

### **Summary of the previously presented research**

MHFA was developed and has been most rigorously evaluated in Australia, albeit predominately by the originators of the course. The course itself has been adapted to be delivered in 15 other countries, but the rigorous evaluation of these adaptations has been limited. Predominantly evaluations of course participants' satisfaction have been published in Scotland, Canada, England, and Wales (Scottish Development Centre for Mental Health, 2004; Alberta Mental Health Board, 2007; National Institute for Mental Health in England, 2010; Welsh Assembly Government, 2009). An evaluation of a pilot cross border initiative has also occurred in Ireland (Health Promotion Agency, 2008)

The research conducted to date, suggests that MHFA training is a valuable tool to assist participants to develop a greater knowledge of mental health issues and positive attitudes and approaches towards people with mental ill-health. MHFA appears to assist participants to recognise mental disorders and subsequent evaluations suggests participants' intent to become involved with, and render assistance to, those in mental distress.

There are methodological difficulties with the majority Australian studies on which the credibility of MHFA has rested. These studies have utilised a variety of designs including uncontrolled quasi-experimental methods (Kitchener & Jorm, 2002), and randomised studies (Kitchener & Jorm, 2004) and cluster randomised control (Jorm et al., 2004) designs. Many of the studies had homogeneous participant populations (see Kitchener & Jorm, 2002) recruited largely from government health departments or associated services (Kitchener & Jorm, 2004). Participants have largely been self-selected and analysis of the data suggested they possessed significant levels of knowledge about mental health prior to training (Kitchener & Jorm, 2002, 2004). When control groups were used they came from the same populations as the participants and were separated by a "wait list" approach that delayed their receipt of the training (Kitchener & Jorm, 2004). It is possible that there

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was contamination of the control groups as the participants and the controls often worked in the same environments or lived close to each other (Jorm et al., 2004). There were also direct personal benefits for the participants in completing the courses as the courses were often conducted during working hours, which may have positively biased the subsequent evaluations (Kitchener & Jorm, 2004).

In one study the mental health of participants was identified as having improved following MHFA training (Kitchener & Jorm, 2004). However, the SF-12 measure used was not designed for small study research (Ware et al., 1996) and the group that showed improvement in mental health following training had a pre-training mental health score that was lower than the general population. Consequently the validity of this finding can be questioned. Another study in the same year actually identified an increase in self-reported mental ill-health in participants following the completion of training (Jorm et al., 2004).

Potential response biases within the research group were acknowledged in the design of the rural control trial (Jorm, et al., 2004). The same authors, however, appeared to under-emphasise the potential impacts of variable content and delivery due to the use of multiple presenters. Also, only 42 percent of the MHFA participant surveys were completed in this study. The reason for this low rate of return is unknown and may reflect the influence of a further, unknown bias in the study. The rural control trial study did appear to have a more heterogeneous participant population than the other studies, although there is no information as to the employment circumstances of the participants within the study. More than half of the course participants undertook the course for “work” reasons, but no information is given regarding training times or venues (ie during working hours or after hours). The only attendance information provided was that the participants had to be available for the duration of the research and willing to complete the study’s surveys.

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The tools used to measure change resulting from the training were paper and pencil based and included vignettes describing individuals with mental ill-health. Depression and psychosis were the conditions presented. This is a potential source of bias, as both these conditions have several unique characteristics which arguably make them more easily identifiable than other conditions, such as anxiety disorders or drug intoxication. Indeed, Jorm, Blewitt, Griffiths, Kitchener and Paslow (2005) in their study of the Australian populations' knowledge of mental disorders found people untrained in MHFA were also able to identify these conditions. While it is reasonable that the mental conditions chosen for inclusion in the assessment vignettes had to be identifiable, one could predict less clear outcome data if potentially more complex and less clearly distinguishable conditions were used. For example, anxiety disorders, the most prevalent mental health disorder in Australia (Australian Bureau of Statistics, 2007), were not used in the vignettes. This contrasts with the use of psychotic disorders which represent less than one percent of mental ill-health in the community (Jablensky, 2000), but which have significant stereotypes and stigma attached to them. Selecting clearly definable conditions increases the chance for successful identification of the condition, by potentially, utilising knowledge gained from outside the training programme. The difficulties in using vignettes rather than real situations for assessment have been raised previously. Vignettes do provide an ethically appropriate mechanism to test knowledge, but they do not provide evidence of the application of skills. This last issue is beyond the scope of the present study, but will need to be addressed in the future if the value of MHFA, as an applied tool to assist those in mental distress, is to be fully substantiated.

The argument that a decrease in social distance equates to a reduction in stigma is problematic. A reduction in social distance may suggest that participants are merely assessing the mental well-being of others more effectively. It does not, however, provide direct evidence of a change in attitude toward someone who is mentally ill. It is the negative evaluation of others which forms the basis of stigmatising attitudes and this is not directly measured by social distance.

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Qualitative evaluations identified that participants were confident of being able to use the skills and the information learned as a result of completing the course (Jorm et al., 2005). The assessment in this study utilised self-report surveys to evaluate the course. The authors do not acknowledge the potential response bias associated with this approach where satisfied participants would be more likely to respond to the survey. Indeed, they contend that people who were unhappy with the course would also have been likely to return their evaluative surveys. It is much more likely, however, that dissatisfied participants would dismissed the invitation to complete and return such a survey.

Only two Australian studies not generated by the authors have been published (Hossain et al., 2009; Sartore et al., 2008). These were uncontrolled studies carried out in rural communities using small study populations ( $N = 32$  and  $N = 99$  respectively). However, the courses were well received with knowledge about mental ill-health, and what to do if facing a crisis improving among participants as a result of training. Participants found the material to be new, well presented and relevant (Hossain et al., 2009). Sartore et al. (2008) identified some hesitancy by the participants to apply the learning as they identified the role of a provider of MHFA as being incongruent with their job roles. This hesitancy to apply MHFA by a group unfamiliar with mental ill-health prior to training might be an important consideration for future studies.

The studies that have been conducted outside Australia have focused on the evaluation of the course adapted for use in that country. The evaluations generally addressed participant and trainer satisfaction with the course, rather than the reliability and validity of the course or the evaluation tools (for example, none of the following studies evaluated the reliability or validity of the course or the evaluation tools: Alberta Mental Health Board, 2007; Mental Health Association of Hong Kong, 2003; The Health Promotion Agency, 2008). On one level, this is an absolutely reasonable course of action. Such studies provide valuable understandings of MHFA to identify the commonalities of the learning experience across settings and cultures. On

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another level, however, this means there is a consistent gap in the research. The international studies have not sought to move past these evaluations to rigorously investigate the content of the course, or challenge the previous research within their own jurisdictions. Instead, much of the support for MHFA stems from the general acceptance of the often quoted original research conducted by the authors of the programme. Table 2.3 provides a summary of some of the strengths, concerns and opportunities that have been identified from the Australian research, to date. The current study will address some of the opportunities described from the gaps identified in the previous studies.

The opportunities for the present study are discussed further in “the current study” section, commencing on page 93.