The evaluation of mental health first aid in a rural area

Determining its effectiveness in improving mental health literacy, attitudes and behaviour towards people with mental health problems

NSW HEALTH

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Abbreviations and acronyms

ACT   Australian Capital Territory

ANU   Australian National University

CMHR   Centre for Mental Health Research (ANU)

D&A   Drug & Alcohol

GP (s)   General Practitioner(s)

LGA   Local Government Area

MHFA   Mental Health First Aid

NSW   New South Wales

RCT   Randomised Controlled Trial

SAHS   Southern Area Health Service

Executive summary

Issue addressed

There is a high prevalence of mental health problems in Australia and a need for greater mental health literacy in the community. Mental Health First Aid (MHFA) is an initiative that has been developed to improve the mental health literacy, attitudes and behaviours towards people with mental health problems in the community.

Evaluation methods

The evaluation of MHFA in a rural area consists of a cluster randomised controlled trial, a qualitative evaluation of MHFA participants and a qualitative evaluation of MHFA instructors.

Cluster randomised controlled trial

Participants were randomly allocated to immediate participation (experimental) or wait-list (control) at the level of Local Government Area. The Local Government Areas were matched in pairs to have similar population and social characteristics. Outcomes were measured pre- and post-course at the individual level by a scripted telephone interview. Data were analysed using an intention-to-treat approach.

Qualitative evaluation of participants

Questionnaires were completed by a non-random, availability sample of participants by mail or email.

Qualitative evaluation of instructors

Semi-structured group and individual interviews with instructors and an analysis of a random sample of participant feedback forms were conducted.

Results

Cluster randomised controlled trial

Seven hundred and fifty three individuals were recruited, 416 of which were randomly allocated to the MHFA group and 337 to the control group. From pre-test to follow-up a significantly larger percentage of the MHFA group than the control group changed from reporting they had not experienced a mental health problem to having experienced one, from incorrectly to correctly diagnosing a case vignette of either a person with schizophrenia or depression and from

reporting not offering help to a person with a mental health problem to offering help. The MHFA group changed significantly more than the control group in their agreement with health professionals about treatment, in the degree of reduction in reported social distance from the person in the vignette and in their confidence in providing help.

Qualitative evaluation of participants

Ninety-four respondents to the questionnaire indicated MHFA was well received by a wide range of participants. The majority of respondents had a direct experience, post-course, of a mental health issue and reported that MHFA enabled them to respond and act positively to the issue. They reported experiencing positive effects both intra-personally as well as inter-personally.

Qualitative evaluation of instructors

Common themes, challenges and recommended changes to the program were identified by four of the five MHFA instructors who took part in the evaluation. They agreed MHFA met the aims of improving the mental health literacy of community participants through providing useful, relevant and evidence based information, decreasing stigma and increasing the skill base of participants.

Conclusion

The MHFA training course produced positive changes in knowledge, attitudes and behaviour when given to members of the public by instructors from a local health service. The quantitative and qualitative evaluation studies demonstrate the MHFA program is a valued and effective strategy in raising the mental health literacy of the community.

Recommendation

MHFA should be considered as a key strategy in broader mental health promotion and workforce development initiatives in the future.

Introduction

This report describes the implementation and evaluation of Mental Health First Aid (MHFA), an initiative developed by the Centre for Mental Health Research (CMHR), Australian National University (ANU) to improve the mental health literacy, attitudes and behaviours towards people with mental health problems in the community.

The main purpose of this report is to describe the implementation of MHFA in a rural area of New South Wales (NSW) in 2003 and to present the findings of its evaluation through a cluster randomised controlled trial (RCT). This research was funded under the NSW Health Promotion Demonstration Research Grants Scheme. Qualitative evaluations have since been conducted with instructors and participants involved in the trial, which were not funded by this Scheme, however are presented here to provide the reader with a comprehensive overview of the evaluation of MHFA in a rural area.

Background and rationale

Since 1992 extensive reform in mental health service delivery has been undertaken throughout Australia. Three National Mental Health Plans have been agreed by state and federal ministers for health[1-3] and substantial reform has been undertaken across all jurisdictions. Recent NSW policy has noted the need to increase the focus on early intervention and coordinated care in the community.[4] There has also been a growing imperative for public moneys to be invested in strategies that are evidence based. There are several pieces of evidence showing the need for MHFA training in Australia, described below.

High prevalence of mental health problems in Australia

In 1997 the *National Survey of Mental Health and Wellbeing* found that close to one in five adult Australians met the criteria for a mental disorder at some time during the 12 months before the survey.[5] The most common mental disorders were depression, anxiety and alcohol misuse. These disorders are so prevalent that everyone can expect to either develop one or have close contact with someone who does.

Poor knowledge amongst Australians regarding mental health problems

Whilst members of the Australian general public have widely available evidence-based knowledge regarding physical health, there is far less available knowledge about mental health. In 1995, the *National Survey of Mental Health Literacy* carried out interviews with 2000 adult members of the general public across Australia.[6] This survey assessed the general public's 'mental health literacy', that is, knowledge and beliefs about mental disorders that aid the recognition, management, treatment or prevention of these disorders.[7] The survey found that there are widely differing knowledge and views between mental health professionals (GPs, psychiatrists, psychologists and mental health nurses) and members of the general public regarding the causes and treatment of mental health problems.[8] This gap between professional and lay people in knowledge and beliefs regarding mental health has serious implications. It may mean that the public may not seek appropriate mental health services and/or that they may not adhere to some types of evidence-based treatment recommended by health professionals.

Unfortunately, there is also some evidence that the medical profession does not always deal appropriately or effectively with people with mental disorders. There is a fairly high rate of non-recognition of many cases of anxiety and depression in primary care. In two Australian studies of patients consulting general practitioners (GP)s, up to half the patients presenting with anxiety or depression had these diagnoses missed.[9-10] However, one of these studies[10] also found that if patients were able to identify that they were feeling depressed, the GP was far more likely to recognise the mental health problem and treat it appropriately.

The need for greater mental health literacy

It seems plausible that greater mental health literacy will help a person better manage a potential or developing mental health problem in him or herself and there is some evidence to support this view.[11] Similarly, a person with greater mental health literacy should be in a better position to help family members and friends who develop a mental health problem. Greater awareness in

the general community about mental illness will also help people recognise their problems and help them feel comfortable discussing these issues with their doctor. Thus any programme to increase the mental health literacy level of members of the general public can be seen as facilitating both mental health promotion and mental illness prevention.

MHFA as a population health strategy

The MHFA course has the potential to become a strategy within a wider population health framework by addressing three specific outcomes of the *National Mental Health Plan 2003–2008*:[1]

■ Increased levels of mental health literacy in the general community and in particular settings, and decreased levels of stigma experienced by people with mental health problems and mental illness

■ Increased capacity of communities to prevent mental health problems, mental illness and suicide, and identify and intervene early with people at risk

■ Improved access for other population groups of all age groups with diverse and complex needs.

MHFA as a means to improve mental health literacy

One approach to improving mental health literacy is to extend the model employed by Red Cross and St John Ambulance First Aid courses. First Aid courses give information and skills regarding the initial treatment of injuries and on handling accident emergencies. These courses are widely available throughout the country and are often sponsored by employers, schools and community groups. This approach can be extended to mental health.

Mental health problems are generally ignored by existing First Aid courses. If they do include a short mental health component, for example St John Advanced Course, this focuses exclusively on mental health crises, such as acute psychosis. The limitations of a purely crisis-based approach are that:

a) mental health crises are rare in daily life

b) most mental health problems develop slowly and help is needed before a crisis develops

c) a crisis approach may misinform the public about the nature of mental disorders and increase stigma.

Rather than incorporate a small component of crisis intervention in a traditional first aid course, the CMHR has developed a specialised course devoted entirely to mental health. This course provides skills and knowledge to enable participants to give initial help to a person experiencing a mental health crisis or on-going mental health problems. Most emphasis is given to the common mental health problems of depression and anxiety in view of their high prevalence in the community.[5]

The need for MHFA in southern NSW

MHFA courses were conducted in the Australian Capital Territory (ACT) in 2002 with over 700 people trained. Additional funding was provided by a tender from ACT Health to the CMHR for a train-the-instructor course. However there was considerable demand for courses in southern NSW and several people living in southern NSW had expressed interest in becoming MHFA instructors. Four courses had been conducted in Southern NSW, with three in Queanbeyan and one in Goulburn. However the CMHR had only one instructor who could not satisfy the demand. Funding was needed to train instructors from southern NSW and to run MHFA courses.

The need for an evaluation of MHFA

The MHFA course had been predominantly trialled in the relatively small and confined jurisdiction of the ACT using assessments at pre-test, post-test and six months follow-up.[12] Data showed improvements in mental health literacy and reductions in stigmatising attitudes. However, this initial evaluation lacked a control group and a gold standard evaluation was required.

The cluster RCT aimed to test the following hypotheses:

a) The trained group will show greater improvement in mental health literacy than a wait-list control group. The change will mean that the trained group's beliefs are more like those of mental health professionals

b) The trained group will show a decrease in stigmatising attitudes compared to the wait-list control group

c) The trained group will report a greater improvement in the frequency and type of helping behaviours towards people with mental health problems than the wait-list control group.

Project aim and objectives

Aim

To determine the effectiveness of MHFA in improving mental health literacy, stigmatising attitudes, and helping behaviours towards people with mental health problems through a cluster RCT.

Objectives

1. Train a minimum of four MHFA instructors in southern NSW

2. Have a minimum of 500 members of the public from southern NSW complete the MHFA course

The intervention

Delivery of a MHFA course

A MHFA course was delivered to 753 residents of the Local Government Areas (LGAs) of the Southern Area Health Service (SAHS) during 2003. The group was divided into an intervention group and a wait-list control group for research and assessment purposes.

A pre-test assessment was administered to the entire group in January-February 2003 and the MHFA courses were delivered to the intervention group in March-April 2003. The outcomes were measured for the intervention group again in July-August 2003. The wait-list control group received MHFA courses in September-October 2003, after which the follow-up outcome assessment was completed.

The MHFA course

The course teaches a five-step approach to providing mental health first aid:

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

All of the strategies in this course are based on published clinical practice guidelines, recently published reviews of relevant research and advice from experts.

The MHFA course consisted of nine hours spread over three hour sessions. Each session or module addressed mental health crisis and non-crisis situations for different mental health problems.

Session one: An overview of the course and the topic of First Aid for depressive disorders, including the crisis situation of suicidal thoughts and/or actions.

Session two: First Aid for anxiety disorders, including the crisis situation of panic attacks and acute stress reactions.

Session three: Substance use disorder and psychosis, a short revision quiz and an evaluation of the course.

Learning objectives of each module were as follows:

Module 1 – Depressive disorders
- To recognise the signs and symptoms of clinical depression
- To give appropriate initial help and support for a person in a depressed state
- To take appropriate action if someone shows suicidal behaviour

Module 2 – Anxiety disorders
- To recognise the signs and symptoms of an anxiety disorder
- To give appropriate initial help and support for a person in an anxious state
- To take appropriate action if someone shows an acute stress reaction or panic attack

Module 3 – Psychosis and Substance use disorders
- To recognise the signs and symptoms of psychotic behaviour
- To give appropriate initial help and support for a person showing acute psychotic behaviour
- To recognise the signs and symptoms of a substance use disorder
- To know that substance use disorders often occur together with the other mental disorders covered

MHFA taught how to help people in the crisis situations such as being suicidal, having a panic attack, being exposed to a traumatic event, or in an acute psychotic state. The symptoms, risk factors and evidenced-based treatments (medical, psychological, alternative and self-help) for the mental disorders of anxiety, depressive and substance use and psychotic disorders were also taught.

MHFA taught current information about mental illness, mental disorders and mental health problems. It was designed to give factual information, in clear, concise and understandable language without prejudice or bias. In this way, information was delivered as any other public health information and knowledge would be delivered. This was based on the principle that accurate, non-judgmental information would contribute to a reduction in the stigma that is based on ignorance.

Selection and training of instructors

Expressions of interest to become a MHFA instructor were sought from staff of the SAHS and associated community organisations. Five instructors were recruited from a pool of ten applicants. All the instructors had experience in mental health work in addition to a background in either training, working with communities or health promotion work.

Instructors were selected using the following criteria:

- Good interpersonal skills
- Good teaching and communication skills
- Favourable attitudes towards people with mental health problems
- Personal or professional experience with people with mental health problems
- Good background knowledge of mental health and community services
- Completed the CMHR MHFA course.

The instructors were trained at a seven-day MHFA Educator Workshop by one of the developers of MHFA. This workshop involved four days teaching detailed information on each of the disorders covered and the MHFA strategies for helping them. The remaining two days covered teaching skills and practice pertaining to delivery of the course. All instructors were given a teaching kit of lesson plans, videos, books, master copies of handouts and a full and comprehensive set of transparencies. Each trainee educator was also supervised while he/she conducted one or two MHFA courses and there was ongoing assistance for educators with any queries or problems. Because the MHFA course was evidence-based in its content, there were on-going updates to the educators from the CMHR on new relevant information or materials.

Project coordination

A project coordinator with experience in mental health and health promotion was employed to work on the project part time. This project coordinator was also trained as an instructor.

Instructor supervision and fidelity checks

The coordinator monitored a sample of courses taught during the trial to assess fidelity to the lesson plans. A fidelity checklist of topics that had to be covered was developed for each session. Four of the instructors had all three course sessions checked, while one of the instructors only had two sessions checked. The percentage of topics covered correctly was 100 per cent for four of the instructors and 81 per cent for one of the instructors.

Recruitment and conduct of MHFA courses

Eligible participants were residents of the catchment area of the SAHS who were over 17 years of age, who volunteered for training in response to publicity, who were available over the period of the trial, and who were willing to receive interviews assessing trial outcomes. Participants had to volunteer as individuals rather than as a group, for example, a workplace.

Eligible clusters were the sixteen LGAs in the catchment area of the SAHS in 2003. These LGAs ranged in population size from less than 5,000 to over 50,000 and varied from popular coastal areas to rural towns and farming communities.

Participants were recruited through articles and advertisements in local newspapers and interviews with local radio, which discussed the project and announced that MHFA was available for enrolment. Existing MHFA brochures were sent to key community organisations in each LGA, such as community service clubs, high schools, employment agencies, social welfare agencies and churches.

Courses were held in local community halls. A minimum of 10 participants was required for a course to be run in a designated location, the ideal number being 15–20 participants. The Project generated a great deal of interest and courses were over subscribed. A minimum of 500 participants was required yet 753 were recruited. Participants received a MHFA certificate at the completion of the course.

Cluster randomised controlled trial

This section of the report describes the MHFA cluster RCT conducted in 2003 funded by the NSW Health Promotion Demonstration Research Grant Scheme. This evaluation has been reported elsewhere and is reproduced here with permission from the authors.[13]

Evaluation methods

Sample size determination

For power calculations and sample size determination, a conservative assumption was made that the waitlist control group would show improvements, possibly due to increased awareness of mental health issues, of about 50 per cent of that of the experimental group. This corresponds to effect sizes in the range 0.28-0.31 for changes on scales and in the range 0.02-0.04 for changes in identifying the correct diagnosis. Sample size estimates using nQuery Advisor software[14] indicated that a sample size of 200 participants in each of the two groups would be sufficient to detect differences with power of at least 80 per cent in two sided tests at the 0.05 level. Clustering effects of individuals in 16 LGAs involved design effects of unknown magnitude in the analysis. It was assumed that these would be of the order of 20 per cent, so that total achieved sample sizes of 250 in each group would be sufficient to detect differences with 80 per cent power.

Randomisation: sequence generation

Randomisation to immediate participation (experimental) or wait-list (control) was at the level of LGA. The LGAs were matched in pairs to have similar population and social characteristics. The variables used for matching were population size, interior versus coastal location, and an index of population education/occupation. The first listed LGA of each pair was assigned to the immediate or wait-list group at random, using the Random Integers option of Random.org[15] to generate a one or a two for each pair. For LGA pairs receiving a one, the first member of the pair received immediate training, while for LGA pairs receiving a two the second member of the pair received immediate training.

Each individual participant was randomly assigned a variable (values of one or two) to determine which case

vignette they received during their interviews. This was done using the Random Integers option of Random.org[15]. Those assigned a one received the interview based on a vignette of a person who is depressed and those assigned two received a vignette of a person with schizophrenia.

Randomisation: allocation concealment

Allocation to experimental or control group was on the basis of cluster, that is, the participant's LGA determined whether they received immediate or wait-list training. Participants were not informed about their allocation to immediate or wait-list training until the end of their baseline interview.

Randomisation: implementation

LGAs were matched in pairs and allocated randomly by the principal researcher to immediate training or wait-list, as described above. Participants were not able to attend a class from outside their own LGA. There was a recruitment period for all LGAs, which was organised by the project coordinator. The coordinator and the participants who were recruited were blind to the allocation of the LGA during the recruitment period. The principal researcher revealed the allocation to the coordinator after the recruitment period ended. The coordinator then organised class times either immediately or after a waiting period, depending on the allocation of each LGA in the pair. The same instructors taught courses in each paired LGA, so that this factor did not differ between the immediate and wait-list LGAs.

Randomisation: blinding (masking)

At the time of the baseline interview, the participants did not know whether they were in an immediate or wait-list LGA. While the interviewers were not told whether the participant was in the experimental or control group, information about which group they were assigned to was given at the end of the interview script. Blinding of participants was not possible at follow-up interviews as participants knew whether or not they had received training. While interviewers were not told the allocation of the participants in these interviews, this might have become known during the interview if participants mentioned whether or not they had done the course. Interviewers were given a scripted interview to minimise

any bias in the assessment due to knowledge of allocation to immediate training or wait-list.

Outcome measurement

Outcomes were measured in January-February 2003 (pre-test assessment) and again in July-August 2003 (follow-up assessment). All outcomes were measured at the individual level by a scripted telephone interview administered by professional interviewers. The interviewers were provided with an ID, name and phone number of each participant and knew whether they were giving the first or second interview to the participant. As far as was practical given the very different sizes of the LGA pairs, the same interviewers interviewed participants in each pair.

The interview content was based on the questionnaire used in the uncontrolled trial of MHFA[12] (Appendix 1). In order to reduce the length of the interview, participants were individually randomly assigned to receive either a depression or a schizophrenia case vignette with the same questions asked in respect to each vignette. Participants were asked what they would do to help if they knew the person in the vignette. This 'mental health first aid intention' involved the presence or absence of eight elements, arrived at by a qualitative analysis of a sample of the responses, and added up to give a score from 0–8. They were asked about the likely helpfulness of a range of interventions for the person in the vignette, which were scored to give a scale of percentage agreement with mental health professionals about treatment. The follow-up questionnaire was the same as the baseline questionnaire except that it omitted the sociodemographic questions (age, gender, education, non-English speaking background, aboriginality) (Appendix 2).

Data analysis

The data were analysed by an intention-to-treat approach, with single imputation used for missing data. For outcomes measured on a numeric scale, the change from pre-test to follow-up was analysed using linear regression. For binary outcomes, individuals scoring the same at pre-test and at follow-up were not used, and for those who changed, the direction of change was analysed as a binary outcome using logistic regression. Standard errors and p-values were adjusted for the cluster design using Huber-White 'sandwich' variance estimator, treating the 16 LGAs as clusters. Analyses were corrected for differences between the LGA pairs by including this as an eight level fixed-effect factor in the regression models. Missing data were imputed using best-subsets regression. All analysis was done using Stata version 8.2.[16]

Results

Recruitment and participant flow

Recruitment of participants took place in October and November of 2002. Seven hundred and fifty three individuals were recruited, 416 of which were randomly allocated to the MHFA group and 337 to the control group. Figure 1 shows the number of participants and clusters at each stage of the trial.

Figure 1 Flow diagram of the number of participants and clusters at each stage of the trial
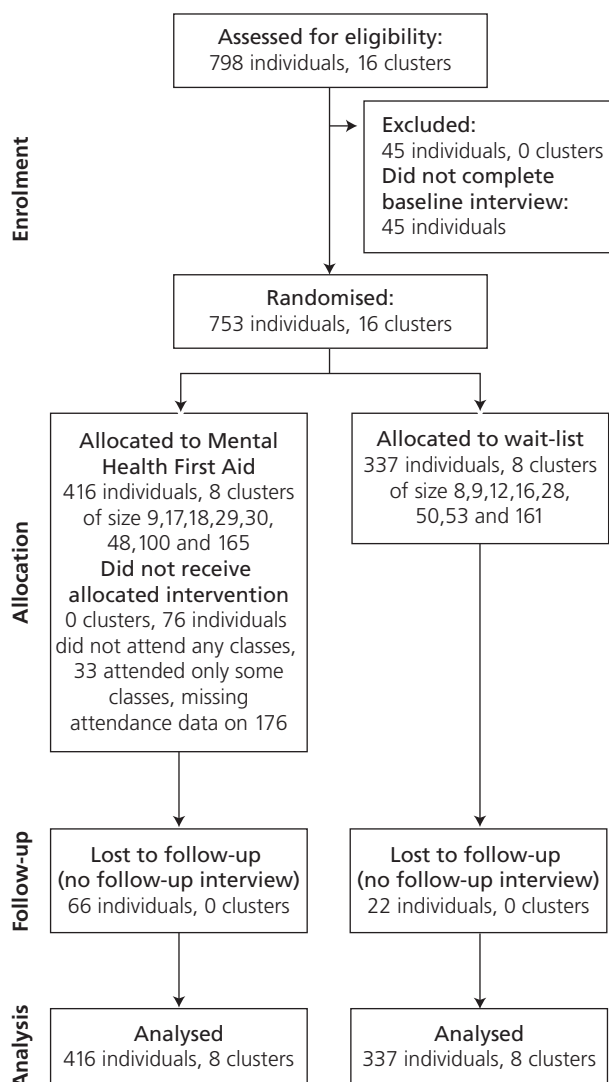
Baseline data

Table 1 shows the characteristics of each group at the cluster and individual level. The two groups appear to be well matched in terms of sociodemographic characteristics and in history of mental health problems in self and family. However, there was a significant difference in the reason for doing MHFA, with more people in the control group doing it for work reasons.

Table 1: Baseline characteristics for MHFA group and control group given at the individual and cluster levels

	Mental Health First Aid group	Control group	P-value
Local Government Area characteristics at baseline			
Number	8	8	
Population size			1.0
<5,000	3	3	
5,000–9,999	2	1	
10,000–19,999	1	2	
20,000–29,999	1	0	
30,000–39,999	1	2	
Number of participants in each area (smallest to largest)	9,17,18,29,30,48,100,165	8,9,12,16,28,50,53,161	
Individual participant characteristics at baseline			
Number	416	337	
Mean age (years)	47.14	47.97	0.42
Number (%) men	79 (19.0)	57 (16.9)	0.40
Number (%) with university degree	85 (20.6)	81 (24.1)	0.36
Number (%) aboriginal	11 (2.6)	10 (3.0)	0.40
Number (%) non-English speaking background	5 (1.2)	7 (2.1)	0.12
Reason for doing course: n(%)			0.011
Relating to workplace/voluntary work	180 (43.3)	188 (55.8)	
Relating to family/close friends	56 (13.5)	29 (8.6)	
Relating to own mental health status	20 (4.8)	10 (3.0)	
Duty as a citizen	49 (11.8)	44 (13.1)	
Just interested	111 (26.7)	66 (19.6)	

Note: P-values are adjusted for clustering by Local Government Area

Data analysis

As the data were analysed by an intention-to-treat approach with single imputation used for missing data the number of participants analysed was the same as the number randomly allocated (Figure 1).

Outcomes and estimation

Tables 2 and 3 show the changes found for the dichotomous and continuous outcome measures respectively and the P-value of the comparison between the MHFA and control group on these changes.

Table 2: Changes in dichotomous outcome measures for MHFA group and control group

Outcome	Mental Health First Aid group	Control group	OR (95% CI) P-value
Mental health problems in self			
Pre-test	154 (37%)	118 (35%)	
Follow-up	172 (41%)	118 (35%)	
Change (95% CI)	4% (2 to 6)	0% (-3 to 3)	0.548 (0.304, 0.986), P = 0.045
Mental health problems in family			
Pre-test	233 (56%)	183 (54%)	
Follow-up	277 (67%)	205 (61%)	
Change (95% CI)	11% (4 to 17)	7% (2 to 11)	0.575 (0.318, 1.037), P = 0.066
Correct diagnosis of vignette			
Pre-test	282 (68%)	249 (74%)	
Follow-up	337 (81%)	255 (76%)	
Change (95% CI)	13% (8 to 19)	2% (0 to 4)	0.311 (0.250, 0.387), P < 0.001
Help offered to person with mental health problem			
Pre-test	305 (73%)	256 (76%)	
Follow-up	340 (82%)	270 (80%)	
Change (95% CI)	8% (4 to 13)	4% (-2 to 10)	0.602 (0.380, 0.953), P = 0.031
Professional help advised to person with mental health problem			
Pre-test	81 (19%)	71 (21%)	
Follow-up	104 (25%)	73 (22%)	
Change (95% CI)	6% (3 to 8)	1% (-4 to 5)	0.734 (0.452, 1.191), P = 0.21

Note: P-values and confidence intervals are adjusted for clustering by Local Government Area

From pre-test to follow-up a significantly larger percentage of the MHFA group than the control group changed from reporting not having experienced a mental health problem to having experiencing one, from incorrectly to correctly diagnosing the case vignette and from reporting not offering help to a person with a mental health problem to reporting offering help. The MHFA group changed significantly more than the control group in their agreement with health professionals about treatment, in the degree of reduction in reported social distance from the person in the vignette and in their confidence in providing help.

Table 3: Changes in continuous outcome measures for MHFA group and control group

Outcome	Mental Health First Aid group	Control group	Treatment effect (95% CI), P-value
Agreement with health professionals about treatment			
Pre-test mean (SEM)	60.55 (3.89)	69.46 (2.18)	
Follow-up mean (SEM)	74.74 (1.91)	70.81 (2.27)	
Change (95% CI)	14.19 (9.53 to 18.85)	1.35 (-6.04 to 8.75)	11.77 (5.98, 17.56), P = 0.001
Social distance			
Pre-test mean (SEM)	8.13 (0.24)	8.06 (0.13)	
Follow-up mean (SEM)	7.59 (0.17)	7.90 (0.20)	
Change (95% CI)	-0.53 (-0.99 to -0.08)	-0.17 (-0.41 to 0.07)	-0.26 (-0.49, -0.03), P = 0.032
Mental health first aid intention			
Pre-test mean (SEM)	1.81 (0.04)	1.88 (0.04)	
Follow-up mean (SEM)	1.83 (0.03)	1.85 (0.07)	
Change (95% CI)	0.02 (-0.11 to 0.15)	-0.03 (-0.15 to 0.08)	0.06 (-0.00, 0.12), P = 0.066
Confidence in providing help			
Pre-test mean (SEM)	3.13 (0.08)	3.17 (0.07)	
Follow-up mean (SEM)	3.39 (0.05)	3.21 (0.07)	
Change (95% CI)	0.27 (0.11 to 0.42)	0.04 (-0.02 to 0.11)	0.21 (0.10, 0.33) P = 0.001
Number of people in contact with who had mental health problem			
Pre-test mean (SEM)	3.97 (0.31)	4.56 (0.20)	
Follow-up mean (SEM)	3.89 (0.30)	4.34 (0.29)	
Change (95% CI)	-0.08 (-0.64 to 0.49)	-0.22 (-0.83 to 0.40)	0.22 (-0.18, 0.63) P = 0.25

Note: Standard errors of the mean (SEM), confidence intervals and P-values are adjusted for clustering by Local Government Area

The intraclass correlations for the continuous outcomes were for:

- agreement with health professionals about treatment, 0.15 [95 per cent confidence interval (CI) 0.01–0.29]

- number of people in contact with that had a mental health problem, 0.02 (95 per cent CI 0–0.06)

- confidence in providing help, 0.03 (95 per cent CI 0–0.07)

- mental health first aid intention, 0.002 (95 per cent CI 0–0.02)

- social distance, 0.04 (95 per cent CI 0–0.08).

Thus for all but one outcome, the correlation was small, justifying our assumption of a modest design effect.

Adverse events

Informally, no adverse events were reported. Given that an educational intervention was evaluated with a non-clinical sample, there was no justification for a systematic inquiry into adverse events.

Qualitative evaluation of MHFA

This section of the report briefly describes two qualitative evaluations conducted with MHFA participants and instructors that were part of the cluster RCT of MHFA outlined above. The first, a qualitative evaluation of MHFA participants was funded by an NHMRC grant[17] and the second, a qualitative evaluation of MHFA instructors was funded by the Mental Health Service, SAHS. The qualitative evaluation of MHFA participants has been reported in full elsewhere[17] and is summarised here with permission from the authors and the qualitative evaluation of MHFA instructors is provided in more detail in Appendix 3.

Qualitative evaluation of MHFA participants

For the full report on this evaluation refer to Jorm et al.[17]

Aim

To gain an in-depth understanding about participants' experience of MHFA and its effects.

Evaluation methods

A questionnaire was developed to gain in-depth accounts of participants' experiences of MHFA and its relevance to them. Research workers at the CMHR contacted former MHFA participants to ask whether they would be prepared to participate in the survey. Consenting participants could complete the survey on paper or on-line and the following information was collected:

- Age, gender and education level
- Whether the participant had, or had not experienced a post-course situation where someone seemed to have a mental health problem. For those who:
  - *had not* had such an experience, the questionnaire asked them a few questions about expectation and about confidence with such a situation if it were to arise in the future
  - *had* experienced such a situation a variety of questions were asked which allowed the respondent to describe that experience.

The data generated were downloaded as Excel spreadsheets and the two data sources were combined for analysis. The data were examined to see if there were any apparent patterns of association, either between independent variables, such as age, sex, education or form of response (on paper versus on line) or between independent and dependent variables (qualities of the experience). The principal method used was to compile contingency tables and then examine various measures of association, as well as visual inspection, as a guide. The research company Qualitative and Quantitative Social Research (QQSR) was contracted to design the questionnaire and carry out the analysis.

Results

There were 94 respondents to the questionnaire, predominantly female (n=75) with an age range from 21–74 years (mean 51 years). Most respondents had experienced, post-course, a situation where someone seemed to have a mental health problem (n=73; 78 per cent). Of those who had experienced a mental health related situation, the majority said they had definitely been able to help (60 per cent), or thought they had been helpful (14 per cent). Only 5 per cent were unsure whether they had been helpful and no one reported they were not able to help. Of those who had not clearly had any encounter with a mental health issue post-course, most felt they could cope well (43 per cent) or moderately well (57 per cent) with such a situation if it arose.

Respondents' stories revealed that the knowledge, understanding and skills acquired in the MHFA training enabled them to respond positively to people experiencing mental health issues. The overwhelming trend in the data indicated the large majority of people had positive experiences resulting from MHFA, either in improving their relationship with someone experiencing a mental health problem or in their feelings towards and ideas about that person, or both.

Reasons for participating in the MHFA course included existing problems with friends and family in participants' life, contact with people experiencing mental health problems through voluntary work and a desire for additional training by professional health care workers.

The responses showed that people did MHFA with a variety of expectations and needs, yet despite this variety, it succeeded across the board in meeting those varied needs and expectations.

Participant's reported actions to situations where clients/friends or family members were experiencing mental health issues varied and included calming the distressed person, listening to them, referring them for specialist assistance, giving concrete support, practical help and information/advice. Importantly, no hint emerged that MHFA led people into an unrealistic position where they became over-confident and hence dealt with a situation inappropriately.

Participants reported improved competence (professional and personal) and increased empathy and understanding towards people suffering from mental health problems. Some respondents were very enthusiastic about MHFA and wanted to see it extended, either by follow on courses or by linking to new audiences.

Qualitative evaluation of MHFA instructors

For the full report on the methods and results of this evaluation refer to Appendix 3.

This qualitative evaluation was considered a beneficial second stage in evaluating MHFA training in order to:

■ Highlight pertinent issues for consideration in implementing the MHFA course for targeted population groups in the rural region

■ Determine the appropriateness of the MHFA course as one strategy within a wider population health framework in addressing outcomes and key directions outlined in the *National Mental Health Plan 2003–2008*[1]

■ Document the experience of the MHFA instructors in conducting the training to further develop the MHFA program and to broaden its role in a wider health promotion strategy.

Aim

To examine instructors' experiences of MHFA, and their ideas and suggestions in relation to the potential for MHFA to penetrate the communities as a population health strategy.

Evaluation methods

Semi-structured group interviews and individual interviews with MHFA instructors and an interview with the MHFA project co-ordinator were conducted. The data generated from the interviews were coded using the inquiry framework of the interview questions. Notes were further analysed and coded to extract additional themes. A random sample of community participant feedback forms was gathered during the ANU trial and were analysed for key themes in order to emphasise and support the common themes identified in the instructor's interviews.

Results

Four out of the five instructors participated in the evaluation. Sixty feedback forms from each instructor were randomly chosen, which represented 240 samples from a total of 753 participants.

The instructors were unreservedly in agreement that there has been an increase in demand for the MHFA Program and that the feedback from participants had been consistently very positive. There was general agreement that the MHFA Program met the aims of improving the mental health literacy of community participants and in decreasing stigma. They agreed that the program empowered people to access services and produced an increase in help seeking behaviour.

Participant feedback also confirmed that their understanding and knowledge of mental health issues had increased. Many community participants reported both to instructors and in feedback forms that they were able to utilise skills learnt through MHFA to handle specific crisis situations with clients and family members. They reported feeling more confident in recognising signs of mental distress and in responding to them.

The instructors identified a few areas where literacy aims were either only partially met or could be enhanced:

■ the substance abuse section

■ service availability issues

■ population subgroups that were not reached

■ the inappropriate use of skills gained.

Instructor discussion and participant feedback forms suggested more of the following could enhance the program content:

- research perspectives
- skills based content
- indigenous perspectives
- focus on the social determinants of health.

It became clear through the participant feedback and instructor interviews that two sections needed revising, namely, the psychosis and the substance abuse sections.

The project co-ordinator stressed that it was important to give consideration to the project marketing strategies to extend the reach of the delivery of the MHFA program and to increase uptake of the program by specific population subgroups within the community, for example, men, indigenous people and young people. This was seen as particularly important due to insufficient mental health services and resources in rural areas.

SECTION 6

Discussion

The quantitative and qualitative evaluations conducted clearly demonstrate that the MHFA program is an effective strategy in raising the mental health literacy of the community and reducing stigma.

The cluster RCT found that the MHFA training produced a number of positive significant changes in participants compared to a wait-list control group. A significantly larger proportion of participants improved in their ability to correctly diagnose the case vignette of a person with either depression or schizophrenia. Significantly more participants reported decreased social distance towards the people portrayed in the vignettes and agreed with health professionals about treatment. There was a significant increase in participants' confidence to provide help to others and an increase in actually providing help.

The findings of the cluster RCT confirm the positive findings of the previously conducted MHFA trial,[12] and are more generalisable. In this trial the participant and wait-list control groups were well matched and conditions better matched those typical in practice. The only difference between the participant and wait-list control groups was that more people in the control group did the course for work reasons.

While the more typical conditions of the cluster RCT are an advantage for generalisability, they produced greater practical difficulties in running the trial. Attendance data on participants were not collected by some of the instructors. Therefore the proportion of the participants that received the complete training course is uncertain. A similar problem was determining the adherence of the instructors to the curriculum. Some formal observations of the instructors' adherence to a list of topics covered by the curriculum were conducted, which revealed 100 per cent adherence for most of the instructors, but one had only 81 per cent adherence.

Another limitation of the cluster RCT is that the mental health of participants was not measured directly. In the earlier trial, an unexpected mental health benefit was found and this requires replication.[12] A mental health measure was not included in this trial as the results of the earlier trial were not available at the time of this trial's development and the time available in the telephone interviews used to assess outcomes was limited.

An intention-to-treat approach to the data was used. Whereas many trials use a last observation carried forward approach to handle missing post-test data, data imputation by best-subsets regression was used. This approach is likely to give better estimates than conventional approaches to missing data even when the missing-at-random assumption is not met.

One potential concern of MHFA training is that it will lead to over-diagnosis of life problems as mental disorders. In the previous uncontrolled trial no evidence was found that indicated the training affects the perception that the participant or their family has mental health problems.[12] However, in the cluster RCT there was a significant increase in the proportion who perceived themselves as having a mental health problem and a non-significant trend for an increased perception of family members as having mental health problems. In absolute terms the changes were not so great as to be a concern and may reflect accurate re-labelling.

The qualitative evaluations indicate the positive value of the MHFA course for participants and instructors. Qualitative instructor data supports the observation that the MHFA program improved the mental health literacy of community participants through the provision of useful, relevant and evidence based information, by decreasing stigma and increasing the skill base of participants. Participants were able to identify specific benefits and many thought MHFA not only useful, but were keen to see it repeated and extended.

The majority of participants who participated in the qualitative participant evaluation had some direct experience, post-course, of a situation where mental health issues were salient and it is clear that for this group MHFA enabled those respondents to take steps that led to better effects than otherwise might have been the case.

The lack of association between independent and dependent variables in the qualitative participant evaluation suggests the MHFA course was equally valuable to a wide range of people, irrespective of age, gender and education. However the qualitative instructor evaluation data indicated a need to address the requirements of specific population groups in the content of the MHFA

program. They recommended MHFA be targeted to specific groups within the community such as men, indigenous people and young people.

MHFA Instructors also identified areas of the MHFA program that could be enhanced in order to better achieve its aims namely, improving the substance abuse section including more skills based content. Instructors raised service availability issues and expressed some concern about the inappropriate use of skills gained by participants.

A limitation of the qualitative participant data is the non-random, availability sample that was used. On the one hand, it was important to gain some 'depth' to the stories that people could share about their experience of MHFA and its relevance to them. On the other, it was important to have a large enough sample to ensure that any results were not based on such a small number as to cause concern that they might be seriously unrepresentative. Such samples can be challenged on the basis that they lack representation and reflect the views only of a self-selected sample, in this case perhaps of the more satisfied clients. However, if there were some dissatisfied clients in the population, it is likely these would have surfaced in the analysis, but none were found. The findings of this qualitative evaluation confirm the findings of the earlier quantitative evaluation, which showed that MHFA was well received and this allows one to be even more confident of the utility of the data.[12]

A limitation of the qualitative instructor data is that only four of the five instructors participated in key informant interviews. As the instructor who had the least mental health experience in the group, it is difficult to generalise any of the data that specifically comments on the need for mental health clinical expertise to effectively deliver the program.

The quantitative and qualitative evaluation studies demonstrate the MHFA program is a valued and effective strategy in raising the mental health literacy of the community. The qualitative data has also provided a number of suggestions to improve the program content, delivery, reach and scope, which, if taken up, could increase its effectiveness in addressing the mental health literacy of participants and thus establish its role as a key strategy in broader mental health promotion and workforce development initiatives. It remains to be seen how further development may improve its effectiveness and how the public health service may consider its use as a strategy in the future.

Conclusion and recommendations

The MHFA training course produced positive changes in knowledge, attitudes and behaviour when given to members of the public by instructors from a local health service in a rural area of NSW. MHFA is a significant evidenced based strategy in the population mental health arena.

Recommendations

1. MHFA program improvements

Where appropriate and possible, make changes to the program to reflect suggestions made by instructors and participants concerning content, structure, facilities and reach.

2. Mental health promotion and capacity building approaches

- Include the MHFA program as a key initiative in a broader rural mental health promotion strategy

- Greater Southern Area Health Service continue the partnership with the MHFA Training and Research Program, which is now auspiced by ORYGEN Research Centre and other relevant partners

- Extend and enhance the target scope of the program, particularly where it fits with business and program planning in rural Mental Health Services

- Include MHFA as a key component in mental health initiatives developed by the Greater Southern Area Health Service.

3. Workforce development

Consider using the expertise of MHFA instructors to provide mandatory training on the management of mental health issues to non-mental health Area Health Staff.

4. Access issues

Expand delivery of MHFA to other rural areas in the Australian setting.

5. Equity

Target the MHFA program to increase the literacy of specific subgroups, in particular men, young people and Indigenous groups.

SECTION 8

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Baseline questionnaire

Mental health first aid trial

Telephone interview 1　　　　　　　　　ID _____

Hello, my name is **[given name]** from the Centre for Mental Health Research at the Australian National University.

I understand that you've volunteered to do a mental health first aid course and that you're willing to answer some questions to help us evaluate the course.

Proceed after respondent confirms that they will participate. Convert any "no" to a "yes" in the nicest possible way.

This will be the first of 3 interviews, the next will be in July or August and finally January or February next year. Your answers will be confidential and all data will be stored by ID number.

This interview will take about 10 minutes. To begin with I'd like to ask a few questions about your own awareness and experience of mental health issues.

1. Have you yourself ever experienced a mental health problem?

   ☐ **1** Yes
   ☐ **2** No

2. Has anyone in your family ever experienced a mental health problem?

   ☐ **1** Yes
   ☐ **2** No

3. How confident do you feel in helping someone with a mental health problem?
   Would you say: *Read out options*

   ☐ **1** Not at all
   ☐ **2** A little bit
   ☐ **3** Moderately
   ☐ **4** Quite a bit
   ☐ **5** Extremely

4. In the last six months have you had contact with anyone with a mental health problem?

   ☐ **1** Yes
   ☐ **2** No (go to Q8)
   ☐ **3** Don't know (go to Q8)

5. How many people?

   Number: _____

6. Did you offer any help?

   ☐ **1** Yes
   ☐ **2** No

7. What type of help?

   _____

   _____

   _____

8. Interviewer:
   Insert the random selection code for the "Mary D" or the "Mary S" vignette, as per the interviewer instructions. *(This must be done prior to interview.)*

   Sequence guide: _____

   ☐ If 8 = **1** answer 8.1
   ☐ If 8 = **2** answer 8.2

8.1 The person I will describe is not a real person, but there are people who are very like her. If you happen to know someone who is exactly like her, then it is a total coincidence.

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

   Only if the person feels unsure ask:

   Would you like me to read that to you again?

   If yes, re-read description of Mary. Then go to Q9.

8.2 The person I will describe is not a real person, but there are people who are very like her. If you happen to know someone who is exactly like her, then it is a total coincidence.

> Mary is 24 and lives at home with her parents. She has had a few temporary jobs since finishing school but is now unemployed. Over the last six months she has stopped seeing her friends and has begun locking herself in her bedroom and refusing to eat with the family or have a bath. Her parents also hear her walking about in her bedroom at night while they are in bed. Even though they know she is alone, they have heard her shouting and arguing as if someone else is there. When they try to encourage her to do more things, she whispers that she won't leave home because she is being spied upon by the neighbour. They realise she is not taking drugs because she never sees anyone or goes anywhere.

Only if the person feels unsure ask:

Would you like me to read that to you again?

If yes, re-read description of Mary. Then go to Q9.

9. What would you say, if anything, is wrong with Mary? *No prompting of the possible answer*

- [ ] **1** Depression
- [ ] **2** Nervous breakdown
- [ ] **3** Schizophrenia/paranoid schizophrenia
- [ ] **4** Mental illness
- [ ] **5** Psychological/mental/emotional problems
- [ ] **6** Stress
- [ ] **7** Has a problem
- [ ] **8** Cancer
- [ ] **9** Other (specify) _____
- [ ] **10** Nothing
- [ ] **11** Don't know

10. Imagine Mary is someone you have known for a long time and care about. You want to help her. What would you do?

_____
_____
_____
_____
_____

There are a number of different people who could possibly help Mary and for each one I would like you to tell me whether you think they would be helpful, harmful or neither for Mary?

11. Firstly, a GP?
- [ ] **1** Helpful
- [ ] **2** Neither
- [ ] **3** Harmful
- [ ] **4** Depends
- [ ] **5** Don't know

12. A counsellor?
- [ ] **1** Helpful
- [ ] **2** Neither
- [ ] **3** Harmful
- [ ] **4** Depends
- [ ] **5** Don't know

13. A psychiatrist
- [ ] **1** Helpful
- [ ] **2** Neither
- [ ] **3** Harmful
- [ ] **4** Depends
- [ ] **5** Don't know

14. A clinical psychologist?
- [ ] **1** Helpful
- [ ] **2** Neither
- [ ] **3** Harmful
- [ ] **4** Depends
- [ ] **5** Don't know

15. Close family?
- [ ] **1** Helpful
- [ ] **2** Neither
- [ ] **3** Harmful
- [ ] **4** Depends
- [ ] **5** Don't know

16. Close friends?
- [ ] **1** Helpful
- [ ] **2** Neither
- [ ] **3** Harmful
- [ ] **4** Depends
- [ ] **5** Don't know

17. A naturopath or a herbalist?
- [ ] **1** Helpful
- [ ] **2** Neither
- [ ] **3** Harmful
- [ ] **4** Depends
- [ ] **5** Don't know

There are also different types of help and treatment that these people could offer. I would like you to tell me whether you think the following different medicines are likely to be helpful, harmful or neither for Mary?

18. Vitamins and minerals?

☐ 1 Helpful
☐ 2 Neither
☐ 3 Harmful
☐ 4 Depends
☐ 5 Don't know

19. St John's Wort?

☐ 1 Helpful
☐ 2 Neither
☐ 3 Harmful
☐ 4 Depends
☐ 5 Don't know

20. Anti depressants?

☐ 1 Helpful
☐ 2 Neither
☐ 3 Harmful
☐ 4 Depends
☐ 5 Don't know

21. Sleeping pills?

☐ 1 Helpful
☐ 2 Neither
☐ 3 Harmful
☐ 4 Depends
☐ 5 Don't know

22. Anti-psychotics?

☐ 1 Helpful
☐ 2 Neither
☐ 3 Harmful
☐ 4 Depends
☐ 5 Don't know

23. Tranquillisers such as valium?

☐ 1 Helpful
☐ 2 Neither
☐ 3 Harmful
☐ 4 Depends
☐ 5 Don't know

Do you think the following treatments are likely to be helpful, harmful or neither for Mary?

24. Becoming more active physically, such as playing more sport, or doing a lot more walking or gardening?

☐ 1 Helpful
☐ 2 Neither
☐ 3 Harmful
☐ 4 Depends
☐ 5 Don't know

25. Reading about people with similar problems and how they have dealt with them?

☐ 1 Helpful
☐ 2 Neither
☐ 3 Harmful
☐ 4 Depends
☐ 5 Don't know

26. Getting out and about more?

☐ 1 Helpful
☐ 2 Neither
☐ 3 Harmful
☐ 4 Depends
☐ 5 Don't know

27. Attending courses on relaxation, stress management, meditation or yoga?

☐ 1 Helpful
☐ 2 Neither
☐ 3 Harmful
☐ 4 Depends
☐ 5 Don't know

28. Counselling?

☐ 1 Helpful
☐ 2 Neither
☐ 3 Harmful
☐ 4 Depends
☐ 5 Don't know

29. Cognitive-behaviour therapy?

What is CBT? It's when a counsellor helps a person to get in touch with and change some of their automatic, negative thoughts that can lead to unpleasant feelings.

☐ 1 Helpful
☐ 2 Neither
☐ 3 Harmful
☐ 4 Depends
☐ 5 Don't know

30. Being admitted to a psychiatric ward or a hospital?

☐ **1** Helpful
☐ **2** Neither
☐ **3** Harmful
☐ **4** Depends
☐ **5** Don't know

31. Undergoing electro-convulsive therapy (ECT)?

☐ **1** Helpful
☐ **2** Neither
☐ **3** Harmful
☐ **4** Depends
☐ **5** Don't know

The next few questions ask about how willing you would be to have contact with someone like Mary.

32. How willing would you be to move next door to Mary? *Read out options*

☐ **1** Definitely willing
☐ **2** Probably willing
☐ **3** Probably unwilling
☐ **4** Definitely unwilling
☐ **5** Don't know

33. How willing would you be to spend an evening socialising with Mary? *Read out options*

☐ **1** Definitely willing
☐ **2** Probably willing
☐ **3** Probably unwilling
☐ **4** Definitely unwilling
☐ **5** Don't know

34. How willing would you be to make friends with Mary? *Read out options*

☐ **1** Definitely willing
☐ **2** Probably willing
☐ **3** Probably unwilling
☐ **4** Definitely unwilling
☐ **5** Don't know

35. How willing would you be to have Mary start working closely with you on a job? *Read out options*

☐ **1** Definitely willing
☐ **2** Probably willing
☐ **3** Probably unwilling
☐ **4** Definitely unwilling
☐ **5** Don't know

36. How willing would you be to have Mary marry into your family? *Read out options*

☐ **1** Definitely willing
☐ **2** Probably willing
☐ **3** Probably unwilling
☐ **4** Definitely unwilling
☐ **5** Don't know

37. Have you ever had a problem similar to Mary's?

☐ **1** Yes
☐ **2** No
☐ **3** Don't know

38. Has anyone in your family or close circle of friends ever had a problem similar to Mary's?

☐ **1** Yes
☐ **2** No
☐ **3** Don't know

Now just a few questions about yourself.

39. What is your interest in doing the mental health first aid course?

_____

_____

_____

40. What is the highest level of secondary schooling that you have completed?

☐ **1** Some primary
☐ **2** All of primary
☐ **3** Some secondary
☐ **4** Three/four years of secondary (intermediate or school certificate)
☐ **5** Five/six years of secondary (leaving or higher school certificate level)

41. What is the highest level of post secondary or tertiary education you have completed?

☐ **1** Trade/apprenticeship
☐ **2** Other certificate
☐ **3** Associate or undergraduate diploma
☐ **4** Bachelor's degree
☐ **5** Higher degree
☐ **6** None

42. Are you presently studying for any of the following?

☐ **1** Trade/apprenticeship
☐ **2** Other certificate
☐ **3** Associate or undergraduate diploma
☐ **4** Bachelor's degree
☐ **5** Higher degree
☐ **6** None

43. Are you of Aboriginal or Torres Strait Islander origin?

☐ **1** Yes
☐ **2** No

44. Do you speak a language other than english as your first language at home?

☐ **1** Yes
☐ **2** No

45. Finally, may I ask how old you are now?

Age: _____

46. Record respondent sex

☐ **1** Male
☐ **2** Female

Now I'll tell you about the course you have been allocated. Do you prefer day or evening?

Offer the appropriate courses in the **Bega Valley, Harden, Goulburn/Mulwaree, Young, Crookwell, Snowy River, Boorowa** area.
(Note there is no choice of class in the Snowy River and the Boorowa area.)

Record the number of the class chosen

_____

Thank you very much for your time and help.
I look forward to speaking with you again with the second questionnaire in July or August.

Follow-up questionnaire

GREATER SOUTHERN
AREA HEALTH SERVICE
NSW⊕HEALTH

Mental health first aid trial

MENTAL HEALTH FIRST AID

Telephone interview 2   ID _____

Hello, my name is **[given name]** from the Centre for Mental Health Research at the Australian National University.

I understand that you completed a mental health first aid course in March or April this year and that you're willing to answer some questions to help us evaluate the course.

Proceed after respondent confirms that they will participate. Convert any "no" to a "yes" in the nicest possible way.

This is the second of 3 interviews, the last one will be in January or February next year. Your answers will be confidential and all data will be stored by id number.

This interview will take about 10 minutes. To begin with I'd like to ask a few questions about your own awareness and experience of mental health issues.

1. Have you yourself ever experienced a mental health problem?

   ☐ **1** Yes
   ☐ **2** No

2. Has anyone in your family ever experienced a mental health problem?

   ☐ **1** Yes
   ☐ **2** No

3. How confident do you feel in helping someone with a mental health problem? Would you say:
   Read out options

   ☐ **1** Not at all
   ☐ **2** A little bit
   ☐ **3** Moderately
   ☐ **4** Quite a bit
   ☐ **5** Extremely

4. In the last six months have you had contact with anyone with a mental health problem?

   ☐ **1** Yes
   ☐ **2** No (go to Q8)
   ☐ **3** Don't know (go to Q8)

5. How many people?

   Number: _____

6. Did you offer any help?

   ☐ **1** Yes
   ☐ **1** No

7. What type of help?

   _____
   _____

8. Interviewer:

   Insert the random selection code for the "Mary D" or the "Mary S" vignette, as per the interviewer instructions. (This must be done prior to interview.)

   Sequence guide: _____

   ☐ If 8 = **1** answer 8.1
   ☐ If 8 = **2** answer 8.2

8.1 The person I will describe is not a real person, but there are people who are very like her. If you happen to know someone who is exactly like her, then it is a total coincidence.

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

   Only if the person feels unsure ask:

   Would you like me to read that to you again?

   If yes, re-read description of Mary. Then go to Q9.

8.2 The person I will describe is not a real person, but there are people who are very like her. If you happen to know someone who is exactly like her, then it is a total coincidence.

Mary is 24 and lives at home with her parents. She has had a few temporary jobs since finishing school but is now unemployed. Over the last six months she has stopped seeing her friends and has begun locking herself in her bedroom and refusing to eat with the family or have a bath. Her parents also hear her walking about in her bedroom at night while they are in bed. Even though they know she is alone, they have heard her shouting and arguing as if someone else is there. When they try to encourage her to do more things, she whispers that she won't leave home because she is being spied upon by the neighbour. They realise she is not taking drugs because she never sees anyone or goes anywhere.

Only if the person feels unsure ask:

Would you like me to read that to you again?

If yes, re-read description of Mary. Then go to Q9.

9. What would you say, if anything, is wrong with Mary?
   No prompting of the possible answer

   ☐ 1 Depression
   ☐ 2 Nervous breakdown
   ☐ 3 Schizophrenia/paranoid schizophrenia
   ☐ 4 Mental illness
   ☐ 5 Psychological/mental/emotional problems
   ☐ 6 Stress
   ☐ 7 Has a problem
   ☐ 8 Cancer
   ☐ 9 Other (specify) _____
   ☐ 10 Nothing
   ☐ 11 Don't know

10. Imagine Mary is someone you have known for a long time and care about. You want to help her. What would you do?

   _____
   _____
   _____
   _____
   _____
   _____

There are a number of different people who could possibly help Mary and for each one I would like you to tell me whether you think they would be helpful, harmful or neither for Mary?

11. Firstly, a GP?

   ☐ 1 Helpful
   ☐ 2 Neither
   ☐ 3 Harmful
   ☐ 4 Depends
   ☐ 5 Don't know

12. A counsellor?

   ☐ 1 Helpful
   ☐ 2 Neither
   ☐ 3 Harmful
   ☐ 4 Depends
   ☐ 5 Don't know

13. A psychiatrist?

   ☐ 1 Helpful
   ☐ 2 Neither
   ☐ 3 Harmful
   ☐ 4 Depends
   ☐ 5 Don't know

14. A clinical psychologist?

   ☐ 1 Helpful
   ☐ 2 Neither
   ☐ 3 Harmful
   ☐ 4 Depends
   ☐ 5 Don't know

15. Close family?

   ☐ 1 Helpful
   ☐ 2 Neither
   ☐ 3 Harmful
   ☐ 4 Depends
   ☐ 5 Don't know

16. Close friends?

   ☐ 1 Helpful
   ☐ 2 Neither
   ☐ 3 Harmful
   ☐ 4 Depends
   ☐ 5 Don't know

17. A naturopath or a herbalist?

   ☐ 1 Helpful
   ☐ 2 Neither
   ☐ 3 Harmful
   ☐ 4 Depends
   ☐ 5 Don't know

There are also different types of help and treatment that these people could offer.
I would like you to tell me whether you think the following different medicines are likely to be helpful, harmful or neither for Mary?

18. Vitamins and minerals?

- [ ] **1** Helpful
- [ ] **2** Neither
- [ ] **3** Harmful
- [ ] **4** Depends
- [ ] **5** Don't know

19. St John's Wort?

- [ ] **1** Helpful
- [ ] **2** Neither
- [ ] **3** Harmful
- [ ] **4** Depends
- [ ] **5** Don't know

20. Anti depressants?

- [ ] **1** Helpful
- [ ] **2** Neither
- [ ] **3** Harmful
- [ ] **4** Depends
- [ ] **5** Don't know

21. Sleeping pills?

- [ ] **1** Helpful
- [ ] **2** Neither
- [ ] **3** Harmful
- [ ] **4** Depends
- [ ] **5** Don't know

22. Anti-psychotics?

- [ ] **1** Helpful
- [ ] **2** Neither
- [ ] **3** Harmful
- [ ] **4** Depends
- [ ] **5** Don't know

23. Tranquillisers such as valium?

- [ ] **1** Helpful
- [ ] **2** Neither
- [ ] **3** Harmful
- [ ] **4** Depends
- [ ] **5** Don't know

Do you think the following treatments are likely to be helpful, harmful or neither for Mary?

24. Becoming more active physically, such as playing more sport, or doing a lot more walking or gardening?

- [ ] **1** Helpful
- [ ] **2** Neither
- [ ] **3** Harmful
- [ ] **4** Depends
- [ ] **5** Don't know

25. Reading about people with similar problems and how they have dealt with them?

- [ ] **1** Helpful
- [ ] **2** Neither
- [ ] **3** Harmful
- [ ] **4** Depends
- [ ] **5** Don't know

26. Getting out and about more?

- [ ] **1** Helpful
- [ ] **2** Neither
- [ ] **3** Harmful
- [ ] **4** Depends
- [ ] **5** Don't know

27. Attending courses on relaxation, stress management, meditation or yoga?

- [ ] **1** Helpful
- [ ] **2** Neither
- [ ] **3** Harmful
- [ ] **4** Depends
- [ ] **5** Don't know

28. Counselling?

- [ ] **1** Helpful
- [ ] **2** Neither
- [ ] **3** Harmful
- [ ] **4** Depends
- [ ] **5** Don't know

29. Cognitive-behaviour therapy?

What is CBT? It's when a counsellor helps a person to get in touch with and change some of their automatic, negative thoughts that can lead to unpleasant feelings.

- [ ] **1** Helpful
- [ ] **2** Neither
- [ ] **3** Harmful
- [ ] **4** Depends
- [ ] **5** Don't know

30. Being admitted to a psychiatric ward or a hospital?

- [ ] **1** Helpful
- [ ] **2** Neither
- [ ] **3** Harmful
- [ ] **4** Depends
- [ ] **5** Don't know

31. Undergoing electro-convulsive therapy (ECT)?

- [ ] **1** Helpful
- [ ] **2** Neither
- [ ] **3** Harmful
- [ ] **4** Depends
- [ ] **5** Don't know

The next few questions ask about how willing you would be to have contact with someone like Mary.

32. How willing would you be to move next door to Mary? Would you say: *Read out options*

- [ ] **1** Definitely willing
- [ ] **2** Probably willing
- [ ] **3** Probably unwilling
- [ ] **4** Definitely unwilling
- [ ] **5** Don't know

33. How willing would you be to spend an evening socialising with Mary? *Read out options*

- [ ] **1** Definitely willing
- [ ] **2** Probably willing
- [ ] **3** Probably unwilling
- [ ] **4** Definitely unwilling
- [ ] **5** Don't know

34. How willing would you be to make friends with Mary? *Read out options*

- [ ] **1** Definitely willing
- [ ] **2** Probably willing
- [ ] **3** Probably unwilling
- [ ] **4** Definitely unwilling
- [ ] **5** Don't know

35. How willing would you be to have Mary start working closely with you on a job? *Read out options*

- [ ] **1** Definitely willing
- [ ] **2** Probably willing
- [ ] **3** Probably unwilling
- [ ] **4** Definitely unwilling
- [ ] **5** Don't know

36. How willing would you be to have Mary marry into your family? *Read out options*

- [ ] **1** Definitely willing
- [ ] **2** Probably willing
- [ ] **3** Probably unwilling
- [ ] **4** Definitely unwilling
- [ ] **5** Don't know

37. Have you ever had a problem similar to Mary's?

- [ ] **1** Yes
- [ ] **2** No
- [ ] **3** Don't know

38. Has anyone in your family or close circle of friends ever had a problem similar to Mary's?

- [ ] **1** Yes
- [ ] **2** No
- [ ] **3** Don't know

Thank you very much for your time and help.
I look forward to speaking with you again with the last questionnaire in January or February next year.

Qualitative evaluation for MHFA instructors

Evaluation methods

Interviews

Both semi-structured group and individual interviews were conducted with MHFA instructors (Boxes 1 & 2, respectively). In general, guided interview approaches were adopted with both individual and group participants. Each topic began with an open-ended question with the interviewer probing where appropriate to gain a deeper understanding of emergent themes.

The group interviews identified common themes and challenges, and recorded recommendations from instructors for changes to the program.

Box 1.

Group interview guide with MHFA instructors

1. How adequately do you think the MHFA program meets the aims of

    a. Improved mental health literacy of participants

    b. Decreasing stigma and misinformation

    c. Increase in help seeking behaviour

    d. Knowledge of help available and how to access it

2. Do you see any content gaps in the training package as it currently exists in relation to different population groups eg CALD communities, men, young people, Aboriginal population?

    a. What specifically needs to be added into the training program to address identified gaps

    b. Are there any current areas of program content that need to be improved or expanded?

    c. Are there any materials in the program that need to be taken out? And why?

3. How well did the MHFA program create linkages or referrals to other organisations that could support participants with future education or service knowledge needs?

4. Do you have any ideas about how we could effectively target the course to those in the community who may be likely to come in contact with someone with a mental health problem?

5. Is there anything else you would like to raise?

The individual interviews provided an opportunity for each instructor to raise other issues in a confidential environment.

Box 2.

Individual interview guide with MHFA instructors

1. In your experience in facilitating the program in SAHS what do you think were the common themes/responses from the participants in regards to the training?

2. Did you encounter any problems during the delivery of the program? If so, do you have any suggestions as to how this could be better handled in the future?

3. Do you think that MHFA trainers need to have a solid background, knowledge and experience in working with mental health issues to adequately present this program and respond to issues or questions raised by participants?

    a. Did you feel confident in delivering this program?

    b. If not, are there any additional support/resources that would have enabled you to feel more confident?

4. Do you have any suggestions on how to make the program more inclusive of other research perspectives while still meeting the requirements of your professional mandate in respect of evidence based practices?

5. Is there anything else you would like to raise?

The researcher for this component of the evaluation conducted an interview with the MHFA project co-ordinator to identify project management issues that may impact on future targeted courses in the SAHS region.

Data analysis

Interview data

The data generated from the interviews were read through several times, then organised and coded using the inquiry framework of the interview questions. The notes were further analysed and coded to extract additional themes that had been broached by the instructors. The themes that emerged are presented

with supporting comments from the instructors who participated in the evaluation.

Participant feedback forms

Community participant feedback forms (Box 3) were gathered during the ANU trial and therefore do not directly reflect the evaluation aims of this study. However a random sample of these forms was analysed for key themes in order to emphasise and support the common themes identified in the instructor's interviews. The feedback form comprised four questions that required a numerical rate response and three open-ended questions for comment.

Box 3.
MHFA participant feedback form

1. How new was this material to you?

   1____2____3____4____5____6____7____8____9____10
   Not at all   Very much

2. How easy was it to understand?

   1____2____3____4____5____6____7____8____9____10
   Very hard   Very easy

3. How well was it presented?

   1____2____3____4____5____6____7____8____9____10
   Really badly   Really good

4. How relevant was the content for you?

   1____2____3____4____5____6____7____8____9____10
   Not at all   Very much

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

6. What do you consider to be the weaknesses of the course?

7. Are there any other issues which you think should be included in this course?

The numerical ratings were calculated to indicate aggregate response ranges. The open ended responses were organised and coded inductively to gather data that validated findings from both the qualitative evaluation of instructors and the cluster RCT, particularly in relation to increasing health literacy and reducing stigma.

Results

Four out of the five instructors participated in the evaluation. The only instructor that did not have mental health training did not participate in the evaluation. Sixty feedback forms from each instructor were randomly chosen, which represented 240 samples from a total of 753 participants. An interview was conducted with the project coordinator.

The results are described under three main headings:

■ Mental health literacy

■ Program content and delivery

■ Marketing of MHFA Training Program

1. Mental health literacy

This section describes ways in which the MHFA program met the aim of improving mental health literacy. Areas where literacy aims were either partially met or could be enhanced are also discussed.

1.1 Improvements in mental health literacy

There was general agreement amongst instructors that the MHFA Program met the aim of improving the mental health literacy of community participants through:

■ Providing useful, relevant, accurate and evidence based information

■ Decreasing stigma

■ Increasing the skill base of participants

■ Providing teaching strategies and supplementary resources.

1.1.1 *Providing useful, relevant and evidence based information*

Participants reported MHFA introduced them to new ideas and issues about mental health that they had not previously considered. In answer to question one concerning newness of material, 64 per cent were at a rating of above five.

Participants reported the information increased their understanding of mental health issues. In answer to question four concerning relevance of information, 97 per cent were at a rating of above five. Additional comments in response to questions five, six and seven concerning strengths and weaknesses of the program, stressed how informative (23 per cent) MHFA was. Many participants noted the information provided was relevant in both professional and personal contexts.

It was asserted by one instructor in an individual interview that people could see that there were good,

effective, scientifically tested treatments available for mental health issues. Community participant feedback comment further strengthened this viewpoint.

"I think the course reinforced the fact that people with a mental illness are as valuable as anyone else in our community and that there is effective treatment as in any other illness." (Participant)

1.1.2 *Decreasing stigma*

The instructors agreed that the program is effective in decreasing stigma, discussing this aspect of mental health literacy in depth within the group interviews. They proposed that one of the ways in which the program endeavours to reduce stigma is by correcting misinformation and dispelling myths and stereotypes.

"Participants saw that treatments have improved since the days of the old institutions/mental hospitals. This helped reduce fear and stigma." (Instructor)

"It gives insight into how a person with a mental health problem feels." (Participant)

"The secret business of mental health is being shared finally in open and honest ways. I feel that this is about time as a lot of families and individuals have been kept in the dark about service issues, treatment paths, course of illness etcetera." (Instructor)

The instructors offered examples of program content that were effective strategies in decreasing stigma:

- Personal stories. All of the instructors agreed that personal stories from participants are often the most potent in decreasing stigma created by misperceptions or misinformation

- The use of videos interviewing the experiences of real people in regard to their mental illness

- Examples from clinical practice.

1.1.3 *Increasing the skill base of participants*

Many community participants reported both to instructors and in feedback forms that they were able to gain and utilise skills learnt through MHFA to handle specific crisis situations with clients and family members. The instructors stated that on a number of occasions participants reported that prior to MHFA they had inadequate skills to respond to anyone experiencing mental distress but after the training they felt more confident and knew what to do.

"One worthwhile spin-off was that the Mental Health Service received a few referrals from participants who attended the course. One or two people contacted me

to see if it was appropriate to refer and my advice to them was that it was. One example is a participant that picked up early psychosis in a member of her church group." (Instructor)

Instructors received feedback from participants, such as Centrelink workers, church group members and other volunteers, who found that the program gave them the confidence to ask questions of someone that they considered to be in distress and to refer them on to mental health services.

"This information helped me to diffuse a suicide situation of a client of mine. I referred to the CPR (ALGEE), remembered what the instructor said, and a good outcome prevailed." (Participant)

One instructor suggested that we often lose sight of simplistic strategies that can be utilised by carers and family members and others to deal with mental health crisis situations. One group of professionals who had participated in the program commented that they found the (ALGEE) steps very helpful in their work.

Other participants stated that the program gave them the confidence to recognise when someone presented with particular signs for example, of depression, and to be able to ask about suicide thoughts and refer on where appropriate.

"It gives people with next to no knowledge a little, but the little is so useful immediately in helping recognise symptoms."(Participant)

The instructors agreed that although it is an area that is difficult to measure they felt that the program produced an increase in help seeking behaviour and were able to provide instances that indicated examples of where participants reported the program had increased their confidence in accessing appropriate services or resources. One instructor reported that one Mental Health Service had several examples of people who sought help on behalf of others and made referrals as a result of participating in the MHFA program.

The instructors felt that the MHFA program increased participant knowledge about what help is available and how to access it. One strategy undertaken for this purpose was the distribution of the Mental Health 1800 card by instructors, which gives emergency numbers, and details of the services available in the local area.

The instructors agreed that the program empowers people to access services. They felt that the sharing of information is powerful for community members in relation to knowledge about services and what will

happen when they access a particular service and negotiate treatment options.

"It empowers communities into action, often inspiring them to lobby etc. It contributes to making mental health issues the responsibility of everyone." (Instructor)

1.1.4 *Providing teaching strategies and supplementary resources*

In response to questions in the group interview, all the instructors agreed that the range of teaching strategies and resources that are offered increase the opportunities for improvements in mental health literacy. They reported receiving positive feedback from participants about the resources, including the manual, the facilitator, overhead transparencies, handouts, videos and stories. The instructors singled out the videos and any supplementary stories from participants as being particularly useful.

In fifteen percent of participant feedback forms analysed, the range of teaching methods employed was noted as a clear strength of MHFA. They specifically referred to the presentation style; the videos; content related real life examples and stories; the handouts; opportunity for personal input; group discussion and interaction. Many participants (19 per cent) also noted the usefulness of the supporting resources and teaching aids.

The instructors identified the use of plain English as a helpful component of the training materials in addressing mental health literacy aims. Many participant feedback forms noted the concise and jargon-free explanations of mental health issues that were easily understood. In response to question two regarding how understandable the material was 98 per cent were at a rating of above five.

Of the feedback forms that were analysed, participants found MHFA introduced them to new ideas and issues about mental health that they had not previously considered. Sixty-four per cent in answer to question one were at a rating of above five for newness of material.

MHFA has created demand for further knowledge and training in this area with frequent requests made to instructors and mental health services for repeat and extended MHFA programs in varied localities. Participants commented in feedback forms that the program inspired them to further learning.

"There is an insatiable appetite for this kind of information. This expressed thirst for knowledge is highlighted by repeated requests for more information in relation to dementia, eating disorders, adolescent issues etcetera." (Instructor)

1.2 Future considerations in improving mental health literacy

Although the instructors agreed that on the whole the MHFA program increased mental health literacy, they identified a few areas where literacy aims were either partially met or could be enhanced. These included:

- Substance abuse section
- Service availability issues
- Particular groups that were not reached
- Inappropriate use of skills gained.

1.2.1 *Substance abuse section*

The instructors agreed that the program and related section in the manual that covers substance abuse improved literacy intentions to a lesser degree. There seems to be some confusion about whether substance abuse should be regarded as a mental illness or as a co-morbidity factor in the majority of mental health cases. These findings are described in more detail in the following section on program content and delivery.

1.2.2 *Service availability issues*

The instructors were of the opinion that the program does not adequately address the issue of referral pathways for either further education or knowledge about mental health services and related issues. All instructors agreed that the linkages to GPs is clearly stated in both the manual and the training sessions, but felt that more attention should be paid to other local services and support networks.

The instructors felt that although the manual is an adequate resource in providing general information, the provision of supplementary handouts detailing referral options, particularly for rural areas, would be an important adjunct. It was recognised that development of these accompanying resources would be developed by local service providers, rather than the program authors.

"Rural communities are parochial and it is important to have local numbers such as the Community Health Centre on a little leaflet or card." (Instructor)

One participant stated that information on where local help can be found should be included in the course, stressing that this should not refer only to websites due to difficulties with computer access and literacy. One participant suggested that a resource list should be given to each library in regions where MHFA is being run as accessibility to resources and choices in the country are limited. Another participant mentioned that local providers were hard to access without lots of follow-up and 'pushing the issue'.

The instructors agreed that the benefits of self-help books are often indispensable in addressing some of the knowledge and service access issues in rural communities.

The instructors agreed that the program creates a lot of discussion about services, in particular negative experiences and comments about them, which in turn raise issues for mental health service delivery. Many participants talked about problems with the SAHS 1800 Mental Health Intake number. MHFA appropriately promotes that participants should contact that number if they need help with a mental health issue, but participants shared many stories where they rang the 1800 number and were unable to access the help they needed. This raises questions about raising community awareness and knowledge about mental health services and other resources whilst also responding to criticisms or issues that may arise when people are unable to access these same services.

1.2.3 *Particular groups that were not reached*

The instructors considered that the program was not reaching specific population sub-groups such as men, Aboriginal people, and young people, which demonstrated a need for targeted courses for these groups.

1.2.4 *Inappropriate use of skills gained*

The instructors expressed concern with the issue of how education can occasionally be misused or be harmful. One example of this was provided by an instructor of a participant who used the information to diagnose a person, even though it is stated to all participants that the program is not intended as a diagnostic tool. Participants expressed similar concerns on the feedback forms.

2. Program content and delivery

2.1 Program content

The instructors' discussions that resulted from interview questioning and participant feedback comments in relation to program content focused on the following main themes:

- Merits of the program
- Content gaps and suggestions for improvement
- Specific sub-groups and additional topics
- Enhancing content material

2.1.1 *Merits of the program*

Although the instructors were not specifically asked to comment on the merit of the MHFA program, they frequently made reference to the quality of the complete package. They agreed that the associated format of the program content and manual in conjunction with the additional teaching resources was excellent, and particularly effective in raising the mental health literacy of the community. Participant comments supported this with many mentioning specifically the excellent format of the manual and the course format.

"Feedback from participants is an affirmation of the course and our facilitation skills." (Instructor)

2.1.2 *Content gaps and suggestions for improvement*

There was broad agreement amongst the instructors that although MHFA is a generalist course and was not designed to meet everyone's needs they asserted that there were a few content gaps that could be either integrated into existing program material or developed as additional modules. The program content could be expanded to address the requirements of specific population groups and to include other mental health issues that were perceived by both themselves and participants as important.

Repeated participant comments were made to instructors, as well as in the participant feedback forms about the lack of content in relation to childhood/adolescent disorders and issues affecting the aged population. Some instructors also felt that the lack of content in relation to specific age groups such as adolescents and the elderly should be addressed in the content material.

One suggestion proposed by the instructors was to include an across the lifespan approach in the course material. One instructor asserted that it would not take much more to address a lifespan approach in the program content as it would simply require the inclusion of age relevant information in each topic for example depression and young people, or depression in the elderly.

2.1.3 *Specific sub-groups and additional topics*

Discussion around this issue focused partly on the matter of the program capacity to address the needs of specific subgroups of the population. Although the instructors were in agreement that the topic scope in the MHFA program was adequate and comprehensive they felt that it would be good to have other modules that considered the issues of specific sub-groups in the population and that could be delivered as add-ons, for example, Aboriginal people, the elderly, youth, and men.

Although most participants felt that the topic scope was adequate for an introductory course they made mention of topic areas that should be included in future program content. These included:

- Eating disorders

- Counselling skills

- Developmental problems across the lifespan

- Epilepsy

- Medication

- Mental health issues for the physically disabled

- Spiritual values and effect on our life

- Dementia and other aged issues

- Young people and adolescent issues such as Attention Deficit and Hyperactivity Disorder (ADHD)

- Autism

- Dual diagnosis/intellectual disability

- Personality Disorders

- Working with Aboriginal People with mental health problems

- Substance abuse as module/program

- Tackling public awareness and lobbying for family support groups

- Political oppression/poverty

- More information on managing psychosis

- Help for families of sufferers.

One topic that was deemed to be significant by an instructor but was absent from the program content was the subject of professional and participant self-care. It was felt that this should include guidance on how to develop skills to look after themselves as workers or carers and so on.

"Although I don't think all areas of mental health can be covered without making the course too long, I do feel that self-care skills – knowing own limitations, how to recognise when you yourself need help etcetera – should be included." (Instructor)

2.1.4 *Enhancing content material*

Instructor discussion and participant feedback forms suggested more of the following could enhance the program content:

- Research perspectives

- Skills based content

- Indigenous perspectives

- Focus on social determinants of health.

It became clear through the feedback and discussions that two sections needed revising:

- Psychosis section

- Substance abuse section

The presentation of feedback on substance abuse and research perspectives are provided separately at the end of section 2 to reflect the level of focus and attention apportioned to them in instructor interview discussions and participant feedback comments.

More skills based content

Most of the instructors agreed that although the MHFA program contained good theory it needed to be more skills based for all topics covered. Although the content included 'how-to' information, the program structure did not often allow opportunity to put this information into practise. The instructors in the group interview suggested the content and delivery of the program was too didactic and not in accord with adult learning principles which translate theory into practical exercises to increase the learning outcomes for participants. One instructor, however, felt that the course was adequate and did provide practical strategies to enable participants to respond to crisis situations.

One of the recurrent participant themes in both feedback to instructors and in evaluation forms was that they stated their expectations were not met in relation to gaining practical skills. They had an expectation that it would be 'First Aid' rather than just increasing mental health literacy and knowledge. One participant suggested that a weakness of the course was help in how the first aid was to be put into practice.

It was suggested by the instructors that hands-on skill learning could be incorporated into the structure of the program, with the addition of a role-play or scenario for each topic going some way to address this. One instructor reported that the best feedback was from participants that had a greater involvement.

One participant suggested that an opportunity to brainstorm helpful and unhelpful things that can be said or done in a crisis situation could be included in each topic session.

More indigenous perspectives

One instructor commented that the MHFA program is an Australian based product but that there is no reference to indigenous perspectives on all issues. It was felt that the program should be more sensitive to the indigenous population with reference to mental health issues, in particular the Drug and Alchohol (D&A) section.

"Differences in drinking, research shows that indigenous men either drink to dangerous high levels, or they don't drink at all. This differs markedly with non-indigenous males." (Instructor)

"…in the case of suicide you would not ring the police if it was an Aboriginal, you would ring an Aboriginal leader." (Instructor)

More focus on social determinants of health

It was proposed that the MHFA program does not address psychosocial issues and the social determinants of health perspectives. The instructors agreed that social determinant issues are relevant and must be considered in the course.

It was proposed by one instructor that the program is not truly representative of the research that exists as there is no discussion about what social factors contribute to mental health in the course framework and that for the program to be well rounded, more of that research and evidence should be included.

"… even just discussing the links between poverty and its impact on mental health status would have made it more broad-based." (Instructor)

One participant commented that issues in relation to political oppression and poverty related isolation should be included in the content matter and another suggesting that an overview of how social issues have impacted on mental health should be included.

Psychosis section

The majority of the instructors agreed that the Psychosis section within the course needed to be expanded as it was often brushed over. It was also acknowledged that depression and anxiety are very common and that people don't always access appropriate support. One instructor expanded the session on Psychosis to address these issues but this involved reducing the time devoted to the 'Alcohol and other Drugs' section. One instructor felt that there was not enough guidance about what participants need to know in relation to psychosis – for example no self-help strategies are included.

One participant commented that additional case study examples should be included in the course.

"help on what you can say to a person during a psychotic episode that helps the situation." (Participant)

Another participant proposed that there should be more content included for psychotic illness

"… as I believe it is the hardest to comprehend to the layman and the most difficult to deal with." (Participant)

2.1.5 ***Materials that need to be removed***

Instructors were asked to comment on material that they felt should be removed. Most of their responses are

discussed in other sections of this appendix with the exception of statistical data and the alcohol tables, described below.

One instructor felt that there are too many statistics in the training material, especially in the introductory session. It was suggested that it was not necessary for participants to know exact statistical occurrences but more important for them to know how to deal with mental health issues. The instructor suggested that much of the statistical data could be cut from the program content.

"… the content and delivery of the program needs to focus less on data and more on destigmatising. We need to focus more on how to live with mental health more effectively."(Instructor)

"…as people appeared bored and wanted to get straight to the 'nuts and bolts'. Statistics should be used minimally where they are effective – to make a specific point – otherwise they lose impact. Statistics often harp on numbers and rely too heavily on data. We all have contact with someone with mental illness – not that comforting to know others or how common it is. Numbers are not necessarily re-assuring." (Instructor)

Some of the instructors felt that the Alcohol – low risk/high risk tables should be removed as they believed these are only relevant to clinicians, not to community members.

2.2 **Program delivery**

The instructors' discussions that resulted from interview questioning and feedback comments in relation to program delivery focused on the following main themes:

■ Length and timing of the course

■ Facilities

■ Expertise of instructors

■ Problems in delivery of the program for the instructors.

The instructors also commented that participation in the trial and being a MHFA instructor brought additional benefits such as being associated with a good product and participating in a project that addressed rural needs. Delivering the program provided opportunities for the instructors to augment their clinical practice or improve relationships with stakeholders in the mental health networks.

"I have learnt things from teaching the course that have helped in my clinical work – such as videos, books and other strategies to use. Other mental health staff have borrowed these resources. It has had a reverse beneficial effect on my clinical practice." (Instructor)

"Delivering the program enhances relationships at a local level and improves how we work together for example in handling sections etcetera." (Instructor)

2.2.1 *Length and timing of the course*

Recurrent themes in relation to lack of time were expressed by both instructors and participants. Instructors reported that participants repeatedly mentioned that the course was not long enough and that topics were skimmed over. They noted program information was good but more time was needed to go into more detail.

The instructors suggested there needs to be more time to cover:

- Bipolar depression
- More detail per topic
- All components of each topic (for example one instructor didn't use ALGEE steps for substance abuse section due to lack of time)
- Case scenarios and stories.

Twenty three percent of participant feedback forms made specific mention of time factors, mostly in relation to the shortness of the course. Comments described how these time constraints impacted on the depth of the content and the opportunity to absorb it. Some experienced an overload of information crammed into the short timeframe. Others felt that the content was too heavy or intense for the shortness of sessions. A number of participants stated that they would like the course to be made longer to include more time to hear more stories, watch more of the video content and for group discussion and interaction.

A few participants stated that they felt the timing was adequate and that it was of good balance and length.

Night classes were difficult to deliver for instructors and did not optimise learning for participants.

"When the program was run with a session at night and then followed by another session the next morning, this was very tiring. It was exhausting which could have impacted on quality of training." (Instructor)

"Three hours a night is heavy going particularly when it is a Mental Health course. I realise that it is difficult to cover the content in a limited time, however I think six two hour sessions would be better." (Participant)

2.2.2 *Facilities*

Participants reported issues relating to the quality of the learning environment. They made specific mention of:

- Poor venues

- Inadequate lighting
- Uncomfortable seating
- Failing equipment
- Overheads difficult to see
- Insufficient food and drinks in break.

Instructors also noted poor training facilities and malfunctioning equipment in some venues.

2.2.3 *Expertise of Instructors*

Instructors were asked to comment in interviews on the importance of having a mental health background to effectively deliver the program and to describe other issues that impact on delivery.

There was general agreement amongst the instructors that they should have a background and expertise in the field of mental health. They deemed clinical expertise to be central in delivering the MHFA training as it enabled them to:

- Reflect on current evidence based practice, in line with the underlying MHFA program model
- Contextualise the theory
- Respond to participant questioning
- Be confident in delivering the training.

It became apparent to the program co-ordinator when conducting the fidelity checks of each instructor that a mental health background was necessary as a result of comparing instructor competence between those who did and did not have clinical backgrounds.

"As fidelity checker, the clinicians fared better as they have their mental health experience to draw on, and are privy to comparative perspectives as well as many clinical examples and stories." (Project Co-ordinator)

One interesting story that confirms the significance of this assertion was told by a participant who had been unsuccessful in being recruited as an instructor. Having attended the program as a participant, he reflected on both his background experience and the content of the course and related to the instructor that he understood the validity of why he had not been selected as an instructor.

Reflect on current evidence-based practice

The instructors agreed that it was important for them to be able to model evidence based practices and to be up-to-date with medical and legal knowledge in relation to mental health issues. Instructors expressed concern that an instructor without a mental health background may promote a personal view rather than

one that is evidence based where the program information is limited.

"It was evident to me as manager of this project that those lacking mental health clinical experience facilitated the course more poorly than the other instructors. One instructor without a mental health clinical background for example also gave value laden opinions to participants, many of which did not reflect current evidence." (Project Co-ordinator)

"With a lack of medical and legal knowledge, there may be a temptation to give personal views as though it is evidence based. There are occasions when I do give a personal view – but state that this is what it is and clarify, for example, for mild to moderate depression there is research to show that a combination of exercise, diet, CBT and medication is effective." (Instructor)

Contextualise the theory

The instructors agreed that having a clinical background enables the use of examples from clinical practice to put the theory into context. Participants also confirmed that these examples helped put things into context and increased their understanding.

Participant feedback comments reflected the value of being trained by experts in increasing their understanding of the theoretical content. A significant number (36 per cent) included detailed comments about not just the style of presentation but also the mix of skills that each presenter possessed which increased their learning outcomes. The skills mentioned included knowledge, professionalism, expertise, humour, ability to communicate effectively, passion for the subject and experience of specific issues.

Respond to participant questioning

Without clinical expertise, instructors agreed that it would be difficult to respond to the finer points raised by participants. Participants commented that a strength of MHFA was being trained by an expert who could respond appropriately to questions.

"I can draw on my clinical experience. It has been of real benefit to be able to draw on these examples." (Instructor)

"However, a consumer with the 'lived experience' of a mental health problem also has much to contribute in terms of knowledge and experience." (Instructor)

Confidence

Most of the instructors felt confident in the delivery of the program because of their clinical background and experience in running groups and teaching, coupled with

the quality of the MHFA package. One instructor stated not being fully confident initially but described strategies that increased confidence.

"Becoming familiar with the content and having the program co-ordinator there to do fidelity checks and help with up-to-date research etc helped. After initial nerves, I became more confident by: seeking help early on; being honest about my lack of knowledge and bulking up my knowledge and receiving feedback. The peer supervision was instrumental in becoming confident." (Instructor)

A number of training strategies to improve confidence were suggested by the instructors.

- Peer supervision and evaluation by the program co-ordinator
- Rehearse each session
- Thorough knowledge of the manual
- Group skills training
- Keep people interested using humour and anecdotes
- Partake in refresher courses regularly.

Although the instructors felt that having a clinical background is more helpful, it was also recognised that it would be possible for someone with a non-clinical background to deliver the program effectively if they had the right mix of skills in other related fields. They noted in this case, it would be important to address this in the ANU training, by providing an opportunity to become knowledgeable of case studies, experiences, and examples to be able to respond to participant questioning.

"If the person has a genuine interest in and cares about mental health issues, coupled with good teaching skills and willingness to research issues, this can be a great advantage." (Instructor)

2.2.4 ### Problems with delivery of program for the instructors

Most of the instructors did not experience any major problems with the delivery of the program, agreeing this was partly due to the support of the program authors and co-ordinator. They identified some topics as being problematic and the occasional occurrence of inadequate facilities and equipment, as reported previously.

The instructors agreed that some individuals can dominate the group but with experienced facilitators this can be managed appropriately.

"One of the biggest problems that I had to deal with was a couple of participants who were oppositional to

the content matter and disliked the presenter and format. They didn't like the statistics detailing suicide numbers etcetera and expressed views that people have rights. It is difficult to rationalise this with what the program aims to do. It was difficult trying to manage that as well as other issues that arise when discussing suicide. It was difficult to contain and thus we ran over time. I didn't get the opportunity to finish the subject matter." (Instructor)

The instructors agreed that some people find some of the topics confrontational, for example, suicide and mental disorders.

"I deal with this by admitting to not always having magical answers, for example, for suicide but being able to be honest about what people do." (Instructor)

The instructors agreed that you occasionally have to deal with people who have little knowledge about a particular mental health issue such as ECT or suicide and who may dominate the session by returning to their viewpoint or personal experience.

As facilitators, it was sometimes difficult to deal with people reacting badly and to support them if in immediate need. One instructor reported a participant who had a panic attack in the session, which had to be dealt with sensitively and discreetly. This was difficult to manage as a sole facilitator. It was suggested that such events could be effectively and appropriately handled if a co-facilitation process was in place.

2.3 Substance abuse section

2.3.1 *Problems*

The delivery of this section raised a range of problems for each of the instructors, irrespective of their levels of comfort with the content matter or clinical expertise in the management of substance abuse and mental health disorders. There was agreement that there was confusion and overlap in the content with regard to substance abuse, although this blurred demarcation may reflect prevailing dilemmas for clinicians generally and therefore cannot be addressed clearly in the program materials.

There is a general feeling amongst the instructors that this section is just a 'tack-on' and that most of them experience a lack of confidence and expertise in that area, and/or a lack of comfort in delivering the topic within the overarching MHFA format. They agreed that the whole chapter needs to be revamped.

Substance abuse: mental health issue or co-morbidity?

The program materials describe substance abuse as symptomatic or as a component of dual diagnosis, not as a mental health issue on its own.

"The program only focuses on dual diagnosis as symptomatic rather than on those that could have underlying mental health issues or where those with substance abuse could result in a mental health issue." (Instructor)

"The content of this section is problematic in addressing co-morbidity issues and treating their symptoms as part of the picture – the program addresses this as a mental health issue." (Instructor)

One instructor recognized that generally there is no infrastructure or integration between D&A and Mental Health services to develop an appropriate model around assessment and treatment and that this confusion comes across in the content.

"For me this causes conflict – the substance abuse and dual diagnosis dilemma. Fifty percent of Mental Health clients have a substance abuse disorder or dependence (Cannabis, tobacco, alcohol). Fifty percent of substance users have a mental health disorder or illness. There is a great difference with a substance abuse disorder under DSM IV – it is seen as a physical disease and medicalised." (Instructor)

The instructors agreed that co-morbidity needs to be included as an issue but were unable to settle on the level of focus that should be apportioned to this in the content matter. They did agree, however, that the topic should not be an add-on. It was felt that there needs to be a significant focus on alcohol issues in the program.

Substance abuse: infidelity to Mental Health model

Some of the instructors felt that the substance abuse content is presented as a medical/disease based issue, which is inconsistent with other sections of the program. One instructor added that it was difficult to present this section in a mental health model as substance abuse is presented as a physical disability.

"In the MHFA program, addiction is only addressed as a mental health issue if there's dual diagnosis. But if addiction exists on its own it is addressed as a physical disease for example, diabetes." (Instructor)

Substance abuse: inconsistency with MHFA Format

Another area where the delivery of the D&A topics was problematic for an instructor was in integrating it into the format of the training as it was perceived to be different to the other Mental Health sections.

"The alcohol audit tool for example didn't flow with the style and content of other topic areas." (Instructor)

"There is a great array of learning tools, for example, videos, booklets, etcetera for most of the sections but none of that for the Drug and Alcohol section." (Instructor)

Substance abuse: lack of instructor confidence in delivery

Most of the instructors stated that they lack confidence in delivery of the D&A content. They stated that mental health training does not necessarily mean D&A training.

"I had to keep this section superficial as there is not enough in-depth in the manual or other literature for this topic." (Instructor)

Substance abuse: content deficit

Content areas that were considered by the instructors to be missing or not addressed in this section included:

- Dependence on prescription medications, client use and dependence on benzodiazepines and tobacco

- Early intervention in the context of addiction

- Contextual issues with substance abuse, for example drugs used, individual and environmental factors

- Substance abuse and men.

2.3.2 Solutions

The instructors provided a number of suggestions that would address the problematic content of this section on substance abuse, described below.

Substance abuse: discrete module

The instructors proposed developing the substance abuse section as a module on its own, that is, 'Mental Health and Substance Use First Aid'.

"As the dual diagnosis issue fits more comfortably into the MHFA approach than substance abuse, perhaps one solution would be to develop a separate book on 'Substance Abuse First Aid' and look at a range of factors including dual diagnosis, substance misuse and symptomatic use." (Instructor)

However instructors had previously commented that the topic should not be addressed as an add-on. Another solution that was put forward was to incorporate a D&A component in each content area throughout the program such as co-morbidity with depression, anxiety, suicide, psychosis etc rather than have as a separate module.

Substance abuse: further training

All instructors agreed that they need more training to up skill them in order to address substance abuse as a key subject and to increase their confidence in this area. For example a D&A session for instructors could possibly be addressed in instructor training or the new

Commonwealth guidelines for D&A could be provided as an additional resource.

"At the 5 day ANU training there should be less attention on standard mental health issues and more time on Drug and Alcohol training and more time in the program to deliver." (Instructor)

Substance abuse: additional resources

Instructors suggested that additional resources such as books, stories, and websites were needed to improve this section for both delivery of the content and to increase participant learning outcomes.

2.4 More research perspectives

The instructors were essentially in agreement that the MHFA program is balanced in recognising other research perspectives that are evidence based, even when they sit outside the bio-medical model.

"I think that the program does this quite well as the lifestyle and alternative therapies that are included are evidence based. A range of choices are mentioned in the manual. It is balanced in the manual with the inclusion of mention of St John's Wort, the benefits of physical activity etc." (Instructor)

"Regardless of research approach used, this program currently addresses what is stated in the literature. The program aims to do this but it is the debate of other professionals such as alternative practitioners in the field who feel sidelined by this information. There is not enough research to say some things are effective. New evidence is constantly emerging and I think the MHFA program is as fluid as it can be at this point." (Instructor)

However, there were some comments from instructors that proposed that the program should not be limited to the bio-medical model and that there is room for recognition and discussion of other therapies dependent on the instructor's knowledge and experience of other treatments and if this is supported by evidence.

"Complimentary therapies could have a bit more of a focus eg the effect of the moon on psychoses which is backed up by heaps of research or talking about common individual instances, for example, melatonin and sunlight theory." (Instructor)

The instructors also reported recurrent themes from some participants reflecting questions and levels of discomfort with the mental health medical model that underpins the MHFA program. One instructor's comment reflects the experiences of the other instructors of the issues raised by participants in this context:

"I received a lot of comments that the program is biased – only focused on scientific model and biomedical model and that there is not enough time to unpack other possible treatment approaches, for example acupuncture or massage." (Instructor)

The instructors provided individual strategies for responding to participant questioning of the focus on the biomedical model.

"I do not recommend non-evidence approaches but I do however state that although I can't recommend other approaches individuals are free to explore them." (Instructor)

"I only give responses where there is evidence to support it and also based on clinical experience. For example St John's Wort – has been shown to be effective in mild to moderate depression but if it doesn't help, I suggest that people try other therapies. But if it is severe depression I stress that people need to seek more clinically, evidence based treatment." (Instructor)

Some approaches were offered by instructors that they had adopted to be more inclusive of a range of research perspectives in the delivery of the program.

"I explain to participants that when the manual talks about seeking professional help for say mild to moderate depression, I stress that professional does not necessarily imply a psychologist – it could be a local spiritual leader for example. It must be about personal choice and local options." (Instructor)

One instructor suggested that extra sections could be incorporated which give space to other therapies. It was felt that there needs to be more focus on psychological treatments such as Cognitive Based Therapy (CBT) and Dialectical Behaviour Therapy.

The instructors stressed that they aimed to be professional and evidence based at all times.

"When it comes to the wacko stuff and you are being professional and evidence based, it is negligent to recommend non-evidenced approaches." (Instructor)

"It is a risk when some things don't work and there is no evidence. It must be evidence based for all therapies and referenced. Presenters can agree that people's choices can be respected and that these can go hand in hand with traditional treatment methods but it is important not to let your own biases come across." (Instructor)

In individual interviews, instructors commented on areas of research that are not included in the program material. These included indigenous and social determinant perspectives.

3. Marketing of MHFA training program

The project co-ordinator stressed that it was important to give consideration to the project marketing strategies to extend the reach of the delivery of the MHFA program. This was seen as important as there are insufficient services and resources in these rural areas.

Instructors stressed in the group interview a particular need to address the mental health literacy needs of people within rural areas. They noted strategies should not be limited to educational support such as web based educational material because of the technological and financial constraints that exist for many rural residents. One participant suggested that an interactive CD could be developed as an alternative to doing the course in person for those living in remote areas.

One instructor suggested that it would be informative to conduct needs analyses in relation to specific issues such as drought, youth suicide, snow season/young people to inform the development of appropriate marketing strategies for such groups or issues. Another suggestion was to analyse the Mental Health Intake 1800 referrals to identify client demographics and other relevant information, which could be used to address specific service delivery and access issues. For example, it could provide information that could streamline referral pathways such as linking GPs with those with mild to moderate symptoms.

The project co-ordinator suggested that the recruitment of specific groups within the community to the program should also be addressed. For example, the proportion of men who participated in the MHFA trial was small (18 per cent) and it was proposed that it may be opportune to develop appropriate marketing strategies to increase uptake of the program by rural men. One instructor suggested that an appropriate strategy to target men was to involve a male celebrity who would use language that men respond to.

The instructors agreed that the program needs to be targeted to increase the mental health literacy of specific subgroups. This view was reinforced by several participants in feedback comments who suggested that it should be presented to high schools students, in particular the substance abuse section.

The instructors were unreservedly in agreement that there has been an increase in demand for MHFA programs and that the feedback from participants had

been consistently very positive. In response to interview questions about how to effectively target MHFA to those in the community who may be likely to come in contact with someone with a mental health problem, the instructors put forward the following suggestions:

■ Utilise the MHFA instructors to provide mandatory training on MHFA to Area Health staff with initial priority to be given to new staff employed by mental health, for example casual drivers with no experience in mental health

■ Conduct MHFA training for other key professional stakeholders, targeting groups such as police, the Department of Community Services, charity workers, housing and employment agencies, Centrelink, the Department of Immigration, Corrective Services, D&A services and teachers

■ Conduct early intervention work with at risk groups who may be experiencing mild to moderate symptoms of depression and anxiety and who have not sought professional help

List of publications and website

Jorm AF, Kitchener BA, O'Kearney R and Dear KBG. Mental health first aid training of the public in a rural area: a cluster randomized trial. BMC Psychiatry [serial on the Internet]. 2004 Oct [cited 2007 Feb 14]; 4(33):[9p]. Available from: http://www.biomedcentral.com/content/pdf/1471-244X-4-33.pdf

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