

Mental Health First Aid in an Irish Context

By

Anne-Lisa Shanahan

M.A. Psych. (Clin.), Grad. Dip. Soc. Sc. (Rehab.), Grad. Dip. Ed.
(07233690)

Being an Investigation and Report Submitted for the
Doctor of Philosophy
Within the
Department of Health Promotion
School of
Health Sciences
College of
Medicine, Nursing and Health Science

National University of Ireland, Galway

Supervisor: Professor Margaret Barry

February, 2013

Table of Contents

	Page
List of tables	v
List of figures	vii
Release statement	ix
Acknowledgments	x
Abstract	xi
1. Introduction	12
2. Literature Review	19
Defining mental health	20
Models of mental ill-health and mental well-being	22
<i>Holistic, Positive Psychology, the Dual Continuum Model, the Complete State of Mental Health, Integrated Contemporary Models</i>	
Factors influencing mental health	29
<i>Individual and cultural factors</i>	
Mental ill-health and stigma	33
<i>Models, discrimination and addressing stigma</i>	
Mental health literacy	39
Mental health promotion	40
<i>The development of inclusive models, principles, applying strategies, individuals and health promotion</i>	
Mental Health First Aid	51
<i>Justification, aims and structure.</i>	
Previous evaluations of Mental Health First Aid	56
<i>Impact of training on mental health literacy and on course participants, the application of skill and replication studies</i>	
Summary of previous research	84
Evaluation of health promotion initiatives	91
<i>Research design</i>	
The current study	96

3. Method	102
Design	103
<i>Internal validity</i>	
Sample	107
<i>Recruitment, MHFA participants, control group matching procedure, statistical power, external validity</i>	
Measures	114
Questionnaire rationale and construction	114
<i>Measurement reliability and construct validity</i>	
Questionnaire content	118
<i>Demographic information, MHFA knowledge, subjective evaluation, psychological well-being and psychological distress, mastery, course content</i>	
Follow up at two and six months	127
<i>Vignettes, questionnaires</i>	
Piloting of the measures	129
Procedure	131
<i>Adaptation of the course material, reliability of application, ethical approval, the course presenter</i>	
Evaluation	134
<i>Considerations for data analysis, analysis</i>	
4. Results	141
Demographic characteristics of the study population	142
Hypothesis 1	148
Key elements of MHFA knowledge	149
<i>Depression, anxiety, suicide, psychosis, drugs and alcohol rated after training and at two and six months</i>	
Application of learning	160
Subjective evaluation	165
<i>Knowledge to manage a mental health emergency, skill, confidence and competence to do so rated after training and at two and six months</i>	

Hypothesis 2	175
<i>The impact of MHFA training on mental health literacy and preparedness to apply the learning</i>	
Hypothesis 3	178
Measuring mental well-being	183
<i>Using three scales of mental well-being following training and at two and six months, subjective evaluations</i>	
Hypothesis 4	190
<i>Mastery and MHFA training</i>	
Hypothesis 5	192
<i>Mastery and participant mental well-being</i>	
Hypothesis 6	196
<i>Evaluation of the structural elements and content of the course</i>	
5. Discussion	202
Introduction	203
Major findings	204
Evaluating the key subject areas	207
Course structure and delivery	216
<i>Effect of prior knowledge, recall of ALGEE, comparison of mnemonics</i>	
Subjective evaluation of the course	226
<i>Application, comparison to physical first-aid, effectiveness</i>	
Participants' mental well-being	226
Contributions of the current research	236
Limitations of the current research	239
<i>Design, sample, measures, data and future research</i>	
Conclusions	250
References	253
Appendices	280

List of Tables

Table		Page
2.1	Factors for the categorical diagnosis of mental health	28
2.2	Overview of MHFA investigations/ evaluations	80
2.3.	Previous Australian studies of MHFA training.	89
4.1	Demographic characteristics of the MHFA course participants and control group.	143
4.2	Knowledge of the key areas of training rated prior to training (T1) and immediately following (T2) training.	150
4.3	Participant rating of key areas of MHFA prior to training (T1), following training (T2), at two month follow up (T3) and six month (T4) follow up.	154
4.4	MHFA course participant and control group subjective rating of knowledge, skill, confidence and competence to apply MHFA prior to (T1) and immediately following (T2) training.	166
4.5	Participant rating of subject elements associated with their capacity to manage a mental health emergency prior to training (T1), following training (T2), at two month follow up (T3) and six month (T4) follow up.	170
4.6	Comparison mental well-being mean scores on EVI and MHI-5 of SF-36 (Ware et al., 1993) from this study and the findings from previous studies of mental well-being	180
4.7	Demographic characteristics of the MHFA participant group and the control group for the mental health scales.	183
4.8	Ratings by course participants and control subjects on the mental well-being scales prior to training (T1) and immediately following (T2) training.	186

4.9	Course participant ratings of their own mental health prior to training (T1), following training (T2), at two month follow up (T3) and six month (T4) follow up.	187
4.10	Total variance explained within the mental health scales prior to and following training.	193
4.11	Variance explained by each predictor variable within the mental health scales before and following training	194
4.12	Usefulness (%) of course content as rated by participants following MHFA training.	199
4.13	Participant rating ($n = 212$) of the value of course elements (%) immediately following training.	199

List of Figures

Figure		Page
2.1	Dual continua of Mental Health and well-being with additions by Keyes (2007)	26
3.1	Timing of the data gathering procedure used in the current study.	106
4.1	Activities undertaken by course participants to manage their own mental health	146
4.2	MHFA course participant responses of actions they would undertake to ease concern about their own mental health.	147
4.3	MHFA course participants' rating of knowledge of depression prior to training (T1), immediately following training (T2) and at two (T3) and six months (T4) following training.	155
4.4	MHFA course participants' rating of knowledge of suicide prior to training (T1), immediately following training (T2), two months following training (T3) and six month follow up (T4).	156
4.5	MHFA course participant rated knowledge of anxiety prior to training (T1), following training (T2), at two month (T3) and six month (T4) follow up.	157
4.6	MHFA course participants' rating of knowledge of psychosis before training (T1), following training (T2) at two month (T3) and six month (T4) follow up.	158
4.7	MHFA course participant knowledge of the effects of drugs and alcohol prior to training (T1), following training (T2) at two months (T3) and six months (T4) post training.	160
4.8	Recall of ALGEE elements and its application to vignettes two months (T3) and six months (T4) following training.	161

4.9	Preparedness to apply MHFA immediately following training (T2) at two month follow-up (T3) and six month (T4) follow up.	163
4.10	MHFA course participants' knowledge of MHFA before (T1), following (T2), at two month (T3) and six month (T4) follow up.	171
4.11	MHFA course participants' rated level of skill to manage mental health crises prior to training (T1), following training (T2) at two month (T3) and six month follow up (T4).	172
4.12	MHFA course participants' confidence in managing mental health crisis before training (T1) following training (T2) at two month (T3) and six month (T4) follow up.	173
4.13	MHFA course participants' reported competence at managing mental health crisis prior to training (T1), following training (T2) at two (T3) and six month (T4) follow up.	174
4.14	Percentage of course participants who indicated applying MHFA training at the two month (T3) and six month follow up (T4).	176
4.15	New elements of the MHFA course as identified by the participant group ($n = 172$).	197

This dissertation contains no material which has been accepted for the award of any other degree, diploma or doctorate in any other university, and to the best of my knowledge and belief, the dissertation contains no material previously published or written by another person, except where due reference is made in the text.

I give consent to the dissertation being made available for photocopying and loan when deposited in the University library following its acceptance for the award of Doctor of Philosophy.

Anne-Lisa Shanahan

Date

Acknowledgements

My sincerest thanks go to:

Professor Margaret Barry my principal supervisor for the Department of Health Promotion, NUI Galway. Thanks for your time, assistance, understanding and support without which this research would have not been completed.

Dr Michal Molcho and Dr Lisa Purcell who provided timely advice and support along the way.

To those who helped generate interest in the course and assisted with the collection of the data, especially, the HSE Health Promotion Unit, Western Rd Cork, Martin O'Sullivan, of the Southern Command of the St John's Ambulance Service, Liam O'Connell and Marion O'Loughlin of the Irish Red Cross and Liz Kyte.

To the training coordinators and managers of the organisations who took the chance to offer a new programme, many thanks for your confidence.

To all those who undertook the training and completed the surveys including those in the St John's and Red Cross First aid courses. The pleasure was all mine.

To my brother Martin for his invaluable assistance.

To my friends, family and colleagues for their ongoing interest and tolerance.

Abstract

Mental Health First Aid (MHFA) is an early intervention training course designed to improve the knowledge, skills and confidence of non-clinicians to manage mental health emergencies. The course aims to minimise the negative impact of mental distress by encouraging the early provision of appropriate care. The course has been evaluated in Australia, but less rigorously in other countries where it is offered. Previous research suggests that participants gain knowledge and skills from completing the course, however, the mechanism by which this learning occurs and the impact of completing the course on the participants' own mental well-being has not been systematically evaluated.

This study evaluated the responses of 216 Irish course participants and a matched control group before and following training. Knowledge of mental ill-health, participant confidence, competence and skills to manage a mental health emergency were rated. MHFA participants' sense of mastery and mental well-being were also assessed using Pearlin and Schooler's Mastery Scale (1978), the Mental Health Index and Psychological Distress scales of the SF-36 (Ware, Kosinski, Keller, 1996) and the Warwick Edinburgh Mental Well-being Scale (Tennant et al., 2007). MHFA course participants were assessed at two and six months following training to evaluate the robustness of their learning and the application of the learning.

Findings from repeated measures analysis indicated that knowledge of mental ill-health is enhanced by MHFA training. Following MHFA training there is a statistically significant increase course the participants' rating of skills, confidence and competence to manage mental health emergencies, in comparison to the control group. Following training, participants reported; an enhanced sense of mastery, applying their knowledge and an increasing preparedness to offer assistance. Further, there were positive benefits for participants' mental health, with ratings of their mental well-being continuing to increase up to six months following training.

MHFA training provides course participants with the knowledge and skills to assist others in distress as well as having an enduring positive impact on the participants' mental well-being. Despite this, questions still remain about the effectiveness of MHFA for those who receive care. The durability of the positive effects of the learning requires further exploration.

1. Introduction

This introduction provides a brief synopsis of the research undertaken. It outlines the importance of improving care to those who are mentally unwell, as well as introducing some of the potential difficulties in that endeavour. The reasons why this study is of value are presented. The study is briefly described including the collection of data and the approaches taken in the analysis. An overview of each chapter is provided.

Mental well-being and mental ill-health are of universal relevance. Mental ill-health is prevalent in western societies with approximately 20 percent of the population experiencing a diagnosable mental illness in any one year (Andrews, Henderson & Hall, 2001). The deleterious impact of mental ill-health has the potential to change lives. Individuals express and experience mental ill-health uniquely, and these experiences are interpreted and influenced by the family, community and cultural environments in which they occur. Individuals with mental ill-health are at risk of exacerbating the frequency, duration and intensity of their illness if they fail to receive timely and appropriate assistance. Yet community understanding of mental ill-health and the capacity of individual and social structures to provide assistance to those with mental ill-health remain underdeveloped. Mental health literacy in the community is low (Jorm, 2000). Many people cannot recognise mental ill-health nor do they have the understanding of what to do if faced with someone who is mentally unwell. This lack of understanding and the corresponding lack of skills within the community to assist someone in distress often results in, at best, disengagement with the person who is unwell, and at worst, the development of stigmatising attitudes and discriminatory behaviours towards those experiencing mental ill-health. Programmes that challenge such ignorance by the provision of evidence based information and skills to assist someone in distress may encourage engagement and contribute to the provision of timely assistance. Further, such approaches may reduce the impact of mental ill-health by identifying preventative options and early warning signs of decline, thus affording the opportunity for early intervention. The provision of appropriate early assistance to someone in mental distress is

Introduction

clearly desirable, but so to is the protection of the mental well-being of the provider of such care.

This study describes the implementation and evaluation of Mental Health First Aid (MHFA) in the Irish community. MHFA was developed in Australia in 2001 and has been designed as a programme to teach non-clinicians approaches to assist individuals experiencing, or at risk of experiencing, mental ill-health. It is a 12 hour training course modelled on the format of standard physical first aid courses. Standard physical first aid courses rely on the provision of care utilising a mnemonic to guide the actions of the person providing care. Being concerned with mental ill-health, MHFA provides information about the signs and symptoms of common mental ill-health conditions in the community. It teaches participants to apply an action based framework, using a mental health focused mnemonic, in response to the needs of someone in distress. MHFA training has rapidly gained in popularity having been adopted in more than 15 countries. To date, one percent of the Australian population has completed this training (B.A Kitchener, personal communication, August 29, 2011).

Despite its apparent popularity, MHFA has had limited evaluation. Most evaluations that have been undertaken have been conducted by the authors of the MHFA course, with few done by other researchers either within Australia or elsewhere. The evaluations that have been completed suggest that MHFA is well accepted by the course participants and is a useful tool for the development of mental health literacy. One previous study (Kitchener & Jorm, 2004) identified some improvement in the mental well-being of course participants, however, the baseline mental health of the evaluated group was lower than the population average before training, and the measures used to obtain the finding were inappropriately applied.

The purpose of this study is to evaluate MHFA in an Irish context. It is primarily concerned with:

Introduction

- the learning achieved as a result of training and the robustness of that learning over time.
- Identifying if MHFA training has any positive benefits for the mental well-being of participants.
- If mental well-being of the participants is enhanced following training, the mechanism involved in this outcome.
- Exploring the proposition that the mastery of skills associated with the provision of emergency assistance may be associated with the enhancement of mental well-being in MHFA course participants. The relationship between enhanced mastery following training and the mental well-being of participants is investigated.
- The evaluation of subject content of the course and the delivery methodology of the training to establish if these factors contribute to the learning achieved.

Utilising a quasi-experimental approach 216 MHFA course participants were matched on age, gender, education and occupation to 216 participants of standard first aid courses. The responses from the two groups were compared before and following their respective training for knowledge of depression, anxiety, suicide, psychosis and drug and alcohol misuse. Rated responses from these groups were used to compare participants' knowledge of how to manage a mental health emergency and their confidence, competence and skill to do so. The MHFA participants were asked to rate any changes in their attitude to their own mental health and their satisfaction with the course and its content. Both groups also completed three scales evaluating mental well-being to identify any changes in their mental well-being following training. A series of repeated measure ANOVA were conducted to compare the interactions of responses within the groups over time.

The MHFA participants were evaluated via telephone interviews two and six months following the training. This was undertaken to identify the robustness of the learning over time, the application of the learning, and the mental well-

Introduction

being of participants over time. Repeated measure ANOVAs were utilised to identify changes over the six month assessment period. MHFA participants also rated their level of mastery over six months and the change in these ratings were analysed. Multiple regression analysis was undertaken to identify the proportion of variance accounted for by factors known to impact on mental well-being within each of the mental well-being scales. In so doing, an indication of the association between mental well-being and mastery was established.

The thesis commences with a literature review that provides an overview of the core concepts and their definitions, together with the theoretical models of mental health, mental ill-health and mental well-being. Factors that are influential to the conceptualisation and experience of mental ill-health are discussed. This includes the individual experience of mental ill-health and the social and cultural factors that are important in the interpretation and amelioration of the illness experience. Culture is particularly relevant with to this study, as the course being evaluated was originally written for use in Australia, and the supporting evaluations have predominately been Australian in origin. Therefore, an exploration of the value of the course in the Irish context is of relevance. The literature review also canvases the importance of improving mental health literacy and reducing stigma and discrimination in the community. An introduction to the role of mental health promotion in advancing this endeavour is presented.

The MHFA course is described and the previous evaluations of the MHFA are presented. A brief introduction as to the complexities of evaluations within the field of mental health promotion is provided prior to the description of this study and its hypotheses.

The Method chapter identifies the approach taken to address the research questions. Design considerations are presented and the participant sample described. This includes descriptions of the recruitment of the study participants and the matching procedure for the MHFA course participants

Introduction

and the control group. The rationale for the construction of the questionnaire including the considerations given to the reliability, validity and content of the measuring tools are provided. The construction of assessment items unique to this study and the selection of existing scales are described. The process for piloting of the measures is discussed as are the procedures for the delivery of the training and the data collection. Considerations for the statistical analysis and the approaches utilised are provided.

The Results chapter presents the demographic and descriptive statistics of the study population which are followed by the analyses undertaken to address each hypothesis. Responses of the MHFA participant group and the control group are compared immediately before and following training. The rated responses of the MHFA participant group are examined at two and six months after training.

The results indicate that after training the MHFA participant group rate their knowledge of mental ill-health and their confidence, competence and skills to manage a mental health emergency as statistically significantly improved. Although there is some decline in ratings of these factors to six months following training, ratings remain above pre training levels. The results also indicate that the training is used to help others, with preparedness to apply the learning increasing over the six month assessment period. In addition, the MHFA participants rate their own mental well-being as being enhanced after training. Despite there being some return of mental health and well-being ratings towards pre training levels in two of the scales used, in the third positively worded Warwick Edinburgh Mental Well-being Scale (WEMWBS: Tennant et al., 2007) participants rated mental well-being as continuing to improve after six months. Course participants also rated their sense of mastery as having been enhanced after training. Mastery was subsequently identified, using multiple regression analysis, to contribute to the variance explained within each mental health and well-being scale.

Introduction

The Discussion chapter highlights the major findings of the study and their implications. It identifies the contributions of the study, particularly its contribution to the understanding of the value of MHFA training. The discussion considers factors associated with acquisition, retention, application and decay of learning. The other major contribution considered is the improved mental health and well-being of the participants after training and the identification of mastery as a possible mediating factor. The importance of the enhancement of the participants' mental health and well-being after training is discussed in the context of the application of the learned skills to address the needs of people in mental distress and also as a possible factor to reduce stigma. The discussion identifies the methodological contributions of this study, and the limitations. In addition, it compares and contrasts the findings of this MHFA evaluation with evaluations of training in physical first aid. This is undertaken as there is a greater depth of research into physical first aid training, and such an approach potentially offers a comparative insight into MHFA training and the contexts in which it occurs. Areas which require further consideration and expansion, and options for future research are presented.

2. Literature Review

This chapter introduces the background information underpinning the current study. It provides a description of the definitions and models to assist in the conceptualisation of the research. It identifies the complexities not only in the conceptualisation of mental ill-health and mental well-being but also those associated with evaluation within the area. The chapter identifies why training in mental health is important and some of the barriers which make training in the area more complex. An overview of the goals of the field of mental health promotion and where the current study is positioned within that field is presented. The course Mental Health First Aid (MHFA) is described as are previous evaluations of the programme. The rationale for this study and the questions addressed in the research are described.

Defining mental health

Within the field of public health, physical well-being programmes have commonly been used to address community health concerns (see Minkler, 1989 for an overview). This is despite this the World Health Organisation (WHO) defining health as:

“...a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO, 1948, p.100).

This definition clearly identifies that mental well-being is integral to human health. However, health promotion initiatives have historically tended to give low priority to mental well-being and its influence on health. Instead they have focused extensively on the physical and social determinants of health. This neglect may have been the result of a presumption that mental well-being would follow if physical and social elements of health were addressed. Alternatively, mental well-being may have been considered too complex a concept to tackle. As a result, health promotion initiatives often relied on quantifiable concepts associated with physical health and social well-being, with these approaches largely being derived from deficiency models of

Literature Review

disease and infirmity. More recently, however, the emphasis of the contribution of mental health to overall health has been reconsidered. Those driving health reform have begun to recognise that the elements within more recent approaches are not mutually exclusive and can not be adequately addressed without consideration of the others (WHO, 2001). In effect, there is no “health” without consideration of physical, social and mental factors which all impact on well-being.

It has been argued that there are numerous reasons for the neglect of mental health within the field of health promotion. One of those reasons is the complexity of mental health and the lack of understanding of these complexities. The complexity of mental health is reflected in the variability within the definitions used to describe it. It largely reflects the uniqueness of the illness experience for the individual and the attempts to interpret the expression of the experience in a form which is more universally accessible. For example mental health has been defined as:

“...a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community” (WHO 2001, p.1.).

Or alternatively,

“...an emotional and spiritual resilience which allows us to enjoy life and survive pain, disappointment and sadness. It is a positive sense of well-being and underlying belief in our own, and others’ dignity and worth” (Health Education Authority, UK, 1997, p.2.)

Or again,

“...mental health influences how we think and feel about ourselves and others and how we interpret events. It affects our capacity to learn, to

communicate and to form, sustain and end relationships. It also influences our ability to be able to cope with change, transitions and life events: having a baby, going to prison, experiencing bereavement” (UK Department of Health, 2001, p.30).

The experience of mental health is, like the definitions used to describe it, uniquely individual. The experience is influenced by multiple factors including, but not restricted to, experience and expectations, culture and religious beliefs, social status and circumstances. It is the understanding of the potential variability of influential factors that is the greatest challenge to successful mental health promotion initiatives. In attempt to understand the individual and interactive nature of these influential factors on mental health and well-being, a variety of explanatory models have been proposed.

Models of mental ill-health and mental well-being

There is more to understanding the complexities of mental ill-health than just being able to define the experience. Understanding the nature of well-being as well as mental ill-health is required if integrated, cohesive approaches to promotion, prevention and treatment are to be developed. Internationally there are many different influences on the policies that drive mental health promotion, prevention, early intervention and treatment approaches. Many of these differences can be considered divergent due to the variability in structural influences (such as funding and political environments) and context (such as community expectations and the perceived need for services: Patterson, 2009). However, more recently there have been advances in the development of converging policy frameworks which attempt to identify areas of priority on which service strategies can be devised (Patterson, 2009).

Holistic concepts of mental well-being

Holistic approaches to mental well-being acknowledge multiple influences on mental well-being, most commonly at the individual, community and

Literature Review

structural levels. These approaches recognise the need for multifaceted policy and service delivery options that may include consideration of “life quality” factors such as quality of housing, the meaningfulness of employment or daily activities, quality of relationships and connectedness to the community, to name but a few (Compagni, Adams & Daniels, 2006). These approaches tend to assume a continuum model of mental ill-health and well-being and attempt to address elements along this continuum with the explicit placement of approaches and policy along side physical health descriptors and determinants (Patterson, 2009). Some of the common themes that have emerged within holistic approaches across several western countries include:

- An increased recognition that positive mental well-being is influenced by policies and programmes found within, and external to, traditional health care boundaries;
- That leadership within and external to specific countries (such as that provided by the World Health Organisation) influences outcomes;
- Treatment approaches alone are unlikely to reverse contemporary trends toward increasing rates of mental ill-health;
- There is wider acceptance of the construct of mental well-being and the determinants that impact on it (such as social inclusion, stigma and discrimination);
- Improved understanding of the specific determinants of mental well-being, such as, culture and language and that understanding the mental health needs of specific populations across the lifespan are required;
- The importance of the role of recovery for those who become mentally unwell with particular emphasis on the value of meaningful participation by those affected, within policy and programme development and delivery;
- The role of marketing for specific mental health promotion programmes (Patterson, 2006).

Holistic approaches to well-being are becoming more universally recognised and valued as a valid way to influence the direction of policy and programme development and implementation. There remains, however, a further need to develop frameworks that can adequately identify mental ill-health and well-being, as well as ways to conceptualise and ameliorate mental ill-health.

Positive Psychology

Positive psychology attempts to contribute to the understanding of mental well-being by identifying factors that contribute to the quality of life experienced by the individual. Similarly to the field of medicine where the focus has been on treating the symptoms of mental ill-health, psychology has traditionally focused on identifying symptoms and provided psychological treatment options for the mentally ill. The aim has been to assist individuals (and communities) to regain function after loss. Positive psychologists, however, apply strategies primarily focussed on the identification and utilisation of strengths and virtues that enable individuals and communities to thrive (Seligman & Csikszentmihalyi, 2000). Positive psychology is built on three central themes of endeavour and encourages the use of empirical approaches to validate the interactions and influences of these themes. The major themes of positive psychology are:

- Positive emotions (including contentment with the past, happiness in the present and hope for the future);
- Positive individual traits (including strengths and virtues such as capacity for love and work, courage, compassion, resilience, integrity etc);
- Positive institutions (their purpose, as well as their capacity to support better communities in areas such as justice, responsibility, leadership, ethics etc).

The contributions of positive psychology are important as they contribute to the development of empirically validated approaches and conceptualisations of the interactive nature of mental ill-health and well-being (Slade, 2010). Developing the empirical understanding of the interactive associations between mental ill-health and well-being requires additional frameworks to guide such examinations.

The Dual Continuum model

The Dual Continuum model of mental ill-health and well-being (Tudor, 1996) challenges the assumption that mental well-being equates to the absence of mental ill-health which can be conceptualised on a single continua. Instead Tudor (1996) argues that there are two interacting continua, one representing mental well-being and the other, mental ill-health. These elements range from low (minimal) to high (maximal) for mental well-being and from absence (minimal) through mild and severe (maximal) clinical mental ill-health. The continua interact, allowing for an individual to experience both elements of mental well-being and mental ill-health simultaneously. Despite the interaction between the elements this model encourages the conceptualisation and practice of approaches addressing the elements of mental well-being and mental ill-health to be considered separately. Figure 2.1 illustrates the Dual Continuum model (Tudor, 1996).

The relevance for this study of such a model is on the impact of learning associated with MHFA training. It is likely that the mental health and well-being of individuals undertaking the training will vary. Although those with active mental ill-health are not, in their own interest, permitted to undertake the training, those who do are likely to range from optimal mental well-being and mental health to those with lower levels of mental well-being. Improvement of mental health and well-being after undertaking training is, therefore, of interest to identify if gaining and knowledge and skills is supportive of more positive mental states.

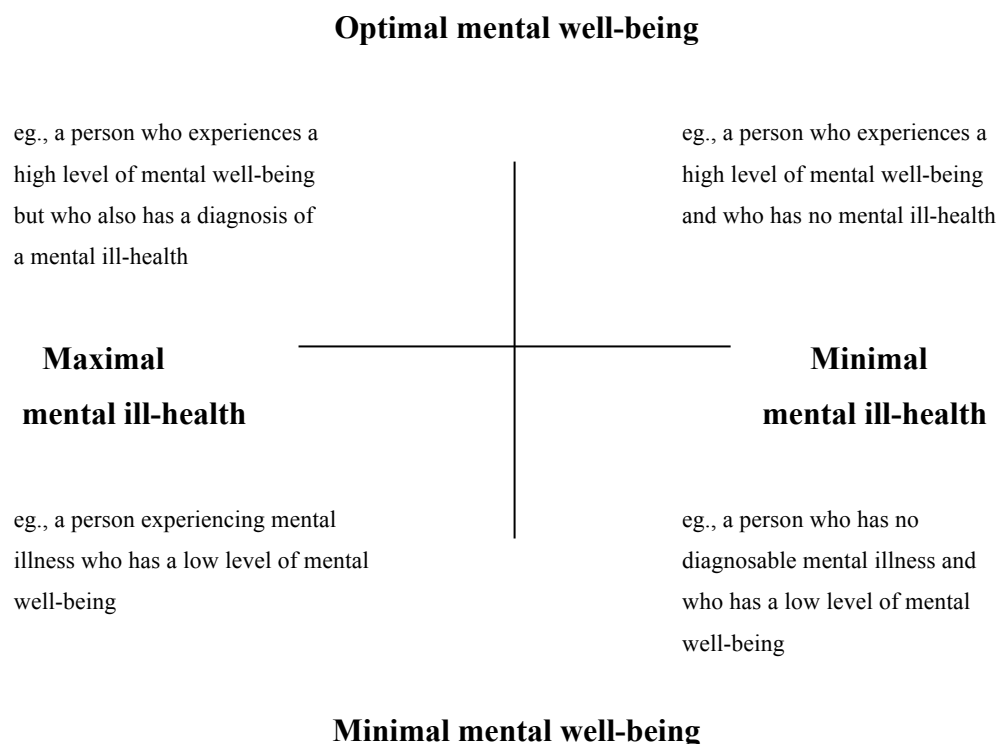


Figure 2.1. The Dual Continua of mental health and well-being (Tudor, 1996).

The Complete State Model of Mental Health

The Complete State Model of Mental Health model was developed from Keyes' (2002) exploration of factors that were associated with positive states of mind. Keyes (2002) suggested that mental health included factors representing both the individual's perceptions and experience of well-being and factors that were identifiable and correlated with positive functioning. From this position 13 measures of mental health were identified which, when factor analysed, represented either the latent structure of hedonic or eudaimonic well-being (Keyes, Shmorkin & Ryff, 2002; Keyes and Waterman, 2003). Table 2.1 presents Keyes (2002) cluster of symptoms and diagnostic criteria for mental health.

Literature Review

Using these factors Keyes (2002) argued that mental well-being or “flourishing” could be identified using a similar process as that used to diagnose mental ill-health such as within the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatry Association, 2000). By display high levels of function on at least one characteristic of hedonic well-being and high levels of function on six of the remaining eleven characteristics of positive functioning, an individual could be considered to be flourishing. To be considered to be languishing, an individual would display low levels of function on one hedonic characteristic and on six of the remaining positive functioning measures. Keyes (2005) suggested that this approach represented an orientation of holistic or continuous assessment of mental health rather than categorical diagnosis which underpins the commonly utilised “two ended” continuum models of mental ill-health and well-being.

Literature Review

Table 2.1 Factors for the categorical diagnosis of mental health (Keyes 2002)

Diagnostic criteria	Symptom description
<p>Hedonia: Requires high level on at least symptom scale (symptoms 1 & 2)</p> <p>Positive functioning: Requires high level on six or more symptom scales (symptoms 3-13)</p>	<ol style="list-style-type: none"> 1. Regularly cheerful and in good spirits, happy, calm and peaceful, satisfied and full of life (positive affect for the past 30 days) 2. Feels happy or satisfied with life overall or domains of life (avowed happiness or avowed life satisfaction) 3. Holds positive attitudes towards oneself and past life and concedes and accepts varied aspects of self (self acceptance) 4. Has positive attitude towards others while acknowledging and accepting people's differences and complexity (social acceptance) 5. Shows insight into own potential, sense of development, and open to new and challenging experiences (personal growth) 6. Believes that people, social groups, and society have potential and can evolve or grow positively (social actualisation) 7. Holds goals and beliefs that affirm sense of direction in life and feels that life has a purpose and meaning (purpose in life) 8. Feels that one's life is useful to society and the output of his or her own activities are valued by or are valuable to others (social contribution) 9. Exhibits capability to manage complex environments. And can choose or manage and mould environments to suit needs (environmental mastery) 10. Interested in society or social life; feels society and culture are intelligible, somewhat logical, predictable, and meaningful (social coherence) 11. Exhibits self direction that is often guided by his or her own socially accepted and conventional internal standards and resists unsavoury social pressure (autonomy) 12. Has warm, satisfying, trusting personal relationships and is capable of empathy and intimacy (positive relations with others) 13. Has sense of belonging to a community and derives comfort and support from community (social integration)

Integrated contemporary models

In 2007 Keyes argued that contemporary models of mental well-being and mental ill health required the incorporation of approaches from several fields of endeavour including the Complete State Model of Health (Keyes, 2002), the Dual Continuum Model (Tudor, 1996) positive psychology (Seligman & Csikszentmihalyi, 2000) and holistic approaches (Compagni, Adams & Daniels, 2006) and including the notion of “flourishing and “languishing” (Keyes 2007). Using such continua, mental well-being is considered “flourishing” and minimal well-being “languishing”. This evolution in the conceptualisation of mental health and well-being supports the perspective of mental well-being and mental ill-health belonging to two separate but interactive continua. Within this model the absence of mental well-being (languishing) can be as problematic for individuals and communities as serious mental ill-health, yet they are not considered to represent the same experience.

Definitions and models of mental health and mental well-being provide an important framework, on which mental health promotion initiatives can be developed. However, such all encompassing conceptualisations are not sufficient to address the specificity and detail required to maximise the success of such programmes. Individuals and the social contexts in which they live, and the individual interpretation of the meaning and experience attributed to mental ill-health, are also important to consider when developing mental health promotion initiatives.

Factors influencing mental health.

Individual considerations

For an individual, becoming mentally unwell can result in significant personal and social detriment. Often individuals are reluctant to explore the experience and are frightened of the stereotypes associated with mental ill-health

Literature Review

(Corrigan, Kerr & Knudsen, 2005). Mental ill-health is largely an invisible disability often only identified when the externalised behaviour, indicating distress, becomes demonstrative. Signs of mental ill-health that elicit the attention of others can be unusual and socially difficult when at their worst, reinforcing interpretations of danger and for some, fear. The lack of knowledge of mental ill-health within the general population fuels these biases (Jorm, 2000). These attitudinal biases are based on the identification of markers of social difference and often result in stigma and discrimination toward a person with mental ill-health. This in turn may have a negative effect on the provision of assistance to that person, and indeed, it also often inhibits self help seeking behaviour by the individual (Rickwood & Deane, 2006). Increasing the general population's understanding of the causes and possible treatments of mental ill-health may result in enhanced tolerance, treatment and better health outcomes.

Additionally, that the majority of people who have mental ill-health are able to continue with functional, or reasonably functional lives, is often under appreciated. That the mental ill-health experienced by most is transitory, and for others may fluctuate in severity, and that people do indeed get well, is greatly misunderstood. This lack of understanding further fuels negative responses towards those who are unwell. The most widely misunderstood element of the nature of mental health is, however, how prevalent mental ill-health is within the community (Kessler, et al., 2007).

The life time risk of mental ill-health in most western countries is approximately 50 percent (Kessler, et al., 2007). In many western countries approximately 25 percent of the population will suffer from a diagnosable mental ill-health in any one year (McGorry, Parker & Purcell, 2006). Some 75 percent of serious mental ill-health will be identifiable before an individual reaches the age of 25, so the potential for lifelong deleterious effects if the person remains unwell, is significant (Kessler, Bergland, Demler, Jin & Walters, 2005). Further, it is well understood that most people do not seek, at least initially, assistance for mental distress from formal sources of care.

Literature Review

Delays in treatment for mental ill-health are associated with poor prognosis with an increased likelihood to relapse (Rickwood, Deane, Wilson & Ciarrochi, 2005). Only 35 percent of people who have a diagnosable condition seek formal assistance (McGorry, 2010). This falls to approximately 25 percent for people under 25 years of age, and 15 percent for males under 25 years of age. Only two to three percent of people with a diagnosable mental ill-health receive treatment in specialist mental health facilities (McGorry, 2010). This lack of assistance may jeopardise an individual's future well-being with positive outcomes from episodes of serious mental ill-health being reduced when diagnosis and treatment are delayed (McGorry, Parker & Purcell, 2006). As access to formal mental health agencies is low, the bulk of assistance for someone who becomes unwell comes informally from family and friends (Rickwood, Deane, Wilson & Ciarrochi, 2005).

Of course, the statistics presented here represent outcomes for those with identified mental health conditions. They do not take into consideration people who hide or do not identify their own distress and, therefore, remain outside clinical populations and statistical consideration. The true prevalence of mental ill-health is likely to be considerably higher.

The true prevalence of mental ill-health is not only difficult to establish due to the uniqueness of the individual experience, but social or cultural factors in the interpretation of mental ill-health can also contribute to the difficulty in the understanding of its impacts

Cultural variations

Culture effects the definitions, expression and the experience of mental well-being and ill-health. While the experience of mental ill-health or well-being may vary, remaining a productive and connected member of society despite the presence of mental ill-health is a universal goal. Stress models of mental ill-health suggest that when an individual is exposed to circumstances under which they fear an inability to cope given the personal, social or structural

Literature Review

resources available, then mental distress can follow (Wolff, 1995). Culturally the behavioural expression of such distress can vary as can the attributed cause and understanding or meaning attributed to the experience (Rousseau, Said, Gagné & Bibeau, 1998). For example, in some African countries demonstrative behaviour of distress has been, and is still often, explained as a result of possession by spirits who are punishing the individual for transgressions. In some western countries a similar display may be considered an emotional outburst or, if more enduring, a mental illness such as psychosis. The specific labels of the condition, perceived causes and the meaning attributed to the impacts of mental ill-health may vary yet the underlying acceptance of distress and loss of homeostasis is broadly accepted. Consequently, mental distress or ill-health despite its variability can be considered a more universal or shared experience. When this shared experience is acknowledged, the expression of mental distress potentially moves from an isolating individual experience to one which can be viewed within a broader social and cultural context. Thus, the influence of the social, cultural and structural contexts are given credibility within the illness process, and in turn can also be given responsibility, for the resolution of such experiences. Although the observed signs of mental ill-health may vary culturally, the underpinning experience of distress appears to be universal. This is important, for this similarity of distress, despite cultural variations in the expression of distress, may assist in the development of uniform, credible mental health promotion and prevention initiatives. The exploration of the experience of mental well-being and ill-health across cultures is, therefore, a valid pursuit.

Occurring within a cultural and social context which has defined expectations, evidence of mental ill-health can lead to the generation of explanations which are intolerant of the uniqueness of the experience. These intolerances are often expressed as poor attitudes towards who are unwell which in turn can result in feelings of shame and avoidance responses in those who are unwell. The importance of creating a better understanding of the impact of mental ill-health is profound. As early care and assistance is considered the best

predictor of a return to mental health (McGorry, 2010), courses that encourage this care are of value.

Mental Ill-health and Stigma

The core attribution underpinning stigma of mental ill-health is that people are disgraced or discredited if they express opinions or display behaviours that are different to the expected social norms. The stereotype that supports this is that people who act differently could have a mental illness and could potentially be dangerous; therefore, avoidance is justifiable. The negative evaluation associated with difference is often applied as a response to circumstances which contain unknown elements and have the effect of creating social, psychological, and actual distance (Doughty, 2005).

Stigma, or the identification of another as being different and of less value due to their health status, is widely acknowledged as being a significant barrier to the achievement and sustainment of mental health. The negative impact of stigma is associated with poor recovery outcomes for people with mental ill-health (Tsao, Tummala & Roberts, 2008). Although stigmatising attitudes are applied to people with perceived mental ill-health by others, insidiously as a consequence of social reflection, often the person who is unwell will apply similar negative attitudes toward him or her self. For people who are unwell, stigma affects the way the individual thinks about his or her experience of mental ill-health, often incorporating, for example, beliefs associated with shame and blame. The adaptive response to private and public shame is secrecy, with the emotional affect resulting in behaviours including withdrawal and isolation (Byrne, 2000). By withdrawing, a person who is unwell may limit social supports, and correspondingly their opportunities for social and personal coherence, potentially further exacerbating, or at best, maintaining their illness. An illness that is of an enduring nature will in turn, potentially threaten a person's long term well-being as financial, social, physical health and environmental determinates of health change, as a consequence of lingering illness (Herrman, Sexena &

Moodie, 2005). An individual who is perceived by others to be mentally ill by virtue of their potentially different behaviours or attitudes tends to contribute to social prejudices about mental ill-health as a result of the interpretation of the differences they portray. Such interpretations can lead to the development of stereotypical negative attributions with respect to the nature of mental illness, focused towards those who are unwell. Stereotypes of mental ill-health often incorporate concepts of defectiveness, weakness or incompetence as central to their conceptualisation. The Royal College of Psychiatrists' campaign, *Changing Minds* (Crisp, 1998), for example, identified a stereotypical belief that 70 percent of a surveyed population believed people with schizophrenia were violent and unpredictable. Stereotypes have the effect of placing people into categories; exaggerating differences and limiting similarities to maintain social, emotional and actual distance from something that is different and potentially feared (Townsend, 1979). Vicarious stigma is also common place with those with mental ill-health often being hidden by their families lest the family be tarnished with the same stereotypes and prejudices (Morrison, 2004).

Models of stigma

Corrigan, Kerr and Knudsen (2005) discussed three motivational models as to why people stigmatise others. They described ego-justification as being the psychological protection of the self by the projection of internal conflict on to others (Bettelheim & Janowitz, 1964). In effect an individual's self esteem is shielded from the effects of personal failings by the transference of the explanation for their own frailties to another. While there appears to be little evidence for this psychodynamic explanation for stigma (Corrigan, Kerr, Knudsen, 2005), the avoidance of perceived threat has been suggested as a motivating influence (Birenat & Dovidio, 2000).

The second motivating influence of stigma is the group justification model. Simply described, stigmatising someone who is out of the group, such as someone with a perceived mental ill-health, supports the goals of those within

the group (i.e. those who are well). Neuberg, Smith & Asher (2000) suggested that this was an evolutionary adaptive survival mechanism for the maintenance of a desired gene pool. Stigmatising others enhances group cohesion, protects against contamination and helps members avoid poor social exchange partners (Kurzban & Leary, 2001). This model is problematic, however, as identification of what the in-group is, against which people with mental ill-health contrast, is not unilaterally definable. Being a member of the in-group is, therefore, a membership of a default category which only gains definition in the absence of mental ill-health. There is no apparent source of in-group motivation to justify this category (Corrigan, Kerr & Knudsen, 2005).

Finally, Jost and Banji (1994) identified a stigmatising justification of “confirming the system”. Social relationships, whatever their genesis, whether they be historical, political, personal or vicarious, serve to justify stereotypes about mental ill-health. This approach helps people make cognitive sense of differences between groups but does not offer an explanation about their origins.

Stigma and discrimination

Stigma and the associated stereotypes and prejudice are more than just the evaluations of individuals of themselves or by others. Mental ill-health does affect those who are close to it (Jamison, 2006) and often results in discrimination. Discrimination occurs when individuals are treated differently on the basis that they have, or do not have, certain characteristics (Corrigan, Kerr, Knudsen, 2005). Discrimination occurs not only between individuals, but more importantly in the context of mental ill-health, it often occurs at a structural level. Structural discrimination is unjust treatment perpetrated by structural social, legal, political or medical institutions (as well as others) as a consequence of the application of stigmatising attitudes (Tsao, Tummala & Roberts, 2008). A prime example of this is the inequitable distribution of health care resources, where mental health is poorly funded in comparison to

physical health services relative to its prevalence in the community. In Ireland in 2010, only 5.4 percent of the Health budget of 14.070 billion euros was allocated to mental health (Department of Health and Children, 2011). This is low in comparison to the European Union standard of 15 percent which is in turn low given the estimation that 20 percent of the population have a diagnosable mental health condition in any one year (Health and Social Care, 2011). Stigmatising beliefs that underpin this discrimination may include beliefs that mental ill-health is incurable or that mental ill-health is not a real illness. Such beliefs can develop as a result of the uniqueness of the individual experience and expression of mental ill-health and the diagnostic difficulties associated with such individuality. Discrimination against people with mental ill-health therefore represents an evaluation by others who utilise negative assumptions to inform their attributions about mental ill-health. In contrast, positive attributes about mental ill-health are considered conspicuous or inconsequential (Raskin, Harasym, Mercuri & Widrick, 2008). This is in direct contrast to physical ill-health which is conceptualised, diagnosed and treated predominately using more objective categorically based methods and definitions.

The irony of structural discrimination and the associated negative impact it has on the course of mental ill-health is that it potentially exacerbates the course of the illness. Concurrently, contemporary health, social and political structures, such as those associated with mental health promotion, emphasise the need for early identification and intervention of mental ill-health with the demonstrated outcome of dramatically limiting the impact of mental ill-health (Mc Gorry, 2010). Early intervention is acknowledged as being not only beneficial for the individual, but for the community as a whole, because of the efficient use of finite health resources (Kelly, 2009). It is estimated that the cost of treatment of mental ill-health is diminished by two thirds if early intervention is successful (McGorry, 2010). Reducing the burden of disease and minimising the cost of remedial treatments that occur with chronic mental ill-health, optimises the use of health resources and ameliorates the potentially chronic effects of mental ill-health. In Ireland the cost of mental health

problems was more than three billion euros in 2008 (O'Shea & Kennelly, 2008), with losses to economic output including unemployment, under employment and premature death exceeding two billion euros. Turner et al., (2009) described the connection between mental ill-health, its association with untreated physical illness and the effect of negative symptoms on quality of life, finding unemployment was nine times higher for people with psychotic disorders than for those without mental ill-health. Although the dramatic positive effects of early intervention have been identified (Kelly, 2009), and despite the increasing prevalence of mental ill-health in the community (Herrman et al., 2005), Ireland's budget for mental health has fallen to less than six percent of the total health budget in 2010 from fourteen percent in 1984 (Kelly, 2008; Department of Health and Children, 2010).

Stigma, therefore, involves problems with knowledge, represented by ignorance; attitudes, reflected as prejudice towards people with mental ill-health and behaviour demonstrated by discrimination, such as, inequity and inequality in service and information provision. Stigma tends to isolate those who are unwell, negatively impacting on their health. The cost of stigma, prejudice and discrimination is, therefore, borne not only by the individual but also by the communities in which they live.

Addressing stigma

Stigma and discrimination are identified as the single most significant barriers to mental well-being in the community (WHO, 2001). Many attempts have been made to address areas of stigma and the discrimination associated with it. Rusch, Angermeyer & Corrigan (2005) identified strategies involving protest about inequity, education about mental ill-health and contact with those who are unwell, as being central to the reduction of stigma. Mental health campaigns aimed at reducing stigma have been applied across a range of social strata, with whole population initiatives, such as, Beyondblue: The National Depression Initiative (Commonwealth of Australia, 2000), Changing Minds: Every Family in the Land (Crisp, 2000) and Like Minds, Like Mine,

Literature Review

National Plan 2007-2013: Programme to counter stigma and Discrimination Associated with Mental ill-health (Ministry of Health 2007). Others have addressed specific mental disorders, such as the programme against stigma of schizophrenia (Sartorius & Schulz, 2005) and the Defeat Depression Campaign (Paykel et al., 1997) and populations vulnerable to mental ill-health, such as within The ACT Action Plan for Mental Health Promotion, Prevention and Early Intervention, 2006-2008 (Mental Health Policy and Planning Unit, 2006), Unfenced Road Ahead: A review of rural and remote mental health service delivery and policy (Kreger & Hunter, 2005).

The results of such campaigns have been mixed. For example, the Defeat Depression Campaign (Paykel et al., 1997) had some limited immediate benefit on public opinion about the illness (Paykel, Hart & Priest, 1998). However, subsequent surveys have identified enduring stereotypes, such as, “people with depression are dangerous” and that they could “pull themselves together” (Crisp & Gelder, 2000). Organisations such as the National Alliance for the Mentally Ill and campaigns such as the “Open the Doors” campaign of the World Psychiatric Association (1996) have successfully used a variety of community based, education and media directed activities to increase awareness of mental ill-health and reduce stigma. What has been identified from such projects is that the reduction of stigma requires more than provision of information. It requires multiple approaches that address discrimination, working toward an attitude change toward people with mental ill-health, acknowledging that people who are unwell are different, and yet that they are worthy of being valued in their own right (Crisp & Gelder, 2000).

In summary, mental health promotion initiatives have in part, a role in addressing the biases underpinning stigma. This is more than just information provision to individuals and the community about the need for equity or the raising of awareness of the nature of mental ill-health. More fundamentally, mental health promotion programmes have a role in addressing social and

structural sources of stigma, prejudice and discrimination. Improving mental health literacy is one approach which may assist in this process.

Mental health literacy

Mental health literacy refers to the knowledge and beliefs about mental disorders which aid their recognition, management or prevention (Francis, Pirkis, Dunt, Blood & Davis, 2002). It includes the ability to recognise specific disorders, knowing how to find information about the disorder, knowledge of risk factors and causal influences, and knowledge of treatments (Jorm, Korten, Jacomb, Christensen, Rodgers, & Pollitt, 1997). Treatments can include self help options and those provided by professionals with specialist knowledge of mental ill-health. It also incorporates the notion that just having information about mental disorders is not sufficient, because applying what is known is dependent on an attitude toward mental ill-health which affords the opportunity for the knowledge to be applied. The responsibility for the development of mental health literacy belongs with social and political structures and individuals (Kelly, Jorm & Wright, 2007).

Mental health literacy in the community is low. Individuals are poor at recognising mental ill-health and have poor knowledge about treatment options (Jorm, Kitchener & Mugford, 2005). A major focus of mental ill-health prevention activities is the delivery of programmes designed to enhance mental health literacy. The intention of such programmes is to encourage early intervention and care, thus reducing the burden of disease associated with untreated mental ill-health. This too in part, is the goal of mental health promotion. Mental health promotion, however, is also fundamentally focused on the provision of information and strategies to enhance mental well-being often by increasing mental health literacy (Herrman et al., 2005). Health promotion activities can be classified in a variety of different ways and can be considered in terms of their scope of application, their mode of delivery, their scale and the setting in which they are applied. Commonly they can be categorised as either whole of

community programmes or programmes targeted to specific populations or conditions (Francis et al., 2002).

Mental health promotion.

The use of conceptual models of mental well-being and mental ill-health can potentially contribute to the planning, implementation and identification of the outcomes of mental health promotion initiatives. However, health promotion initiatives must also take into consideration the context in which mental ill-health or well-being is experienced. In effect, understanding mental ill-health and well-being requires consideration of the individually expressed yet shared experience that affects the capacity of the individual to function independently, and within a wider community, across his or her life span. Each person is unique and will experience and express mental ill-health or wellness differently. Each community will hold different beliefs, affiliations and expectations of the course of mental ill-health. The understanding of mental ill-health within the community is generally poor, as are attitudes towards those who are unwell (Jorm et al., 1997), and so the hesitancy to engage in mental health promotion is partially understandable.

Mental health promotion reflects contemporary thinking about the causal influences on mental well-being. Contemporary approaches in mental health promotion have generally moved away from medically focused, diagnostic and cure orientated interventions, towards more holistic approaches. These more recent approaches acknowledge the complexity of the correlates of mental ill-health, its prevention, and more recently, the influences which impact on positive mental health and its promotion. Meyers (in Wilson, 1993) provides one such bio-psycho-social model. Meyer's states:

- The boundary between mentally well and mentally ill people is fluid because normal people can become ill if exposed to sufficient trauma;

Literature Review

- Mental ill-health is conceived along a continuum of severity from neurosis, through borderline conditions to psychosis;
- An untoward mixture of noxious environment and psychic conflict causes mental ill-health;
- The mechanisms by which mental ill-health emerges in an individual are psychologically mediated;
- Post-modernity provides doctors with an opportunity to refine their roles and responsibilities.

More recently, Bracken and Thomas (2001) suggested:

- Faith in the ability of science and technology to resolve human and social problems is diminishing;
- This creates challenges for medicine, particularly traditional psychiatry;
- Psychiatry must move beyond its “modernist” framework to engage with recent government proposals and the growing power of service users;
- Post-psychiatry emphasises social cultural contexts, places ethics before technology and works to minimise medical control of coercive interventions.

These approaches suggest individual and structural contributions to the process of well-being and indeed, some of the most recent policy initiatives also reflect this. For example in the document, “Australia: The healthiest country by 2020”, some of the core elements of the strategic approach are:

- Shared responsibility; developing strategic partnerships at all levels of government, industry, business, unions, the non-government sector, research institutions and communities.
- Act early and throughout life; working with individuals, families and communities.
- Engage communities; act and engage with people where they live, work and play, at home, in schools, workplaces and the community. Inform enable and support people to make healthy choices.

Literature Review

- Influence markets and develop coherent policies; for example, through taxation, responsive regulation, and through coherent and connected policies.
- Reduce inequality through targeting disadvantage; especially in low socio economic status population groups.
- Refocus primary health care toward prevention (Commonwealth of Australia, 2008).

The shift in the focus of mental health promotion strategies has been, therefore, from medical deficit models focusing on the individual to models that incorporate individual, social and structural factors that impact on ill-health and well-being. Understanding why there has been such a shift from the relatively exclusive control of mental health by the medical community toward a more population based approach directed by policy makers and consumers requires some consideration.

Despite the best attempts of the medically orientated classification systems still currently in use to define mental ill-health, the concept of mental well-being remains nebulous. Commonly the concepts of mental health and ill-health have been linked. Such a dichotomous link euphemistically suggests that mental health represents the treatment and support mechanisms used to manage mental ill-health, thus confusing the concepts of both (Herrman, et al., 2005). Mental well-being is often considered to be a lack of mental ill-health, rather than a state to be achieved in its own right, to sustain an individual in accomplishing a full and healthy life. This semantic confusion has resulted in services designed to address mental ill-health, with the individuals who are unwell having to navigate an enormous burden of misunderstanding and stigma. This is not however, only a semantic dilemma, for even within the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; American Psychiatric Association, 2000) and the International Classification of Disease (ICD-10; WHO, 1992) the consistent ongoing

revisions would indicate that an objective and sound understanding of the nature of mental ill-health is at all levels, problematic.

The development of inclusive models of health promotion.

In more recent times the conceptualisation of mental health has tended away from diagnostic and quantitative conceptualisations of illness that focus on medical intervention and cure, toward more inclusive models that consider qualitative and interpretive understandings of mental ill-health. More contemporary models have included, for example, the promotion of positive mental health rather than cure, focusing on the well, those at risk of becoming unwell and those experiencing mental ill-health (see VicHealth, 1999, 2005 for examples of these approaches). Within such models responsibility for mental well-being falls to individuals, the society in which they live and the structures which sustain the communities in which they live (Kickbusch, 2003). In these more contemporary models of mental health and its promotion, attempts are made to address the multifactorial influences that impact on mental well-being. This includes enhancing factors that maintain mental well-being, ameliorating factors that contribute to mental ill-health, and lastly, minimising factors that sustain ill-health. The ultimate goal of these models being to restore mental well-being. It is the importance given to sustaining mental well-being and the targeting of early intervention approaches to prevent illness, and the relative de-emphasis on approaches associated with cure, that move contemporary mental health promotion activities into their own field. Such approaches tend away from more traditional, medically based health promotion initiatives. Antonovsky's salutogenic model (1996) conceptualised this approach by emphasising positive mechanisms for coping, and thus the maintenance of mental well-being, rather than focusing on risk factors. He emphasised related or salutary factors such as the need for social coherence and the need for the individual to make sense of his or her experience so as to be able to respond flexibly to manage life stressors. Approaches that result in positive outcomes enhance the capacity of individuals to be able to remain productive and connected

members of the community who collectively contribute to the social, human and economic capital of the communities in which they live (Barry, 2009).

Principles of mental health promotion

Approaches addressing the needs of those with mental ill-health have changed in conceptualisation from those based on narrow medically focussed diagnostic and curative orientations to a discourse about the importance of preventative, broad based, inclusive approaches of mental health and well-being (Jane-Llopis & Anderson, 2005). This reflects an not only improved understanding of the causal factors contributing to mental ill-health but an improved understanding of the consequences of mental ill-health and its detrimental impact upon the individual. In addition, contemporary approaches to mental health promotion seek to understand mental well-being and the factors that enhance resilience and ameliorate decline.

The factors underpinning mental health promotion initiatives and the potential influence and inter-relationships between them are vast. In an attempt to explore the relationships between the determinants of mental health, factors such as biological, psychological, social, economic and environmental influences have been studied (Mrazek & Haggerty, 1994; Rogers & Pilgrim, 2005). Life stage and developmental influences such as age, gender and ethnicity are also important contributing factors as they tend to buffer or expose individuals to elements of risk associated with mental ill-health (Barry, 2009). Early research attempting to explain what maximises mental well-being utilised models that assumed a lack of illness equated to well-being. These approaches often extrapolated well-being outcomes from epidemiological studies of psychiatric morbidity (Barry & Freidli, 2008), in effect, identifying health determinants from the indicators associated with illness (Keyes, 2007).

Contemporary approaches, however, incorporate individual elements of positive mental health such as hedonic and eudaimonic influences (Ryan &

Literature Review

Deci, 2001) and community based indices, such as volunteer participation rates, support group existence and utilisation, recreational opportunities and family dynamics to name but a few. Finally, structural elements such as employment rates, average incomes, and access to information such as internet or provision of services including health may provide strong evidence as to the health of individuals and the communities in which they reside.

How the individual, community and structural elements that contribute to mental well-being are evaluated becomes an important consideration. Many measures of mental well-being have, like the conceptualisation of mental well-being itself, previously reflected an approach of identifying the absence of pathology equating to well-being. Contemporary measures, however, utilise positive measures of mental well-being and are an important aspect to the development of contemporary mental health promotion approaches. Measures such as the Warwick Edinburgh Mental Well-being Scale (Tennant et al., 2007) and the Energy and Vitality Index of the SF-36 (Ware, Snow, Kosinski & Gandek, 1993) to name but two, necessarily must provide reliable and valid measurement of mental well-being to ensure credibility within the field.

With all the influences on mental well-being and the concurrent need to be able to demonstrate the value of mental health promotion initiatives via the application of appropriate tools of measurement, one could reasonably conclude that the additional application of cross cultural influences on mental health promotion would be unmanageably complex. However, the WHO continues to attempt such a coordinated universal approach to the conceptualisation and implementation of mental health promotion activities.

The Ottawa Charter for Health Promotion (WHO, 1986) outlined the principles of health promotion based on fostering processes that encourage participation in collaborative processes, which aim to increase control over health and its determinants. The focus of the Charter was to emphasise contexts in which health was supported, including addressing the meaning

Literature Review

placed on health supporting behaviour, and protective factors to keep individuals and communities healthy (Kickbusch, 2003). The desire to keep individuals healthy does not preclude the consideration and incorporation of vulnerable groups or people with mental ill-health. Specifically the Ottawa Charter stated the principles relevant to health promotion were:

1. Build public policy which seeks to promote health across sectors and not just from within health portfolios. This involves, investing in social development, organisational change and social partnerships.
2. Create supportive environments encouraging social, cultural and economic environments that embrace preventative approaches to health.
3. Strengthen community action, by encouraging identification and ownership of health needs and changes.
4. Develop personal skills via education and information provision encouraging the incorporation of health into daily living activities and to empower capacity for health by fostering responsibility and autonomy.
5. Orientate health resources to incorporate promotion and prevention and not just treatment and rehabilitation.

Over time many programmes have attempted to produce evidence of the multi faceted and highly interrelated influences of mental well-being. The complexity of the influencing factors makes the study of the efficacy of the programmes daunting. Recently Barry and Jenkins (2007) examined the implementation details of model programmes considering international case studies. They synthesised from these multiple initiatives the characteristics of effective mental health promotion programmes. To be effective, the programmes should:

- be developed from sound theory using research principles that target the efficacy of the programme with consideration of the needs of the target population;

Literature Review

- be focused and targeted to programme planning, implementation and development;
- adopt a competence enhancement approach and an implementation process that is empowering, collaborative and participatory, carried out in partnership with key stakeholders;
- address a range of protective and risk factors;
- employ a combination of intervention methods operating at different levels
- use a comprehensive approach to intervene at a number of different time periods rather than once;
- include the provision of training and support mechanisms that will ensure high quality implementation and sustainability.

Applying mental health promotion strategies

Mental health promotion is multifaceted and complex. There is an established link between mental health and physical health and these in turn are influenced by personal, cultural, social and economic factors (Friedli, 2003). The concept of positive mental health incorporates the capacity and ability of the individual to develop psychologically, emotionally, intellectually, socially and spiritually within an environment or context (Barry, 2009). The added complexity of multiple areas of focus often results in difficulty in measurement of results, which arguably has slowed the implementation and uptake of mental health promotion activities. For funding bodies, the need to provide quantifiable reconciliation and evidence of achievement of outcomes attributable to the funds provided has been significant (Council of Australian Governments, 2006). Consequently, much activity of mental health funding initiatives has focused on demonstrating that mental ill-health does exist and that there is a need for programme to address this need (for example see Australian Bureau of Statistics, 2007). Demonstrating a need, to justify expenditure on mental health focussed activities, has not been sufficient to drive health promotion programmes. Demonstrating the link between risk factors and mental ill-health, and the identification of the corresponding

Literature Review

preventative factors and mental well-being, had given impetus to the preventative strategies contained with mental health promotion initiatives.

There have been many studies that demonstrate the importance of risk and protective factors that affect mental health (Friedli, 2003). Age and gender have been identified as key correlates to mental ill-health. Early life experience, for example, is also influential and has been demonstrated through various studies concerning issues such as parenting and neglect or abuse (Aggleton, Hurry & Warwick, 2004). Socio-economic status been directly implicated, through studies addressing poverty and unemployment, homelessness, poor housing and the like (St John, Leon & McCulloch, 2004). Further influences may also include drug and alcohol use, abuse, life stress, disability and disease, social isolation to name some of the areas of concern (Friedli, 2009).

Some studies have attempted to identify protective or preventative influences to address some of these areas. Others have looked at the role of the individual in the maintenance of mental well-being including factors associated with resilience and psychological well-being which may include a person's experiences of support, connection to the community, hope and respect (Friedli, 2009).

Friedli (2003) states that mental health promotion programmes enhance mental well-being and have largely been characterised by initiatives that;

- Strengthen psychosocial, life and coping skills of individuals. These interventions attempt to promote self efficacy, competence through education and developmental activities and preventative measures such as stress reduction, anger management or relaxation. The focus of these initiatives is the individual, and the strengthening of his or her role in the maintenance of mental well-being.

Literature Review

- Increase social influences that act as a buffer against adverse life events through, for example, the building of social networks, friendships and self-help groups. These activities focus on a community or social level to maximise outcomes for individuals, the community as a whole or specific focus groups within the community.
- Increase access to resources and services that protect mental health such as promotion of healthy activities, provision of supportive services in areas such as employment or education and ensuring accessibility to mainstream services. This segment of activity involves the creation of structures including policies and procedures which allow for the development of healthy communities and individuals and therefore is primarily the responsibility of government and socially focussed decision makers. (Friedli, 2003).

Day (1987) in an early review of the literature provided a number of recommendations for the development of effective mental health promotion activities. As an objective within this study is to evaluate a mental health training programme his review of the characteristics of the information provided to achieve the desired promotional outcome is important. Although largely based on the Canadian experience Day examined aspects of the message, the audience, the medium, the goals and the objectives of mental health promotion programmes. He identified that messages should be interesting and informative but also simple enough for the information to be conveyed easily to the target audience. The content and theme could vary to address the aims of the programme, but the delivery of the programme needed to address the characteristics of the audience. Simple and direct information was considered to be most effective at raising awareness, but attitude change was more complex. Changes in behaviour were more likely to occur with the presentation of more complex information delivered from a sound theoretical base, such as social psychology theory. He also warned of avoiding “authoritarian pronouncements” as he argued that these created anxiety in an audience when applied to the subject of mental ill-health. Finally, Day argued

that three groups should be targeted within mental health promotion initiatives: those vulnerable to emotional disorders, those in positions of power within the community and those with care giving roles (Day, 1987).

In considering the appropriate medium for delivery, Day argued that the mass media, while a value tool, tended to be expensive and risked over-simplifying messages. He recommended moving toward a participant model of mental health education, utilising small groups, rather than relying on passive approaches. Using media to raise awareness followed up by small group learning was optimal (Day, 1987). Subsequent reviews such as Shanahan, Elliot & Dahlgren (2000); Fletcher, Stewart-Brown & Barlow, 1997; Serra, Cabezas, Bonfill & Pladevall-Vila, 2000 and others have added further to the specificity of the optimal characteristics of mental health promotion activities.

Individuals and health promotion.

How mental health promotion initiatives influence individuals and their mental well-being is central to the business of health promotion. The literature focuses on the need for structural direction to be provided by governments and policy developers, to address inequity and encourage health focussed behaviours (Council of Australian Governments, 2006). Connecting the structural intentions of health promotion initiatives and the desired responses of individuals exposed to such programmes into a cohesive field of endeavour remains, arguably, underdeveloped.

How individuals learn, and their motivations to do so, is an area of research that requires consideration if programmes to change attitudes and behaviours are to be successful. Social psychology has endeavoured to understand “deviant”, and antisocial behaviour of individuals and groups yet less research has focused on learning associated with more proactive, altruistic endeavours. According to “learning theory” such as proposed by Klein (1987), for every message provided, characteristics of the sender of the message, the mode in which the message is sent and the characteristics of the receiver influence the

outcome of the learning. Tolman (1959) proposed that the characteristics of the sender and receiver would likely be influenced by goals set by each in their approach to learning. This purposeful behaviour assumes that learning has an expected direction and purpose. This results in the development of corresponding goals and expectations which in turn produces the identification of rewards for the desired outcomes or avoidance of aversive events. In mental health promotion initiatives, the demonstration of the value of engaging in such initiatives may include rewards associated with being able to assist others (i.e. intrinsic rewards associated with the altruistic application of the self) or the receipt of status due to the recognition of having skill from which others may benefit. Conversely, discomfort may be avoided by not experiencing a circumstance where the individual is unable to appropriately respond. Pearlin and Schooler (1978) argue that the mastery of concepts and rules of response serve to reduce personal stress and thus enhance well-being. So the motivation to engage in mental health promotion activities may involve learning to help others, while also reducing the potential for personal stress, if placed in a position of having to respond. Such a reduction in person stress may also result in enhanced mental well-being. While appropriate definitions and models can assist with the conceptualisation of mental well-being, mental ill-health and mental health promotion, it is the unique nature of the experience of mental well-being and mental ill-health that makes the development of promotional, preventative and remedial programmes complex. Factors that have a profound impact on the individual experience and expression of mental distress must be accommodated in any comprehensive understanding of the area.

Mental Health First Aid

Justification and aims

Mental Health First Aid (MHFA, Kitchener & Jorm, 2002) is a programme which has the potential to contribute to the field of mental health promotion. Kitchener and Jorm describe the course as an early intervention, skill based

Literature Review

training programme aimed at non-clinicians and designed to increase understanding of mental health (referred to by the authors as mental health literacy) while providing skills to manage crisis situations. Its aim is to utilise social connections to prevent negative outcomes for an individual who may be experiencing a mental health crisis. It attempts to do this by training community members to identify risks, signs and symptoms of mental distress and to enable those trained to assist in the procurement or administration of appropriate assistance on behalf of the person in distress.

In Australia, population surveys of the mental health of the adults in the community have been carried out since 1997 (McLennan, 1998). MHFA was developed in response to the data provided by the 1997 survey. This survey and others like it (for example, Andrews, Hall, Teeson & Henderson, 1999; Jorm, et al., 1997) identified high prevalence rates of mental health problems (approximately a 20 percent risk of adults developing a mental health problem in any one year) and poor knowledge or literacy of mental health by the Australian public. Poor literacy was identified as poor recognition and knowledge of the symptoms and causes of mental ill-health, little understanding of where to seek help and little knowledge of what treatments were effective. Other findings such as the widespread stigmatising of people with mental ill-health were also identified. It is widely accepted that stigma inhibits those who are unwell and those around them who may be in a position to assist them, from seeking and providing treatment (McNair, Hight, Hickie & Devenport, 2002). This frequently results in delays in treatment that may negatively impact on the course, frequency of occurrence and duration of the existing and potential future ill-health. (Jorm, 2000). The framework for how mental disorders are managed within the MHFA training course is based on the understanding that early response is likely to influence recovery positively (McGorry, Purcell, Hickie & Jorm, 2007). It also takes into consideration the behaviour that many individuals will initially speak to family or friends who are supportive and not critical, in preference to professionals (Rickwood & Deane, 2006; Hooley & Teasdale, 1989; Andrews, Issakidis & Carter, 2001).

MHFA was devised by Kitchener and Jorm (2002a) to improve mental health literacy in the Australian population and to reduce stigma. In addition the course aimed at providing non-clinicians, who were likely to be the first contact for people in mental distress, with the skills to encourage those people to seek appropriate and timely care.

Structure of the course

MHFA is an intensive education and skill development programme which parallels the format of standard first aid courses. The format consists of didactic teaching approaches utilising lecture style presentation, small and large group discussions, the use of audio visual tools and practical exercises where a framework for action is applied to case studies. This approach was chosen because the general population was considered to be familiar with the format of standard physical first aid courses in terms of their content, learning and delivery expectations and accessibility (Kitchener, personal communication April 28, 2008). As a consequence of the prevalence and significance of mental health concerns within the community, the authors considered it necessary to create a separate “stand alone” course in preference to simply annexing mental health content into the existing physical first aid courses (Kitchener & Jorm, 2002). The authors argued that this approach had an advantage over other broad-based, government-sanctioned, community focused programmes such as the Defeat Depression Campaign in the UK (Paykel et al., 1997), the Depression Awareness Recognition and Treatment (DART) programme in America (Reiger et al., 1998) and the TIPS programme (Tidlin Intervensjon ved PSykose, 1997-2000) in Norway (Johannessen, et al., 2001). In contrast MHFA provides a skills-based training programme rather than just information about mental health and illness. This also has the practical outcome that MHFA can be self-sustaining, as it can be funded from participants’ payments for their training.

Literature Review

Originally a nine hour course designed for an adult audience, it was delivered in three sessions of three hours duration. Following the initial evaluation of participant feedback, the course was expanded to a twelve hours as the evaluation identified a need for further information in all the sections of the course, but particularly within the section addressing the impact of drug and alcohol use on mental health. Evaluations of the course from 2002 to 2006 evaluated the nine hour course and from 2006 the twelve hour course has become the delivery and evaluation standard. This study will similarly evaluate the twelve hour adult course. The twelve hour course is generally delivered over four sessions of three hours, but because the sections of the course are self-contained, a two day (six hours per day) course is also available, depending on the delivery needs of participants.

The content of the course provides a framework for assisting people experiencing or in the early stages of developing mental ill-health. Following the National Survey of Health and Well-being the areas covered in MHFA are the most prevalent within the community (McLennan, 1998). The areas addressed within the course are:

- depression, including suicidal ideation;
- anxiety related disorders including panic attacks, acute stress reaction, post traumatic stress reactions;
- psychosis focusing on schizophrenia and bipolar disorder; and
- substance misuse and its impact on mental health.

Participants learn the signs and symptoms of these disorders, risk factors associated with their onset, where and how to get assistance and evidence based techniques to assist. Each participant receives a manual written to reflect the content of the course (Kitchener & Jorm, 2002a). The central action plan that is utilised for all the presented mental health conditions consists of a five step plan for approaching and delivering assistance. The five steps, referred to by the mnemonic “ALGEE”, are:

Literature Review

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

People selected to be trained as course facilitators are selected for training on the basis of their capacity to deliver the course appropriately. Most are social care or allied health professionals and all have experience in the area of mental health. Once accepted as having the pre-requisites to be a facilitator, individuals attend a five day “train the trainer” course where the course content and delivery methods are honed. Facilitators are required to attend refresher courses for two days every three years and must deliver a minimum of three courses per year to maintain their facilitator status. Courses can be conducted for groups with similar interests (such as on worksites) or in mixed environments such as for community groups.

The authors of MHFA have been keen to ensure that the course is taken up widely and to facilitate this, they have encouraged its modification to meet the needs of particular target populations. Permitted modifications are to the emphasis on the elements within the course, and to the modes of delivery, but not to essential content. Where adaptations have occurred to meet the needs of specific target groups or populations, the course authors have maintained a quality assurance role to ensure the integrity of the course. There now are courses focusing on the mental health needs of youth, Aboriginal and Torres Strait Islander populations and in the Vietnamese, Finnish and Cantonese languages. There is also a computer-based learning version of the course available. The course materials and statistics have been adapted for delivery in Singapore, Hong Kong, Finland, Canada, Wales, England, South Africa, Sri Lanka, the USA and Scotland. A tailored course for the border regions of the Republic and Northern Ireland was piloted in 2007 using local area data.

In 2009 an adapted course was launched for delivery in Northern Ireland (Kitchener & Jorm, 2008).

Despite the wide international uptake of course, its evaluation has been limited. The most detailed evaluations have been undertaken by the two authors of MHFA, and many of the non-Australian evaluations only address participant satisfaction. A summary of the evaluations undertaken to date, appear in Table 2.2 (pp. 78).

Previous evaluations of Mental Health First Aid in Australia

Evaluations of the MHFA training course have predominately been undertaken by Kitchener and Jorm, the original authors of the course. Their approach to evaluation has become more sophisticated with time, and generally reflects the necessity for more comprehensive approaches to the evaluation of the course as interest in the course has increased. The following review presents the major evaluative studies of MHFA done to this point.

Impact of MHFA on the development of mental health literacy

The original evaluation of the course (Kitchener & Jorm, 2002) occurred soon after its inception. The nine hour version was delivered by the course author, and data were obtained from 210 participants described as representative of the general public. The study design was quasi-experimental as there was no assignment of a control group in the study. The participants completed pre and post course questionnaires and a post returned follow-up questionnaire after a further six months. Some 210 pre course questionnaires were completed, 168 following the course and 166 were returned at six month follow-up.

The pre-course questionnaire sought baseline information about demographic characteristics, mental health experience and reasons for undertaking the

Literature Review

course. Questions were also asked about the individual's confidence in being able to assist someone with mental ill-health, if they had done so, and what type of care the individual had provided.

As part of the evaluation participants were randomly assigned one of two vignettes describing either depression or schizophrenia. These were taken from the National Survey of Mental Health Literacy (Jorm et al., 1997) and participants received the same vignette after completing the course and at the follow-up assessment. Respondents were asked to identify the condition, and if they thought professional assistance was required. Then followed a list of people, treatments and actions which the participants were asked to rate as either helpful, harmful or neither. Responses were summed and converted to percentages for comparison. Attitudes and stigma were investigated using a social distance scale. Participants were asked if they would be prepared to move next door, socialise, make friends with, work with, or have the person in the vignette marry into their family. Finally they were asked about their experience with the condition described in the vignette. They were asked if they, a family member, or close friend had experienced the condition.

The post-course and follow-up questionnaires used the same vignette as randomly assigned in the pre course questionnaire. In the post-course questionnaire socio-demographic information about personal and family mental health experiences, their confidence in providing help and actual help they may have provided, were not collected. At the six month follow-up the questionnaire was the same as the pre-course questionnaire except the socio-demographic questions were excluded.

An analysis of the interaction between time (pre-training, post-training and six month follow-up) and condition (depression or schizophrenia) was undertaken. All pre-course responses were analysed despite some participants not completing the subsequent questionnaires. In these cases the pre-course information was substituted for the missing values in the incomplete questionnaires, therefore, assuming no improvement.

Literature Review

In the initial evaluation 84.3 percent of the course participants were female, of whom 61.2 percent were aged between 40-59 years. Some 44.2 percent had a university qualification with almost a third (31.0 percent) working within the health sector. Of these the occupations most commonly identified were support worker, respite care worker, administration officer or nurse. Reasons given by the participants for undertaking the course were identified as: for work purposes (41.6 percent), for interest (24.3 percent), for reasons relating to family or friends (21.3 percent), for reasons relating to their own mental health (6.7 percent) or as duty as a citizen (4.8 percent).

Participants were asked before and following training if they or any member of their family had experienced a mental health problem. The percentage reporting this occurrence increased but not significantly from 41.4 percent to 47.4 percent for self ($p = 0.05$), and from 73.4 percent to 79.0 percent for a family member ($p = 0.05$).

Participants of the MHFA course received the depression vignette ($n = 104$) or the description of schizophrenia ($n = 106$). For those who received the depression vignette recognition of the condition when assessed prior to training was close to maximum (91.4 percent recognition). Given this result, a ceiling effect appeared to have occurred as no significant improvement was identified following the training (95.2 percent recognition) or at the six months follow-up (93.3 percent recognition). A significant change in recognition occurred for the schizophrenia vignette, however, as before training 56.6 percent recognised the condition, while after training 76.4 percent recognised it and at the six month follow-up there was a 67.9 percent, recognition rate ($p < .001$).

Beliefs about initial treatment options (what treatment would be appropriate and beneficial) moved toward those offered by health professionals immediately after the training but tended to revert somewhat at the six month follow-up (pre-treatment: $M = 76.97$, $SD = 25.37$, post-treatment: $M = 89.19$,

Literature Review

$SD = 17.86$, follow-up: $M = 86.71$, $SD = 29.69$, $p < .001$). A similar trend was observed for social distance, which was used as a measure of stigmatising attitudes (pre-treatment: $M = 9.27$, $SD = 2.92$, post treatment: $M = 8.69$, $SD = 2.85$, follow-up: $M = 8.79$, $SD = 3.00$, $p < .001$). There was no statistically significant interaction between the type of vignette and the responses of the participants.

The confidence of the participants in providing assistance and the actual assistance provided was assessed using data provided by the participants from six months prior to the course to six months after the conclusion of training. Participants' confidence rose significantly from 62.2 percent in providing assistance prior to the course to 83.3 percent ($p < .001$) following training. The amount of contact with people requiring assistance did not vary (before the course 88.5 percent; at follow-up, 89.0 percent). Despite this there was a significant increase in the amount of help provided (before training 54.5 percent, six month follow-up 61.9 percent, $p = 0.04$) but no significant change in the provision of more than one form of assistance (before training 45.6 percent and at the six month follow-up, 52.2 percent, $p = 0.09$). A small but not significant decrease in the provision of advice to seek professional assistance was also identified (before training 14.6 percent, at the six month follow-up, 9.0 percent, $p = 0.05$).

The authors of MHFA concluded that the benefits of the training were:

- improvement in the ability of participants to recognise a mental disorder from a vignette;
- changed beliefs about treatment options towards options expected to be recommended by health professionals;
- decreased social distancing (argued to reflect a decrease in stigmatising attitudes);
- increased confidence in providing help; and
- an increase in the help provided.

Literature Review

Kitchener and Jorm identify some weakness in this study. They identified that the un-controlled quasi-experimental design made it difficult to identify clearly whether the results occurred purely because of the training or as the result of a response bias from the participants who may have wanted to please the researcher.

Beyond these acknowledgements by Kitchener and Jorm, there appear to be more difficulties with the study population than just the uncontrolled study design. The employment background of the participants (mostly health sector workers), their education level (44 percent with university qualifications) and their significant experience with mental ill-health (41 percent having or had mental ill-health and 73 percent having a friend or a member of the family with mental ill-health) may have influenced the results. The participant group appear to have had significant prior knowledge of mental ill-health and this may have had an impact on the obtained results. The results indicated a return to similar levels of response at the six month follow-up (the movement of treatment choices congruent with professionals and social distance, for example) and despite the suggestion by Kitchener and Jorm to the contrary, this would suggest that a desire to please the researcher was not a central motivator in participant responses. Similarly, the participants' ability to be able to recognise the mental condition described within a vignette fell at the six month follow-up assessment. This is despite the same vignette being presented to the participant at all assessment points. Such a result was unexpected, as a positive response effect due to learning from the multiple presentations of the same vignette would have been more likely. It is interesting that the participants recommended seeking less professional assistance following training. This may reflect an improvement in their own competence at managing mental health difficulties effectively, or potentially, an over-confidence in their ability to manage difficulties.

Methodologically the use of vignettes requires some consideration. It would be unethical to expose deliberately people experiencing the onset of mental ill-health to "first aiders" just to establish if the first aid was forthcoming and

Literature Review

appropriate. However, the use of written vignettes ensures the characteristics of the mental illness described in the vignette are present and recognisable in the text. It is less likely that such a clearly definable presentation of illness would occur in a real crisis situation. In addition, the mental health condition within the vignette was written to be clearly identifiable using the diagnostic characteristics of the illness. Therefore, the condition described within the vignette is well defined, unlike the sub-clinical presentations of mental distress which are more often indicative of prodromal states of mental ill-health. If MHFA is an early intervention programme as the authors suggest, then its utility for the identification of distress and its subsequent application to sub-clinical populations is important. Within this research the consideration of the vignettes occurs in a controlled and unstressed environment, which is unlikely to be the case in an emergency. The repeated use of the same vignettes at both testing points also poses problems if the likely possible positive effects of practice, on the final results are considered.

Kitchener and Jorm suggest that the decrease in the percentage of participants advising the need for professional help from the six months prior to the course to the six months after the course, may be explained by the participants having little or no further contact with people requiring assistance following the course's completion. Indeed, the authors state that the participants reported having less contact with people experiencing mental health difficulties after the course, thus explaining the decrease in the provision of advice. An alternative explanation could also be suggested. It could be argued that as a consequence of training, the participants' confidence to provide assistance increased, resulting in care giving which did not necessitate recommendations to seek professional help. Such a result may indicate a genuine improvement in the personal and applied skills of the participants to manage mental health crises. If as a result of completing the course, the participants were able to identify potential mental health crises with greater accuracy, then "having less contact" with people with mental ill-health may in fact reflect improved mental health literacy. This may be reflected as skills

that enabled them to recognise a variety of issues to be other than mental ill-health related.

Several other shortcomings emerge from this study. Kitchener and Jorm also assume that social distance is a measure of stigma. Where social distance might well be a characteristic associated with stigma, stigma itself is defined as negative attributions applied to others or the self as a result of perceived difference (Biernat & Dovidio, 2000). Social distance does not measure attributions or attitudes and, therefore, may be more indicative of the behaviour of discrimination rather a measure of attitudes associated with stigma. To state that social distance equates to a measure of stigma appears simplistic. The authors also acknowledge that the homogeneous characteristics of the study population are problematic as such a group makes the generalisation of the results to the population difficult. There is another significant concern with this study that is not acknowledged by the authors. It is unknown if the intervention provided as a result of completing MHFA training resulted in any positive treatment outcomes for the recipients of the provided care. In terms of research into the efficacy of MHFA, being unable to assess the effect of the application of MHFA on the recipients of the care is greatly problematic.

The first evaluation of MHFA showed some positive impact of the training upon the participants' understanding of mental ill-health and their willingness to apply their learning. There were methodological difficulties and the ratings tended to move back toward pre-training levels after six months. The outcomes from the application of the learning remained untested. A second evaluation attempted to address some of these limitations.

The second evaluation of the impact of MHFA on the development of mental health literacy was undertaken in a rural setting and the course was delivered by instructors from the local health area (Jorm, Kitchener, O'Kearney & Dear, 2004). A rural population was chosen as the focus of the delivery because people living in rural Australia are less likely to receive general practitioner

Literature Review

services for common mental health disorders and are less likely to be able to access specialist mental health services (Caldwell, Jorm, Knox, Braddock, Dear & Britt, 2004; Paslow & Jorm, 2000). Jorm et al. (2004) argued that the value of the course in such areas is potentially greater than in urban areas given the limited formal resources. Such mental health first aid programmes, therefore, represent a community capacity building approach to manage mental health disorders, something eminently justifiable given the need for mental health support in remote locations.

This cluster randomised trial consisted of 753 study participants who were aged 17 years and older. Participants were recruited into the study having responded to radio, press, newspaper advertisements and community discussions describing the course. Those selected were available over the period of the trial and were willing to be interviewed by telephone during the assessment phase of the research. The participants either received training or were wait-listed for six months (the control group). The local council areas from which participants were recruited were matched for population size and social characteristics such as education and geography (inland and coastal) and then randomly assigned to either the training or wait list conditions. Local government council areas were chosen for randomisation rather than individuals because there may have been contamination of information provided across allocated groups. In addition, the wait list group may have been difficult to maintain if others in the same locality were receiving training and randomising individuals in some small towns may have resulted in too few participants to be able to run the course.

Five instructors who were employees of the local health service and who had experience in mental health were trained to deliver the course. After delivering the training, these facilitators were themselves assessed by a course coordinator to ensure their adherence to the course content. Each trainer delivered both the initial training and the wait list group training in the same local council area.

Literature Review

Information in the pre-course and post-course assessment was the same as had been used in the initial research, as was the methodology of allocating the individual participants to either the depression or schizophrenia vignette (Kitchener and Jorm, 2002). The study did not include questions about the participants own mental health. The questionnaires were completed using a scripted interview delivered by a professional interviewer via the telephone.

Groups were matched for age ($M = 47$ yrs), gender (19 percent male), education (22 percent had university education), Aboriginality (2.6 percent) and English as a second language (1.2 percent). Reasons for doing the course varied between the training and control group, in that significantly more participants in the control group (55.8 percent) were undertaking the course for work-related reasons compared with (43.3 percent) in the training group. Incomplete data was imputed for statistical analysis (participant group $n = 416$, 42 percent of data were incomplete; control $n = 337$, 6 percent being incomplete).

Results showed that the group that had received training identified more mental health concerns from pre-course to follow-up testing (pre-course self-report experience 37 percent, follow-up self report experience 41 percent, $p = .045$) when compared to the control group (pre-course and post-course self report 35 percent). The trained participants also identified more mental health concerns in their family members (but not significantly so) following training. The group that received training were able to diagnose a mental health condition from a vignette more effectively after training (pre-course 68 percent, follow-up 81 percent, $p < .001$), and reported an intention to provide more mental health assistance following training (pre-course 73 percent, follow-up, 82 percent, $p = 0.03$). The trained group became more congruent with the treatment expectations of health professionals (pre course $M = 60.55$, $SD = 3.89$ and follow-up $M = 74.74$, $SD = 1.91$, $p = .001$), reported reduced social distance after training (pre course $M = 8.13$, $SD = 0.24$, follow-up $M = 7.59$, $SD = 0.17$, $p = 0.03$) and improved confidence (pre course $M = 3.13$, $SD = 0.08$, follow-up $M = 3.39$, $SD = 0.05$, $p = .001$). There was no change in the

Literature Review

number of people with whom the participants had contact with mental health problems or in the percentage advising a recipient to seek professional assistance.

The authors provide the explanation that the participants who were identifying more mental health concerns in themselves and a tendency to identify more issues in family members, were reflecting a capacity to be able to accurately re-label existing conditions rather than identifying new conditions. This was in acknowledgement of concerns raised that MHFA training could potentially result in over diagnosis of life problems as mental ill-health.

The authors acknowledge that difficulties with the study included some of the administration of the courses, as multiple trainers were involved. For example, several instructors did not keep records of all attendances, so it was not clear how many individuals completed all of the training. Similarly, despite a project coordinator being in place to monitor the training and the adherence of the training to the course as written, there was likely to have been some variation due to the use of multiple presenters. One presenter was identified within the study to have had only an 81 percent adherence rate to the course content.

Jorm et al., (2004) fail to acknowledge in their discussion the low completion rate of responses (42 percent completion) in the MHFA participant group. They do identify the use of imputed statistical analysis as a result of this low return, but again they do not offer an explanation as to the likely effects of such a technique. Further, there was no acknowledgement of the outcome finding that the MHFA trained participants in this study indicated an increase in their self reported mental health concerns. Whether this result is an outcome of the low return rate (that is, those who chose not to return surveys represented a mentally well subgroup) or whether it is due to some other influence, is not discussed.

Literature Review

The authors of the research conclude that this study demonstrated the generalised positive effects of the nine hour MHFA training course on knowledge, attitudes and behaviour of the general public who received training. They argue that despite some methodological difficulties it does not appear that the presenter characteristics had a major effect on the achieved outcomes.

The first two evaluations of MHFA training concentrated on the effectiveness of the course to improve the mental health literacy of the participants. The second study improved on the first by moving from a homogeneous population to more heterogeneous population and from an uncontrolled quasi-experimental design to more adequately controlled experimental approach. The evaluations focused on the learning development of the participants by assessing their confidence and their intention to apply the learning. The studies, however, did not attempted to identify if the learning had actually been applied to assist someone in distress, the impact on the recipient of the care, nor specifically, the impact of the learning on the participants' own mental health.

Impact of MHFA on course participants

In 2004, Kitchener and Jorm undertook a study that addressed the lack of an adequate experimental control group in their initial 2002 study and evaluated if the course had any benefits on the mental health of participants.

This randomised control trial recruited public servants involved in health, family and aged services. Participants ($N = 301$) were randomly assigned to receive training after a one or six month wait interval. The “six month wait listed” group served as the control group. Recruitment was via email and training and data collection occurred during work hours. The training was conducted by the course author (Betty Kitchener). The training was extended to include two workplaces as responses from a single workplace were insufficient. Kitchener and Jorm suggest that the need for participants to

Literature Review

commit to either an immediate or delayed training “wait list” condition (i.e. there were two training periods) was a factor which impacted on commitment, necessitating the expansion of the sample population to two work places.

Assessment was undertaken using the same self-completed questionnaires used in the initial evaluation, with an additional measure of general health (SF-12 Health Survey, Ware, Kosinsk & Keller 1996). The addition of the SF-12 was an attempt to identify if any positive mental health benefits resulted from completing the course (Kitchener and Jorm, 2004). The control group received training after a six month wait.

Analysis of two groups (intervention and control) and at two times points (one month prior to training and five months following training) was undertaken. Analysis of 146 ($n = 146$) intervention group questionnaires were undertaken although only 107 completed the final questionnaire. Incomplete data was entered as “no change” within the data set. Within the control group 155 ($n = 155$) follow-up questionnaires were analysed with 22 incomplete follow-up questionnaires entered as “no change”. Due to the two different locations from where participants were drawn, characteristics the place of employment were also evaluated, but no effects were identified.

Some 78.1 percent of participants were female and 49.2 percent aged 18-39. A further 50.2 percent were aged 40-59 and the remaining 0.6 percent over 60. A total of 60.6 percent had university degrees, and 8.6 percent did not have English as a first language. Some 13.0 percent described themselves as mental health consumers, 9.6 percent as carers and 6.3 percent as mental health care providers. When asked why they wanted to do the course 29percent said they were just interested, 27.2 percent stated they were doing the course for reasons related to their work, 20.5 percent stated it was their duty as a citizen, 11.7 percent for reasons relating to friends or family, 6.7 percent wanted accurate and up to date information about mental health and 4.9 percent for reasons relating to their own mental health.

Literature Review

The level of self-reported mental ill-health (pre-course within the intervention group was 60.0 percent and the control group 49.7 percent) did not change significantly as a result of training. Following the training 65.5 percent within the intervention group and 55.6 percent of the control group reported mental ill-health. The rates associated with the identification of family members before training in the intervention group (74.5 percent) and within the control group (73.05 percent) remained similar following training (within the intervention group 77.2 percent and 75.7 percent for the control group).

Results for the recognition of the vignette showed high recognition in both groups at the pre-course assessment (depression: intervention group 90.2 percent, control group 87.7 percent, schizophrenia: intervention group 74.6 percent, control group 83.9 percent, and combined data of both vignettes: intervention group 70.6 percent, control group 76.5 percent). There was no significant difference in the recognition rates between groups at following training (depression: intervention group 95.8 percent, control group, 90.3 percent, $p = 0.09$. Schizophrenia: intervention group 82.6 percent, control group 81.9 percent, $p = 0.08$ and for data of both vignettes combined: intervention group 80.2 percent and control group 77.8 percent, $p = 0.19$).

The participants' ideas on treatment options became more concordant with those of professionals in the intervention group when the data from both vignettes was combined (before training $M = 83.28$, $SD = 16.65$ and following training $M = 86.98$, $SD = 16.78$, control group before training $M = 88.21$, $SD = 16.76$ and following training $M = 88.41$, $SD = 16.11$, $p = 0.04$ for group by time interaction). This trend did not hold when depression and schizophrenia data were considered separately or when the intervention and control group data were compared.

There was a decrease in social distancing in the intervention group when the data of the vignettes was combined (prior to training $M = 20.88$, $SD = 5.79$, following training $M = 19.14$, $SD = 5.43$, control group before training

Literature Review

$M=20.79$, $SD = 5.53$ and following training $M = 20.07$, $SD = 5.30$, $p = 0.02$ for group by time interaction). However, when the vignettes were considered separately the effect was accountable by changes in response to the depression vignette (intervention before training $M = 8.74$, $SD = 2.80$, following training $M = 7.86$, $SD = 2.50$, control group before training $M = 8.63$, $SD = 2.63$ and following training $M = 8.46$, $SD = 2.54$, $p = 0.01$ for group by time interaction).

Confidence in providing help to others improved more for the intervention group from before training to after completing the course (before training 54.5 percent and after training 74.5 percent,) than within the control group (before the intervention group received training, 49.7 percent and after the intervention group received training, 57.4 percent, $p = .001$ for group by time interaction). Despite having completed the training, the intervention group did not report having more contact with people with mental health problems nor did they provide more help. Within the intervention group more advice was given to those in mental distress to seek professional help. The incidence of advice provided by the intervention group (before training 28 percent, after training 29.4 percent) remained unchanged where the control group reported providing less advice at the follow-up assessment (before intervention group training 27.1 percent and after intervention group training 16.8 percent, $p = 0.01$ for group by time interaction).

Using the SF-12 measure of mental health the participants' indicated a significant improvement in their own mental health following training (before training; intervention group $M = 45.43$, $SD = 11.40$, and after training $M = 47.48$, $SD = 11.11$ and within the control group before MHFA participant training, $M = 45.40$, $SD = 10.17$ and after the MHFA participant group training $M = 45.11$, $SD = 11.25$, $p = 0.04$ for group by time interaction). There was no such change for the physical health component of the SF-12, nor was there any reported analysis of the individual subscale changes within the SF-12. Kitchener and Jorm described this result as unexpected, as the course is not aimed at improving the participants' mental health nor is it

Literature Review

deemed to be therapeutic in content. Kitchener and Jorm identified that although only 5 percent of the participants stated they were doing the course for their own mental health, the participant population had mean mental health scores on the initial questionnaire about half a standard deviation below the Australian population norm (Andrews, Henderson & Hall, 2001). This participant population's characteristic indicates some ongoing mental health concerns, so an improvement in mental health may be more likely than if they demonstrated scores equal to the Australian population norm. Certainly, there is an argument that a selection bias occurred despite the random allocation of participants within the study, as it appears that those with a personal interest in mental health volunteered for the training. That is, the population within this study appears to represent a low initial starting point for mental health, increasing the potential for the demonstration of improvement after training. Despite this apparent selection bias, Kitchener and Jorm explained that the improved mental health of the participants was likely due to the evidence-based information given in the course which allowed participants to identify strategies and make choices beneficial to their own mental health.

Kitchener and Jorm concluded that the mental health first aid training appeared to be effective in improving some aspects of mental health literacy, confidence in providing help to others, and the type of help provided. They also argued that MHFA has positive benefits for the participants' own mental health.

There are, however, some difficulties with the study. The study population was relatively small ($n = 107$ completed questionnaires in the intervention group and $n = 133$ in the control). As in the first study (Kitchener & Jorm, 2002), the study group consisted largely of well educated, employed women. These characteristics mean that the results are difficult to generalise to a non-study population. Kitchener and Jorm cite the intervention groups' rate of return of follow-up questionnaires as problematic (73 percent of participants completed both questionnaires compared to 86 percent within the control group) as the unreturned questionnaires resulted in the minimising of any

Literature Review

effects obtained due to the inclusion of a “no change” value in the analysis. They go on to speculate that the reason for the decreased return rates from the intervention group was because they had completed the training and there was little incentive for them to complete the questionnaires. In contrast, the control group was still waiting for training and was therefore more motivated to complete the questionnaires. There appears, therefore, to be variable motivation between the groups.

There is another element to this study which requires consideration. The workplace and the selection process were arguably important influences on the findings. All participants were public servants involved in social care with knowledge of mental health, as indicated by the high rates of recognition of the initial presentations of the vignettes. In this group, before training took place, there were also high levels of understanding of their own or other mental health issues and high concordance with advice to seek professional assistance. Of the 4800 eligible participants, 300 lodged interest for training. While these people were obviously interested enough to want to do the training, there was difficulty in recruitment due to the “wait list” condition, as two government departments had to be enlisted to ensure sufficient numbers of participants. It may, therefore, have been individuals who were most motivated perhaps because they thought they had most to gain, (as suggested by a higher score for personal mental health concerns than within the general population), who persevered with the selection process. Second, within the workplaces it is likely that participants discussed the programme with colleagues and amongst themselves. The workplace discussions that potentially occurred at between training sessions may account for the decrease in the control group’s willingness to provide advice about seeking professional help at the follow-up (and before their training had occurred) assessment. What may have occurred was the “stepping back” of the untrained control group at times when assistance may have been required, in preference to allowing the trained intervention group participants to offer assistance.

Literature Review

The improved mental health of the participants may have been influenced by factors other than the training, such as discussions amongst participants external to the training process. MHFA has, as a goal, to increase mental health literacy within a population. It is reasonable to expect that increased knowledge, leading to a decrease in stigma and presumably, more open communication within a group in the same work environment, is likely to have a greater effect than the impact of training on an individual who does not interact with similarly informed people. It would be short-sighted to suggest that only the learning achieved by attending the course could have a positive effect on an individual's mental health under such circumstances. As mental health is at least in part a social construct (Walker, 2006) it would seem reasonable to suggest that enhancing the social environment, such as creating common discussion points and improving the knowledge of the population in a workplace, could and indeed should, result in greater satisfaction about one's own mental health if the literacy and confidence objectives of the course have been realised. In short, it is quite possible that the results could have been overstated due to the contamination of factors outside the training environment.

It is interesting to note that Kitchener and Jorm appear somewhat disinterested in finding improvement in the mental health of the participants following training. They indicated this finding was unexpected, yet the measures for identifying effects of the course on the participants' mental health were dropped from their subsequent research. This may be because the SF-12 measure used to assess mental health in this study is not designed for small group application. Ware, Kosinsk and Keller (1996) state the SF-12 as the truncated version of the SF-36 (Ware, Snow, Kosinsk, & Gandek, 1993) measure, is unsuitable for use in populations less than 500. Kitchener and Jorm's results may have been invalidated due to the study population consisting of only 240 individuals.

Their study appears to have assessed the effect of MHFA training on a homogeneous, knowledgeable participant population. It is therefore difficult

Literature Review

to isolate the effects of the training, the work environment in which it occurred and the characteristics of the participants, on the results, especially those suggesting a change in the participants' attitudes to their own mental health. If undertaking MHFA training does have a positive effect on a participant's own mental health then a content analysis to identify what it is about the course which results in this improvement is required.

The initial evaluations of MHFA investigated the responses of groups primarily composed of well-educated women. The results of the studies into MHFA to this point, demonstrated the efficacy of the course in a somewhat homogeneous populations. The rural cluster controlled trial (Jorm et al., 2004) attempted to evaluate the course in a less well-controlled environment using a more varied participant population, to test if the positive effects of the course could be replicated in more varied circumstances. The delivery of the course for two of the studies was done by the course author, and within the rural cluster control trial, by others who may not have delivered the course strictly as documented. At least some participants were given time off work to attend the training which may have impacted on their motivation for the course. The study which evaluated the impact of the training on the mental health of participants was methodologically compromised, by a small sample size, and a sample who indicated more mental health concerns than within the general population. To this point in the research of the impact of MHFA training, no evaluation into the impact of the application of the skills upon the mental health of those in distress had been undertaken.

Consequently, there is scope in the MHFA research to improve on some of these factors for evaluation. Evaluation of the training using a more heterogeneous study population that has mental health more representative of the population from which it is drawn would add to the knowledge of the impact of MHFA training. Using methodological approaches that minimise confounding influences (such as inputs from multiple presenters) are appropriate. Measuring mental well-being of the participants rather than the absence of mental ill-health is also warranted as a contribution to the area. So

too, is the exploration of factors associated with the application of the learning to those in distress.

The impact of MHFA training and the application of skills

A further study was undertaken to qualitatively assess the application of MHFA skills. Jorm, Kitchener and Mugford (2005) approached participants who completed a nine hour MHFA training course (Jorm et al., 2004) some 19 to 21 months earlier. People excluded from this follow-up study included those who did not attend the original training after random assignment to the intervention group ($n = 76$), those who only attended some sessions ($n = 33$) or who had missing attendance data ($n = 176$). Of the 131 contacted for this follow-up, 94 completed a questionnaire (72 percent), by posting it back to the researchers or by completing online and returning it electronically.

The questionnaire gathered demographic information and data on the use of MHFA since training. Respondents who had applied MHFA were asked to describe the experience, including if they had been able to identify the mental health concern; what they did or did not do; their understanding of the effects of their intervention and if completing the course changed the way they related to the person they assisted.

The mean age of the respondents in this follow-up study was 51 years (range 21-74) and the group was predominately female (75 of 94 respondents). Of the respondents 31 had a university qualification which was a higher proportion than in the original study (33 percent in this study compared with 22 percent in the original study). Some 29 individuals (31 percent) reported personal experiences with mental ill-health, 21 (22 percent) had experience of a family member's illness, 8 (9 percent) reported both personal experience and family experience and 36 (38 percent) reported no previous experience with mental ill-health.

Literature Review

Of all the respondents 73 reported having an experience after the course in which someone was experiencing a mental ill-health. Some 79 percent said they had definitely been able to assist, 17 percent stated they had been able to help and 7 percent were unsure. Of those who had not encountered a mental health emergency most believed they could cope well or moderately well with such a situation if it arose.

Jorm, Kitchener and Mugford (2005) described several key findings. First, the majority of the respondents identified that they had had some direct experience with mental ill-health since completing the course. For this group the course provided a positive support for their experience. Second, the positive effects identified changes in both the attitude of the participants toward mental ill-health generally, (increased empathy, understanding and confidence to respond) and toward the person experiencing the difficulties (increased capacity to handle a crisis, manage difficult relationships and offer effective help). Participants with professional backgrounds reported enhanced competence, family members and friends of those with mental ill-health reported dealing more effectively with the pressing concerns, and those with their own mental health concerns also viewed the course favourably. Importantly the findings also suggest that participants had not over stepped their competence dealing with difficult issues. Respondents reported the specific benefits and utility of the course and were keen to see it extended.

A potentially significant element of this study, not highlighted by the authors, was the self-selection of the survey sample. It would be reasonable to suggest that a positive selection bias could account for the positive evaluation received. Thus, the reason why individuals did not respond to the follow-up questionnaire becomes important. However, the Jorm et al., (2004) study was less concerned about this loss of information, stating that had anyone been significantly opposed to the course, some negative feedback could have been expected, as the return of the questionnaire was anonymous. Further, they suggest that the results of this qualitative study parallel the positive findings

of the value of the course obtained in previous studies and this outcome provided them with some confidence as to the utility of the findings.

For the first eight years of MHFA, the primary evaluations of the course were conducted by the authors of the course. While attempts were made to progressively improve the rigour of the analysis, there were issues identified within each study that questioned the internal and external validity of the described findings. In addition, these seminal studies, upon which the credibility of MHFA has been widely based, have all been produced by the authors of the original course. To strengthen their findings of the benefits of MHFA, expanding the evaluation to situations and populations independent of the course authors is required.

MHFA replication studies

Hossain, Gorman, Eley and Coutts (2009) provided MHFA training with the intention to enhance the skills of farm advisors who came into regular contact with farmers who might be experiencing, or in the prodromal stages, of mental ill-health. This application of the course was deemed appropriate as rural communities have high levels of mental stress (Farberow, 1985; Raphael, 1986; Sartore, Kelly, Stain, Albrecht & Higginbotham, 2008) and premature mortality (Australian Institute of Health and Welfare, 2002) including suicide (Brumby, Martin & Wilder, 2005; Caldwell, Jorm & Dear, 2004). Given their geographic isolation, such communities also have less access to formal resources of care (Judd, 2003; Judd et al., 2002). Hossain et al. (2009) conducted an uncontrolled quasi-experimental study that collected data from 32 farm advisors who were employees of government departments concerned with agriculture, fisheries, natural resources and water and who had indicated an interest in the course.

Following delivery of 12 hours of training, Hossain et al. assessed the participants to determine changes to mental health literacy. Evaluations of the influence of demographic factors (particularly age), work experience and

Literature Review

previous experience with mental ill-health were also conducted. Participants were also asked to describe their experience of the learning. The relevance of the training and the ease of understanding of the presentation were assessed. Assessment of mental health knowledge and the skills to address mental ill-health situations was undertaken using the MHFA Literacy Assessment Tool, and a nine item questionnaire developed by the course authors (Kitchener & Jorm, 2002).

In this programme the majority of the participants were female (59 percent) and just over half (56 percent) had five years or less work experience in the field as farm advisors. In response to the question “Have you ever experienced a mental health problem yourself or in someone in your family?” the majority (72 percent) had not.

The mental health knowledge scores of participants before training ranged from 1 to 17 with a mean of 10.75 ($SD = 3.56$). Following training knowledge scores (or mental health literacy) were significantly improved, ranging from 18 to 24 with a mean score of 22.19 ($SD = 1.46$; $t(31) = -15.80$, $p = .001$). At the pre-training assessment those over 40 years of age had better mental health knowledge ($M = 12.20$, $SD = 3.78$) than those aged under 40 ($M = 9.54$, $SD = 2.87$; $F(1,21) = 6.18$, $p = 0.02$). Although there was no main effect of work experience on mental health knowledge, there was a significant interaction between age and work experience. Farm advisors who were aged under 40 with more than 5 years work experience ($M = 13.17$, $SD = 2.08$) had better mental health knowledge than those who were over 40 years of age with less than 5 years work experience ($M = 10.28$, $SD = 1.57$; $F(1, 21) = -6.33$, $p = 0.01$). This suggests that younger inexperienced farm advisors had better pre-training knowledge about mental health than their older colleagues. Following training age, gender and work experience had no influential effect on mental health knowledge.

Following the course, participants were asked to evaluate the course in terms of the “newness” of the materials, the ease of understanding, the presentation

Literature Review

format and the relevance of the content. Each of these areas was evaluated favourably with comments such as “broad range of relevant topics. Course materials were easily understood and the manual was clear and concise”. The presentation was described as; “presented well with facts and provided insight into mental health as well as the treatments” and “it was very helpful information that I can use personally and in the workplace with clients” giving participants “ a much greater awareness of mental health” (Hossain et al, 2009, p. 5). In summary, the farm advisors identified that completion of the course gave them a much greater knowledge and awareness of mental health. It provided them with an understanding of the positive benefits of early intervention and their role in assisting those with mental health concerns.

One could argue that the small, self-selected, uncontrolled sample and the use of evaluation materials generated by the MHFA course authors, limited the generalisability of this study. Despite this, the results obtained suggest that MHFA had a positive short-term effect on mental health literacy. This was an interesting finding, as unlike previous studies, the farm advisors in this study reported very little previous experience with mental health issues. Age and work experience impacted on mental health knowledge before training, but these factors together with gender had no measurable impact on the results after the completion of training.

It is worth noting that in a similar study of front line agricultural workers (Sartore, Kelly, Stain, et al., 2008), comprising of rural support workers and community volunteers, similar results were obtained. However, in this second study participants expressed concerns with applying the knowledge they had learned, as they deemed its application fell outside their job roles.

There have been few other studies that have attempted to evaluate rigorously MHFA’s contribution to the development of mental health literacy and mental health. Some international evaluations have been undertaken, however, when completed, these have primarily focused on participant satisfaction, using

Literature Review

uncontrolled qualitative assessments. Table 2.2 describes the evaluations that have been undertaken or are in progress, as identified by the authors of MHFA. Countries in which the course have been offered but are yet to formally publish evaluations are: Finland, Northern Ireland, Singapore, USA, Japan, Hong Kong, South Africa, Cambodia, Thailand and New Zealand. Consequently, despite the apparent international popularity of the MHFA programme there remains significant scope for more rigorous, international, independent evaluations of MHFA.