MH101® Impact Evaluation

Final report, June 2023

Acknowledgements

This report was written by Te Pou for Te Whatu Ora – Health New Zealand, formerly the Ministry of Health. The authors of the report include Dr Katie Palmer du Preez, Charito Tuason, James Millington, and Heather Kongs-Taylor.

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Te Pou is the national workforce centre for mental health, addiction and disability in New Zealand. Blueprint for Learning is a leading provider of mental health, wellbeing, and addiction literacy training. They are the learning and development partner of Te Pou.

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Background

Increasing mental health and addiction literacy can assist communities to support people experiencing mental distress, through appropriate support and referrals to early intervention, treatment, and recovery services. Additionally, countering stigma and discrimination can result in greater recognition of mental health problems, increased help-seeking and increased support and inclusion of people who experience mental distress. MH101® workshops aim to give participants greater confidence to recognise, relate and respond to people experiencing mental health challenges. Te Whatu Ora – Health New Zealand, formerly the Ministry of Health, has funded the development and implementation of MH101® since 2009.

MH101® learning outcomes include:

- using Te Whare Tapa Whā[1] to support mental wellbeing
- recognising signs of good mental health and of mental health challenges
- relating to what people with mental health challenges are experiencing and
- responding supportively to people experiencing mental distress.

Aims and objectives

The aim of the evaluation is to identify the impact of MH101® over the period from the beginning of 2020 to mid-2022. Blueprint for Learning seeks to understand to what extent people attending a workshop have maintained and used any increased confidence and knowledge around the learning outcomes, and any reduction in stigma and discrimination because of attending the workshop.

Method

A mixed methods impact evaluation approach was adopted to gather workshop participants' feedback on their knowledge, confidence and ability to provide support for people experiencing mental health and addiction challenges three to six months after taking part in the training. Participants had completed MH101® between 2020 and 2022. Data collection involved a follow up survey (393 participants, response rate 14 percent) and six focus group discussions (23 participants).

[1] Te Whare Tapa Whā represents the four cornerstones (or sides) of Māori health and wellbeing, including: Taha tinana (physical health), Taha wairua (spiritual health), Taha whānau (family health) and Taha hinengaro (mental health). This model was developed in 1982 by Mason Durie following a hui of Māori health workers at the time, to challenge a Western biomedical view of health as primarily focussed on the physical dimension (Rochford, 2004).

Key findings

Evidence of the impact of MH101® was positive, showing that most participants retained their knowledge and confidence around each of the learning outcomes three to six months after they had attended a workshop. Most participants were still using their learning to actively support their own and others' wellbeing and felt that doing so was making a positive difference. Focus group discussions illustrated how MH101® can create sustainable behaviour change, from small shifts in self-care and communication style to supportive referral to mental health services, that promote individual, whānau and community wellbeing.

Almost three quarters of learners have had a meaningful conversation with someone they were concerned about. Most of these learners had received a positive response and over two in five have had conversations about suicide. Hearing facilitators' personal experiences of mental health challenges in a safe and discussion-based learning environment contributed highly to this outcome. Learners who had visible mental health support options and policies available in their workplace were more likely to have these conversations earlier.

Māori and Pasifika learners reported a significantly greater drop in confidence ratings at follow up than other ethnic groups around: maintaining mental wellbeing, knowing a range of ways to support someone, and supporting someone in mental distress. These learners were also more likely to be supporting friends and whānau experiencing high levels of distress around suicide, psychosis, and addiction. Given small sample sizes these findings are indicative only. Māori and Pasifika learners also experienced unique factors that affected the translation of their MH101® learning into practice, including additional layers of stigma within Māori and Pasifika communities regarding mental health challenges.

While most aspects of workshop design, content and delivery were rated highly, more than half of learners had not completed the optional e-learning module, and most wanted more follow up support.

Conclusion

The programme is well positioned to enable the vision outlined in Kia Manawanui Aotearoa for New Zealanders having better understanding of mental wellbeing, being able to support themselves and each other, and to get help in the places they already visit (Ministry of Health, 2021). The impact of MH101® could be increased by providing additional support for Māori and Pasifika learners, exploring additional avenues for follow up support and advocating for good workplace mental health promotion policy and practice.

Recommendations

Key recommendations for Blueprint from this impact evaluation are to:

- use targeted recruitment strategies and oversampling in future evaluation to improve engagement with priority groups, including Māori and Pasifika learners, rainbow communities, people living in rural communities and men
- include measurement of stigma and change in future evaluation
- consider how MH101® could be developed to offer additional support for Māori and Pasifika learners
- scope redevelopment options for follow up to support learners to put their learning into practice
- consider how MH101® could complement initiatives aimed at managers and leaders such as Leading Wellbeing at Work by encouraging critical reflection on the ways that our environment, including our workplace, shapes wellbeing.

Background

Community knowledge of mental distress and illness, addiction and suicidal behaviours is often limited. Lack of knowledge and confidence contributes to stigmatising attitudes and limits the support that people might otherwise provide or receive. Mental health literacy has been defined as “knowledge and beliefs about mental disorders which aid their recognition, management or prevention” (Jorm et al., 1997, p. 184). Increasing mental health and addiction literacy can assist communities to support people experiencing mental distress, through appropriate interventions and referrals to early intervention, treatment, and recovery services (Jorm, 2000, 2012; ten Have et al., 2010). Using methods that counter stigma and discrimination can result in:

- greater recognition of mental health problems
- increased help-seeking and
- increased support and inclusion of people who experience mental distress (Lien et al., 2021; McBride, 2015).

Mental Health 101 (MH101®)

MH101® is a mental health and addiction literacy programme developed and provided by Blueprint for Learning. It was developed to increase knowledge about mental health, mental illness, addiction, gambling harm and suicide prevention and to counter stigma and discrimination associated with mental illness in New Zealand. MH101® workshops aim to give participants greater confidence to **recognise** mental illness or distress; **relate** better to those experiencing mental illness or distress and **respond** in an appropriate way by providing practical tools and ideas. The programme has a dual focus on maintaining personal wellbeing and supporting others.

MH101® targets community members who are: 18 years and older, likely to have contact with people experiencing mental distress and well-placed to respond in their day-to-day work or lives. Target groups include government, non-government and private organisations involved in wellbeing mahi in a broad sense, encompassing health, education, community work and social welfare. MH101® also aims to reach communities and groups who are prioritised in relation to mental health and wellbeing equity and suicide prevention. These groups include Māori and Pasifika people, rainbow communities, people living in rural communities and men.

MH101® learning outcomes include:

- using Te Whare Tapa Whā[2] to support mental wellbeing

[2] Te Whare Tapa Whā represents the four cornerstones (or sides) of Māori health and wellbeing, including: Taha tinana (physical health), Taha wairua (spiritual health), Taha whānau (family health) and Taha hinengaro (mental health). This model was developed in 1982 by Mason Durie following a hui of Māori health workers at the time, to challenge a Western biomedical view of health as primarily focussed on the physical dimension (Rochford, 2004).

- recognising signs of good mental health and of mental health challenges
- relating to what people with mental health challenges are experiencing
- responding supportively to people experiencing mental distress.

Engagement with people who have firsthand experience is an effective means of increasing empathy and addressing prejudice, stigma and discrimination (Dovidio et al., 2017; Lien et al., 2021; McBride, 2015). A unique aspect of the MH101® programme is the use of a co-facilitation model (Postelnik et al., 2022). This involves workshop facilitation by a person with lived experience of mental health or addiction challenges in partnership with a facilitator with clinical experience in mental health services. Facilitators talk about their experiences and link them to the learning outcomes during the workshop. MH101® facilitates contact with lived experiences as a key method for supporting MH101® attendees to better relate to friends, whānau, clients, and colleagues who experience mental health issues.

MH101® workshop format and delivery draws on other evidence-based adult education principles, prioritising: active interaction, practice and roleplaying, storytelling and responding to feedback (Salas et al., 2012; Te Pou, 2019). A variety of activities, videos and teaching tools cater for different learning styles of participants, i.e., visual, auditory, and kinaesthetic (movement based). Questions stimulate reflection and thinking about the topic rather than information being presented lecture-style. MH101® was delivered as a one-day face-to-face training until April 2020. Delivery mechanisms shifted during COVID-19, and the programme was adapted to be delivered over three days in two-hour online workshop sessions. MH101® online workshops provide the same content and engagement with lived experience and adult learning principles adapted for the online environment. MH101® now provides learners with both online and in-person workshop options.

Te Whatu Ora – Health New Zealand, formerly the Ministry of Health, has funded the development and implementation of MH101® since 2009. During the evaluation period, MH101® was funded to provide a minimum of 120 MH101® workshops, and a maximum of 3,000 people to access MH101® training per year. Participant numbers are limited to five per organisation per funded workshop. MH101® is also available for purchase on a cost neutral basis.

Previous MH101® evaluation

Post-workshop evaluation is carried out routinely after each workshop delivered (see Appendix A). Every learner who completes a workshop is invited to rate their knowledge and confidence around each of the learning outcomes before and after the training[3], and other

[3] We increase our ability to measure change by asking participants to gauge their confidence and knowledge level both pre- and post-workshop in the same post-workshop survey. This enables comparison of the average change across the same set of participants and avoids the complications that occur when those answering a pre-

key factors related to their experience of workshop, content, and delivery. These results are reviewed by the programme team weekly, summarised every six months, and used internally to inform programme planning.

Previous impact evaluation of MH101® involved 475 participants (19 percent Māori, 13 percent Pasifika, 65 percent New Zealand European) who responded to a follow up survey three to six months after they had attended a workshop (Malatest International, 2020). Similar impact evaluation was also conducted in 2016. Both impact evaluations showed substantial increases in knowledge and confidence following the workshop, which were largely sustained three to six-months later. Key findings were that the MH101® workshops:

- were very positively received by participants,
- increased participants' awareness and confidence in recognising and responding to mental health issues,
- made a difference to how participants responded to mental health issues in their workplaces,
- made a difference to participants' personal lives through improved self-care and the support they provided to friends and whānau, and
- benefitted participants from all ethnic groups equally.

Suggestions for improvement included providing follow up and additional sessions to maintain confidence and knowledge. Following the evaluation, a wallet-sized 'backpocket resource' was developed for workshop participants to immediately take away from training, allowing ongoing easy access to quick content reminders. This resource was translated into te reo Māori, Samoan and Tongan, and into simplified Chinese, traditional Chinese, Filipino, Hindi and Punjabi in collaboration with Asian Family Services. A follow up e-learning module was also developed and began to be delivered to learners in 2021. The e-learning is positioned as a complement to the workshop, providing an opportunity to reengage with key content as well as access to new videos, downloadable worksheets, and additional resources.

Online MH101® delivery has proven popular and routine evaluation results and monitoring consistently demonstrates that online learners' self-rated confidence and understanding against the programme learning outcomes are comparable to results from in-person learners. Exploration of post-workshop evaluation data from 762 MH101 participants who completed the programme in 2019 showed high satisfaction with the co-facilitation model (Postelnik et al., 2022). The personal stories shared by facilitators were perceived as bringing the workshop content to life and providing important insights into people's experiences and well-being journey.

workshop question about confidence level may not be the same people answering a post-workshop question (see Sufi et al., 2018).

Aims and objectives

The aim of the current evaluation is to identify and explore the impact of MH101® between January 2020 and June 2022. Blueprint for Learning seeks to understand to what extent people attending a workshop (learners) have maintained and used any increased confidence and knowledge around personal wellbeing and supporting others experiencing mental health and addiction challenges, including any reduction in stigma or discrimination linked to attending the workshop.

Key evaluation questions

1. To what extent have MH101® attendees (including learners from priority groups) utilised their learnings, e.g., changed their behaviours, from attending the MH101® workshop?
    a. How well have attendees maintained their increased knowledge and confidence in relation to their learning?
    b. In what ways, if any, have attendees applied their learnings, e.g., changed their behaviours, from MH101®?
        i. How have workplace implementation factors affected attendees' ability to apply their learnings?
    c. To what degree does the delivery of MH101® affect attendees' motivation and ability to utilise their learnings, e.g., changed their behaviours?
        i. How did the workshop facilitation affect attendees' motivation and ability to learn?
        ii. How well were adult learning principles integrated into workshop delivery?
2. To what extent has applying their MH101® learnings reduced attendees' stigma and discrimination?
    a. How much has attendees' measured stigma and discrimination reduced?
    b. How does the facilitators' use of storytelling add value to attendees' awareness of their own stigma and discrimination?
    c. How has experiencing the dynamic of co-facilitation affected attendees' response to people experiencing mental distress?

Evaluation approach

A mixed methods impact evaluation approach was adopted. Learners' feedback was gathered on their knowledge and confidence in relation to learning outcomes three to six-months after taking part in MH101® training. This included their ability to maintain their own wellbeing and provide support for people experiencing mental health and addiction challenges.

Data sources, data collection and analysis

Surveys

All learners who attended a MH101® workshop between 2020 and 2022 and completed a post-workshop survey[4] (refer Appendix A) were invited to complete the MH101® follow up survey (see Appendix B) three to six months after their training[5]. The response rate for the follow up survey was 14 percent and a total of 393 participants took part.

The MH101® follow up survey included some repeated measures derived from the post-workshop survey and new content relevant to the evaluation questions. This included: self-assessment (rating) of knowledge and confidence in recognising and responding to mental health challenges, attitudes and beliefs around mental health, and action taken to support personal wellbeing and respond to people in distress. Participants were asked open ended questions around their experiences putting their learning into practice, and the usefulness of resources provided. The survey also sought feedback on workshop design and delivery including format, content, resources and follow up.

The responses between the post-workshop and follow up surveys were matched using participant email addresses. Survey data were summarised using descriptive tables and charts, crossed by key interest groups and variables relevant to the evaluation questions. Individuals' self-rated confidence and understanding against the learning outcomes were analysed in Excel, where the differences between means were tested using Cohen's d to identify how well respondents maintained their confidence and understanding six months after the workshop (Cohen, 1988). Where the difference between two groups' means is less than 0.2 standard deviations, the difference is considered negligible, even if it is statistically significant. A Cohen's d of 0.2 is considered a small effect size, 0.5 is considered a medium effect size and 0.8 or above is considered a large effect size. Open-ended questions were coded and analysed in relation to the evaluation questions using a qualitative descriptive method (Sandelowski, 2000), supported by MAXQDA software.

Focus groups

All learners who completed the MH101® follow up survey were asked if they would like to participate in a focus group to explore their experience of MH101® in more depth. Those who were interested (500 participants) were contacted by e-mail and invited to join one of three general focus groups held at given times. Eleven learners took part in these general focus groups. A further three focus groups (12 participants) were held with a range of staff recruited via email from one government social support agency, to explore contextual factors influencing uptake and impact of MH101® in an organisational setting.

[4] A total of 2,896 learners completed a post-workshop survey over the evaluation period.
[5] Attendees at both Te Whatu Ora funded and paid workshops were included.

Focus groups were mainly facilitated by a contractor external to Te Pou and Blueprint. A copy of the focus group Participant Information Sheet and Consent Form is provided in Appendix C. The focus group topic guide is provided in Appendix D. Focus group data were analysed descriptively in relation to the evaluation questions (Sandelowski, 2000), using MAXQDA software.

Results

Participant profiles

This section describes the MH101® learners who took part in the follow up survey (393 respondents).

Follow up survey participants

Survey participants were mostly women (84 percent), of New Zealand European heritage (70 percent) and aged between 25 and 64 years (88 percent), see Table 1. Some participants identified as Māori (18 percent) and fewer as Pasifika (5 percent). MH101® learners of Māori and Pasifika heritage were underrepresented in the follow up survey.[6] Survey participants were proportionately representative of MH101® learners by gender, age, workplace type, and access mode (online, in-person).

Table 1. Survey participant characteristics

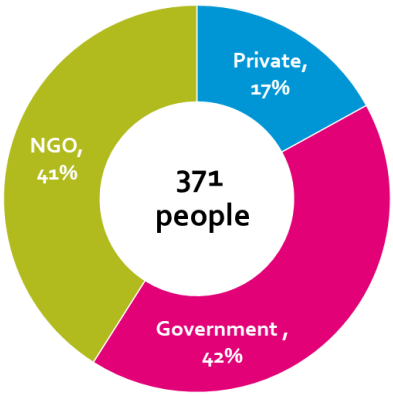
Characteristics of participants (393 total participants)	Number (%) of participants
Gender	
Female/Wahine	330 (84.0%)
Male/Tāne	57 (14.5%)
Gender diverse/Non-binary	6 (1.5%)
Age	
Under 25 years	27 (6.9%)
25 to 44	167 (42.5%)
45 to 64	178 (45.3%)
65 and over	21 (5.3%)
Ethnic background	(Multiple responses allowed)
Māori	69 (17.6%)
Pasifika	21 (5.3%)
Asian	33 (8.4%)
New Zealand European/Pākehā	276 (70.2%)
Other ethnicity	46 (11.7%)

Workplace type

There was equal representation of participants who worked within government and non-government organisations (NGOs, 42 percent, and 41 percent respectively), and a smaller proportion worked in private companies (17 percent), see Figure 1. Across the sample of learners, education (26 percent) and health (20 percent) sectors were the most represented, followed by social services and welfare (18 percent).

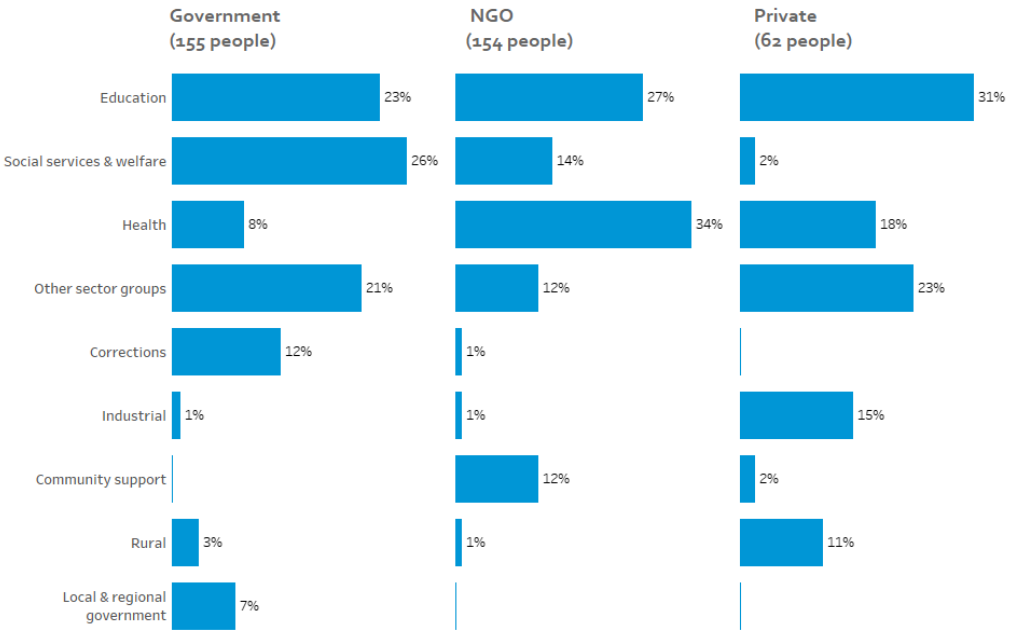
[6] Registration data from the evaluation period suggests that around 25 percent of learners identified as Māori and around 10 percent as Pasifika.

Figure 1. Organisation type



A range of sector groups were represented within each of the organisation types (Figure 2). Government organisations tended to be engaged in social services and welfare (26 percent), education (24 percent) or corrections (12 percent) mahi. NGOs were largely based in the health (34 percent), or education (27 percent) sectors, followed by social services (14 percent) and community support (12 percent). Private organisations tended to be based in the education sector (31 percent), a range of other sector groups (23 percent), or health (18 percent).

Figure 2. Organisation types by sector group*

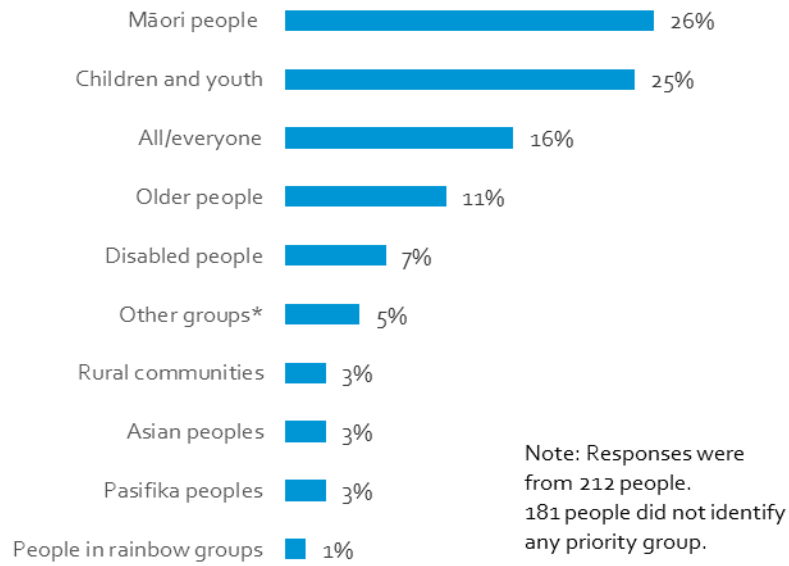


*Other sector groups included: government (non-specified), conservation, justice, defence and military, employment support, science and research, disability, sport, youth, rainbow, tourism, admin, retired people, and other unspecified groups.

Priority groups served at work

About half of participants (54 percent) worked in an organisation designed to serve at least one specific community within their sector (Figure 3). A quarter of participants indicated that they work directly with Māori and a quarter with children and youth.

Figure 3. Priority groups served at work (393 people)



*Responses to Other included: Melting pot of people, anyone needing support, refugees and migrants, anyone except rainbow groups, people with illness/unwell, and not that I 'm aware of.

Work with Māori people tended to be based in the health (16 learners), social services (14 learners) or corrections (10 learners) settings. Only two learners identified that they mainly work with Pasifika peoples, through their community support mahi. Rural communities were served by learners (5 people) working in the education, health and rural sectors.

In-person or online access

About half of learners had attended MH101® training in 2021 (49 percent, see Table 2). A slightly larger proportion had attended in-person workshops (55 percent) than online (45 percent) over the evaluation period.

Table 2. Year attended MH101® by mode of delivery

Year attended MH101®	In-person	Online	Total
2020	65 (30.2%)	54 (30.3%)	119 (30.3%)
2021	98 (45.6%)	95 (53.4%)	193 (49.1%)
2022*	52 (24.2%)	29 (16.3%)	81 (20.6%)
Total	**215 (100%)**	**178 (100%)**	**393 (100%)**

*Follow up recruitment took place for the first half of 2022 only.

Significance testing (Cohen's d) showed small or negligible difference between in-person and online workshop participants' confidence in recognising and responding to people experiencing mental health challenges or their engagement in meaningful conversations at follow up (see Appendix E). Results for in-person and online workshop learners are therefore analysed together in the following sections.

Focus group participants

Twenty-three participants took part in six focus group discussions, guided by the evaluation questions. Most focus group participants were women (four participants were men), and approximately half were employed in government and half in non-government organisations. Two participants worked in private or corporate businesses. Most participants were engaged in the health or social services sectors. Five participants worked in education.

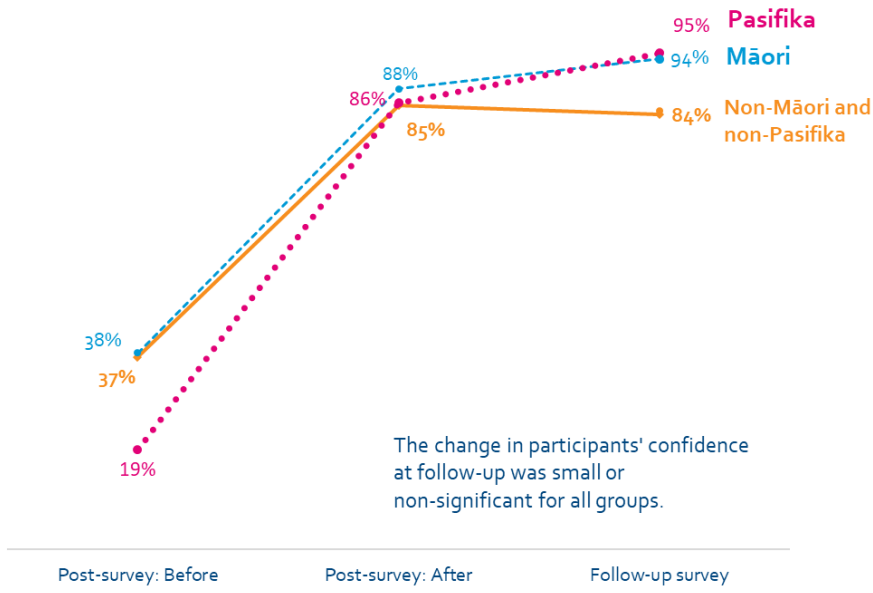
Knowledge and confidence in recognising and responding to mental health challenges

This section describes how well participants maintained any increased knowledge and confidence in understanding, supporting, and relating to the experiences of people with mental health and addiction challenges.

Confidence in recognising and responding to mental health challenges was sustained

Self-ratings of confidence in recognising and responding to mental health challenges were similar, on average, between the post-workshop and follow up survey, indicating that confidence had been sustained (Figure 4). This was true for Māori (69 people) and Pasifika (21 people) learners as well as non-Māori and non-Pasifika participants (304 learners).

Figure 4. Percent confident in recognising and responding to mental health challenges by ethnicity



A focus group participant working in social services discussed how recognising their own signs of mental health and wellbeing had benefitted them both personally, and as a leader at work.

> "What we have walked away with [from MH101®] is awesome. I can have a look at what my signs are: Do I feel like I'm going to hit rock bottom? Or do I need a bit more support? It helps me individually, but also kind of realise what the limits [might be] for others in the workplace."

Another participant described how self-recognition enabled and enhanced their support work with others.

> "In work related settings, it's just letting them know that 'it's okay not to be okay'. I wanted to let clients know that we're here to help… But I think the hard part is not offering that to other people, it's realising what is needed for myself. Sometimes it's hard for me to admit that I'm not okay. And that actually affects my work."

When asked to detail how attending the workshop impacted their ability to support others, most survey participants mentioned the workshop increased their confidence or understanding around mental distress and how to respond to it.

> "The workshop gave me the ability to be able to recognise when someone was having difficulties and the confidence to approach the person and have the conversation. I feel more able to be more forthright about asking people if they have

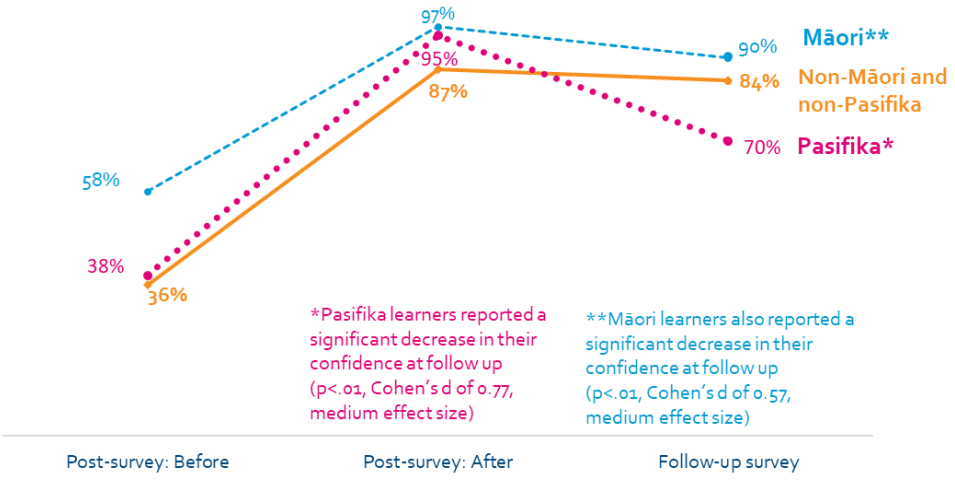
a problem and if they would like to talk about it or ask how [I can] help them to fix things."

"It has helped me become more aware of signs, also be more confident to have those conversations. Has also helped my own well-being. Thank you."

Confidence in knowing a range of strategies to maintain wellbeing reduced for Māori and Pasifika learners

Confidence in knowing a range of strategies to maintain wellbeing was similar, on average, between the post-workshop survey and six-month follow up. However, while confidence was sustained for non-Māori and non-Pasifika participants, this was not the case for Māori and Pasifika participants, whose ratings showed a significant decrease in confidence since completing the training, see Figure 5.

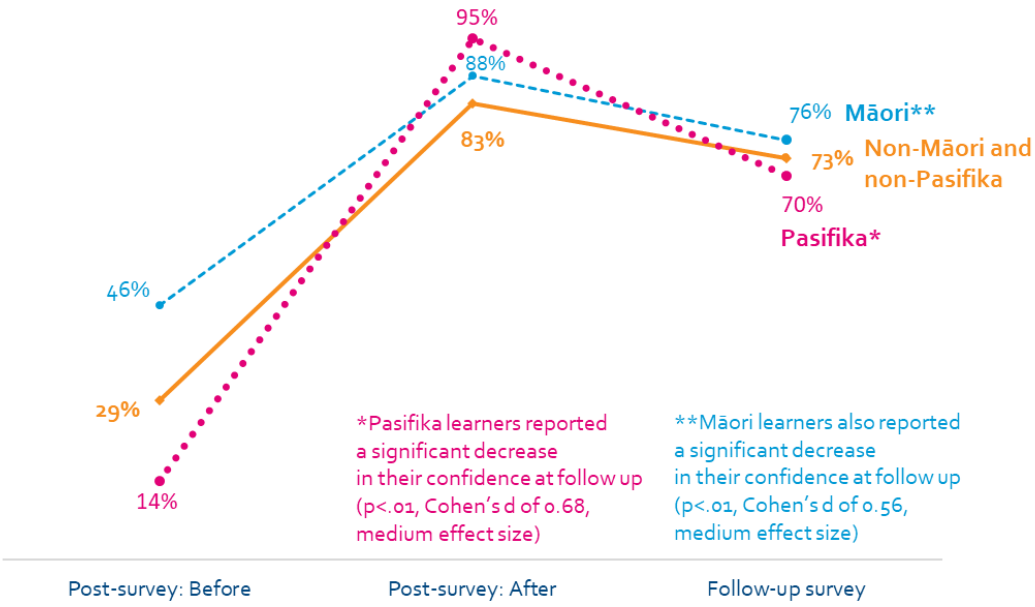
Figure 5. Percent confident in knowing a range of strategies to maintain wellbeing by ethnicity



Confidence in knowing a range of ways to support someone reduced for Māori and Pasifika learners

Confidence in knowing a range of ways to support someone who experiences mental health challenges was largely sustained overall. On average, Māori and Pasifika learners were more confident than non-Māori and non-Pasifika post-workshop. However, Māori and Pasifika learners reported a significant decrease in their confidence at follow up, see Figure 6.

Figure 6. Confidence in knowing a range of ways to support someone with mental health challenges over time by ethnicity

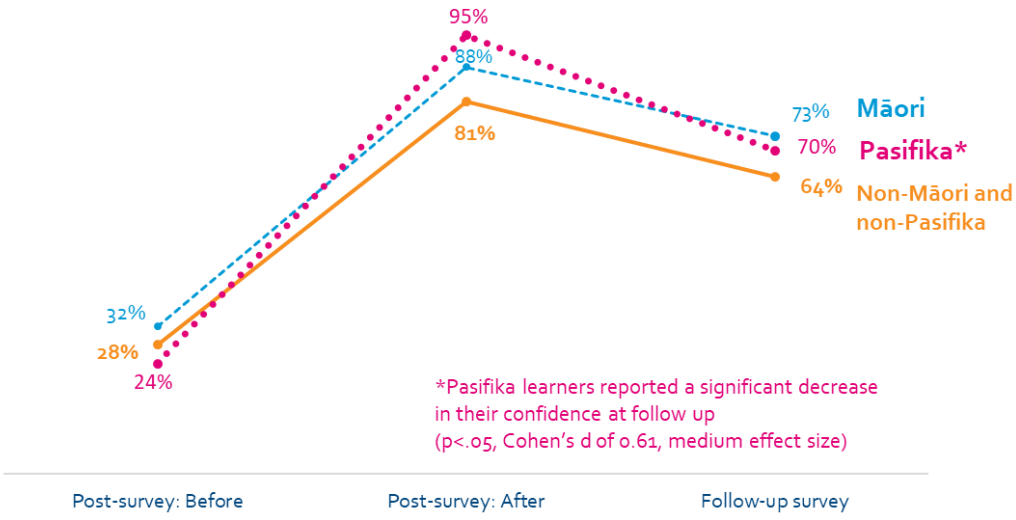


Confidence in knowing a range of ways to support someone in heightened distress was maintained for all except for Pasifika learners

Similarly, confidence in knowing a range of ways to support someone in heightened distress was maintained on average. Though Pasifika learners rated their confidence highly after the workshop, they reported a greater decrease in confidence at follow up, ($p<.05$, Cohen's *d* of 0.61, medium effect size[7]).

[7] Full tables for significant testing appear in Appendix F: Supporting people experiencing mental health challenges.

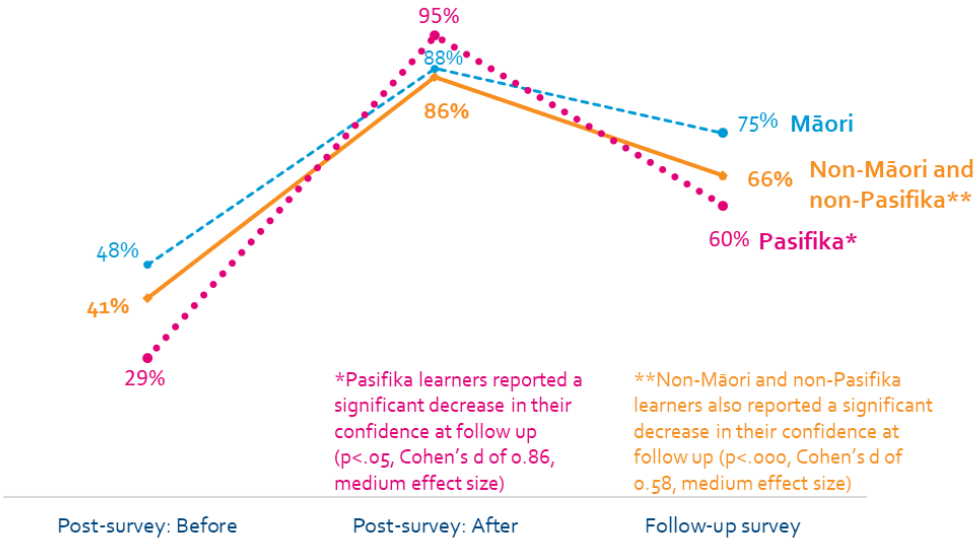
Figure 7. Confidence in knowing a range of ways to support someone in heightened distress over time by ethnicity



Confidence in knowing when to suggest mental health support options to others was sustained for Māori learners but not other groups

Learners maintained a high level of confidence in knowing a range of mental health support options and knowing how to contact appropriate mental health professionals (67 percent and 75 percent confident or very confident at follow up) regardless of ethnicity. However, confidence in when to suggest these options to others was significantly reduced for Pasifika and non-Māori and non-Pasifika learners (Figure 8).

Figure 8. Confidence in knowing when to suggest mental health support options to others over time by ethnicity



Confidence was low around suicidality

Confidence in having a courageous conversation with someone, was largely sustained at follow up (73 percent confident or very confident, compared to 28% before MH101®), with no significant differences by ethnicity. The same was true for 'supporting someone who may be suicidal', but at a much lower rate (51 percent confident or very confident at follow up, compared to 23% before MH101®).

The complexity of building and sustaining confidence around supporting someone who may be suicidal was described by several focus group participants. One focus group participant described how their confidence in talking with people about mental health and suicide was limited by ongoing uncertainty around timing.

> "[I do lack confidence in applying my learning] because I'm not very good at pinpointing, for example, if somebody's not in a good mood, or the best frame and timing in terms of approaching people... So those things sometimes hold me back in approaching someone."

Another focus group participant described struggling on a work call with someone who was experiencing thoughts of suicide, and wishing they could do more in their role including follow up with the client.

> "When dealing with a suicidal caller there was a lot of reservations in my confidence that left me with an overwhelming feeling that I might have made things worse for them because I didn't do it right. Much of what we do is provide information [about support available] that ultimately leaves the work of getting that support up to someone that is already in a place of stress and pain. That they now have to go and do more on a plate that already seems so full for them. It leaves me with a feeling of we could do more."

Several other participants mentioned that a lack of momentum or opportunity to put their learning into practice had contributed to a decrease in their confidence. This was particularly true for some at work.

> "[MH101®] has allowed me some additional tools I did not have before, but it has not been enough to feel happy and confident that I can address all areas... as some of the topics addressed were fairly new to me. I would benefit from repetition on this subject and additional tools to allow me to retain the skills to address more areas of mental health.
>
> For example, I have more confidence with friends, colleagues, and acquaintances but not whole heartedly with clients. Building rapport with someone and taking the time to sit and listen to these aspects of their lives is key to feeling able to give this

> kind of support. [MH101®] is a helpful start but I feel we need follow up seminars to further practice and cement these skills. We still need more knowledge and to have a platform to discuss our improvements in our knowledge and practice with observations from our own experiences after this course."

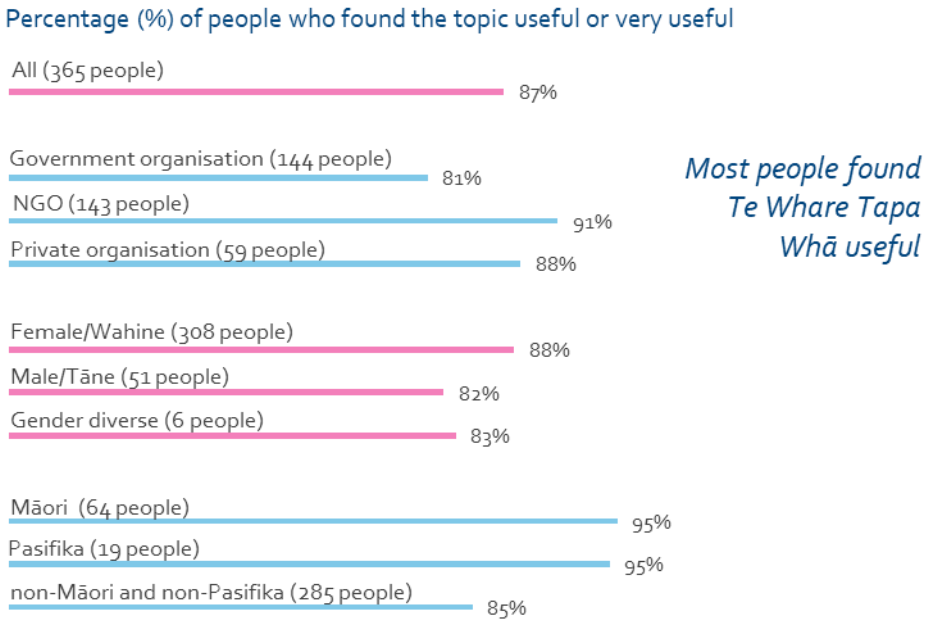
This learner identified that additional support, such as involvement in further discussion with others about practical implementation of learning, would be necessary to sustain their confidence around responding to suicidality at work.

Action and behaviour change

Engagement with Te Whare Tapa Whā enhanced mental health literacy

Survey feedback suggested that Te Whare Tapa Whā provided a helpful model to explore mental health and wellbeing values, concepts, and practices (Figure 9). Overall, most participants found the topic useful or very useful (87 percent). This was even more true for participants working in NGOs (91 percent), and Māori and Pasifika participants (95 percent each).

Figure 9. Usefulness of Te Whare Tapa Whā



Several focus group participants found that Te Whare Tapa Whā provided a foundation and shared understanding to start conversations at work and with friends and whānau about mental health. For example, one participant talked how attending MH101® encouraged them to incorporate Te Whare Tapa Whā into their work. The respondent described how Te Whare Tapa Whā was easily adopted by their students and is a useful model to facilitate discussions about their wellbeing.

> "[MH101®] reignited the Te Whare Tapa Whā in my background, it's always been there but you tend to go off track a little bit and I had to come back to that. Because in my daily practice [looking after] pastoral needs for our students we need to make sure their houses are firm. And that's how I explain it to our young people 'If one of the walls is crooked, your house is crooked. So we have to make sure that they're all even and strong so they hold the roof' And it's really quite unique because our young people they grasp that concept… I've taken that that lesson and embedded it with them now. So even though we can have a laugh [about their 'walls'], but if one of them are coming in and looking a little bit down on the day, and they say 'My walls are a bit shaky today' and I'm like, 'Okay, let's make some time today and we'll sit down and we'll talk about what's going on with these walls and how we can fix it'."

The open discussion and joking about their 'walls' from the students and participants demonstrate how Te Whare Tapa Whā can reduce some of the stigma around talking about mental wellbeing.

When asked what the primary takeaway from MH101® was, one focus group participant described how Te Whare Tapa Whā encouraged her to focus on her own wellbeing to support those around her.

> "Te Whare Tapa Whā [was helpful] because I'd never heard the concept before… to realise I had to get myself in order to be able to move on to be able to help my friend, to be able to help anybody else… And that made a huge difference. Getting myself back to myself and feeling alive again."

Another focus group participant told the story of how they are using Te Whare Tapa Whā together with the concept of 'lenses and filters'[8] to support their child's recovery from addiction.

> "I have a [child] who's in the midst of addiction. [They've] been in and out of prison just recently, following on from actions through [their] addiction. Being his mum, I needed to use the lenses process to take myself out of mum role and put myself in the role of a friend, of somebody that understands addiction. I myself am a recovering addict. There was a lot of blame on myself as a mum, there was a lot of looking at myself thinking 'if you hadn't done this this wouldn't be the result'.

[8] How we respond and behave is shaped by how we view the world and how we are doing in ourselves at the time. Understanding one's own and others' lenses and filters can improve communication and foster empathy.

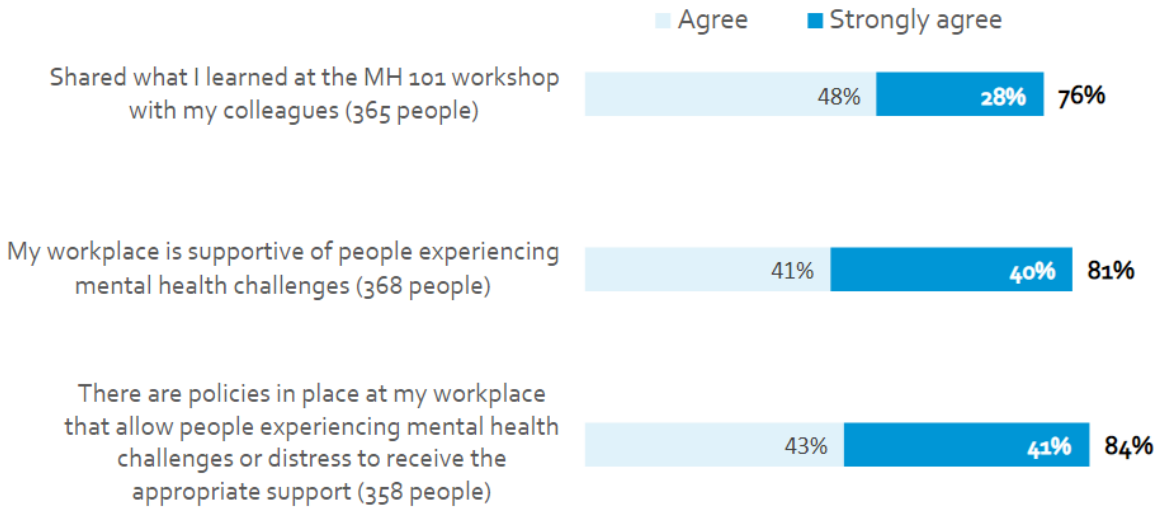
> Once I dealt with that then I was able to put myself in a better position to support [them]. It's a daily process you know, but my encouraging words are always to continue your programs to keep liaising with your support networks. [They] often ring me and I say 'I'm not the right person for this job'. I just have to be your mum in this role, and we have to let the professionals help and take over.'
>
> We use Te Whare Tapa Whā together a lot. And we use that for [their] own understanding of [their] well-being and make sure that he understands that all parts of that need to be well balanced for him to be able to recover well. By doing that we're putting ourselves in a good position in preparation for relapse and making sure that [they are] well supported throughout that process. MH101® has helped me through that."

MH101® had provided this whānau with a language and strategy to talk about addiction, wellbeing, and prepare to manage relapse as a part of recovery.

Most learners had used MH101® at work and in everyday life

Most participants had found their MH101® learning useful both at work (83 percent) and in their personal lives (84 percent). Most participants felt able to share what they learned in MH101® with their colleagues (76 percent), that their workplace was supportive of people experiencing mental health challenges (81 percent) and had policy in place to enable this (84 percent), see Figure 10.

Figure 10. Mental health promoting workplace culture and support available to participants



Most learners felt they had some support or policy in place in their workplace (88 percent). Forty-four participants identified an absence of support at their workplaces in social services and welfare (10 participants), education (9 participants), health (8 participants), corrections

(5 participants) and other settings[9] (12 participants). We explore participants' ability to use what they had learned to promote mental health and respond supportively by the presence or absence of workplace support factors in the following sections.

Staff from one government social support agency described how MH101® had led to improved workplace culture and support around mental health and wellbeing. Mental health check-ins had become more frequent among their team.

> "So, with our teams that we generally do the mental health check, 1 to 10, how you're feeling each day and whatnot. And that just gives everyone an opportunity to check-in with everyone and just make sure that 'yeah everything's good'. I know we had been doing that previously, but not on a regular basis. As we became more aware through these workshops, we're doing it regularly."

The respondent linked this shift to a high level of staff engagement across their organisation.

Most learners were taking action to promote good mental health

Most learners said they were taking action to promote good mental health because of taking part in MH101® training. This was particularly true for Māori, over 90 percent of whom said they were: 'doing more things to keep mentally well', 'suggesting self-help strategies to others' and feeling 'more confident talking about mental health challenges' (Table 3).

Table 3. Action to promote good mental health by ethnicity

Action	Māori % agree (63 people)	Pasifika % agree (19 people)	non-Māori and non-Pasifika % agree (289 people)
I am doing more things to keep myself mentally well	90%	89%	73%
I am suggesting self-help strategies to others more often	97%	68%	75%
I am more confident talking about mental health challenges	97%	100%	86%

Having support at work was associated with talking about mental health and early intervention to support people in distress

Learners' confidence to talk about mental health challenges was significantly associated with having workplace support around mental health available (p<0.001, 91 percent of learners with support felt confident, compared with 72 percent without workplace support). There also appeared to be a relationship between having support in place at work and responding supportively to people experiencing mental distress (Table 4). Those who had support at

[9] Other settings included: community support and work in the rural, disability, sports, and tourism sectors.

work were more likely to have ‘intervened at an early stage to encourage people to seek help’ (72 percent, compared to 49 percent of those without support at work).

Table 4. Responding supportively to people experiencing mental distress by workplace mental health support

	% agree/strongly agree		p-value
	No support identified at work	Support at work	
I have intervened more at an early stage to encourage people to seek help for their mental distress before it got more serious	49% (39 people)	72% (296 people)	p< .01
I am providing more support around mental health challenges to people I interact with at work	58% (43 people)	71% (309 people)	p< .01
I am providing more support around mental health challenges to friends and family	72% (43 people)	80% (316 people)	Not significant (p=.208)
I have made more effective use of referrals to professional help options	31% (39 people)	62% (274 people)	p< .001
I have intervened when someone has been having suicidal thoughts	34% (29 people)	46% (241 people)	Not significant (p=.236)

Note: Statistical p-values were based on Chi-square test of association.

Learners who had workplace support were also more likely to be ‘providing support around mental health to others at work’ (71 percent, compared to 58 percent) and to have ‘made effective referrals to professional help options’ (62 percent compared to 31 percent). Support at work was not related to ‘providing more support to family and friends’, or ‘intervening with someone has been having suicidal thoughts’.

Focus group participants described how the workshop prompted personal reflections about their mental wellbeing and how this could be promoted by supportive workplace policies.

> “[My own mental health] can often get shelved, you soldier on with your life and everything that's going on in it… at the workshop I stopped and did a wee stocktake of my own life and went ‘Wow. Yeah, there are areas of my own life where I'm not doing so great’. I haven't thought about those areas in a long time.”

> “A little thing that made a big difference to me was being able to go to my boss and say, ‘Look, I'm not okay, I need a duvet day, I just need time out’… and my boss was amazing. She was like, ‘Absolutely, you've got to do it, mental health has got to come first’… But my gosh I needed it, and I was so glad I did it. I've never done a duvet day or take a sad day or anything before but I needed it.”

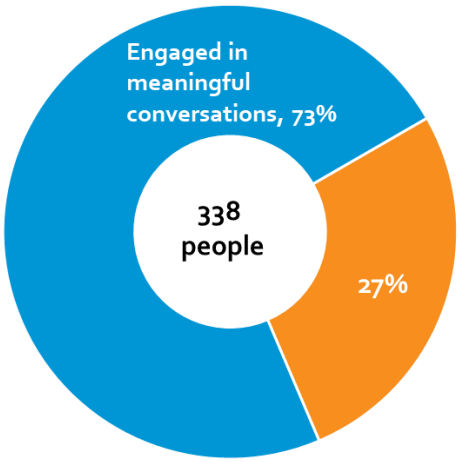
A focus group participant described how attending MH101® in combination with visible workplace policy and support had enabled her to ask her colleague about suicide:

> "In a one-on-one meeting [at work], someone was talking about suicide. And I came out and said: "Are you thinking of harming yourself in any way? You can tell me, and I will help". It was knowing we've got EAP and a counsellor as well. And I think just going to MH101® gave me that confidence to just come out and say something that I wouldn't have before. To see it like: what's the worst that can happen? And in the end, she was OK. But I felt better after asking it [directly]. That's been a huge learning for me."

Three in four learners had a meaningful conversation with someone they were concerned about

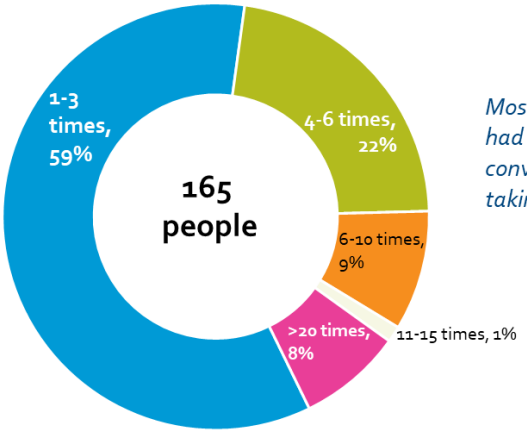
Almost three-quarters of participants said they had used their MH101® learning to engage in a meaningful conversation about mental health with someone they were concerned about (Figure 11). This proportion was broadly similar regardless of their gender, workplace type, level of support at work or ethnic background.

Figure 11. Percentage of participants who engaged in a meaningful conversation



Most participants had had 1-3 meaningful conversations since taking MH101® but some had had more than 4 (Figure 12). The number of conversations did not differ markedly by ethnicity, gender, or level of workplace support.

Figure 12. Number of times a conversation was initiated since the MH101® workshop



Most participants had 1-3 meaningful conversations since taking MH101® .

Over two in five learners who had meaningful conversations had talked about suicide.

Key concerns that prompted learners to engage in meaningful conversations were signs of anxiety (81 percent) and depression (82 percent) in others (Table 5). Over two in five (43 percent) of learners who had meaningful conversations had talked about suicide. Māori learners seemed more likely to identify having meaningful conversations about signs of substance abuse, and Pasifika learners about psychosis; however, the sample sizes are small and these findings are indicative only. There were no noticeable differences by gender and workplace support.

Table 5. Specific mental health issues that prompted meaningful conversations by ethnicity

	All (247 people)	Māori (44 people)	Pasifika (14 people)	non-Māori and non-Pasifika (192 people)
Signs of anxiety	81%	80%	93%	81%
Signs of depression	82%	82%	86%	82%
Psychosis	13%	16%	29%	12%
Signs of substance abuse	29%	45%	29%	26%
Signs of thinking about suicide	43%	57%	50%	40%
Other*	14%	27%	14%	11%

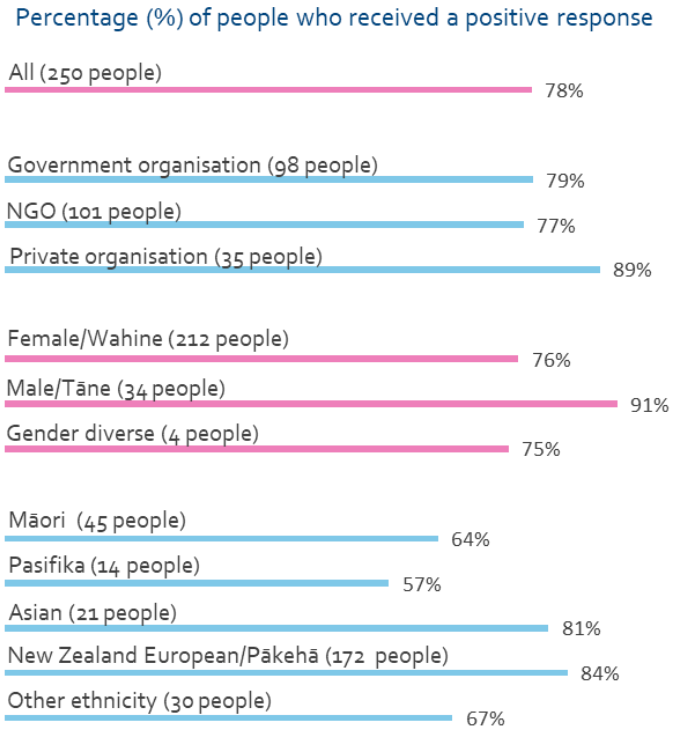
Note: Learners could make multiple responses.

*Other responses included disordered eating, burnout or stress related to work, bullying, divorce, COVID and other health issues such as cancer

Most learners who had a meaningful conversation received a positive response

Most participants had received a positive response when they initiated a conversation about mental health (78 percent), see Figure 13. This did not differ markedly by workplace type (i.e., NGO, government, or private organisation). A lower proportion of Māori (64 percent) and Pasifika (57 percent) participants reported experiencing a positive response. Almost all men (91 percent) who said they had engaged in a conversation experienced a positive response.

Figure 13. Percentage of participants who received a positive response to initiating a conversation about mental health.



Most people who engaged in meaningful conversations received a positive response.

Meaningful conversation stories

Focus groups gave participants an opportunity to tell their stories of engaging in meaningful conversations supported by their learning in MH101®. One person's story shows the range of conversations and impacts that were possible. This participant described using MH101® in their work at a public library to initiate a conversation with a new parent.

> "I had a new mum come in and I thought she was doing great, and instead of just giving her the usual platitudes, I actually said to her, very seriously 'How are you doing?' And she started crying and she said 'it's not going like everybody else is'. And I just thought 'Wow, it really does make a difference just to ask.' And I ended up giving her some [phone] numbers of people who could help her. She came back

> a couple of weeks later and said that it really made a difference to her that somebody had stopped and actually listened. For me it was one of those 'lightbulb aha' moments."

Subtle shifts in communication style could be meaningful to support others' wellbeing by allowing them to be more open about how they are feeling. For this participant, MH101® had also dispelled stigma around their child's anxiety and given them the confidence to support them to access counselling.

> "[They] suffer from anxiety and I just had no idea what to do, where to go. Where do I start? Or do I just ignore it and hope it goes away? But instead of just waiting to see if it gets worse or gets better, after [MH101®] I was like 'nope, we've got to do something now'. And it did it made a huge difference. They ended up going to the doctor a couple of days later and now they're getting counselling, and **what a difference** [emphasis added]."

This represents a more significant change in attitude and behaviour towards their child, resulting in working with their GP and gaining access to counselling.

A sense of connection had developed within another participant's MH101® cohort, who live in a small community.

> "It was surprising, you see them on the street or in the supermarket and again it's a genuine 'how are you?'. Not just the tokenistic [question]. [MH101®] really impacted everybody in that room… we all came away feeling **invigorated** and enthusiastic and positive and confident, that even doing something small can make a big difference [emphasis added]"

Meeting fellow workshop participants again in everyday life reactivated a shared understanding of mental health and wellbeing and renewed commitment to genuine inquiry into others' wellbeing.

Two participants shared how MH101® had provided them with the tools and confidence to have a conversation about suicide that resulted in improved whānau functioning and reduced distress.

> "Because of the things I learned in the workshop, I finally had the tools and knowledge available to have a conversation with my mother that I had needed to have for a very long time. This was in a situation in which the suicidal ideology she was displaying was directly negatively impacting my little brother. I was able to talk them both through the situation effectively, gain support and minimise the fallout from the situation."

Another participant shared how they used MH101® resources at work to provide a client experiencing thoughts of suicide with the support and information that they needed.

> "The day after the workshop at work I took a phone call from a young woman in distress who mentioned suicide. I felt very empowered to provide support to her, to guide her towards another agency who could support her and assisted in a positive outcome."

Impact on stigma and discrimination

Most learners' attitudes aligned to reducing stigma and discrimination

Most learners' attitudes and views at follow up were aligned with reducing stigma and discrimination in communities (Table 6). There were minimal differences by ethnicity, gender, and workplace factors. Most held an understanding of what it is like to experience a mental health challenge (87 percent) and felt comfortable talking to a person experiencing challenges (93 percent). Almost all learners felt a person with mental health challenges could lead a happy and productive life and reported understanding how their personal reactions can impact on the thoughts, feelings and behaviours of someone experiencing mental health challenges (94 percent, and 99 percent respectively).

Table 6. Relating to the experiences of people with mental health challenges

	% Agree/ strongly agree
I understand how my own reactions can impact on the thoughts, feelings and behaviours of someone experiencing mental health challenges (391 people)	99%
A person with mental health challenges can lead a happy and productive life (391 people)	94%
I feel comfortable talking to someone with experience of mental health challenges or distress (390 people)	93%
I have an understanding of what it is like to experience a mental health challenge (391 people)	87%

In the focus group discussions, a few participants described how attending MH101 made them recognise the stigmas around mental wellbeing in their own communities.

> "I liked how the workshop highlighted that there is a bit of a stigma towards mental health conversations when it comes to our Pacific and Māori cultural background. It's a taboo subject, nobody really wants to talk about it, because they associate it with something that's not a problem for us [as Pacific communities], it's a problem with them [Pākehā communities]."

Some focus group participants linked their improved understanding of mental health challenges to engagement with the lived experience of MH101® facilitators.

> "Something that I took away from my session in particular was the facilitators' stories about their own mental health and their journey. There was one around addiction, and when he told his story, I was bit taken aback. But when he spoke about his journey, and how he got to where he is today, it really helped us identify with him and not label him as anything."

Survey participants indicated that improved understanding of challenging mental health experiences led to reduced judgement and increased empathy.

> "[Understanding] the lenses and filters [different ways people view the world] really helped me understand where this person was coming from."

> "By increasing my understanding of mental wellbeing I feel I am less judgmental of it now."

There was also a clear sense among survey participants that increased understanding and empathy contributed positively to personal wellbeing and supporting others.

> "[MH101®] has made me more of a careful listener and more empathetic to how people act when under mental distress. It's also made me kinder towards myself as I keep an eye on how close I am to the vulnerability line."

Building a culturally informed understanding of holistic mental health was seen as vital to counter shame and silencing, and open conversation among men and in some Pasifika communities.

> "There's no such thing as mental health when you're brown or Pacific Islander. So it helps to open up that conversation within our own groups that make it okay to talk about that."

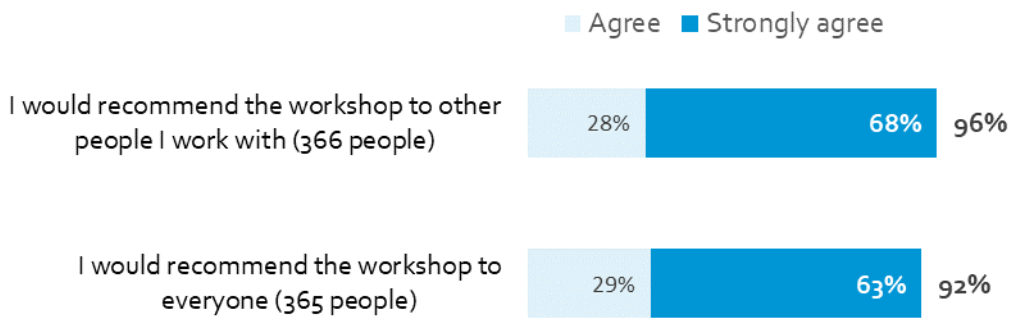
> "[It's challenging] generational stereotypes where your uncles or elders will say 'harden up, you weakling' … the macho masculine, you know, toughen up, you're not gonna survive out in the real world… we're possibly the first generation that's trying to say, 'hey, it's alright to say how you are'."

Impact of workshop content and delivery on learning

Almost all learners would recommend the workshop to others

Almost all learners would recommend the MH101® workshop to others at work (96 percent) or in their everyday lives (92 percent), see Figure 14.

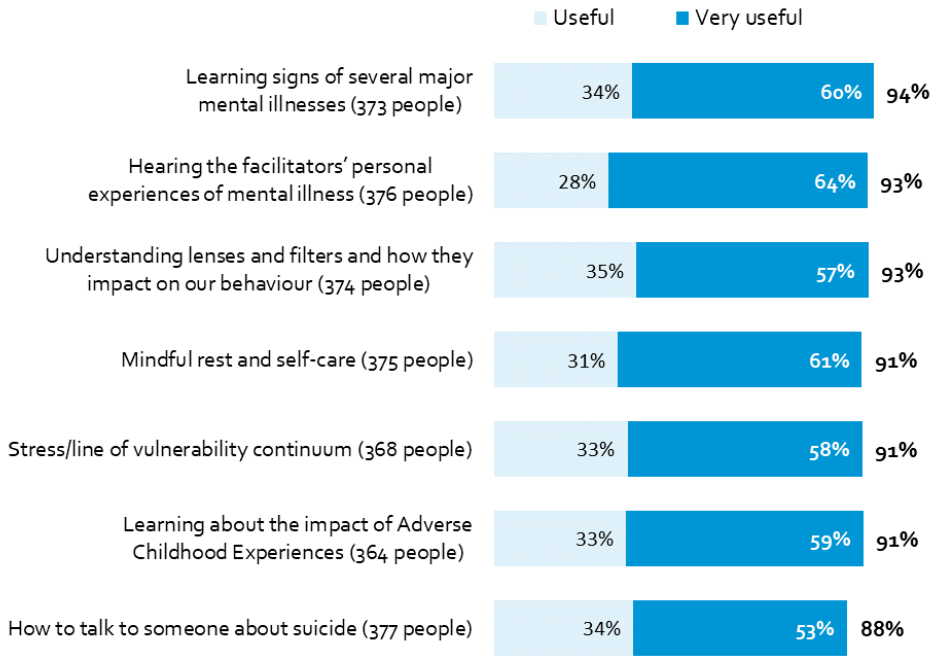
Figure 14. Recommending MH101® to others



Hearing facilitators' personal experiences of mental illness was considered most useful

The most useful topics included 'learning signs of several major mental illnesses' (94 percent), 'hearing facilitators' personal experiences of mental illness' (93 percent), and 'understanding lenses and filters and how they impact on our behaviour' (93 percent) seeFigure 15. Slightly fewer learners rated the content around 'how to talk to someone about suicide' as useful (88 percent).

Figure 15. Usefulness of MH101® topics



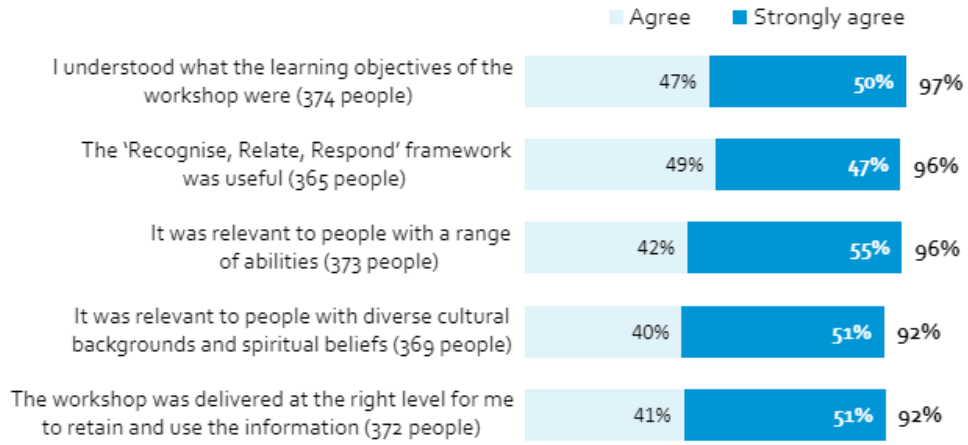
A focus group participants explained the impact of hearing facilitators' stories on their ability to engage with and retain the learning:

> "I really enjoyed the stories that they told, but also that they spoke from their own experience. I'm one of those people that I'll just clock out if it just becomes boring… But if you [tell] a story about the way you've walked in your life, how its impacted you and some things that helped you get on more, then I'm more likely to remember and obviously use those types of things. So that was really cool that was really helpful."

The workshops were considered safe and culturally appropriate spaces

The workshop was considered relevant and culturally appropriate, and the learning objectives were clear

Figure 16. Views on workshop design and content



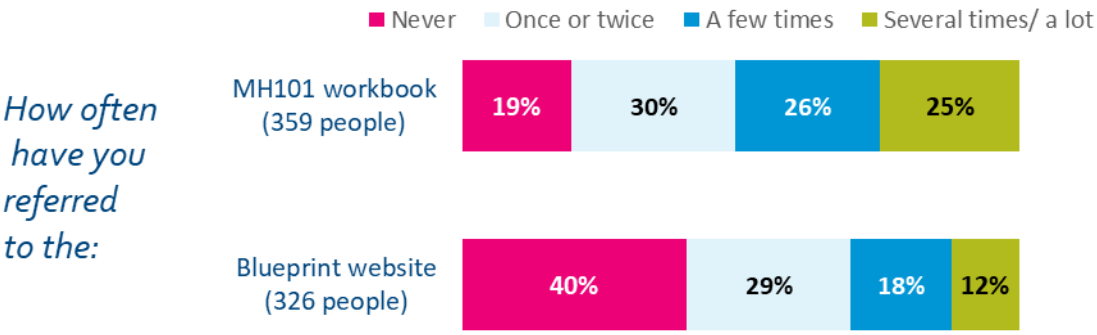
In addition to the above, some focus group participants emphasised the mutual sharing and learning happened because of the conversational workshop style and facilitators' ability to draw out a variety of experiences in the room safely:

> "It felt so nice to be amongst people that had lived similar and different lives to myself. It was sharing more experiences. And there was this feeling like you'd found a village. That you belonged to a group of people that cared about feelings that you'd felt yourself. Others could empathise and didn't sort of go 'Something's obviously wrong with you'."

Engagement with the MH101® workbook was high and positive

Learners found the MH101® workbook useful (80 percent) and continued to refer to both the workbook and the Blueprint website since the workshop (Figure 17).

Figure 17. Reference to the MH101® workbook and Blueprint website



A focus group participant described how she refers to her workbook to renew her commitment to the MH101® kaupapa:

> “I have [a workbook] in my locker. I'll go and get it to read back through it and get those things top of mind again. But I'm sure a lot of it I hold in my heart anyway and it'll just come out when it needs to.”

More than half of learners had not completed the optional e-learning and most wanted more follow up

Engagement with the optional e-learning follow up module was low (46 percent of learners indicated they had completed the e-learning). Survey respondents who had completed the e-learning found it was a useful refresher or content reminder. These comments largely summarise most respondent’s perspectives on the e-learning.

> “The e-learning serves as an exercise to help people like myself to be able to apply when we learnt via the workshop.”

> “Ability to reflect on learning and consolidate the workshop learning. It provided another lens to the learning.”

> “A good resource, reminder to refresh one’s memory and continue to be aware of the scenarios people faced, trauma and impact of peoples actions on others, past and present.”

> “Recap of everything we had covered made it useful for retention of skills.”

Participants liked having the ability to complete the e-learning at their own pace, and the opportunity to reflect upon the topics outside of their work hours.

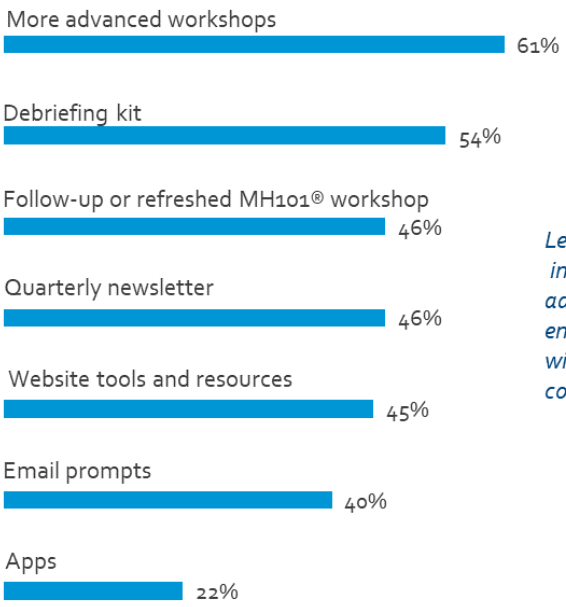
Participants (214 people) who did not complete the e-learning tended not to say why. Those who did said that they had forgotten to complete it or became too busy. There were 14 respondents who showed interest in the e-learning in their comments, despite not having completed it.

> “I may have, don't recall it. At that time our workplace was responding to the Auckland Covid outbreak so anything non-Covid was a low priority.”

> “To be honest, I cannot remember [the e-learning]. However, any learning whether e-learning or workshop is always valuable and appreciated.”

Learners were interested in additional engagement with MH101® including more advanced workshops (61 percent), debriefing (54 percent), and follow up meetings (46 percent), see Figure 18. Some wanted newsletters (46 percent), more website tools and resources (45 percent), and/or email prompts around their learning (40 percent). Around one in five learners were interested in app-based support (22 percent).

Figure 18. Types of follow up support desired by learners



Learners were interested in additional engagement with MH101® *content .*

Note: Responses were from 353 participants.

Discussion

Evidence of the impact of MH101® was positive, showing most participants retained their knowledge and confidence around each of the learning outcomes three to six months after they had attended a workshop. Most participants were still using their learning to actively support their own and others' wellbeing and felt that doing so was making a positive difference. Almost three quarters of learners had had a meaningful and positive conversation with someone they were concerned about. Hearing facilitators' personal experiences of mental health challenges in a safe and discussion-based learning environment contributed positively to this outcome. Visible mental health support options and policies available in the workplace made these conversations and early intervention more likely. Focus group discussions illustrated how MH101® can create sustainable behaviour change, from small shifts in self-care and communication styles to supportive referral to mental health services, that promote individual, whānau and community wellbeing. The MH101® programme is well positioned to enable the vision outlined in Kia Manawanui Aotearoa for New Zealanders having better understanding of mental wellbeing, being able to support themselves and each other, and to get help in the places they already visit (Ministry of Health, 2021).

Māori and Pasifika learners seemed to have lost more confidence at follow up than other ethnic groups around maintaining mental wellbeing, knowing a range of ways to support someone, and supporting someone in mental distress. Māori and Pasifika learners were also less likely to report positive responses to their efforts to put their learning into practice via meaningful conversations. These learners were more likely to be supporting friends and whānau experiencing thoughts of suicide and more serious mental distress including psychosis and addiction. Given the small sample sizes the survey findings are indicative only. However, participants' stories show that Māori and Pasifika learners experienced unique factors that affected the translation of their MH101® learning into practice. These included additional layers of stigma regarding mental health challenges. New Zealand mainstream approaches to promoting mental health do not tend to consider cultural understanding in depth. A key example discussed in recent research is some Pasifika peoples' spiritual beliefs about the causes of mental health challenges, e.g. spiritual possession resulting from breach of tapu or sacred covenant by the affected person or a member of the family (Fa'alogo-Lilo & Cartwright, 2021; Mila-Schaaf & Hudson, 2009).

Challenges for Māori and Pasifika learners reflect persistent mental health inequities and support needs faced by these communities in New Zealand. For example, Māori and Pasifika peoples continue to report higher psychological distress (1.5 times as likely to be distressed over the past 2–4 weeks) compared to other groups (Minster & Trowland, 2018). Māori and Pasifika peoples experience more serious mental health challenges and are much less likely to access services. In 2006, New Zealand's most comprehensive epidemiological mental-health survey, Te Rau Hinengaro, found that only 25 percent of Pasifika and 33 percent of Māori who experience severe mental health challenges have contact with any kind of formal support service, compared to 58 percent of New Zealanders overall (Baxter et

al., 2006). Higher rates of mental health challenges and lower rates of access to mental health services continue (He Ara Oranga, 2018). Known barriers include commitment to finding solutions within the family, past mistreatment, mistrust, and lack of knowledge of services (Fa'alogo-Lilo & Cartwright, 2021). A range of inequities associated with colonisation e.g., poverty and loss of tūrangawaewae will compound challenges and shape priorities for Māori and Pasifika learners, as they seek to apply their learning.

Limitations

Exploration of impact was limited by low engagement with priority learners as part of the evaluation, including Māori and Pasifika people, rainbow communities, people living in rural communities and men. The response rate was also low for the follow up survey overall (14 percent). Survey participants were proportionately representative of MH101® learners by gender, age, workplace type, and access mode (online, in-person); however, generalisability of the findings to all MH101® learners may be limited. The following discussion of opportunities for the development of MH101® suggested by the findings should be read with these limitations in mind. Future impact evaluation of this programme should make use of more targeted recruitment strategies and oversampling of priority groups to address these important limitations.

Focus group participants drew links between MH101® and reduction in their own stigmatising beliefs. MH101® is designed to reduce mental health stigma. As elsewhere, New Zealanders often accept the presence of mental health challenges in communities; however, they still hold negative views of people experiencing these challenges (Cunningham et al., 2017). Mental health stigma discourages help-seeking and undermines good mental health support systems, frameworks and services (Corrigan et al., 2014; Thornicroft et al., 2022). Future evaluation should incorporate measurement of stigma using validated scales such as the California Assessment of Stigma Change (CASC) (Corrigan et al., 2015) to enable the impact of MH101® on stigma to be explored. The CASC has already been adapted for and used in the New Zealand context (Gordon et al., 2018).

Enhancing MH101® for Māori and Pasifika learners

Further exploration of learning experiences and development of MH101® with Māori and Pasifika learners and facilitators is warranted. Māori and Pasifika learners may benefit from additional support to engage in meaningful conversations in ways that are grounded in the cultural significance and meaning of mental health challenges for the person, whānau, and their community. To address mistrust, promote engagement and reduce stigma, having health promotors and educators who look like you, who sound like you and who have experienced what you have experienced is critical (Cunningham et al., 2017; *He Ara Oranga*, 2018). Growing the number, capacity and connectedness of Māori and Pasifika MH101® facilitators would support the development of MH101® Māori and Pasifika offerings.

He Ara Oranga called for all mental health improvement strategies to embrace Te Ao Māori and Pasifika ways of knowing and doing, while empowering Māori and Pasifika workforce (*He Ara Oranga*, 2018).

'Māori MH101®' or 'Pasifika MH101®' sessions and follow up could take on a different shape and form to upskill individuals and whānau in a way that addresses some of the additional nuances and challenges for these groups. The ways in which MH101® could be developed to offer support and maintain connection and learning for Māori and Pasifika learners should be workshopped within these communities. Possibilities include MH101® as a platform to help build a cohort of Māori and Pasifika champions or alumni who then become buddies and coaches for others in their communities. Promoting the workshop within established community groups such as sports clubs and churches may also create opportunities for ongoing conversations and support.

Exploring additional possibilities for follow up support

Over half of learners had not completed the optional e-learning, yet most learners desired additional engagement with MH101® beyond the workshop (i.e., more follow up support). This apparent paradox would benefit from further reflection. Results suggest some possibilities for redesigning follow up to better support learners to put their learning into practice. The following options could be explored and trialled.

Areas of lower confidence at follow up included: knowing when to suggest mental health options to others, and how to support someone who may be suicidal. Follow up could be focussed on building and sustaining knowledge, confidence, and action around these aspects. Building confidence around responding to people experiencing thoughts of suicide is a specialised area, and high levels of confidence would not be expected after a general mental health literacy programme such as MH101®. However, further support around responding to suicide, such as the one-day workshop provided by LifeKeepers – National Suicide Prevention Training, could be highlighted more within workshops and follow-up for learners wishing to develop their knowledge and confidence further.

A quarter of learners had not engaged in a meaningful conversation yet, and more than one in ten (14 percent) had tried but not received a positive response. The impact of these experiences on their supporting others in the future is unknown but unlikely to be positive. Follow up could usefully focus on engaging in meaningful conversations and recovering from setbacks.

More advanced and additional workshops were requested by over half of learners, which can be interpreted as a desire for ongoing engagement with the kaupapa. Participants found the learning about mental health that comes from the stories and experiences of others impactful. Many learners found 'a village' of likeminded people within their MH101® cohort and some wanted to continue that connection and learning in some way. Follow up could be

designed to support further sharing about how learners are putting MH101® into practice. For Pasifika, face-to-face or even online reconnection shows care and is nurturing of the *Va* or sacred space that connects separate entities together in unity. MH101® could offer coaching or a buddy system to improve engagement and support with retaining and implementing their learning.

Raising awareness of mental health promoting environments

Working in an organisation actively supporting mental health was significantly associated with using MH101® learning to have conversations and intervene early to support others. Early access to support, information and referral is critical to improving mental health and wellbeing in New Zealand communities (Ministry of Health, 2021). However, one in ten learners working across social services, education and health felt they did not have access to any workplace support.

Specific support for managers and leaders to recognise, understand and support staff experiencing mental health challenges in the workplace is available through the Blueprint programme Leading Wellbeing at Work[10]. MH101® content and follow up should raise awareness and encourage reflection on the ways that our environment, including our workplace, shapes wellbeing. This practice would recognise that advocacy for improvement in the workplace may not always be driven by those in managerial positions. Encouraging ongoing talanoa and kōrero at work can be mana enhancing and helps to build *Va* or a relationship between individuals at all levels. This could involve reference to key strategies workplaces can implement to create mental health promoting work environments. For example, designing work to minimise harm, building organisational resilience through good management, enhancing personal resilience, promoting early help-seeking and supporting recovery and return to work (Petrie et al., 2018). While each workplace needs to develop tailored solutions, some simple frameworks exist to help both employers and employees to consider the adequacy of existing support and opportunities for further enhancements. Additional content and resources to support culture change may be helpful where MH101® workshops are run with whole teams and workplaces.

Conclusion

Evidence of the impact of MH101® was positive. Most participants had sustained knowledge and confidence around each of the learning outcomes and were using their learning to actively support their own and others' wellbeing. The programme is well positioned to enable the vision outlined in Kia Manawanui Aotearoa for New Zealanders having better understanding of mental wellbeing, being able to support themselves and each other, and to get help in the places they already visit (Ministry of Health, 2021). The impact of MH101® could be increased by providing additional support for Māori and Pasifika learners, exploring

[10] Leading Wellbeing at Work is a one-day workshop designed to equip managers and leaders to recognise and respond supportively to staff experiencing mental health challenges in the workplace. Key learning outcomes are to link employee wellbeing to productivity and legislation, recognise signs of mental wellbeing and mental distress in the workplace, understand what people with mental health challenges are experiencing, and provide appropriate support to staff experiencing mental distress.

additional avenues for follow up support and encouraging critical reflection on the ways that our environment, including our workplace, shapes wellbeing.

Recommendations

Key recommendations for Blueprint from this impact evaluation are to:

- use targeted recruitment strategies and oversampling in future evaluation to improve engagement with priority groups, including Māori and Pasifika learners, rainbow communities, people living in rural communities and men
- include measurement of stigma and change in future evaluation
- consider how MH101® could be developed to offer additional support for Māori and Pasifika learners
- redevelop follow up to support learners to put their learning into practice
- consider how MH101® could complement initiatives aimed at managers and leaders such as Leading Wellbeing at Work by encouraging critical reflection on the ways that our environment, including our workplace, shapes wellbeing.

Appendices

Appendix A: MH101® post-workshop survey 2021

MH101 Evaluation 2021

We'd love to hear what you thought of the MH101 workshop or webinars. Your feedback will help us to make sure future workshops create a positive learning environment and meet the needs of each participant.

Your feedback is anonymous. The survey results and comments may be used in a summary report for the Ministry of Health or for your organisation (if applicable) but individuals will not be identified.

Comments made in the survey may be used anonymously to promote the workshop or webinar on the Blueprint for Learning website, in marketing collateral and on social media platforms.

At the end of the survey, you're invited to enter Blueprint for Learning's monthly draw to win a $50 Prezzy card by providing your name and email. Your contact details are not associated with your survey answers to ensure your privacy.

If you have any questions about this survey, please contact us at info@blueprint.co.nz or on 04 473 9009.

Thank you for your participation.

Did you attend an in-person workshop or a webinar series?

- In-person workshop
- Webinar series

MH101 Evaluation 2021

In person workshop

* Please rate the workshop's content and overall:

	Poor	Satisfactory	Good	Very good	Excellent
Overall rating	○	○	○	○	○
Usefulness of the content	○	○	○	○	○
Amount of content	○	○	○	○	○
Cultural relevance of the content	○	○	○	○	○

* Please rate the workshop's facilitation, activities and resources:

	Poor	Satisfactory	Good	Very good	Excellent
Workshop facilitation	○	○	○	○	○
Usefulness of the activities	○	○	○	○	○
Usefulness of the resources (e.g. workbook)	○	○	○	○	○

* Please rate the workshop on the following:

	Poor	Satisfactory	Good	Very good	Excellent
Venue and food	○	○	○	○	○
Registration process	○	○	○	○	○

MH101 Evaluation 2021

In person workshop

* Please rate your agreement with the following:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
MH101 has helped to meet my learning needs about mental health	○	○	○	○	○
The facilitators' stories added value to the workshop	○	○	○	○	○
The workshop provided a respectful and supportive environment to fully participate in	○	○	○	○	○

Which parts of the workshop were most useful?

Any other comments to help explain your ratings?

MH101 Evaluation 2021

Webinars

* Please rate the webinars' content and overall:

	Poor	Satisfactory	Good	Very good	Excellent
Overall rating	○	○	○	○	○
Usefulness of the content	○	○	○	○	○
Amount of content in each webinar	○	○	○	○	○
Cultural relevance of the content	○	○	○	○	○

* Please rate the webinars' facilitation, activities and resources:

	Poor	Satisfactory	Good	Very good	Excellent
Webinar facilitation	○	○	○	○	○
Usefulness of the activities	○	○	○	○	○
Usefulness of the resources (e.g. workbook)	○	○	○	○	○

* Please rate the webinars on the following:

	Poor	Satisfactory	Good	Very good	Excellent
Instructions for accessing the webinars and workbook	○	○	○	○	○
Time and schedule of the webinars	○	○	○	○	○
Audio and video quality of the webinars	○	○	○	○	○
Registration process	○	○	○	○	○

MH101 Evaluation 2021

Webinars

* Please rate your agreement with the following:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
MH101 has helped to meet my learning needs about mental health	○	○	○	○	○
The facilitators' stories added value to the webinar	○	○	○	○	○
The webinars provided opportunities for interactive participation	○	○	○	○	○
The webinars provided a respectful and supportive environment to fully participate in	○	○	○	○	○

Which parts of the webinars were most useful?

Any other comments to help explain your ratings?

MH101 Evaluation 2021

Knowledge and confidence

We are interested in how the workshop or webinars has impacted on your knowledge and confidence around mental health. This is not a test and there are no right or wrong answers.

The following questions will ask you to rate your level of confidence *after* completing the workshop and reflect on how you felt *before* the workshop.

* My confidence in recognising the signs of positive mental health

	Not confident	A little confident	Somewhat confident	Confident	Very confident
After the workshop or webinars	○	○	○	○	○
Before the workshop or webinars	○	○	○	○	○

* My confidence in knowing a range of strategies, such as Te Whare Tapa Whā, to support ***my own*** mental wellbeing

	Not confident	A little confident	Somewhat confident	Confident	Very confident
After the workshop or webinars	○	○	○	○	○
Before the workshop or webinars	○	○	○	○	○

* My confidence in knowing a range of strategies, such as Te Whare Tapa Whā, to support ***other people's*** mental wellbeing

	Not confident	A little confident	Somewhat confident	Confident	Very confident
After the workshop or webinars	○	○	○	○	○
Before the workshop or webinars	○	○	○	○	○

* My confidence in recognising the signs of mental distress

	Not confident	A little confident	Somewhat confident	Confident	Very confident
After the workshop or webinars	○	○	○	○	○
Before the workshop or webinars	○	○	○	○	○

MH101 Evaluation 2021

Knowledge and confidence

We are interested in how the workshop has impacted on your knowledge and confidence around mental health. This is not a test and there are no right or wrong answers.

The following questions will ask you to rate your level of confidence *after* completing the workshop and reflect on how you felt *before* the workshop.

* My confidence in knowing a range of ways to relate and respond supportively to someone experiencing mental distress

	Not confident	A little confident	Somewhat confident	Confident	Very confident
After the workshop or webinars	○	○	○	○	○
Before the workshop or webinars	○	○	○	○	○

* My confidence in having a courageous conversation with someone whose mental health I am concerned about

	Not confident	A little confident	Somewhat confident	Confident	Very confident
After the workshop or webinars	○	○	○	○	○
Before the workshop or webinars	○	○	○	○	○

* My confidence in supporting someone who may be experiencing suicidal thoughts

	Not confident	A little confident	Somewhat confident	Confident	Very confident
After the workshop or webinars	○	○	○	○	○
Before the workshop or webinars	○	○	○	○	○

* My confidence in knowing ***when*** to seek professional support

	Not confident	A little confident	Somewhat confident	Confident	Very confident
After the workshop or webinars	○	○	○	○	○
Before the workshop or webinars	○	○	○	○	○

* My confidence in knowing ***how*** to contact appropriate professional support

	Not confident	A little confident	Somewhat confident	Confident	Very confident
After the workshop or webinars	○	○	○	○	○
Before the workshop or webinars	○	○	○	○	○

* My confidence in responding to mental distress amongst people in my workplace and/or community

	Not confident	A little confident	Somewhat confident	Confident	Very confident
After the workshop or webinars	○	○	○	○	○
Before the workshop or webinars	○	○	○	○	○

MH101 Evaluation 2021

Demographics

* In what sector do you work?

- ○ Health
- ○ Education
- ○ Rural, eg farming, agriculture
- ○ Industrial, eg manufacturing, construction
- ○ Other sector, eg Corrections, Social

* Which option best describes where you work:

- ○ A government agency, eg Work and Income, Kāinga Ora, Department of Corrections
- ○ A non-government organisation
- ○ A private or corporate business

* If your organisation provides services to people, who do you mainly serve?

- ○ Māori people
- ○ Pasifika peoples
- ○ Asian peoples
- ○ Children and youth
- ○ Older people
- ○ People in rainbow groups
- ○ Disabled people
- ○ Not applicable

* Your gender

- ( ) Female / Wahine
- ( ) Male / Tāne
- ( ) Another gender

* Your age group

- ( ) Under 25
- ( ) 25 to 44
- ( ) 45 to 64
- ( ) 65 and over

* Which ethnic groups do you belong to?

- [ ] Māori
- [ ] Pasifika
- [ ] Asian
- [ ] New Zealand European / Pākehā
- [ ] Other (please specify)

MH101 Evaluation 2021

Thank you for completing this survey. Please provide your contact details to:

- enter our monthly draw to win a $50 Prezzy card
- be invited to participate in our future research activities.

Blueprint for Learning regularly reviews our workshops to ensure they are the best they can be. We also carry out research to show the effectiveness of the skills and knowledge gained in each workshop.

Your details are not connected to your survey answers to ensure your privacy.

Name

Email address

Phone

If you do not want to be contacted about further research, please tick the box below. You will still go in the draw to win the $50 Prezzy card.

☐ Opt-out

MH101 Evaluation 2021

Thank you for completing the survey. We appreciate you taking the time to share your feedback.

If you would like to find out more about Blueprint for Learning workshops, please visit www.blueprint.co.nz or you can contact us at info@blueprint.co.nz or on 04 473 9009.

Appendix B: MH101® follow up survey 2021

Thank you for agreeing to complete the survey. The survey will take approximately 10-15 minutes to complete and there is space at the end of the survey for general comments. All information submitted in this survey will be kept confidential and any comments used in reporting will be anonymous.

At the end of the survey, we ask for your name and email address but you only need to provide this if you wish to go in the draw for the $50 Prezzy card. Your name will not be linked to your survey responses. If you have any questions, please contact Heather Kongs-Taylor, Manager Evaluation and Monitoring at Te Pou by emailing heather.kongs-taylor@tepou.co.nz or calling 09 300 6764. For further information about MH101® please contact Blueprint for Learning at: info@blueprint.co.nz.

When did you attend MH101?

Did you attend a MH101 workshop or webinar? (Tick box workshop/webinar)

Please answer all the questions below by ticking the box or circling the option that most applies to you.

Attitudes and beliefs around mental health

1) How much do you agree with the following statements?

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree	Don't know
A person with a mental health challenges can lead a happy and productive life						
I feel comfortable talking to someone with experience of mental health challenges or distress						
I have an understanding of what it is like to experience a mental health challenge						
I understand how my own reactions can impact on the thoughts, feelings and						

behaviours of someone experiencing mental health challenges						
I feel confident in recognising and responding to mental health challenges						

2) How confident do you feel about each of the following?

	Not confident	A little confident	Somewhat confident	Confident	Very confident	Don't know
Knowing a range of strategies to maintain mental wellbeing						
Knowing a range of ways to support someone who experiences mental health challenges						
Knowing a range of ways to support someone who is experiencing heightened distress						
Having a courageous conversation with someone whose mental health you are concerned about						
Supporting someone who may be suicidal						
Knowing when to suggest different types of mental health support options						
Knowing a range of professional mental health support options						
Knowing how to contact appropriate professionals						
Dealing with mental health challenges amongst clients or customers in your workplace						
Dealing with mental health challenges amongst staff in your workplace						

3) How useful were the following topics covered in the workshop?

	Not very useful	A little useful	Somewhat useful	Useful	Very useful	Don't know
Te Whare Tapa Whā						
Stress/line of vulnerability continuum						
Learning signs of several major mental illnesses						
Mindful rest and self-care						
How to talk to someone about suicide						
Hearing the facilitators' personal experiences of mental illness						
Understanding lenses and filters and how they impact on our behaviour						
Learning about the impact of Adverse Childhood Experiences (ACE's)						

Changes since the MH101 workshop

4) How much do you agree with the following statements?

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly agree	Don't know/NA
I understood what the learning objectives of						

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly agree	Don't know/NA
the workshop were						
The 'Recognise, Relate, Respond' framework was useful						
The workshop was delivered at the right level for me to retain and use the information						
The workshop content was relevant to people with a range of disabilities						
The workshop content was relevant to people with diverse cultural backgrounds and spiritual beliefs						

5) Because of the workshop, how much do you agree with the following statements?

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree	Don't know/NA
I am doing more things to keep myself mentally well (i.e. self-help strategies)						

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree	Don't know/NA
I am suggesting self-help strategies to others more often I am more confident talking about mental health challenges						
I am more confident talking about mental health challenges						
I have intervened more at an early stage to encourage people to seek help for their mental distress before it got more serious						
I am providing more support around mental health challenges to people I interact with at work						
I am providing more support around mental health challenges to friends and family						

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree	Don't know/NA
I have made more effective use of referrals to professional help options						
I have intervened when someone has been having suicidal thoughts						

Supporting people experiencing mental health challenges or distress at your workplace

6) Since you completed the MH101® workshop, how useful has what you learned in the workshop been for you in your:

	Not useful	A little useful	Somewhat useful	Useful	Very useful	Don't know
Job or workplace						
Personal life						

7) How much do you agree with the following statements?

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Don't know
I have shared what I learned at the MH101® workshop with my colleagues						
My workplace (including colleagues, policies, management etc.) is supportive of						

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Don't know
people experiencing mental health challenges						
There are policies in place at my workplace that allow people experiencing mental health challenges or distress to receive the appropriate support						

8) Since you completed the MH101® workshop, have you initiated a conversation with someone whose mental wellbeing you were concerned about (i.e. someone in distress or having suicidal thoughts or needed support)?

Yes No (to Q14) Don't know (to Q 14)

9) How many times have you initiated a conversation like this since the MH101® workshop?

10) What aspects of their mental wellbeing were you concerned about? (Select all that apply) If you have had more than one conversation like this, think about the most recent time you intervened. (Please circle or highlight your answer below)

Signs of anxiety Signs of depression Signs of psychosis Signs of substance use
Signs of thinking about suicide Other – please specify:

11) How did the other person respond to you raising concerns? If you have had more than one conversation like this, think about the most recent time you intervened. (Please circle or highlight your answer below)

Very positively Positively Neither positively or negatively Negatively
Very negatively

12) What differences did attending the workshop make to how you responded in this situation(s)?
Please record your answer here:

MH101® workshop and resources

13) How much do you agree with the following statements?

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree	Don't know
I would recommend the workshop to other people I work with						
I would recommend the workshop to everyone						

14) Since the workshop, how often have you referred to the:

	Never	Once or twice	A few times	Several times	A lot	Don't know
Blueprint website						
MH101® workbook						

15) How useful is the:

	Not useful	A little useful	Somewhat useful	Useful	Very useful	Don't know or haven't used it
Blueprint website						
MH101® workbook						

16) Did you complete the MH101 e-learning which was sent to you 6 weeks after your training?

- Yes: What was useful about the e-learning
- No: Why did you not complete the e-learning?

17) Which of the following types of follow up training or support would you want?

E-learning opportunities						

Email prompts (with take home messages)						
Debriefing kit (i.e., that can be used in the workplace)						
Quarterly newsletters or useful tips mailer						
Website tools and resources						
Apps						
More advanced workshop (e.g., MH201)						
Follow up or refresher MH101® workshop						

18) Do you have any other final comments about MH101®?

19) If you would like to go in the draw to win a $50 Prezzy card, please provide your name and contact details below:

Name: Contact email address: Contact phone number:

Thank you for taking our survey. Your response is very important to us.

Appendix C: Focus group participant information sheet

MH101 Impact Evaluation

Participant Information Sheet

Tēnā koe

Thank you for taking the time to join this impact evaluation. Blueprint for Learning is conducting this follow-up evaluation of participants who completed a MH101 workshop or webinar between February-September 2020. The purpose of this evaluation is to understand how you have maintained and used your learning and inform improvements to the workshop. This document outlines further information about the focus group, and the consent to take part in the survey.

What is involved?

You will be involved in an online focus group which will take approximately one hour. It will be facilitated by Paula Parsonage, Health & Safety Developments via Zoom.

Participation in this focus group is voluntary; it is up to you if you choose to participate. If you do not want to participate or withdraw before the session is over, you do not have to give a reason, and it will not affect your relationship with Blueprint for Learning.

If you agree to take part, you are asked to read the Participant Consent information on the last page of this document. You can keep a copy of this Information Sheet and the Participant Consent information for your records.

What will happen with the information I provide?

With your permission, and only with the permission of the whole group, the focus group will be audio recorded. This recording will be used by the evaluation team to check the accuracy of our notes. It will not be shared outside the team.

All information will be stored securely and kept confidential for a period of ten years before deletion. Names of all participants will be stored separately so they cannot be linked to focus group notes. Audio recordings are stored on a password-protected computer until analysis and writings that contribute to the research project are complete. At which point after ten years, all paper documents will be shredded, and all digital data erased.

Your name and information will not be shared with anyone outside the focus group and the evaluation team, and no individual will be identifiable in summary reports. All responses from people participating will be combined into a summary report by Blueprint for Learning for the Ministry of Health to inform improvements to MH101.

Summarised findings shared with the Ministry of Health may be published on our website and may also be used to promote the workshop in promotional materials such as the Blueprint for Learning website, printed information, and social media platforms. All individuals will remain anonymous in the summary report and promotional materials, and all efforts will be made to protect the identity of participants.

Right to withdraw from participation

If you decide to participate, you have the right to withdraw from participating at any time. You do not have to give a reason, and it will not affect your relationship with any organisation involved. You can tell us you do not want to take part at any time during the focus group and you need not answer every question.

Risks to participating

MH101 workshops and webinars discuss sensitive topics and it is possible that revisiting aspects of this content during your focus group may cause some distress. We encourage you to take time out during the focus group if needed and seek support from your contacts or through the number below.

Who can I contact if I need support?

Call or text 1737 – free 24-hour phone or text support.

If you agree to take part

Your participation in the focus group will be used as consent and you can keep this emailed copy of the Information Sheet and the Consent Form.

Who can I contact if I have any questions?

- If you have any questions about this focus group or how your information may be used, please contact Heather Kongs-Taylor, Manager, Evaluation at heather.kongs-taylor@tepou.co.nz or phone 09 300 6764.
- Paula Parsonage, Interviewer, at hsd@xtra.co.nz

Appendix D: Focus group consent form

Participant Consent

I have read, or had read to me, the Participant Information Sheet and I understand what it says.

- I have been given enough time to decide to participate or not in this focus group.
- I have had the opportunity to ask questions, so I know what I am agreeing to.
- I understand that participating in the focus group is voluntary (my choice) and that I may withdraw from the focus group at any time without this affecting my relationship with any organisation involved.
- I understand that if I take part in this focus group, my details will be kept anonymous and nothing that could identify me will be reported.
- I agree to keep the names of participants and information shared during the focus group confidential.
- I know who to contact if I have any questions about the focus group.
- I understand the focus group will be audio recorded.
- I understand the data will be kept for a period of ten years then deleted.
- By participating in this focus group, I consent to the above points.

Appendix E: In-person vs. online workshop ratings

	Percentage who noted "confident" or "very confident"			Mean rating ± SD (1 - Not very confident, 5 - Very confident)			Post-survey vs. Follow up	
	Post-survey	Follow up	Change	Post-survey	Follow up	Change	p-value*	Cohen's d (effect size)
Confidence in recognising and responding to mental health challenges								
All (390 people)	86%	86%	0%	4.15 ± 0.69	4.04 ± 0.63	-0.12	p<.01	0.17 (Small)
In-person (215 people)	82%	85%	2%	4.09 ± 0.72	4.00 ± 0.61	-0.09	Not significant (P=.0919)	--
Online (175 people)	90%	87%	-2%	4.23 ± 0.66	4.08 ± 0.66	-0.15	p<.05	0.23 (Small)
Confidence in having a courageous conversation with someone whose mental health you are concerned about								
All (385 people)	73%	73%	0%	3.93 ± 0.85	3.92 ± 0.84	-0.01	Not significant (P=.908)	--
In-person (211 people)	71%	74%	3%	3.90 ± 0.84	3.96 ± 0.86	0.06	Not significant (P=.313)	--
Online (174 people)	75%	72%	-3%	3.97 ± 0.87	3.87 ± 0.83	-0.09	Not significant (P=.168)	--

* p-value <.05 indicates a significant difference between mean post-survey and follow up ratings.

Cohen's *d* indicates the magnitude of the difference between the means, expressed in standard deviation units: .2 to .5 is considered a small effect size; .5 to .8 a medium effect size; .8 and higher a large effect size.

Appendix F: Supporting people experiencing mental health challenges

	Percentage "confident" or "very confident"			Mean rating ± SD (1 - Not very confident, 5 - Very confident)			Post-survey vs. Follow up results	
	Post-survey	Follow up	Change	Post-survey	Follow up	Change	p-value*	Cohen's *d* (effect size)#
Confidence in recognising and responding to mental health challenges								
All (390 people)	86%	86%	0%	4.15 ± 0.69	4.04 ± 0.63	-12%	p<.01	0.17 (Small)
Māori (69 people)	88%	94%	6%	4.35 ± 0.72	4.14 ± 0.55	-20%	p<.05	0.32 (Small)
Pasifika (21 people)	86%	95%	10%	4.29 ± 0.72	4.33 ± 0.58	5%	Not significant (p=.747)	--
Non-Māori and non-Pasifika (304 people)	85%	84%	-2%	4.11 ± 0.68	4.00 ± 0.65	-10%	p<.05	0.15 (Small)

* p-value <.05 indicates a significant difference between mean post-survey and follow up ratings.

Cohen's *d* indicates the magnitude of the difference between the means, expressed in standard deviation units: .2 to .5 is considered a small effect size; .5 to .8 a medium effect size; .8 and higher a large effect size.

	Percentage who noted "confident" or "very confident"			Mean rating ± SD (1 - Not very confident, 5 - Very confident)			Post-survey vs. Follow up results	
	Post-survey	Follow up	Change	Post-survey	Follow up	Change	p-value*	Cohen's *d* (effect size)#
Confidence in knowing a range of strategies to maintain wellbeing								
All (386 people)	89%	84%	-5%	4.27 ± 0.73	4.13 ± 0.74	-0.14	p<.01	0.19 (Small)
Māori (68 people)	97%	90%	-7%	4.62 ± 0.55	4.25 ± 0.72	-0.37	p<.01	0.57 (Medium)
Pasifika (20 people)	95%	70%	-25%	4.60 ± 0.60	4.00 ± 0.92	-0.60	p<.01	0.77 (Medium)
Non-Māori and non-Pasifika (301 people)	87%	84%	-3%	4.18 ± 0.75	4.12 ± 0.73	-0.05	Not significant (p=.2984)	--

	Percentage who noted "confident" or "very confident"			Mean rating ± SD (1 - Not very confident, 5 - Very confident)			Post-survey vs. Follow up	
	Post-survey	Follow up	Change	Post-survey	Follow up	Change	p-value	Cohen's d (effect size)
Confidence in knowing a range of ways to support someone who experiences mental health challenges								
All (386 people)	84%	73%	-11%	4.14 ± 0.75	3.91 ± 0.78	-0.24	p<.000	0.31 (Small)
Māori (68 people)	88%	76%	-12%	4.46 ± 0.70	4.04 ± 0.76	-0.41	p<.01	0.56 (Medium)
Pasifika (20 people)	95%	70%	-25%	4.55 ± 0.69	4.00 ± 0.92	-0.55	p<.01	0.68 (Medium)
Non-Māori and non-Pasifika (301 people)	83.1%	73.1%	-10.0%	4.05 ± 0.75	3.88 ± 0.77	-0.18	p<.01	0.23 (Small)

	Percentage who noted "confident" or "very confident"			Mean rating ± SD (1 - Not very confident, 5 - Very confident)			Post-survey vs. Follow up	
	Post-survey	Follow up	Change	Post-survey	Follow up	Change	p-value	Cohen's d (effect size)
Confidence in knowing a range of ways to support someone who is experiencing heightened distress								
All (384 people)	83%	66%	-17%	4.07 ± 0.77	3.77 ± 0.86	-0.29	p<.000	0.36 (Small)
Māori (67 people)	88%	73%	-15%	4.21 ± 0.73	3.96 ± 0.75	-0.25	p<.05	0.34 (Small)
Pasifika (20 people)	95%	70%	-25%	4.45 ± 0.76	3.95 ± 0.89	-0.50	p<.05	0.61 (Medium)
Non-Māori and non-Pasifika (300 people)	81%	64.3%	-16.3%	4.01 ± 0.77	3.73 ± 0.88	-0.28	p<.000	0.34 (Small)

	Percentage who noted "confident" or "very confident"			Mean rating ± SD (1 - Not very confident, 5 - Very confident)			Post-survey vs. Follow up	
	Post-survey	Follow up	Change	Post-survey	Follow up	Change	p-value	Cohen's d (effect size)
Confidence in having a courageous conversation with someone whose mental health you are concerned about								
All (385 people)	73%	73%	0%	3.93 ± 0.85	3.92 ± 0.84	-0.01	Not significant (p=.908)	--
Māori (67 people)	79%	87%	7%	4.12 ± 0.79	4.19 ± 0.70	0.07	Not significant (P=.488)	--
Pasifika (20 people)	85%	70%	-15%	4.25 ± 0.85	3.95 ± 0.89	-0.30	Not significant (P=.1372)	--
Non-Māori and non-Pasifika (301 people)	71%	71%	0%	3.87 ± 0.86	3.87 ± 0.86	0.00	Not significant (P=.948)	--

	Percentage who noted "confident" or "very confident"			Mean rating ± SD (1 - Not very confident, 5 - Very confident)			Post-survey vs. Follow up	
	Post-survey	Follow up	Change	Post-survey	Follow up	Change	p-value	Cohen's d (effect size)
Confidence in supporting someone who may be suicidal								
All (381 people)	65%	51%	-14%	3.73 ± 0.91	3.45 ± 1.08	-0.29	p<.000	0.29 (Small)
Māori (67 people)	82%	63%	-19%	4.15 ± 0.74	3.76 ± 1.05	-0.39	p< .01	0.43 (Small)
Pasifika (20 people)	75%	60%	-15%	4.10 ± 0.91	3.60 ± 1.10	-0.50	p<.05	0.50 (Small)
Non-Māori and non-Pasifika (297 people)	60%	47%	-12.8%	3.62 ± 0.91	3.37 ± 1.07	-0.25	p<.000	0.25 (Small)

	Percentage who noted "confident" or "very confident"			Mean rating ± SD (1 - Not very confident, 5 - Very confident)			Post-survey vs. Follow up	
	Post-survey	Follow up	Change	Post-survey	Follow up	Change	p-value	Cohen's d (effect size)
Confidence in knowing when to suggest different types of mental health support options								
All (387 people)	87%	67%	-20%	4.26 ± 0.77	3.77 ± 0.93	-0.50	p<.000	0.58 (Medium)
Māori (68 people)	88%	75%	-13%	4.15 ± 0.74	4.04 ± 0.82	-0.10	p< .01	0.13 (Negligible)
Pasifika (20 people)	95%	60%	-35%	4.55 ± 0.60	3.75 ± 1.16	-0.80	p<.05	0.86 (Medium)
Non-Māori and non-Pasifika (302 people)	86%	66%	-20%	4.21 ± 0.77	3.72 ± 0.93	-0.49	p<.000	0.58 (Medium)

	Percentage who noted "confident" or "very confident"			Mean rating ± SD (1 - Not very confident, 5 - Very confident)			Post-survey vs. Follow up	
	Post-survey	Follow up	Change	Post-survey	Follow up	Change	p-value	Cohen's d (effect size)
Confidence in knowing a range of professional mental health support options								
All (386 people)	81%	69%	-11%	4.04 ± 0.79	3.81 ± 0.95	-0.23	p<.000	0.26 (Small)
Māori (67 people)	90%	76%	-13%	4.25 ± 0.77	4.06 ± 0.81	-0.19	Not significant (P=.0795)	--
Pasifika (20 people)	95%	75%	-20%	4.30 ± 0.73	3.90 ± 1.02	-0.40	Not significant (P=.088)	--
Non-Māori and non-Pasifika (302 people)	78%	68%	-10%	3.98 ± 0.79	3.76 ± 0.97	-0.22	p<.01	0.25 (Small)

	Percentage who noted "confident" or "very confident"			Mean rating ± SD (1 - Not very confident, 5 - Very confident)			Post-survey vs. Follow up	
	Post-survey	Follow up	Change	Post-survey	Follow up	Change	p-value	Cohen's d (effect size)
Confidence in knowing how to contact appropriate professionals								
All (385 people)	85%	71%	-14%	4.25 ± 0.80	3.85 ± 0.98	-0.40	p<.000	0.45 (Small)
Māori (67 people)	90%	76%	-13%	4.43 ± 0.76	4.06 ± 0.92	-0.37	p< .01	0.44 (Small)
Pasifika (20 people)	90%	75%	-15%	4.55 ± 0.69	3.75 ± 1.02	-0.80	p<.01	0.92 (Large)
Non-Māori and non-Pasifika (301 people)	84%	69%	-14%	4.20 ± 0.81	3.82 ± 0.99	-0.38	p<.000	0.42 (Small)

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