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EVALUATION OF YOUTH MENTAL HEALTH FIRST AID TRAINING FOR ILLINOIS SCHOOLS

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Abstract: Nearly one in six U.S. children have been diagnosed with a mental disorder. Exacerbated by the COVID-19 pandemic, youth mental health has been declared a national emergency. Schools are at the forefront of youth interventions to promote positive mental health and address mental health concerns. One intervention model includes training school personnel on to identify and help students with mental health issues. ICJIA researchers evaluated Youth Mental Health First Aid training offered to school personnel across Illinois (n = 81) with observations and surveys, including pre- and post-tests. The evaluation revealed participants gained mental health knowledge and were satisfied with the training format and content. The training program appeared to meet its goal of teaching school personnel about mental health issues in young people and interventions to address them.

Introduction

Ensuring healthy learning environments is a top priority for educational institutions, families, health agencies, policymakers, and other stakeholders.[1] Childhood and adolescence set the trajectory for social, cognitive, and emotional development and behavior across a lifetime.[2] Educational institutions understand the importance of supporting school-aged youth's emotional development, with many implementing school-based mental health programs.[3] These programs can play a critical role in supporting students and providing a safe, non-stigmatizing, and caring environment.[4]

We evaluated six Youth Mental Health First Aid (YMHFA) trainings coordinated by the Illinois State Board of Education (ISBE) for school personnel in Illinois. ISBE,[5] which sets educational policy guidelines for Illinois schools, was awarded a U.S. Department of Justice Office of Justice Programs Bureau of Justice Assistance grant to fund the trainings. YMHFA is an 8-hour training for school personnel on youth mental health and providing young people with support and referrals for professional help. Certified instructors teach the course to adults in their communities and schools.[6] Certified instructors are first trained to:

- Teach the YMHFA course.
- Present the training with fidelity.
- Apply training to different audiences, learning styles, and learning environments.

According to the National Council for Mental Wellbeing, YMHFA training developer, over 1.5 million adults nationally and nearly 15,000 adults in Illinois have been trained as mental health first aid instructors.[7] A systematic review and meta-analysis of mental health first aid trainings for adult and youth found increased mental health literacy and improved support for persons with a mental health problem 6 months following training.[8]

We observed a training and administered surveys, including pre- and post-training questionnaires, to answer the following research questions:

- How were the trainings conducted?
- Who were the participants?
- To what extent was there knowledge gain and retention following the training?
- How satisfied were participants with the training?

Background

One in six children aged 2 to 8 years old have a diagnosed mental, behavioral, or developmental disorder, and many others remain undiagnosed.[9] According to federal data systems, from 2013 to 2019, children aged 13 to 17 were diagnosed with the following:

- Attention deficit hyperactivity disorder (9.8%).
- Anxiety (9.4%).
- Behavior problem (8.9%).
- Depression (4.4%).[10]

Some of these conditions commonly occur together. For instance, about 3 in 4 children aged 3-17 years with depression also have anxiety (73.8%) and almost 1 in 2 have behavior problems

(47.2%). More than 1 in 3 children aged 3-17 years with anxiety have behavior problems (37.9%), and about 1 in 3 with anxiety also have depression (32.3%). Additionally, for children with behavior problems also have anxiety (36.6%), and about 1 in 5 also have depression (20.3%).[11] Therefore, school-age youth may experience many of these conditions, in addition to social and school pressures, which can affect school performance, self-esteem, and the risk of substance misuse.

COVID-19 and Youth Mental Health

The COVID-19 pandemic has drastically impacted the mental health of school-aged youth. In October 2021, the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the Children's Hospital Association declared the pandemic-related decline in child and adolescent mental health had become a national emergency.[12] The mental health consequences of the COVID-19 pandemic in school-aged youth include the onset of stress-related disorders and the exacerbation of preexisting disorders.[13] The grief, anxiety, and depression children have experienced during the pandemic are apparent in U.S. schools and classrooms.[14] Teachers and education professionals report seeing increases in crying and disruptive behavior in many younger children and increased violence and bullying among adolescents.[15]

Preparing Schools to Help Youth

Schools can ensure that students get treatment for mental health issues through early identification, referral for treatment, training teachers in early mental illness detection and response, training faculty to address pervasive violence, and training mental health professionals to provide mental health services in schools.[16] School-based mental health programs can promote students' current and future success, as mentally healthy students are more likely to:

- Go to school ready to learn.
- Actively engage in school activities,
- Have supportive and caring connections with adults and young people,
- Use appropriate problem-solving skills,
- Have nonaggressive behaviors,
- Add to positive school culture.[17]

Methods

We used surveys and observations to evaluate the training, similar to prior evaluations of YMHFA trainings.[18] IRB approval was not needed as it is evaluation of a program, not research.

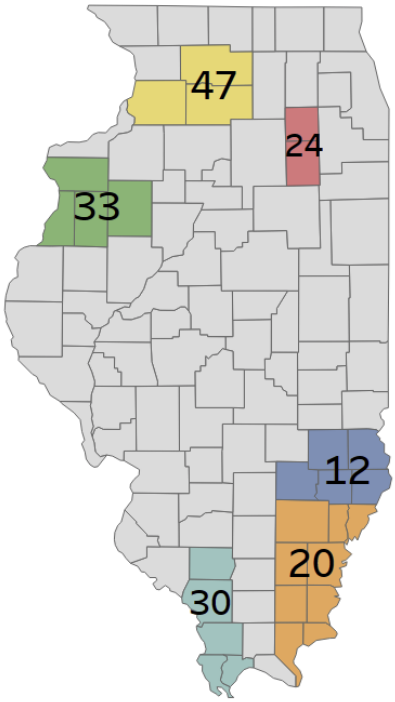
Trainings and Participant Sample

We evaluated seven YMHFA trainings, which were train-the-trainer style, so participants were expected to train other school personnel on the material following the training. The trainings were held in June and December 2020 and in June, July, and August 2021. Three were virtual, three were in person, and one was blended. YMHFA in-person is an 8-hour course; virtual is a 2-hour online class with 5.5 hours instructor-led training; and blended courses include a 2-hour

online class with 5.5 hours in-person. At the conclusion of training, participants would be certified to teach both virtually and in-person.

Trainings were hosted by six regional offices of education (ROEs) covering 29 counties. (Figure 1). ROEs assist school districts as local point of access to student supports and services.[19] ROEs designated staff members to be trained as instructors, as well as invited members of the state association of school resource officers.

Figure 1
YMFA Training Hosts by Location



Note: Region 12 includes Clay, Crawford, Jasper, Lawrence, and Richland counties. Region 20 includes Edwards, Gallatin, Hamilton, Hardin, Pope, Saline, Wabash, Wayne, and White counties. Region 24 includes Grundy and Kendall counties. Region 30 includes Alexander, Jackson, Perry, Pulaski, and Union counties. Region 33 includes Henderson, Knox, Mercer, and Warren counties. Region 47 includes Lee, Ogle, and Whiteside counties.

Table 1 shows demographics of 81 participant based on survey responses. A majority of respondents were women and 30% were teachers. Nearly half of the respondents had received other mental health training.

Table 1
Training Participant Demographics

Demographic	*n*	%
Age		
18-24	6	7.4
25-35	21	25.9
36-45	12	14.8
46-55	20	24.7
56+	9	11.1
Prefer not to say	1	1.2
Unknown	12	14.8
Gender		
Woman	62	76.5
Man	5	6.2
Prefer not to say	2	2.5
Unknown	12	14.8
Job category		
Administrator	5	6.2
Library professional	2	2.5
Preventionist/Community Outreach Advocate	3	3.7
School Counselor	5	6.2
School Psychologist	4	4.9
School Social Worker	2	2.5
Special Education professional	13	16.0
Speech/Language professional	2	2.5
Teacher	24	29.6
Other	8	9.9
Unknown	13	16.0
Prior mental health training		
None	20	24.7
High school class	3	3.7
College level	12	14.8
Master's level	18	22.2
Ph.D. level	0	0.0
Medical/psychiatric	0	0.0
Workshops	37	45.7
Unknown	13	16.0

Note. Sample included 81 pre- and post-test respondents. Gender and job categories were self-identified.

Materials

Field Observation

From June 15-17, 2020, an ICJIA research analyst attended a YMHFA virtual training of 7.5 hours over three days. Field notes were recorded to describe what occurred during the training, the topics covered, the questions posed by trainees, and the overall impressions of the training.

Surveys

Pre- and Post-Training Survey. Pre- and post-training surveys were developed to measure changes in participant knowledge before and after training completion. The surveys included four items on demographics, nine items on mental health knowledge, five items on perceptions of skills, and 10 items on use of YMHFA skills.[20]

Training Satisfaction Survey. We distributed the ISBE standard satisfaction training survey to evaluation participants via Google Forms. The survey included three items on the training logistics and 13 items on the respondents' perceptions of training outcomes.

Six-Month Follow-Up Survey. We emailed a six-month follow-up survey to training participants. The online survey was designed to measure knowledge retention and experiences employing information from the training and garnered additional feedback. The survey was created in Qualtrics, a web-based survey software. Four individuals completed the survey—two in June 2021 and two in August 2021.

Study Limitations

Small sample sizes created the biggest limitation to this study. Therefore, it is unknown to what extent the participants used what was learned in the trainings. Small sample sizes and response rates may have been impacted by COVID-19. In the 2020-21 school year, the pandemic disrupted and taxed education systems, as well as school administrators and staff, teachers, and students.[21] The pandemic made it difficult to convene trainings and may have impacted participation and response rates.

Findings

Training Observation

A researcher conducted one field observation to provide context and a nuanced understanding of the YMHFA trainings. In attendance were 16 participants and two instructors. A majority of trainees had some prior mental health training and most worked at an education agency or school. Since YMHFA is a trademarked training program, the curriculum could not be shared.

The researcher observed a three-day virtual training via Zoom video conferencing. It was observed that the virtual format made it difficult for the trainers to speak one-on-one to

individual participants. Some participants expressed frustration at how much time was spent managing technical issues rather than teaching and learning the curriculum.

Virtual Training Day 1

The virtual training instructors began with an overview of the course and group introductions. Throughout discussions, participants often switched between answering questions via video or in the chat. Participants had their cameras on; trainees noted cameras were preferred to make eye contact with other participants. Instructors emphasized to participants that they should actively participate every eight minutes in person, but every four minutes virtually. The researcher observed the three-day virtual training moved faster than in-person training.

Participants were first required to complete 2 hours of online self-initiated instruction. The videos covered course materials, the role of YMHFA, spectrum of interventions, and the Mental Health First Aid action plan. The researcher observed different slides were being used in the PowerPoint presentation than those used during the in-person training. Instructors asked for reactions after each segment of training.

As part of the training, participants received personal coaching. Two participants were joined in designated a virtual breakout room with an instructor. The instructor discussed the curriculum and answered questions with the rest of the group and used polls for feedback on the training. A virtual whiteboard was used for activities.

Virtual Training: Day 2

Participants were assigned to online breakout rooms to discuss how they will teach the curriculum. The instructors continued to switch between breakout rooms and full sessions to teach.

Virtual Training: Day 3

Instructors completed their presentations went over next steps. Instructors emphasized fidelity to the YMHFA model. Participants were not allowed to take photos of slides and were not to edit slides or change exercises. A pledge was taken by all participants at the end of training—a call to action to teach YMHFA and improve communities.

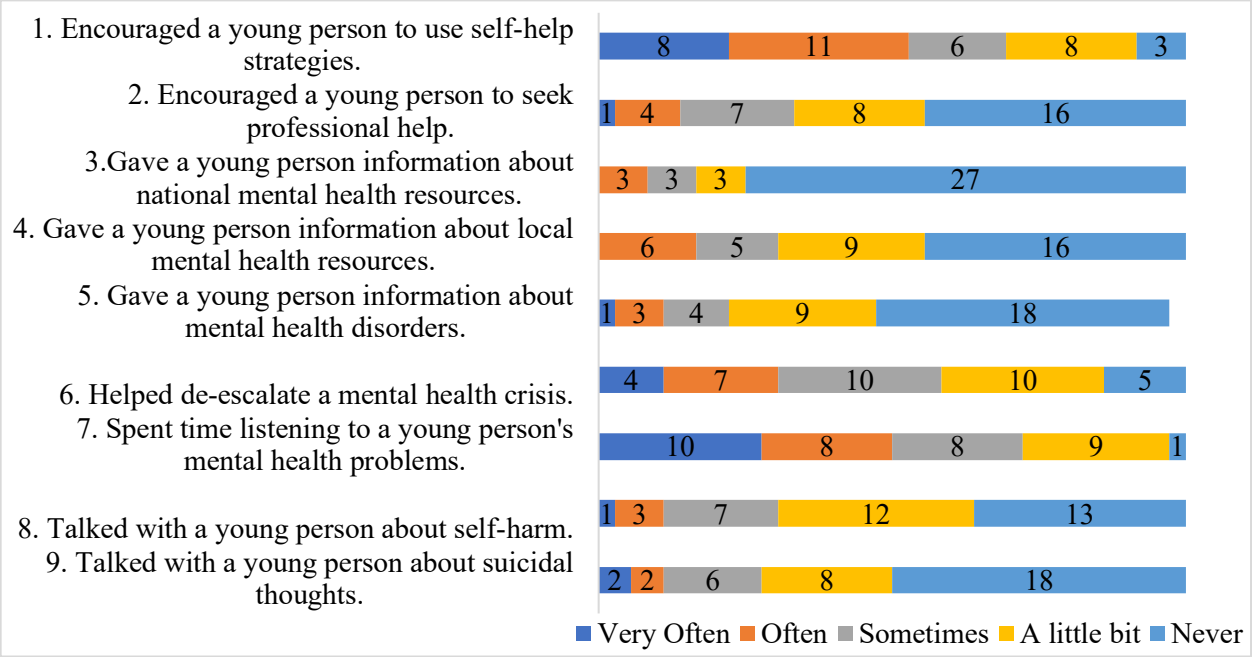
Training Participant Feedback

Prior Experience Helping Youth

A majority of training participants reported talking with a young person at least “A little bit” about a mental health problem in the previous6 months (70.6%, $n = 48$). Those respondents further indicated specific ways they helped youth (Figure 2). Most participants had previously listened to a young person with mental health problems and encouraged self-help strategies. A smaller number gave a young person information about mental health resources.

Figure 2

Training Participants' Prior Experience Helping Youth with a Mental Health Problem



Note. The sample included 36 Youth Mental Health First Aid training participants on all items but item 5, which had a sample size of 35. Researchers gathered these responses from pre-tests.

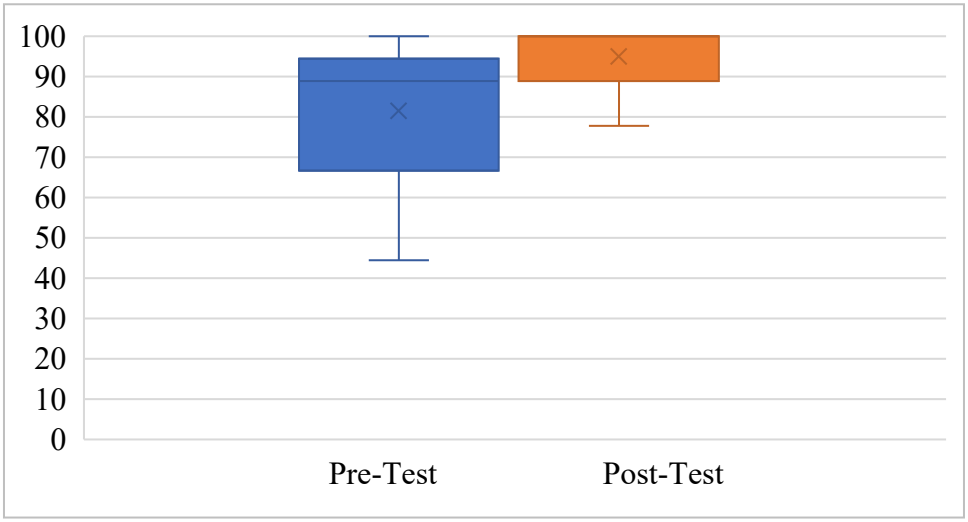
Mental Health Knowledge

Training participants were asked to share their levels of knowledge on youth mental health disorders before and after the training. Of 68 respondents, 14.7% before training and 30.9% after training indicated they knew "A great deal" or "A lot."

Figure 3 depicts pre and post-test score distribution based on the responses to nine items in Table 3. The figure displays the high and low ends of score distribution. The bottom and top of the box are the lower and upper quartiles, the horizonal line is the median score, the two lines outside the box are the minimum and maximum scores. The average pre-test score was 81.6%; the average post-test score was 95.0%. The relatively high pre-test scores suggested participants had prior mental health knowledge; a majority of participants indicated they had had prior mental health training. A t-test was performed and confirmed a statistically significant difference in scores from before and after the training, $t(53) = -6.569$, $p < .001$.

Figure 3

Training Participants' Test Score Distribution Before and After Training



Note. The sample included 54 Youth Mental Health First Aid training participants who completed the pre- and post-tests.

Participants were given two vignettes and asked to choose the correct responses (Table 2). In survey research, a vignette item describes an event, happening, circumstance, or other scenario and ask for responses.[22] Participants increased their test scores on both items but had a larger increase of 39.6% in their scores on the second vignette.

Table 2

Training Participants' Knowledge of Mental Health Responses Pre- and Post- Training

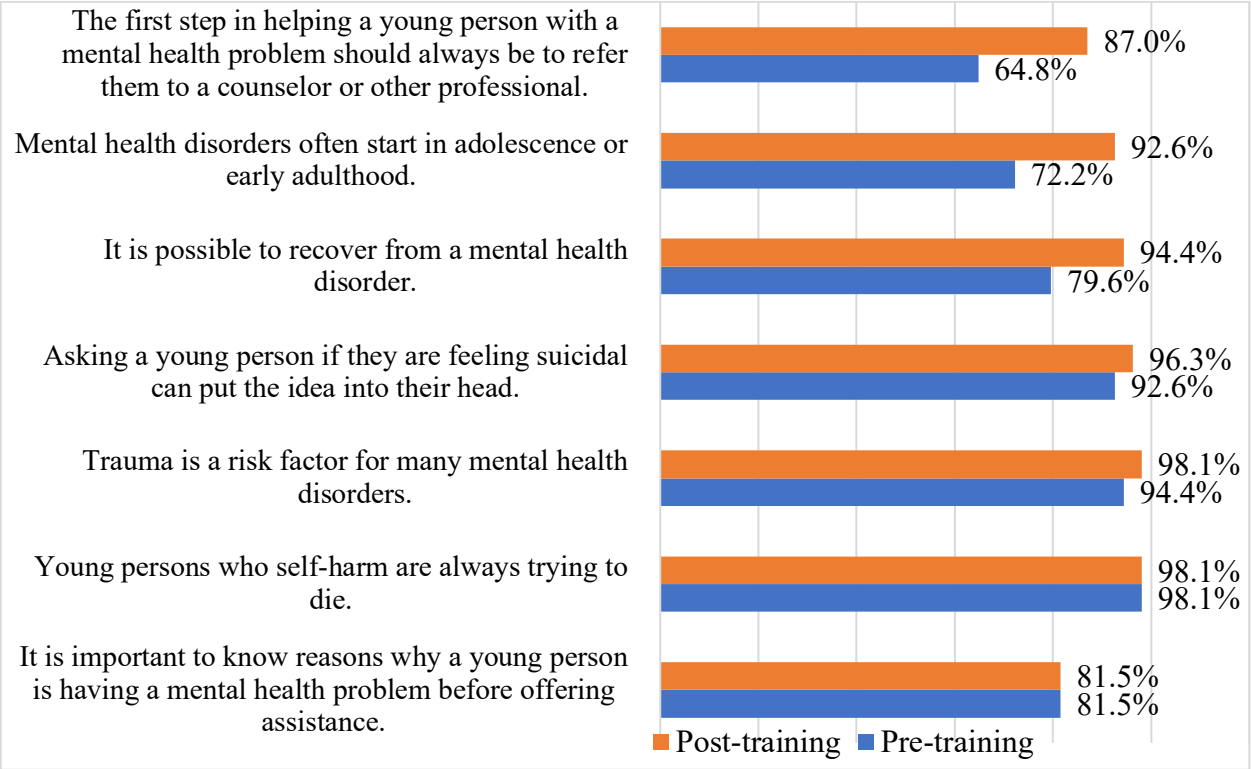
Vignettes	Pre-test	Post-test
	% correct	% correct
1. As a school club supervisor, you notice one of the students refuses to join in activities and often seems nervous when asked to participate. They frequently complain of headaches when given tasks and become highly embarrassed when asked to contribute to discussions. You have the opportunity to chat with the student after tonight's meeting.	92.6	96.3
2. You notice that one of your students has recently had difficulty participating in your class at school. Though they used to be outgoing, they have recently been confused and withdrawn, often choosing to sit alone or skip class entirely. After chatting with the student, they mention to you that they sometimes hear unfamiliar voices speaking to them that no one else can hear. At this moment, you have determined through your conversation that the student is fearful, but not at risk for suicide or self-harm.	68.5	92.6

Note. The sample included 54 Youth Mental Health First Aid training participants. The correct response to the first vignette was *Ask the student what you can do to help them feel more comfortable at meetings*. The correct response to Vignette 2 was *Provide them reassurance and listen to their concerns*

Figure 4 shares the percentage of correct responses on youth mental health on the pre- and post-tests in order of greatest knowledge gain to the lowest or no change.

Figure 4

Training Participants' Knowledge of Youth Mental Health Pre- and Post-Training



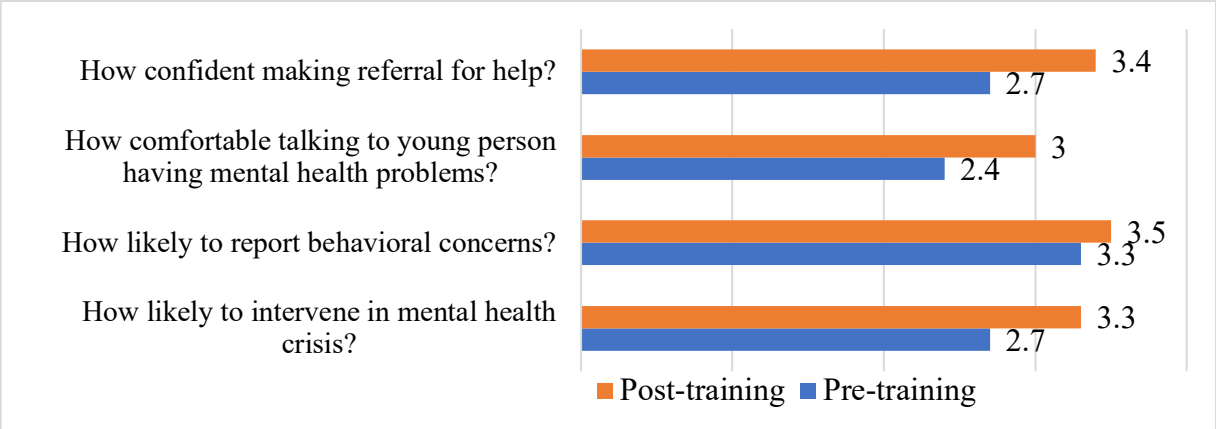
Note. The sample included 54 Youth Mental Health First Aid training participants. The percentages reflect correct responses.

Mental Health Assistance

Participants were asked about helping youth with mental health concerns (Figure 5). After training, participants increased their confidence in, comfortability with, and likelihood of assisting youth.

Figure 5

Training Participants' Assistance of Youth Pre- and Post-Training



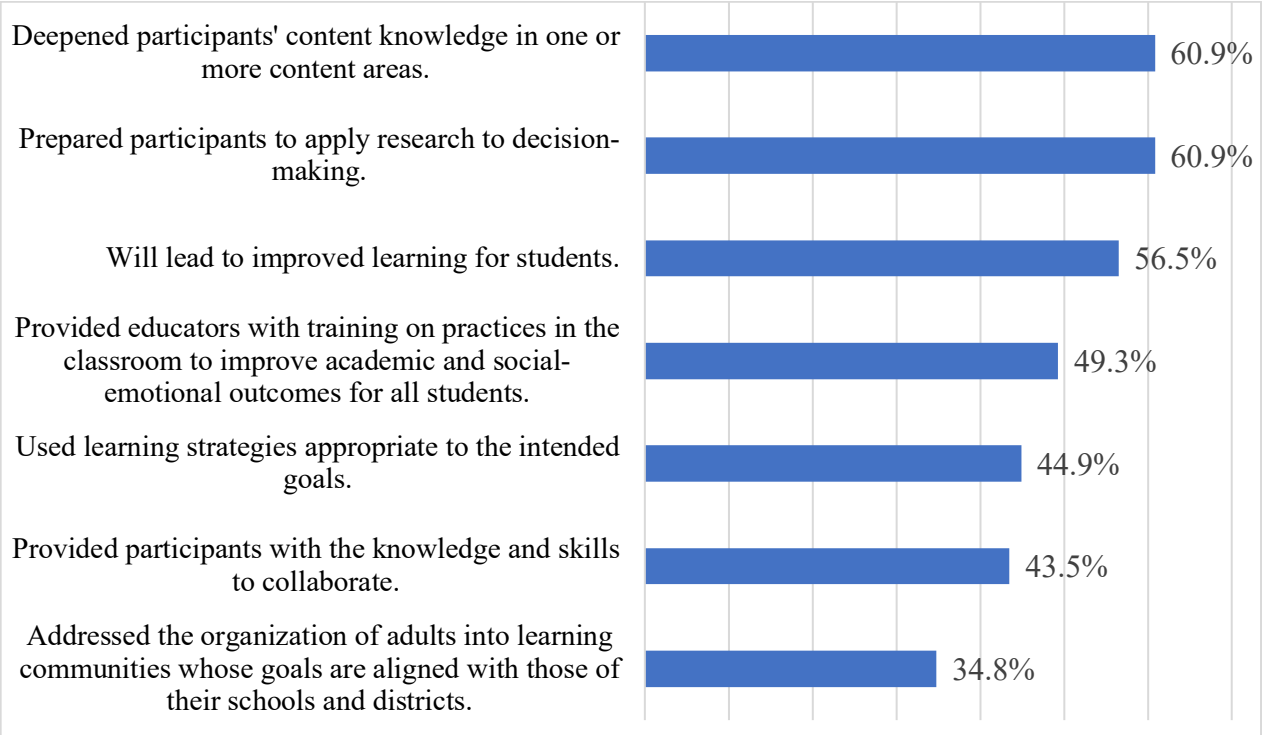
Note. The sample included 56 Youth Mental Health First Aid training participants who completed both pre- and post-tests. Mean responses were based on Likert scale of 0 = Not at all, 1 = Slightly, 2 = Somewhat, 3 = Moderately, and 4 = Extremely.

Training Feedback

Respondents were given an Illinois Association of Regional Superintendents of Schools survey to gauge the quality of the training. The Illinois Association of Regional Superintendents of Schools requires the same questions are asked of participants of every training for school personnel regardless of topic area or content.[23] A majority indicated the training increased knowledge and prepared them to apply research to decision making (Figure 6).

Figure 6

Participants' Feedback on YMHFA Training



Note. The sample included 69 Youth Mental Health First Aid training participants. Respondents could "Agree" or "Disagree." Percentages reflect participants who agreed with the statements.

Respondents were surveyed on how the training related to their professional development. All respondents "Agreed" to "Strongly agreed" the training would impact their or their students' emotional growth and that the training aligned with their school or district improvement plans. Almost all participants noted the training will have a positive impact on their personal growth or student growth (97.1%).

Potential Future Challenges

YMHFA training participants were asked to identify challenges to applying the skills learned in training. Four noted "student cooperation" as a future challenge. Many reported no challenges or did not respond (66.7%, $n = 46$).

Participants listed the following potential challenges:

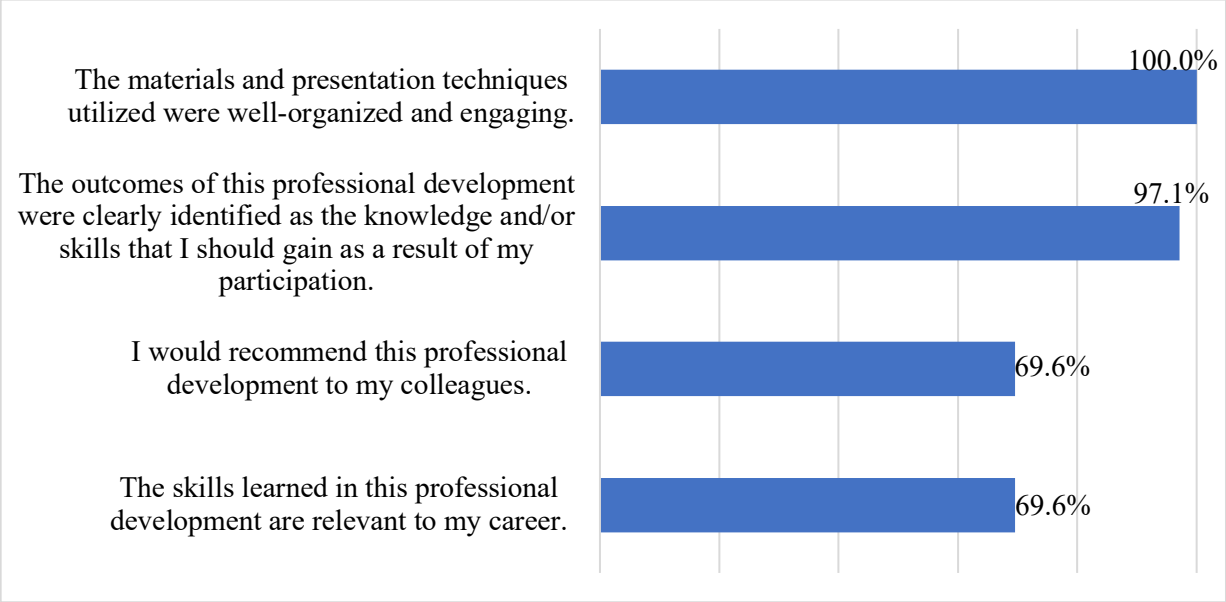
- Student cooperation ($n = 4$)
- Sigma ($n = 3$)
- Virtual learning ($n = 3$)
- Staying up to date on mental illnesses and best practices ($n = 3$)
- Not having enough time to talk to students individually ($n = 3$)
- Understanding how students feel ($n = 1$)

- Making sure students are safe and able to learn (*n* = 1)
- Dealing with teenagers and not overlooking them (*n* = 1)
- Local viewpoints on mental health minimizing the help they can provide, (*n* = 1)
- Not enough staff (*n* = 1)
- Not acting upon a situation fast enough (*n* = 1)
- Remembering what they have learned when a crisis happens (*n* = 1)

Training Satisfaction

Most participants were satisfied with the training design, materials, and outcomes (Figure 7).

Figure 7
Training Participants' Satisfaction with Training



Note. The sample included 69 Youth Mental Health First Aid training participants. Percentages reflect participants who "Agreed" or "Strongly Agreed" with the statements.

Six-Months Post-Training Feedback

Four participants completed a six-month follow up survey to gauge longer term outcomes. Overall, the respondents retained much mental health knowledge gained in the training; all four correctly answered seven of nine items. All respondents reported feeling comfortable and confident in being able to intervene when young people need help with mental health problems. They indicated that they knew a "moderate amount" to "a lot" about mental health disorders in young persons. The four respondents used their skills at least "A little bit" to talk to a young person about a mental health problem in the six months following the training. All respondents strongly agreed the training was important for people in their line of work. Three respondents agreed they were supported by their administrations to use their skills, had opportunities to use what was learned, and felt what was learned was useful.

Conclusion

In the United States, youth mental health issues are prevalent and a critical concern. Education systems are employing training for school personnel to provide the tools needed to assist youth. YMHFA is a training for adults to understand youth mental health and offer support and referrals to youth in need of professional help. We evaluated seven Regional Offices of Education YMHFA trainings provided to Illinois school personnel across the state in 2020 and 2021. The evaluation employed a field observation and surveys to measure training impact.

Most of the 81 YMHFA training participants were women ages 25 to 55 years old who were teachers or other school staff. Almost half had attended prior mental health training workshops. We observed a virtual YMHFA training course, which featured presentations, virtual coaching, and practice teaching the curriculum. Overall, participants gained knowledge from the training and increased their confidence to and comfortability with assisting youth experiencing a mental health issue. Six months post-training, four participants retained most of the knowledge of what was learned at the training and had used the skills they learned.

In general, training participants were satisfied with how the material was presented. A small number saw potential challenges to using the skills they learned, such as a lack of student cooperation. Perhaps student cooperation could be addressed during the coaching or practice portions of the training. Research indicates students may be reluctant to seek help for mental health concerns, so this topic would be appropriate to address.[24]

We found YMHFA was effective at teaching school personnel how to support and assist young people experience mental health issues. These findings are supported by prior research that found increased mental health knowledge and improved support following training.[25] More research on YMHFA is needed to measure long-term positive outcomes.[26]

One criticism of YMHFA is that it trains non-mental health professionals rather than schools employing sufficient professional mental health professionals and services.[27] Despite a growing number of students in need of support, schools are facing a national shortage of school-based mental health personnel.[28] YMHFA and other youth mental health training for school personnel can help fill that gap and meet students' needs.

If you or someone you know is struggling emotionally or with mental health, you can contact:

SAMHSA's National Helpline
Call 1-800-662-HELP (4357)
Helpline is for general information on mental health and to locate treatment services in your area. SAMHSA also has a Behavioral Health Treatment Services Locator to search by location.

National Suicide Prevention Lifeline
Call 1-800-273-TALK (8255); En español 1-888-628-9454
Use Lifeline Chat on the web
The Lifeline is a free, confidential crisis service that is available to everyone 24 hours a day, seven days a week. The Lifeline connects people to the nearest crisis center in the Lifeline national network. These centers provide crisis counseling and mental health referrals.

Crisis Text Line
Text "HELLO" to 741741
The Crisis Text hotline is available 24 hours a day, seven days a week throughout the U.S. The Crisis Text Line serves anyone, in any type of crisis, connecting them with a crisis counselor who can provide support and information.

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