	TITLE (AUTHORS)	DESIGN	OUTCOMES	KEY RESULTS	3.1	3.2	3.3	3.4	3.5	Total
1.	Evaluation of culturally and linguistically diverse teen Mental Health First Aid, (Slewa-Younan et al., 2019)	Quantitative Non-randomised Study - Cohort Study	Study developed surveys to measure MHL, stigmatising attitudes, MHFA behaviours, and the help-seeking status of adolescents in Year 10. Within the adult group, questions focused on MHL, stigmatising attitudes, MHFA behaviours, and appropriate help-seeking and youth mental health knowledge. Statistical	**Adults thought to be helpful** Following training, students were more likely to endorse 'helpful' adults as valid source of help ($p<.001$) and these gains were maintained at follow-up ($p<.01$). **Helping intentions** Significant higher levels of consistent (helpful) helping intentions were found after training ($p<.01$), and this was maintained at follow-up ($p<.05$). **Helping intentions - Harmful** Significant lower levels of discordant (harmful) helping intentions were found after training ($p<.001$), and this was maintained at follow-up ($p<.01$). **Knowledge of mental health problems** A significant improvement in participants' knowledge about youth mental health problems and youth	*	*		*	*	****

				mental health first aid was noted from pre- to post-training ($p < 0.01$) and were maintained at follow-up ($p < 0.01$). **Confidence helping** Confidence when helping a young person with mental health problems increased significantly after training ($p<.001$) and this was maintained at follow-up ($p<.05$).						
2.	Impact of Mental Health First Aid on Confidence Related to Mental Health Literacy: A National Study with a Focus on Race-Ethnicity. (Crisanti et al., 2016)	Quantitative Non-randomised Study - Cross-sectional Study	Confidence levels in applying skills matched against age, gender and race-ethnicity	**Confidence scores** The mean and median mental health literacy confidence level was 41.06±4.95 and 43 respectively. Confidence levels were reported higher amongst females 41.20 versus 40.61 males. There was also a reported difference in total confidence score by age groups and race. Both were $p<.0001$ MHFA increased one's confidence in being able to apply various skills and knowledge related to MHL, including the ability to recognize someone who may be dealing with	*		*	*	*	****

				a mental health problem or crisis and to listen actively and compassionately to someone in distress.						
3.	Enhancing mental health literacy in rural America: Growth of Mental Health First Aid program in rural communities in the United States from 2008–2016.(El-Amin, Anderson, Leider, Satorius, & Knudson, 2018)	Quantitative Non-randomised Study - Cross-sectional Study	• Growth of MHFA in the rural areas in the US. • Post training impact of MHFA in relation to MHFA related knowledge, skills attributed to the training	The review focused on the post training results reported. The study reported that participants engaged in either adult or youth form of MHFA, comparison between urban–rural trained settings showed a difference within 3 percentage points	*	*		*		***
4.	Improving mental health capacity in rural communities: Mental health first aid delivery in drought-affected rural New South Wales (NSW). (Sartore et al., 2008)	Quantitative Non-randomised Study - Cohort Study	• Recognitions of mental health disorders • Concordance of beliefs • Social Distance measures • Experience & confidence levels	**Recognitions of mental health disorders** Depression (Pre = 82.1 and Post = 94.1) Schizophrenia (Pre = 55.7 and Post= 67.1) **Concordance of beliefs** Depressions (Pre= 74.72 and Post= 88.05) Schizophrenia (Pre=80.65, Post=87.86) **Social Distance measures** about depression reduced from 9.87 (SD= 2.66) to 8.03	*	*	*	*	*	*****

				(SD= 3.65). Schizophrenia reduced from 12.75 (SD=3.61) to 9.91 (SD=3.18) **Experience & confidence levels** Significantly confident to help post intervention was reported (P < 0.05; 60% pre versus 89% post course) Experience in rendering help post intervention were reported not significantly different (P = 0.975, paired-sample t-test).						
5.	Mental health first aid training among pharmacy and other university students and its impact on stigma toward mental illness. (McCormack, Gilbert, Ott, & Plake, 2018)	Quantitative non-randomized studies-Quantitative descriptive studies	• Social Distance Scale (SDS) • Attitudes to Mental Illness Questionnaire (AMIQ) Both to access stigmatizing behavior.	**Social Distance Scale (SDS)** Study reported that pharmacy students displayed an improvement (p < 0.05) in six of the seven responses for the schizophrenia vignette while non-pharmacy students displayed an improvement in only four of the vignettes. Both cohorts displayed an improvement in only one item on the depression vignette.		*	*	*	*	****

				Attitudes to Mental Illness Questionnaire (AMIQ) Study reported an improvement observed amongst pharmacy student on four and five items in the schizophrenia and depression vignette respectively. Study reported that for non-pharmacy students, they displayed an improvement in two separate items for both vignettes						
6.	Exploring Youth Mental Health First Aider Training Outcomes by Workforce Affiliation: A Survey of Project AWARE Participants. (Haggerty, Carlson, McNall, Lee, & Williams, 2018)	Quantitative Non-randomised Study - Cohort Study	• Mental health literacy (MHL) • Perceived mental health stigma (MHS) • Confidence in helping behavior.	Pre-test: First aiders scored significantly higher than non-mental health workforce first aiders did for MHL and confidence in helping behaviour ($p < .001$), but no differences were found for MHS. Non-mental health workforce aiders scored significantly better from pre-test to post-test for MHL and confidence in helping behaviour ($p < .001$), to levels consistent with participants from the mental health workforce,	*	*	*	*	*	*****

				who did not show improvements at post-test over relatively high pre-test levels. With no additional training, non-mental health workforce participants were able to maintain the positive gains at the 3-month follow-up						
7.	Evaluation of Mental Health First Aid USA Using the Mental Health Beliefs and Literacy Scale. (Banh et al., 2019)	Quantitative Non-randomised Study - Cohort Study	• Mental Belief & literacy scale (Unified theory of Behavioral change)	**Mental Belief & literacy scale (Unified theory of Behavioral change)** Study reported a significant effects of time (pre-post), F11,101 =23.13, P < .000; mental health experience (yes-no), F11,101 = 2.35, P < .013; and the interaction of time and mental health experience, F11,101 = 2.95, P < .002.	*	*		*	*	****
8.	Mental health first aid training for the Chinese community in Melbourne, Australia: effects on knowledge about and attitudes toward people with mental illness. (Lam, Jorm, Wong, Angus, & Wong, 2010)	Quantitative Non-randomised Study - Cohort Study	• Mental Literacy (Using Vignette) • Stigmatizing attitudes (Social distance scale)	**Mental literacy** Participants reported to have improved in their recognition of the disorder from pre-test to post-test (p < .001 for depression and p = .029 for schizophrenia).	*	*	*	*	*	*****

				Stigmatizing attitudes There was a reported decrease in stigmatizing attitudes as measured by social distance with P reported as .003 and .005 for both depression and schizophrenia respectively.						
9.	Farm Advisors' reflections on Mental Health First Aid training. (Hossain, Gorman, Eley, & Coutts, 2010)	Quantitative Non-randomised Study - Cohort Study	• Mental health knowledge (Using mental health literacy scale) • Demographic influence on mental health knowledge (Sex, age & work experience)	**Mental health knowledge** There was a reported improvement in mental health first aid literacy. Mean of 10.75 (SD = 3.56) at pre-test and 22.19 (SD = 1.46) at post-test. **Demographic influence against mental health knowledge** There was no reported effect of sex, age or work experience on knowledge post-training compared to pre-training.	*	*	*	*	*	*****
10.	Mental Health First Aid Training: Initial Evaluation by Private Sector Participants. (Borrill, 2010)	Quantitative Non-randomised Study - Cohort Study	• Confidence level (Self-rating 10-point scale) • Knowledge (Numerical rating)	**Confidence ratings** Pre-training rating median was 3 (55%) of participants rated their confidence 3 and lower. Post-training ratings of participants' reported confidence showed a statistically significant	*	*	*		*	****

				increase from baseline to post-intervention (z = 4.55, p= <.0001)						
11.	Ash. (Aakre, Lucksted, & Browning-McNee, 2016)	Quantitative Non-randomised Study - Cohort Study	• Identification of appropriate assistance behaviors (Used 4 written vignettes) • Likelihood of providing help • MHFA knowledge	**Identification of appropriate assistance behavior** Mean score reported on the vignette questionnaire showed a slight increase post training when considered against the ALGEE approach Pre SD= 0.80 and Post SD1.87. It was reported that there was a difference observed in only 4 elements of ALGEE with no significant different observed on the G element of the approach p=.139 **Likelihood of providing help** Participants were reported to be more confidence post-training t-test reported were 5.25, 4.44 and 3.36 on the vignette ratings. **MHFA Knowledge** Quiz administered post-	*	*			*	***

				training 83% was reported to have scored 9 or 10 on all the 10 items.						
12.	Do Mental Health First Aid™ courses enhance knowledge? (Morrissey, Moss, Alexi, & Ball, 2017)	Quantitative Non-randomised Study - Cohort Study	• Knowledge (Self-developed questionnaire)	After completing the course, the percentage of correct responses increased from 57.8 to 71.0 percent ($p<0.001$).	*	*	*		*	****
13.	An Evaluation of Youth Mental Health First Aid Training in School Settings. (Gryglewicz, Childs, & Soderstrom, 2018)	Quantitative Non-randomised Study - Cohort Study	• 76-item self-reported questionnaire addressing the following constructs: 1.Mental health literacy. 2.Attitudes toward mental illness and treatment. 3.Confidence in addressing mental health issues. 4.Intentions to engage in help-seeking behaviors	Study reported a 57% improvement in mental health literacy post training, 64% reduction in negative attitudes. Study also reported an 89% increase in confidence level and 76% increase in their intentions to offer help.	*	*	*		*	****

14.	Evaluation of Mental Health First Aid training with members of the Vietnamese community in Melbourne, Australia. (Minas, Colucci, & Jorm, 2009)	Quantitative Non-randomised Study - Cohort Study	• Knowledge & Skills using Vignette • Attitudes (Vignettes) • Previous personal & professional contacts of recipients.	**Knowledge & Skills** Reported improvement between pre & post-test in ability to recognize disorder Depression (53.5, 85.2) Early schizophrenia (40.6, 66.3) Depression with suicidal thoughts (68.3, 79.2) chronic schizophrenia (28.7, 69.2) ($P < 0.001$). For the skills element against ALGEE, it was reported that scores were significant for all elements of the ALGEE action plan ($p < 0.0001$, except for encouraging the person to seek professional help which were relatively high at pre-test. **Attitudes** There was a higher level of disagreement reported on the negative attitudes of participants towards people with mental health challenge. Also reported impact on personal stigma & perceived stigma using a vignette.	*	*	*	*	*	*****

15.	Effectiveness of Youth Mental Health First Aid USA for Social Work Students. (Rose, Leitch, Collins, Frey, & Osteen, 2019)	Quantitative Non-randomised Study - Non Randomized Controlled Trial	Mental health beliefs & literacy scale which included the following construct: 1. Attitudes and beliefs about performing ALGEE actions 2.Subjective norms on social pressures to engage or not engage in ALGEE 3.Self-efficacy measuring the confidence to perform targeted ALGEE actions 4. Knowledge	**Attitudes and beliefs about performing ALGEE actions** The study reported less difficulty in the implementation of ALGEE actions after the intervention across all time-points post training but sustained between T2(Post-test) and T3(5-Months Follow up). A Bonferroni-adjusted (α= .03) post hoc analyses revealed a statistically significant decrease in difficulty between T1 and T2 (p = .02; 95% CID [0.05, 0.74]; Cohen's d = .56), and between T1 and T3 (p < .001; 95% CID [0.37, 0.89]; Cohen's d = .96), but not between T2 and T3 (p = .18. Also, students in this sample perceived that implementing ALGEE would be rewarding over the course of the 5-month time period T1 and T2 (p = 1.00) T2 and T3 (p = .51). **Subjective norms** Students' view of what	*	*	*	*	*	*****

				people close to them think about the mental health of others did not change significantly over the course of the time. It was reported that changes in scores were observed over time based on the repeated measures ANOVA, F (2, 50) =1.81, p =. 174.Thought on the need to implement ALGEE was reported to have changed over time F (1.4, 36.58) = 5.36, p = .02. **Self-efficacy** ANOVA result reported explained that students' confidence in their ability to carry out ALGEE actions over time showed changes F (2, 44) = 22.74, p < .001. Bonferroni-adjusted (a = .03) post hoc analyses reported explained an increase between T1 and T2 (p < .001; 95% CI∆ [-0.91, -0.28]; Cohen's d =1.20) as well as T1 and T3 (p < .001; 95% CI∆ [-1.01, -0.37]; Cohen's d = .98), but not between T2						

				and T3 (p = .81) **Knowledge** There was reported changes in student knowledge post training. F (2, 44) = 9.25, p< .001. A Bonferroni-adjusted (a = .03) post hoc analyses reported showed an increase in knowledge between T1 and T2 (p = .01; 95% CI∆ [-3.29, -0.36]; Cohen's d = 1.07) and between T1 and T3 (p =.004; 95% CI∆ [-4.76, -0.80]; Cohen's d= .48), but not between T2 and T3 (p= .42).						
16.	Evaluating the Effectiveness of Mental Health First Aid Program for Chinese People in Hong Kong. (Wong, Lau, Kwok, Wong, & Tori, 2017)	Quantitative Non-randomised Study - Non-Randomized Controlled Trial	• Mental health literacy (Questionnaires based on 2 vignettes) • Stigmatization towards mental illness (Personal attributes scale & Social distance)	**Mental health literacy** Study reports positive changes in the recognition of depression (F= 20.71, p < .00) and schizophrenia (F= 6.74, p < .00); social distance concerning depression (F = 11.48, p < .00) and schizophrenia (F = 5.73, p < .00); and confidence	*	*	*	*	*	*****

				in offering help to others ($F= 9.78$, $p < .05$) were found in the participants across pre-test, post-test, and follow-up test, except for dangerousness and dependency measures. Also reported were Cohen's d ranging from .20 to .499 for modest improvement and .50 to .799 for moderate improvement between pre-test to post-test and between pre-test and follow-up respectively.						

17.	Improving the capacity of community-based workers in Australia to provide initial assistance to Iraqi refugees with mental health problems: an uncontrolled evaluation of a Mental Health Literacy Course. (Uribe Guajardo et al., 2018)	Quantitative Non-randomised Study - Cohort Study	• Recognition and knowledge of mental health problems • Attitudes (Social distance scale), Personal stigma, intention to help, confidence helping, helping behaviours	**Recognition and knowledge of mental health problems** Study reported a significant impact on improving recognition of PTSD and depression, increasing knowledge of mental health problems post training. 56% of participants Could recognize 'PTSD' before training while 77% of them did after training ($p = 0.001$) which was reported to have improved at follow-up to 82% ($p=0.032$). Compared to the identification of depression, 69% of participants were able to correctly identify 'depression' at pre-training. This was reported to have increased to 83.5% at post-training and then to 82.2% at follow-up. With regards to beliefs of helpfulness of treatment for both mental health problems, participants were reported to be more	*	*	*	*	*	*****

				likely to endorse professional recognized treatment for PTSD and depression ($p < 0.001$for both) at post-training but an increase was only observed in the beliefs towards depression at follow-up ($p=0.010$). **Attitudes (Social distance scale), Personal stigma, intention to help, confidence helping, helping behaviors.** Study reported a reduction in levels of personal stigma post-training, for both the subscales of 'weak-not-sick' ($p < 0.001$) and 'dangerous/ unpredictable beliefs' ($p < 0.001$). Scores were reported low at follow-up compared with pre-training. Also, the social distance scale reported a decrease at ($p = 0.006$) after training with regards to PTSD vignette. A significant decrease in social distance towards						

				PTSD from pre-training to follow-up was also found ($p < 0.001$). Compared to the depression vignette, study reported a decrease from pre-training to follow-up ($p = .007$).						

18.	Mental Health First Aid training evaluation. (Heer et al., 2010)	Quantitative Non-randomised Study - Cohort Study	• Reasons for attending • Use of MHFA post training. • Knowledge & Skills (Help rendered) • Attitudes	Reasons for attending training 64.4% were reported to have attended the training based on work-related reasons (own choice) whilst 11%, 10.3% attended because were either asked to go by their manager or due to their community involvement respectively. Use of MHFA 68.5% (n=100) reported to have used an element of the training to help someone. Though a majority of those were spread across Clients 44.3% & Family or friends 26.4% Type of help rendered (Skills against ALGEE) It was reported that respondents claimed to have used a combination of elements thoughts on the training with listening skills as the most used skillset. 80% of respondents reported an improving	*		*	*	*	****

				knowledge of mental health issues. Changing attitudes Checking the respondent's attitudes against a statement developed by the departments of health's attitudes to mental illness survey, it was reported that people who completed MHFA showed a greater tolerance towards mental illness compared to the general survey conducted on the general public.						
19.	An Evaluation of the Impact of MHFA Training in Kingston Upon Hull. (MacDonald, Cosquer, Flockton, & Humber, 2008)	Quantitative Non-randomised Study - Cohort Study	• Confidence levels • Skills compared to the ALGEE • Mental health of trainees	**Confidence levels** 93% of respondents reported an increase in their confidence to help someone with a mental health problem. **Skills Rendered** • 89% reported offering help post training. • Most commonly used help was (83%) listening and giving assurances. • 61% felt able to offer advice or self-help strategies and 65%	*	*	*	*	*	*****

				encouraged people to seek appropriate professional help. **Mental health of trainees** • 74% reported a positive impact on their mental health.						
20.	Mental Health First Aid USA in a Rural Community: Perceived Impact on Knowledge, Attitudes, and Behavior (Mendenhall, Jackson, & Hase, 2013)	Quantitative Non-randomised Study - Cohort Study	• Knowledge & Skills (self-reported) • Self-reported outcomes	**Knowledge & skills** General MHFA content were reported high 82% by respondents whilst a 71% only remembered the meaning of ALGEE. 63% reported to have used MHFA. **Self-reported outcomes** 90% participant was reported to have picked up a new skill most especially in the recognition of mental illness signs whilst 73% was reported to be more confident to render help. 56% participant was reported to have change their attitudes as a result of attending the training.	*				*	**

TABLE 3: QUANTITATIVE NON-RANDOMIZED STUDIES