to changes at an institutional and policy level (Eide, 2020). While the MHFA program is not financially conservative in comparison to other ThriveNYC projects, it is a less costly alternative to the funding that would be required to reform the healthcare and associated systems in the city (ThriveNYC, 2020a).

Current Evaluations and Measurements

ThriveNYC has been running its own internal quarterly evaluations of the program since 2015, which can be accessed via their open data portal (NYC Open Data, 2020). Their evaluation includes eight items:

1. Number of individuals trained in MHFA.
2. Number of individuals trained in MHFA/Youth MHFA among city agency employees.
3. Percentage of MHFA trainees who have reported that they shared the knowledge they gained from the training with other people one-month post-training.
4. Percentage of MHFA trainees who have reported that they shared the knowledge they gained from the training with other people six months post-training.
5. Percentage of MHFA trainees who have reported that they used the knowledge and/or skills learned in the training to help others one-month post-training.
6. Percentage of MHFA trainees who have reported that they used the knowledge and/or skills learned in the training to help others six months post-training.
7. Percentage of MHFA trainees who have reported that they used the knowledge and/or skills learned in the training to help themselves one-month post-training.
8. Percentage of MHFA trainees who have reported that they used the knowledge and/or skills learned in the training to help themselves six months post-training.

While these items capture useful data about the reach of the program, they are not adequate indicators to measure its efficacy or impact. There are questions that ask about knowledge and skills shared and/or used by trainees, but there is no further information regarding which specific knowledge points or skills were used, how often they were used, or in what type of situations. Similarly, when asking about the use of training to help others, it is unclear how many people were helped, what skill(s) was used to help, whether the individual was helping a stranger or someone they knew. There are also no questions aimed at gauging the

success or effectiveness of the training skills and knowledge used to intervene in a mental health crisis. This would require the creation of a rubric to define and assess what success would look like in these situations. A better understanding of whether the application of the training in real situations was perceived as successful or not, by either the MHFA trainee or its recipient, would be integral to comprehending the impact it has on community members and those who are in distress. It would also be important to include follow-ups that go beyond a year, first, to assess if trainees continue to apply their training in their daily lives even once its novelty has worn off, and second, to assess whether one training is sufficient in equipping individuals to handle situations involving more serious mental health issues. The latter might require the incorporation of a renewal or refresher training. Lastly, it would help to have demographic data of trainees in order to understand if this training those in the communities most in need. Tracking more specific impact measures such as these are necessary to evaluate the effectiveness and fidelity of a program and to help address problem areas, strengths and barriers.

Rigorous evaluations also inform the budgets that fund these programs. According to ThriveNYC's programmatic budget, the MHFA training program falls under 'Goal 2' which aims to 'Eliminate barriers to care' (ThriveNYC, 2020c). Over the next three years (2021-2023), the MHFA program has been allotted 6.3 million dollars per year. This is the third highest budget allotted under Goal 2 following 'NYC Well' (\$12.6 million) and 'Connections to Care' (\$6.5 million) (ThriveNYC, 2020c). With a sizable budget it is extremely important to know whether or not a program is successful in achieving its goal of increasing access to care. The only way to know this is by conducting more thorough evaluations through targeted measures and consistent follow-ups.

Proposed Contribution of Evaluation Plan

This proposal aims to provide a comprehensive evaluation plan to assess the process indicators, short-term outcomes, and mid-term outcomes of ThriveNYC's MHFA program. The current evaluations and findings regarding the effectiveness of the program to date (see *pp. 19-20*), are limited, with only eight measures being monitored (NYC Open Data, 2020). These measures do not assess the program's fidelity, the extent and type of influence it has on the

attitudes and behaviors of trainees, and what benefits MHFA provides to those who complete the training (NYC Open Data, 2020).

The stated mission and goals of ThriveNYC is to serve the growing mental health needs amongst NYC residents, as was earlier mentioned. However, with numerous programs running simultaneously, overlapping objectives, and substantial amounts of funding dedicated to these initiatives, it is important that programs like ThriveNYC's MHFA training are thoroughly evaluated to inform conclusive decisions on funding and continuation. Rigorous evaluations are necessary to ensure that limited resources are being directed towards effective programs that help ThriveNYC move closer to its goals. This requires an assessment of both the implementation of the program as well as its impacts on the target population in order to determine its viability.

Using the literature from past MHFA studies and guided by the CDC's evaluation framework, this proposal puts forth an evaluation plan that addresses the shortcomings of the current measures and broadens the use and applicability of its findings (CDC, 1999).

The following five aims will be addressed in this evaluation proposal:

1. To develop an evaluation plan that has measurable goals and objectives and rigorous methods for evaluation.
2. To create an instrument that measures the program's impact on behavior, knowledge, and attitudes of trainees in relation to mental health awareness and crisis response.
3. To develop a tool to measure the short-term and long-term impacts of the training program in relation to eliminating barriers to care.
4. To create a plan to measure process goals of the program, including program inputs and fidelity.

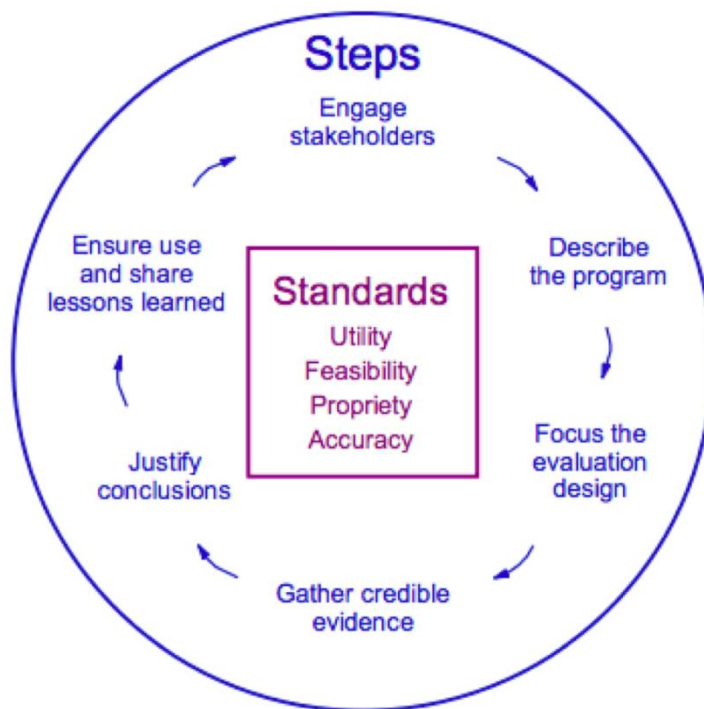
Evaluation Design

Theoretical Evaluation Framework

This proposed evaluation plan for Thrive NYC's MHFA program is designed using the CDC's Framework for Program Evaluation (1999). This framework places an emphasis on procedures that are "useful, feasible, ethical and accurate" (CDC, 1999). The Framework for Program Evaluation consolidates the most essential elements of an effective program evaluation into six steps (see Figure 1.). The steps are interdependent, which suggests that, while they do

not necessarily need to follow a linear sequence, the initial steps help set up a base for the subsequent elements and allow for a stronger evaluation (CDC, 1999). Below are brief descriptions of each step.

Figure 1. CDC's Recommended Steps for Program Evaluation (CDC, 1999)



Step 1: Engage Stakeholders. Any public health project or initiative involves partnership, whether with other organizations, government entities, or community members (CDC, 1999). These stakeholders have an equal interest in the program that is being evaluated, how effective that program is, and how the findings of the evaluation are going to be used to improve it (CDC, 1999). It is key that the values and perspectives of the stakeholders are taken into consideration when designing a program evaluation to ensure that the evaluation being developed addresses the needs and goals of its stakeholders and provides valuable and useful information that will allow them to make informed decisions about the program. The CDC highlights three main groups of stakeholders whose involvement is considered crucial to the development of an effective program evaluation (1999):

- A. Those involved in the program operations such as sponsors, funding officials and administrators.
- B. Those served or affected by the program such as clients, family members, and community organizations.
- C. The primary users of the evaluation.

Step 2: Describe the Program. It is important to clearly state the mission and goals of the program being evaluated (CDC, 1999). Additionally, the description should succinctly highlight all the necessary information that will be needed and used to inform the creation of the evaluation. The CDC suggests prioritizing the following aspects in the description (1999):

- A. Need
- B. Expected effects
- C. Activities
- D. Resources
- E. Stage of Development
- F. Context
- G. Logic Model

Step 3: Focus the Evaluation Design. It is important to identify and prioritize the key goals of the evaluation that match those of the stakeholders (CDC, 1999). This prioritization must also take into consideration the most cost and time to ensure an efficient evaluation process. The CDC recommends focusing evaluations on the following items (1999):

- A. Purpose
- B. Users
- C. Uses
- D. Questions
- E. Methods
- F. Agreements

Step 4: Gather Credible Evidence. An evaluation should incorporate information regarding all aspects of the program to ensure a holistic approach (CDC, 1999). It should provide findings that are relevant and actionable. According to the CDC, the components the components that affect perceptions of credibility include (1999):

- A. Indicators
- B. Sources
- C. Quality
- D. Quantity
- E. Logistics

Step 5: Justify Conclusions. The conclusions drawn from an evaluation should be clearly linked to the findings and should be in-line with the mission and goals of the program and key stakeholders (CDC, 1999). The key stakeholders should also be a part of the discussion of the conclusions and should agree with them. The CDC highlights the following components as being necessary in justifying conclusions:

- A. Standards
- B. Analysis and Synthesis
- C. Recommendations

Step 6: Ensure Use and Share Lessons Learned. It is critical that the findings of an evaluation can be translated into actionable steps to help improve the program. Strategic plans for the use and dissemination of the findings should be incorporated into the evaluation plan itself. The CDC outlines the following elements as critical in ensuring the use of an evaluation (1999):

- A. Design
- B. Preparation
- C. Feedback
- D. Follow-Up
- E. Dissemination
- F. Additional Uses

In addition to these six steps, the CDC outlines four main standards for an effective evaluation (1999). These standards help ensure that the evaluation is not only fair but also practical. These four standards include:

1. *Utility* - Ensures that the evaluation can provide useful information to its users.
2. *Feasibility* - Ensures that the evaluation is practical and that resources are used efficiently.
3. *Propriety* - Ensures that the evaluation is in line with ethical principles.
4. *Accuracy* - Ensures that the findings of the evaluation are authentic and backed by evidence.

Evaluation Approach

The CDC's Framework for Program Evaluation (1999) was used to shape the proposed evaluation plan for MHFA. This section discusses how the six steps and four standards from the Framework are incorporated into or addressed in this evaluation plan for ThriveNYC's MHFA program.

Incorporation of the six steps:

1. *Engage stakeholders.* For the ThriveNYC MHFA program, those involved in the program operations are the Thrive NYC staff, the MHFA program planners and trainers, and the NYCDOH staff who were working on this project. Those served or affected by the program are community members who are the expected benefactors of the program, individuals and those in organizations who have hosted and/or participated in previous MHFA trainings held by ThriveNYC. Community involvement would be further broadened by inviting a few local CBOs with similar mental health focused missions to highlight the needs of their communities that can be addressed by this MHFA program. The primary users of the evaluation are the ThriveNYC senior administrators who will use the findings of the proposed evaluation to inform important decisions regarding the MHFA program's continuation, funding or adaptation in order to best meet the needs of the community.
2. *Describe the program.* This proposal provides as much information regarding the mission, goals, structure, and function of the ThriveNYC MHFA programs as is

publicly available via its websites and progress reviews. With this information in mind, a logic model (*Table 2*), has been created to reflect the inputs, outputs, and outcomes of this program.

3. *Focus the evaluation design.* With the mission and goals of the ThriveNYC MHFA program in mind, along with the needs of key stakeholders, this proposal has formulated relevant questions and a rigorous method plan to ensure the efficient use of resources. These can be found under the sections labelled *Evaluation Questions and Data Sources* (p. 30) and *Data Collection* (p. 35), respectively.
4. *Gather credible evidence.* This evaluation proposal is designed with indicators that reflect the program goals and stakeholder needs. The *Data Collection* section (p. 35) provides insight into the logistics and procedures necessary to ensure the use and creation of credible information.
5. *Justify Conclusions.* In the proposed evaluation, the analysis and synthesis components that are outlined under this step are addressed under the *Data Management* section (p.39). This section outlines the detailed analysis plan for the data collected to provide evidence-based findings regarding the efficacy of the MHFA program.
6. *Ensure use and share lessons learned.* - As described in *Uses and Dissemination of Findings* (p. 44), the proposed evaluation plan contains suggestions about ways to apply and incorporate the potential findings of the evaluation, a plan for the dissemination of the findings with an emphasis on inclusion of stakeholders, and a process to collect feedback.

Logic Model

The logic model (*Table 2*) was created using the program goals found on the ThriveNYC website and integrates the information shared regarding the process of planning and conducting the ThriveNYC MHFA training (ThriveNYC, 2020a). Barkman (2000) describes a logic model as a vital tool that connects a program design and evaluation. It is considered a “road map for your program” that provides a blueprint for how the program should be carried out, including the needed resources and activities, for it to achieve the pre-defined goals (Barkman, 2000). A precise logic model provides a rubric for the necessary steps to get from a program’s start to

“finish”. This is helpful not only in the planning of the program, but also in its evaluation, as it highlights the most significant components that the program set out to accomplish at each stage.

A logic model presents a sequence of the “if-then” relationships between the *inputs*, *outputs*, and *outcomes* of a program (Barkman, 2000). Inputs refer to all the necessary resources such as people, time, funding, materials, and equipment needed to get the program running as well as for it to achieve its goals (Barkman, 2000). In the case of the ThriveNYC MHFA program, some of the key inputs included in the logic model (*Table 2*) are ThriveNYC and NYCDOH staff who plan and conduct the program, ThriveNYC funding to pay staff and purchase resources, community partners the program hopes to collaborate with, and the materials necessary to run the trainings.

The resources from these inputs are then used to fulfill the output requirements. Outputs refer to the activities and participation necessary to run the program (Barkman, 2000). This may include activities such as meetings, websites, or media events, and participation details such as the characteristics, roles and number of participants needed to perform these activities (Barkman, 2000). For the ThriveNYC MHFA program, activities include trainings, budget allocation and reviewing materials, while participation includes the staff needed to run the trainings, individuals and organizations to host trainings, and individuals to take the trainings.

The purpose of these inputs and outputs is to help the program achieve its goals in the form of outcomes. Outcomes are the changes the program is expected to have on the target population, which may vary to include social, economic, or environmental impacts (Barkman, 2000). Outcomes may also range from short-term to long-term changes (Barkman, 2000). Short-term outcomes include changes in awareness, knowledge, attitudes or behaviors seen amongst individuals who participate in the program (Barkman, 2000). Mid-term outcomes include slightly broader goals such as changes in behavior or attitudes on a community level, changes in policies, or social action (Barkman, 2000). The long-term outcomes are the broadest and relate to the larger mission of a program such as social, economic, civic, or environmental changes in the greater population (Barkman, 2000).

For the ThriveNYC MHFA program, the short-term outcomes are the direct impact the MHFA training is expected to have on the awareness, knowledge and behaviors of the individuals who attend the trainings. The mid-term outcomes include the goals set by ThriveNYC for their MHFA program (ThriveNYC, 2020a). If the short-term outcomes expected

from the training are achieved amongst program participants, they will help the MHFA program get closer to achieving these broader mid-term program goals such as a deeper understanding of mental health or how to help people respond in crisis. The long-term outcomes presented in this model (Table 2) are the collective goals that drive all ThriveNYC programs (ThriveNYC, 2020a).

The logic model presented in *Table 2* specifies the requirements that are necessary for ThriveNYC's MHFA program to run efficiently and to enable the design of a focused evaluation plan to measure program impact as per the guidelines of the CDC's Framework for Program Evaluation (CDC, 1999).

Table 2. Proposed Logic Model for Thrive

INPUTS	OUTPUTS		OUTCOMES		
	ACTIVITIES	PARTICIPATION	SHORT-TERM	MID-TERM	LONG-TERM
ThriveNYC Staff	Train staff to plan and organize MHFA trainings in the community	Number of staff who help run and organize MHFA trainings	Increase knowledge about what mental illnesses are and what they may look like	To help participants build an understanding of mental health	Strengthening crisis prevention and response
NYCDOH Staff	Train paid staff members to run MHFA training	Number of staff who are trained to run MHFA trainings	Increase awareness about stigma around mental illnesses and its negative impacts	Participants learn how to respond to signs of mental health need or substance misuse	Eliminating barriers to care
Community Partners	Manage budget allocation	Number of organizations or individuals who host an MHFA training	Increase ability to identify signs of mental illness or a mental health crisis	Participants understand how to connect people in need to care	Promotion of mental health amongst younger New Yorkers
ThriveNYC Funding	Review training materials to ensure they are updated and community relevant	Number of individuals who complete the MHFA training	Increase knowledge of available resources for mental health	Participants learn how to support people in crisis	Reaching those with the highest need
Training Material & resources	Administer surveys and phone interviews at pre, post and follow-up periods		Increase behaviours associated with helping or supporting someone in a mental health crisis		
Organizations and individuals interested in hosting a MHFA training			Reduce social distancing behaviors towards those with a mental illness		

Evaluation Questions & Data Sources

Evaluation questions were formulated using the logic model (*Table 2*) and *Steps 3* and *4* of the CDC's Framework for Program Evaluation (1999).

Process Evaluation

Process evaluations serve the purpose of helping monitor the implementation of a program and ultimately allow for an understanding of why a program succeeded or failed (Sanders, Evans and Joshi, 2005). According to Sanders, Evans and Joshi (2005) a process evaluation typically measures *fidelity*, *dose-delivered*, *dose-received*, *reach*, *recruitment* and *context*. This section will discuss the conceptualization and measurement of five of these components, while the recruitment procedure will be discussed separately under the *Data Collection* section of this proposal.

Fidelity tries to assess the quality of a program by measuring the extent to which a program was implemented in accordance with the original plan (Sanders, Evans and Joshi, 2005). For ThriveNYC's MHFA program, fidelity is measured using process indicators that evaluate whether all components of the program were administered as planned (see *Table 3*). Dose-delivered refers to the number of components of the program that were delivered (Sanders, Evans and Joshi, 2005). For the MHFA training, dose-delivered is measured by evaluating the completion of training checklists and the number of materials provided (see *Table 3*). Dose-received is the extent to which participants interact with the training and whether they find it useful (Sanders, Evans and Joshi, 2005). For the MHFA training, this will be measured by gauging participant satisfaction. Reach refers to the number of people who participated in the program which, in the case of the MHFA training, can be measured by tracking the attendance of each training. Context takes into consideration any external factors that may influence the ability to implement the program in accordance with protocol (Sanders, Evans and Joshi, 2005). For the MHFA program context will be analyzed using the feedback from program administrators and participants (see *Table 3*).

The following five process evaluation questions incorporate the five process elements:

1. To what extent was the MHFA training implemented as planned? (Fidelity)

2. To what extent was the complete MHFA training and training materials provided to participants? (Dose-delivered)
3. To what extent were participants of the MHFA training satisfied with the program? (Dose-received)
4. What is the number of participants who attended the complete MHFA training? (Reach)
5. What barriers or facilitators influenced participation in the MHFA training? (Context)

Outcome Evaluation

The outcome evaluation aims to assess the program's ability to achieve the outcomes identified in the logic model. While the outcomes presented in the logic model for ThriveNYC's MHFA program are divided into short-term, mid-term and long-term outcomes, the focus of this evaluation proposal is short-term and mid-term outcomes, which measure changes in knowledge, attitudes and behaviors of participants immediately post-MHFA training and again several months post-training. If the MHFA training can achieve these short-term and mid-term outcomes, it would suggest that the program is moving towards achieving its long-term outcomes (as described in Table 2).

Short-term outcome evaluation questions developed are:

1. To what extent did participant's knowledge, attitudes and behaviors toward mental illness change immediately after participating in the MHFA training?
2. To what extent did participants knowledge, attitudes, and behaviors toward mental health care change immediately after participating in the MHFA training?
3. To what extent did the MHFA training impact participants self-efficacy to help someone in a mental health crisis?
4. To what extent did the MHFA training impact participants behavioral intent to help someone in a mental health crisis?
5. To what extent did the MHFA training change participants perceptions of people with mental illnesses?

Mid-term outcome evaluation questions are:

1. To what extent did the MHFA training impact participants self-efficacy to help someone in a mental health crisis in the months following the training?
2. To what extent did the MHFA training impact participants behavioral intent to help someone in a mental health crisis in the months following the training?
3. To what extent did the MHFA training change participants perceptions of people with mental illnesses in the months following the training?
4. To what extent did the program change participants perceptions of the importance of the MHFA training?

Performance Indicators

Performance indicators help measure progress made by the program towards achieving its pre-defined goals. Performance indicators are designed using the logic model and help monitor the link between inputs, outputs, and outcomes (CDC, 2012). The indicators listed in *Table 3* and *Table 4*, were developed to measure each of the process evaluation questions and outcome evaluation questions, respectively. These will ultimately help determine if ThriveNYC's MHFA program is running as planned and is achieving its outcomes.

Table 3. Process Evaluation Questions, Indicators and Data Sources

Evaluation Questions	Indicators	Data Source
To what extent was the MHFA training implemented as planned? (Fidelity)	The quantity of the MHFA training that was delivered as planned.	Training records (Length of training)
To what extent was the complete MHFA training and training materials provided to participants? (Dose-delivered)	The quantity of the MHFA covered and materials provided.	Training records (training checklist and training materials provided)
To what extent were participants of the MHFA training satisfied with the program? (Dose-received)	Perceive participant satisfaction with the MHFA training.	Participant surveys (post-test)
What is the number of participants who attended the complete MHFA training? (Reach)	Proportion of the target population that participated in the MHFA training.	Training records (attendance)
What barriers or facilitators influenced participation in the MHFA training? (Context)	Identify external factors that influence the participation in the MHFA training	Training records (facilitator notes) Participant surveys (post-test)

Table 4. Outcome Evaluation Questions, Indicators and Data Sources

Evaluation Questions	Indicators	Data Source
To what extent did participant's knowledge, attitudes and behaviors toward mental illness change after participating in the MHFA training?	Changes in self-reported knowledge, attitudes and behavior measures between the pre- and post-test.	Participant surveys (pre-test and post-test)
To what extent did participant's knowledge, attitudes and behaviors toward mental health care change after participating in the MHFA training?	Changes in self-reported knowledge, attitudes and behavior measures between the pre- and post-test.	Participant surveys (pre-test and post-test)
To what extent did the MHFA training impact participant's self-efficacy to help someone in a mental health crisis?	Changes in self-reported self-efficacy measures between pre- and post-test and between post-test and follow-ups.	Participant surveys (pre-test, post-test, follow up -1, follow up -2 and follow up -3)
To what extent did the MHFA training impact participant's behavioral intent to help someone in a mental health crisis?	Changes in self-reported behavioral intent measures between pre- and post-test and between post-test and follow-ups.	Participant surveys (pre-test, post-test, follow up -1, follow up -2 and follow up -3)
To what extent did the MHFA training change participant's perceptions of people with mental illnesses?	Changes in self-reported perception measures between pre- and post-test and between post-test and follow-ups.	Participant surveys (pre-test, post-test, follow up -1, follow up -2 and follow up -3)
To what extent did the program change participant's perceptions of the importance of the MHFA training?	Changes in self-reported perception measures between pre- and post-test and between post-test and follow-ups.	Participant surveys (pre-test, post-test, follow up -1, follow up -2 and follow up -3)

Data Collection

Process evaluation questions will be measured using two data collection methods:

1. Training records and 2. Participant surveys (post-test).

Short-term and mid-term evaluation questions will measure the impact of the program on participants knowledge, attitudes and behaviors both immediately post-training and at three follow-up times. These are measured using participant surveys at five data points: *1. Pre-test, 2. Post-test, 3. Follow up - 1, 4. Follow up - 2 and 5. Follow up – 3.*

Training Records

Training records are documents that are created to assist staff in conducting the MHFA trainings. The training records help ensure that the staff running the MHFA training do so in accordance with the training plan and make note of anything that might have gone wrong. For this evaluation proposal, the senior staff member at any given ThriveNYC MHFA training will be required to fill out the training record. The senior staff member will collect the following information: where the training is being conducted, number of staff members present, number of participants at the beginning and at the end of the training, the number of training materials distributed, the number of participant surveys completed (*pre-test*), the time at which the training began, time at which the training ended, the number of participants who completed the training, and the number of participant surveys completed (*post-test*). The training record will also contain a training checklist that the senior staff member completes, noting any deviations from the planned training. See *Appendix A* for a sample training record.

Participant Surveys

Participant surveys are the primary means for measuring the impact of the training on its target audience. In this evaluation a pre-post quasi-experimental survey method to assess program outcomes at multiple time intervals is utilized. (Shaddish, Cook & Campbell, 2002). Surveys are a time efficient and cost-effective quantitative method of data collection, which is appropriate to use when creating a budget sensitive government program (Shaddish, Cook & Campbell, 2002), as well as easy to administer and easy for participants to use. Surveys will be

provided in English, Spanish and Chinese, the same languages that the trainings are currently offered in.

Designing brief survey with measures that are clear to participants is important to ensure the collection of accurate data and increase the chances of survey completion (Shaddish, Cook & Campbell, 2002). Participant surveys will be administered at five different time points so that changes in knowledge, attitudes, and behaviors amongst participants post MHFA training can be measured over time. Each of the five participant surveys contain similar multiple-choice questions and have one comment section for free responses. Samples of each of the surveys can be found in *Appendices B, - F*.

Table 5. Participant Survey Types

Survey Type	Time and method for dissemination
Pre-test	Participants will complete the survey prior to the start of the MHFA training upon arrival at the training location.
Post-tet	Participants will complete the survey immediately after the completion of the MHFA training at the training location.
Follow up 1	Participants will be emailed an online survey one-month post completion of the MHFA training.
Follow up 2	Participants will be emailed an online survey six-months post completion of the MHFA training.
Follow up 3	Participants will be emailed an online survey one year post completion of the MHFA training.

The *pre-test* survey, referenced in *Table 5* above, is a pen and paper survey that will be administered in person to all training participants before the start of the MHFA training. It includes a statement of consent that emphasizes the protection of all personal data and survey responses and informs participants that their de-identified data will be used to study the efficacy of the MHFA training program. Participants are asked to enter their email addresses in order to receive follow-up surveys. The survey has three sections: demographic data, current knowledge, attitudes and behaviors regarding mental illnesses, mental health care and stigma, and a section focusing on changes in self-efficacy, behavioral intent, and perceptions regarding mental illnesses and the MHFA program. Demographic information collected includes age, gender

identity, sexual identity, race and ethnicity, language preference, residential zip code, and education level.

The *post-test* survey is also a pen and paper survey that will be administered in person to all training participants immediately after completion of the in-person MHFA training (see *Table 5*). The post-test survey is identical to the pre-test survey except it does not include demographics questions. The *post-test* survey includes feedback section with multiple choice questions assessing perceptions of usefulness and importance of the MHFA training and a free response space for participants to provide any additional feedback or comments regarding the MHFA training.

The first follow up survey (*follow up 1*) is administered one month following the completion of the MHFA training (see *Table 5*). This survey will be emailed to the participant with an imbedded Qualtrics link and is accessible on a computer, tablet, or smartphone. The *follow up 1* survey is identical to the post-test survey with the addition of questions asking participants about the use, frequency of use, and helpfulness of the skills learned in the MHFA training.

The second and third follow up surveys (*follow up 2* and *follow up 3*) are identical to *follow up 1* and will be administered six months and one year after the completion of the MHFA training, respectively (see *Table 5*).

Data Management & Analysis

Data Management

The data will be collected by program staff conducting the MHFA trainings via the collection of training checklists and participant surveys (*pre-/post-test*). These paper surveys will be given to the ThriveNYC MHFA program evaluation team within 24 hours of the training. The data will be immediately entered into the statistical software platform, SPSS, and the physical surveys will be scanned and saved to password protected files, before being shredded. The data from the *follow up surveys (1, 2 and 3)* will all be collected on the Qualtrics platform that will be monitored and managed by the same program evaluation team. After the data from each follow up is received, it will be downloaded and then uploaded into the SPSS software. The Qualtrics account and SPSS files will both be password protected. Additionally, all these procedures will

be conducted on secure servers accessible only to the approved evaluation team members at the Thrive main offices and no data or documents will leave the facilities once submitted. On SPSS, responses from each participant will be given a unique ID and email IDs will be kept hidden, all documents will be de-identified.

Quantitative Analysis

For process evaluation, various descriptive and frequency statistics will be run on the data collected via the *Training Checklists* to identify and measure program specific information: the date of the training, time length, number of staff, number of participants at the beginning and end of the training, number of training materials distributed, the number of *pre-/post-test* surveys completed, and the number of training sections completed. Statistical analyses of these variables will be used to measure program fidelity, dose-delivered, dose-received and program reach.

For outcome evaluation, univariate analyses will be conducted to calculate descriptive and frequency statistics of the demographic data in the *pre-test* survey. This data will identify the section of the population that the MHFA trainings are able to reach and if this group differs from the target population. Paired sample t-tests will be used to run statistical comparisons between the data measuring changes in participant's knowledge, attitudes, and behaviors between the *pre-* and *post-tests*, as well as changes in self-efficacy, behavioral intent and perception variables between the post-test survey and *follow up surveys (1, 2 and 3)*. Results will identify what impacts the MHFA training has on participants and whether these changes are maintained over sustained periods of time.

Qualitative Analysis

Qualitative approaches will be used to analyze the open-ended questions on the respective training checklists and participant surveys. Comments from the notes section on the training checklist will be coded and any significant events, barriers or facilitating factors mentioned will inform the interpretation of the quantitative data received from the same training checklist. Notes across trainings will be analyzed for emerging themes and patterns and will supplement the qualitative analysis to heighten the understanding of program implementation and efficiency.

Responses from open-ended feedback questions in the *post-test* and *follow up surveys* (1, 2 and 3) will be coded and recurring patterns or themes, as well as outliers, will be identified. The qualitative data will help identify which aspects of the training are working, which are not, and may provide a deeper understanding of the quantitative measure of program impact and efficacy.

Validity

Validity refers to the accuracy of a measure's ability to assess what it is supposed to. (Shaddish, Cook & Campbell, 2002). This is an essential aspect of any experiment or tool, and it is necessary to address any possible factors that may impede this validity. *Accuracy* is identified by the CDC Framework (1999) as one of the standards for an effective evaluation (see p. 25). Validity can either be internal or external. Below are discussions of what factors to consider in developing this specific evaluation proposal.

Internal Validity

Internal validity focuses on determining the validity of the internal components of an intervention (Shaddish, Cook & Campbell, 2002). Specifically, it looks at an intervention's ability to result in the desired outcomes. For this evaluation proposal, internal validity refers to whether the MHFA training results in changes in the knowledge, attitudes, and behaviors of participants. In order to accurately assess this change, it is important to consider possible confounding variables.

The testing phenomenon suggests that in a pre-/post-test design, the process of taking the pre-test itself can increase participant's knowledge levels which may be reflected in the responses gathered in the post-test or follow-ups (Shaddish, Cook & Campbell, 2002). However, the pre-test briefly asks about topics that are covered in much greater detail in the training. Hence, while it may contribute to some increase in knowledge, it can be assumed that most of the increase in knowledge can be attributed to the MHFA training itself.

Instrumentation includes issues regarding the implementation of an intervention or the administration of data collection methods (Shaddish, Cook & Campbell, 2002). This proposal lays out an entire process evaluation to ensure and check that the MHFA training is delivered as

it should be in every iteration of the program. Additionally, the training checklists provided to training staff will further help guide the appropriate delivery of the MHFA training.

Some other confounding variables to consider include other experiences or sources of information that participants may be exposed to between the training and subsequent follow up surveys. It is possible that during these extended periods of time (one month, six months and one year), participants encountered mental health problems themselves or amongst family or friends that may have spurred motivation to learn more about mental health and influenced their attitudes towards mental illnesses. This is one of the desired outcomes of the MHFA training; to equip participants with the tools needed to identify mental illnesses. Participants are asked, in the follow up surveys, if they or people they know have ever experienced a mental health problem, which enables researchers to take these possible changes in mental health status or exposure to others with mental health problems into consideration.

Social desirability bias, which suggests that participants may provide false responses in their surveys in order to be perceived in a desirable way, is another possible confounding variable. Given the sensitive and stigmatized topic of mental illness, it is likely that some participants may not want to report their own experiences with mental illness. The measures used in this evaluation try to address this problem by ensuring confidentiality to all participants thereby providing them with the trust that their responses will not be connected back to them or shared with others.

External Validity

External validity focuses on the generalizability of the findings from a study. In the case of the ThriveNYC's MHFA training program, the target audience is all New York City (NYC) Residents. NYC is composed of a diverse population with many cultural and racial backgrounds. To ensure that the data collected from this study is representative of the larger NYC population, it is important to make sure that the demographic composition of participants matches that of the city at large. The pre-test survey collects this demographic information from participants which can be analyzed to check whether they are a representative sample of the target population.

Ethics

This section addresses the *Propriety* standard identified in the CDC's Framework for Program Evaluation (1999) (see *page 25*).

Any evaluation that involves collecting data from human subjects raises issues of ethical concern. This proposal involves the evaluation of knowledge, attitudes and behaviors associated with mental illness and mental health care. With these topics considered personal and in many cases stigmatizing, protection of this data is of utmost importance. To ensure this security to participants, appropriate protocols will be followed during the collection, analysis, and dissemination of participant data. All participant data will be de-identified and survey responses will be kept confidential and protected. Participant's responses will only be used internally by ThriveNYC to assess the effectiveness of the MHFA program and will not be shared or used for any other purposes. Participation in the surveys is voluntary and not required of any individuals to participate in the MHFA training itself.

Use and Dissemination of Findings

This section further elaborates on the *Utility* standard stated in the CDC's Framework for Program Evaluation (1999).

The findings from this proposed process and outcome evaluation are meant to inform improvements, funding, and any expansion of ThriveNYC's MHFA program. The results from the process evaluation will provide insight into the successes or failures associated with the implementation and delivery of the MHFA training. Results will address the fidelity of the program and be used to make the needed adjustments to program delivery. The outcome evaluation will assess the efficacy of the MHFA training by measuring its impact the knowledge, attitudes and behaviors of participants who complete the training. The key stakeholders (identified on *page 25*) will review the findings of this evaluation. Results will inform decisions about whether the program is successful in creating the desired outcomes. Findings that support the efficacy of the training will provide evidence-based support for the expansion of the MHFA program and inform the allocation of ThriveNYC funding and resources.

The data collected add to the limited literature on the effectiveness of MHFA programs, particularly in the U.S., and implementation and effectiveness of MHFA programs across the country.

Feasibility

Feasibility is one of the four standards outlined in the CDC Framework as necessary for the creation of an effective evaluation (CDC, 1999). Feasibility refers to the practicality of the evaluation regarding the time, staff and funding required to conduct it.

This evaluation proposal is designed to make use of existing resources whenever possible. The administration of the pre- and post-test surveys will be conducted by the same ThriveNYC or NYCDOH staff members who are running the MHFA training. This would add two additional steps to their existing workflow and would require an additional 15 minutes at the beginning and end of the training. Handing out the pre-test surveys to participants as they join, while waiting for the rest can also help maximize time. Similarly, the training checklist would be completed by the senior staff member at the training and would only take a few minutes to complete. While these steps do not require much additional time or staffing, the data entry and analysis would require both time and expertise. Given that the *pre-* and *post-test* surveys are on paper, the data entry and analysis of survey responses would be added work for the analysis team at ThriveNYC. Time and funding could be saved by training and employing ThriveNYC and NYCDOH interns to assist with these steps. While these interns would be paid, it would be a more economical option than using full-time staff for such a time-intensive job. The use of Qualtrics for the delivery of the three follow up surveys provides a time- and cost-efficient method for data collection and organization.

With the purpose of this proposed evaluation to improve program efficiency and effectiveness, these proportionately small investments of resources now would help reduce larger costs in the long run.

Recommendations

The ongoing COVID-19 pandemic has resulted in a temporary pause in ThriveNYC's ability to offer the MHFA training program. With an increased prevalence of mental health problems during this time as well as an uncertainty as to when in-person trainings may be safe to resume, now would be the ideal time to pilot a virtual MHFA program.

E-formats of the MHFA trainings have been previously conducted and were found to be effective in increasing knowledge and confidence as well as reducing stigma (Jorm, Kitchener,

Fischer & Cvetkovski, 2010). Given the restrictions of this pandemic, assessing the reach and effectiveness of a virtual MHFA program would be extremely valuable. Existing research can be used to adapt the MHFA training into a digital format, which can be piloted amongst a select sample of the NYC population. An evaluation with tailored measures to gauge the impact of virtual program can be designed to understand whether this format can effectively address the goals of ThriveNYC's MHFA program. The findings of this proposed evaluation would provide insight as to whether this virtual program is a viable option. If proven to be effective, a virtual MHFA training would allow ThriveNYC to continue addressing its goals over the course of this pandemic and hence meeting an overwhelming mental health need amongst the NYC population. Further however, it would also provide a cost-effective way to make the MHFA training more accessible beyond the pandemic, by reaching a wider audience to whom it may be currently inaccessible.

Conclusion

ThriveNYC's MHFA program is designed to address the growing mental health needs of New Yorkers. This training program aims to spread awareness about mental illnesses and increase access to resources by teaching participants how to identify and respond to mental health crises. By equipping NYC residents with the knowledge and skills to deal with these situations appropriately, this program aims to help reduce stigma and open more avenues to care. However, the current evaluation process used by ThriveNYC collects limited data about whether the MHFA program is meeting its aims. A more comprehensive and thorough evaluation of the program is necessary to assess its viability.

This evaluation proposal puts forth a detailed plan using the CDC's Framework and LOR to assess the program's process, short-term and mid-term outcomes. The process evaluation helps to monitor program goals and track implementation by measuring program reach, fidelity, dose-delivered and dose-received. The proper and equitable delivery of this program is key to ensuring that it meets its purpose of reaching all communities in need. The outcome evaluation provides a rigorous assessment of short-term and mid-term outcomes of the MHFA training. Understanding the impact of the training on the knowledge, attitudes and behaviors of participants is necessary to know if the MHFA program is meeting its aims to combat stigma and

increase awareness, and its utility in real life scenarios. The findings of this proposed evaluation will influence the allocation of funding and resources, and ultimately inform decisions to pause, adapt or expand the program.

This evaluation proposal, if implemented, can help identify gaps, inefficiencies, and successes of the ThriveNYC's MHFA program, which can be acted upon to ensure that the organization's limited resources are being utilized in ways that best "reach those with highest need."

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Appendix A. Training Record

ThriveNYC's MHFA Training Record

Senior Staff Member Name: _____ **Signature:** _____

Training Information

Training Date: _____	No. of Participants (start): _____
Start Time: _____	No. of pre-test surveys completed: _____
End Time: _____	No. of Training Materials distributed: _____
No. of Training Staff: _____	No. of post-test surveys completed: _____
	No. of Participants (end): _____

Training Checklist

Activity	Completed	Partially Completed	Not Completed
Administer & collect pre-tests			
Distribute training materials			
Training: "Section 1"			
Training: "Section 2"			
Training: "Section 3"			
Training: "Section 4"			
Administer & collect post-tests			

Facilitator Notes

Appendix B. Participant Survey: Pre-test

ThriveNYC's MHFA: Participant Survey Pre-test

This survey explores your knowledge about mental illness and mental health care. Please respond to the following questions as truthfully as possible. The responses are for internal use only and will remain confidential. Emails will ONLY be used to send you the 3 follow-up surveys.

Date: _____

Participant's Email-ID: _____

Demographic Information:

The following questions ask you a bit about yourself. Please answer to the best of your ability.

1. How old are you? (in years) _____
2. What is your gender identity?
 - Female
 - Male
 - Trans
 - Genderqueer
 - I prefer to self-describe: _____
3. What is your sexual orientation?
 - Asexual
 - Bisexual
 - Gay/Lesbian
 - Heterosexual (Straight)
 - Questioning
 - I prefer to self-describe: _____
4. Which racial/ethnic groups do you identify with the most? (Select all that apply)
 - Alaskan Native
 - Asian

- Arab American or Middle Eastern
- Black or African American
- Hispanic or Latino
- Native American
- Native Hawaiian
- Other Pacific Islander
- White
- Other, please specify: _____

5. What is your preferred language?

- English
- Spanish
- Other, please specify: _____

6. What is the highest level of education you have completed?

- Less than high school
- High School Diploma/ GED
- Technical Certificate
- Some College
- Bachelor's Degree
- Master's Degree
- Professional/ Doctorate Degree (i.e. PhD, J.D., M.D.)
- Other, please specify: _____

Knowledge or Experience

*The following questions ask about your knowledge regarding mental health. **

1. Have you ever experienced a mental health problem?

- Yes
- No
- Unsure

2. Has anyone close to you experienced a mental health problem?

- Yes
- No

Unsure

3. I understand what a mental illness is.

Strongly agree

Agree

Disagree

Strongly disagree

Unsure

4. Mental illnesses can be a serious health problem.

Strongly agree

Agree

Disagree

Strongly disagree

Unsure

5. Mental health problems aren't real.

Strongly agree

Agree

Disagree

Strongly disagree

Unsure

6. People with mental health problems are often overreacting.

Strongly agree

Agree

Disagree

Strongly disagree

Unsure

7. Mental health problems can be treated.

Strongly agree

Agree

Disagree

Strongly disagree

Unsure

8. In the last 6 months have you had contact with anyone with a mental health problem?
- Yes
 - No
 - Unsure

If you said "yes" to Question 8, complete Question 9-11 and skip 12. If you said "no" to Question 8, skip to Question 12.

9. How many people have you had contact with who have had a mental health problem?

10. Have you offered any help to them?

- Yes
- Sometimes
- No

11. What type of help did you offer? (Select all that apply)

- Offered to speak with them.
- Offered to listen.
- Suggested physical activities/meditation.
- Suggested medication.
- Recommended counselling or therapy.
- Recommended seeing a psychiatrist.
- Recommended a general physician.
- Recommended going to a hospital or institution.
- Other, please specify: _____

12. Which of the following forms of help would you offer someone with a mental health problem? (Select all that apply)

- Offer to speak with them.
- Offer to listen.
- Suggest physical activities/meditation.
- Suggest medication.
- Recommend counselling or therapy.
- Recommend a psychiatrist.

Recommend a general physician.

Recommend a hospital or institution.

Other, please specify: _____

13. I can suggest at least 3 mental health resources.

Strongly agree

Agree

Disagree

Strongly disagree

Unsure

14. I can identify someone experiencing a mental health problem.

Strongly agree

Agree

Disagree

Strongly disagree

Unsure

15. I know how to help someone experiencing a mental health problem.

Strongly agree

Agree

Disagree

Strongly disagree

Unsure

16. How confident are you in your ability to help someone experiencing a mental health problem?

Very confident

Confident

Moderately confident

Not very confident

Not at all confident

17. How likely are you to approach someone experiencing a mental health problem in the future?

Very likely

- Somewhat likely
- Somewhat unlikely
- Very unlikely
- Unsure

18. How likely are you to offer help to someone experiencing a mental health problem in the future?

- Very likely
- Somewhat likely
- Somewhat unlikely
- Very unlikely
- Unsure

**Knowledge-based questions will be adapted to match training curriculum content.*

Appendix C. Participant Survey: Post-test

ThriveNYC's MHFA: Participant Survey Post-test

This survey explores your knowledge about mental illness and mental health care. Please respond to the following questions as truthfully as possible. The responses are for internal use only and will remain confidential. Emails will ONLY be used to send you the 3 follow-up surveys.

Date: _____

Participant's Email-ID: _____

Knowledge or Experience

*The following questions will ask you about your knowledge regarding mental health. **

1. Have you ever experienced a mental health problem?
 Yes
 No
 Unsure
2. Has anyone close to you experienced a mental health problem?
 Yes
 No
 Unsure
3. I understand what a mental illness is.
 Strongly agree
 Agree
 Disagree
 Strongly disagree
 Unsure
4. Mental illnesses can be a serious health problem.
 Strongly agree
 Agree

Disagree

Strongly disagree

Unsure

5. Mental health problems aren't real.

Strongly agree

Agree

Disagree

Strongly disagree

Unsure

6. People with mental health problems are often overreacting.

Strongly agree

Agree

Disagree

Strongly disagree

Unsure

7. Mental health problems can be treated.

Strongly agree

Agree

Disagree

Strongly disagree

Unsure

8. I can suggest at least 3 mental health resources.

Strongly agree

Agree

Disagree

Strongly disagree

Unsure

9. I can identify someone experiencing a mental health problem.

Strongly agree

Agree

Disagree

Strongly disagree

Unsure

10. I know how to help someone experiencing a mental health problem.

Strongly agree

Agree

Disagree

Strongly disagree

Unsure

11. How confident are you in your ability to help someone experiencing a mental health problem?

Very confident

Confident

Moderately confident

Not very confident

Not at all confident

12. How likely are you to approach someone experiencing a mental health problem in the future?

Very likely

Somewhat likely

Somewhat unlikely

Very unlikely

Unsure

13. How likely are you to offer help to someone experiencing a mental health problem in the future?

Very likely

Somewhat likely

Somewhat unlikely

Very unlikely

Unsure

Program Feedback

1. The training material covered was relevant to me.
 Strongly agree
 Agree
 Disagree
 Strongly disagree
 Unsure
2. The length of the training was appropriate.
 Strongly agree
 Agree
 Disagree
 Strongly disagree
 Unsure
3. The facilitators administered the training well.
 Strongly agree
 Agree
 Disagree
 Strongly disagree
 Unsure
4. How likely are you to recommend the ThriveNYC MHFA training to others?
 Very likely
 Somewhat likely
 Somewhat unlikely
 Very unlikely
 Unsure
5. Do you have any comments or feedback regarding the ThriveNYC MHFA training?

**Knowledge-based questions will be adapted to match training curriculum content.*

Appendix D. Participant Survey: Follow up - 1

ThriveNYC's MHFA: Participant Survey Follow up - 1

This survey to explore your knowledge about mental illnesses and mental health care. Please respond to the following questions as truthfully as possible. The responses are for internal use only and will remain confidential.

Date: _____

Knowledge or Experience

*The following questions will ask you about your knowledge regarding mental health. **

1. Have you ever experienced a mental health problem?
 Yes
 No
 Unsure
2. Has anyone close to you experienced a mental health problem?
 Yes
 No
 Unsure
3. I understand what a mental illness is.
 Strongly agree
 Agree
 Disagree
 Strongly disagree
 Unsure
4. Mental illnesses can be a serious health problem.
 Strongly agree
 Agree
 Disagree
 Strongly disagree

- Unsure
5. Mental health problems aren't real.
- Strongly agree
- Agree
- Disagree
- Strongly disagree
- Unsure
6. People with mental health problems are often overreacting.
- Strongly agree
- Agree
- Disagree
- Strongly disagree
- Unsure
7. Mental health problems can be treated.
- Strongly agree
- Agree
- Disagree
- Strongly disagree
- Unsure
8. I can suggest at least 3 mental health resources.
- Strongly agree
- Agree
- Disagree
- Strongly disagree
- Unsure
9. I can identify someone experiencing a mental health problem.
- Strongly agree
- Agree
- Disagree
- Strongly disagree
- Unsure

10. I know how to help someone experiencing a mental health problem.
- Strongly agree
 - Agree
 - Disagree
 - Strongly disagree
 - Unsure
11. How confident are you in your ability to help someone experiencing a mental health problem?
- Very confident
 - Confident
 - Moderately confident
 - Not very confident
 - Not at all confident
12. How likely are you to approach someone experiencing a mental health problem in the future?
- Very likely
 - Somewhat likely
 - Somewhat unlikely
 - Very unlikely
 - Unsure
13. How likely are you to offer help to someone experiencing a mental health problem in the future?
- Very likely
 - Somewhat likely
 - Somewhat unlikely
 - Very unlikely
 - Unsure
14. In the last 1 month have you had contact with anyone with a mental health problem?
- Yes
 - No
 - Unsure

If you said “yes” to Question 14, complete Question 15-20. If you said “no” to Question 14, skip to Question 19.

15. How many people have you had contact with who had a mental health problem? _____

16. Have you offered any help to them?

Yes

Sometimes

No

17. Were you able to use what you learned from the MHFA training?

Yes

Sometimes

No

18. In your opinion, were you successful in helping them?

Yes

Sometimes

No

19. I have found the MHFA training helpful.

Strongly agree

Agree

Disagree

Strongly disagree

Unsure

20. Do you have any comments or feedback regarding the ThriveNYC MHFA training?

**Knowledge-based questions will be adapted to match training curriculum content.*

Appendix E. Participant Survey: Follow up - 2

ThriveNYC's MHFA: Participant Survey Follow up - 2

This survey aims to explore your knowledge about mental illnesses and mental health care. Please respond to the following questions as truthfully as possible. The responses are for internal use only and will remain confidential.

Date: _____

Knowledge or Experience

*The following questions will ask you about your knowledge regarding mental health. **

1. Have you ever experienced a mental health problem?
 Yes
 No
 Unsure
2. Has anyone close to you experienced a mental health problem?
 Yes
 No
 Unsure
3. I understand what a mental illness is.
 Strongly agree
 Agree
 Disagree
 Strongly disagree
 Unsure
4. Mental illnesses can be a serious health problem.
 Strongly agree
 Agree
 Disagree
 Strongly disagree

- Unsure
5. Mental health problems aren't real.
- Strongly agree
- Agree
- Disagree
- Strongly disagree
- Unsure
6. People with mental health problems are often overreacting.
- Strongly agree
- Agree
- Disagree
- Strongly disagree
- Unsure
7. Mental health problems can be treated.
- Strongly agree
- Agree
- Disagree
- Strongly disagree
- Unsure
8. I can suggest at least 3 mental health resources.
- Strongly agree
- Agree
- Disagree
- Strongly disagree
- Unsure
9. I can identify someone experiencing a mental health problem.
- Strongly agree
- Agree
- Disagree
- Strongly disagree
- Unsure

10. I know how to help someone experiencing a mental health problem.
- Strongly agree
 - Agree
 - Disagree
 - Strongly disagree
 - Unsure
11. How confident are you in your ability to help someone experiencing a mental health problem?
- Very confident
 - Confident
 - Moderately confident
 - Not very confident
 - Not at all confident
12. How likely are you to approach someone experiencing a mental health problem in the future?
- Very likely
 - Somewhat likely
 - Somewhat unlikely
 - Very unlikely
 - Unsure
13. How likely are you to offer help to someone experiencing a mental health problem in the future?
- Very likely
 - Somewhat likely
 - Somewhat unlikely
 - Very unlikely
 - Unsure
14. In the last 6 months have you had contact with anyone with a mental health problem?
- Yes
 - No
 - Unsure

If you said “yes” to Question 14, complete Question 15-20. If you said “no” to Question 14, skip to Question 19.

15. How many people have you had contact with who had a mental health problem? _____

16. Have you offered any help to them?

Yes

Sometimes

No

17. Were you able to use what you learned from the MHFA training?

Yes

Sometimes

No

18. In your opinion, were you successful in helping them?

Yes

Sometimes

No

19. I have found the MHFA training helpful.

Strongly agree

Agree

Disagree

Strongly disagree

Unsure

20. Do you have any comments or feedback regarding the ThriveNYC MHFA training?

**Knowledge-based questions will be adapted to match training curriculum content.*

Appendix F. Participant Survey: Follow up - 3

ThriveNYC's MHFA: Participant Survey Follow up - 3

This survey aims to explore your knowledge about mental illnesses and mental health care. Please respond to the following questions as truthfully as possible. The responses are for internal use only and will remain confidential.

Date: _____

Knowledge or Experience

*The following questions will ask you about your knowledge regarding mental health. **

1. Have you ever experienced a mental health problem?
 Yes
 No
 Unsure
2. Has anyone close to you experienced a mental health problem?
 Yes
 No
 Unsure
3. I understand what a mental illness is.
 Strongly agree
 Agree
 Disagree
 Strongly disagree
 Unsure
4. Mental illnesses can be a serious health problem.
 Strongly agree
 Agree
 Disagree
 Strongly disagree

- Unsure
5. Mental health problems aren't real.
- Strongly agree
- Agree
- Disagree
- Strongly disagree
- Unsure
6. People with mental health problems are often overreacting.
- Strongly agree
- Agree
- Disagree
- Strongly disagree
- Unsure
7. Mental health problems can be treated.
- Strongly agree
- Agree
- Disagree
- Strongly disagree
- Unsure
8. I can suggest at least 3 mental health resources.
- Strongly agree
- Agree
- Disagree
- Strongly disagree
- Unsure
9. I can identify someone experiencing a mental health problem.
- Strongly agree
- Agree
- Disagree
- Strongly disagree
- Unsure

10. I know how to help someone experiencing a mental health problem.
- Strongly agree
 - Agree
 - Disagree
 - Strongly disagree
 - Unsure
11. How confident are you in your ability to help someone experiencing a mental health problem?
- Very confident
 - Confident
 - Moderately confident
 - Not very confident
 - Not at all confident
12. How likely are you to approach someone experiencing a mental health problem in the future?
- Very likely
 - Somewhat likely
 - Somewhat unlikely
 - Very unlikely
 - Unsure
13. How likely are you to offer help to someone experiencing a mental health problem in the future?
- Very likely
 - Somewhat likely
 - Somewhat unlikely
 - Very unlikely
 - Unsure
14. In the last 12 months have you had contact with anyone with a mental health problem?
- Yes
 - No
 - Unsure

If you said “yes” to Question 14, complete Question 15-20. If you said “no” to Question 14, skip to Question 19.

15. How many people have you had contact with who had a mental health problem? _____

16. Have you offered any help to them?

Yes

Sometimes

No

17. Were you able to use what you learned from the MHFA training?

Yes

Sometimes

No

18. In your opinion, were you successful in helping them?

Yes

Sometimes

No

19. I have found the MHFA training helpful.

Strongly agree

Agree

Disagree

Strongly disagree

Unsure

20. Do you have any comments or feedback regarding the ThriveNYC MHFA training?

**Knowledge-based questions will be adapted to match training curriculum content.*