Evaluating Mental Health First Aid Training in Ireland: A Study of Participants’ Post-training Experience and Helping Behaviour

Thesis submitted to the University of Limerick in fulfilment of the requirements for the degree of Doctor of Clinical Psychology

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Declaration

I hereby declare that this project is entirely my own work, other than the counsel of my supervisors. Any contributions made by other authors have been recognized appropriately. The work herein has not been submitted for any academic award or part thereof at this or any other establishment.

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Janine O’Gorman
2020
Acknowledgements

In loving memory of Annie O’Gorman
(1934-2020)
Grandma
An unspoken feminist and eternal optimist
Thank you for providing me with a lifetime of wisdom and unconditional love
What is loved is never lost

My sincere appreciation to my supervisor Dr Barry Coughlan for his support, guidance and patience in getting this project over the line. Your consistent feedback and reassurance have made this often-difficult task much easier.

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Abstract

**Introduction:** The current study sought to add to existing Mental Health First Aid (MHFA) literature by investigating the post-training experiences and helping behaviour of MHFA trainees in Ireland. In particular, this study aimed to understand the long-term outcomes of MHFA and the nature and quality of MHFA helping behaviours. The present research adopted a critical lens through which to examine MHFA experiences, exploring the impact of discourses constructing mental health and in doing so addressing a gap in the existing research.

**Method:** A qualitative design was used to address the current research questions. Adopting a critical realist approach, previous MHFA trainees (n=256) completed an online survey gathering demographic details and brief qualitative information about their experiences. Individual telephone interviews were then conducted with 30 self-selecting survey participants (12 male; 18 female). Survey answers were downloaded online through Qualtrics. Interviews were audio recorded and transcribed verbatim for analysis.

**Results:** Separate thematic analysis (TA) was carried out with survey and interview data, focusing on in-depth analysis of the interview data. Survey data addressed each of the following: Reasons for doing MHFA, Previous training or professional experience in mental health, Changes experienced as a result of MHFA, and Challenges in attempting to use MHFA. Interview analysis produced 6 core themes: Helping for Mental Health Problems; MHFA Narratives & Experiences, Resources & Services for Mental health, Subjective Norms, Understandings of Mental Health, and Covid-19.

**Conclusions:** Findings confirmed the utility of MHFA training for improving general knowledge, attitudes and behaviour towards mental health problems. MHFA was found to influence helping behaviour and trainees’ confidence to provide help. Factors such as stigma, social support, previous experience and resources to support MHFA were also found to impact these outcomes. The present research provides support for mental health training that uses diverse and inclusive understandings of mental health. It also highlights the limits to using knowledge to change behaviour towards mental health. It is suggested that in order for MHFA to be effective, it should be reinforced by contexts which promote inclusion and equality for people with mental health problems.
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1 Chapter One: Introduction

1.1 Overview of Present Study

Mental disorder is classified by the World Health Organisation as:

“disturbances to a person’s mental health that are often characterized by some combination of troubled thoughts, emotions, behaviour and relationships with others. Examples of mental disorders include depression, anxiety disorder, conduct disorder, bipolar disorder and psychosis” (WHO, 2019a, p.1).

The terms mental disorder, mental illness and mental health problem are often used interchangeably when referring to such experiences. Mental health problems are said to restrict a person’s ability to achieve the factors involved in good mental health and are identified by symptoms which meet the clinical thresholds established by diagnostic classification systems (OECD, 2018; WHO, 2013). Whilst mental disorders tend to be severe and enduring, some conditions may be experienced over the shorter term. It must also be noted that the language of mental illness and its associated diagnostic terminology have been linked to negative consequences for individuals labelled with these terms (Larkings & Brown, 2018). Arguments have been made against the language of mental illness and the concepts underlying it, proposing the use of terms that are both more accurate and inclusive (Johnstone & Boyle, 2018; Kinderman, Bentall, Read & Moncrieff, 2012). The current research seeks to adopt a critical approach towards understandings of mental illness, with the researcher’s positionality more inclined towards inclusive terminology. The term mental health problem (MHP) will therefore be adopted throughout this thesis in an effort to acknowledge the construct of mental illness, whilst adopting a critical and more inclusive approach to mental health discourse.

In Europe, mental health problems are estimated to affect over one third of the population each year with at least 18.5% of the Irish population classified as having one or more mental disorders (OECD, 2018). Identified as the greatest source of disability in the European Region, mental illness presents a significant public health challenge (WHO, 2019a). Despite these implications, it is also recognised that most people with mental health problems go untreated and mental illness prevalence rates remain problematic (Thornicroft 2007; WHO, 2019c). A
number of structural and attitudinal barriers to accessing treatment for mental health problems have been identified, with global mental health policy seeking to address these issues.

One initiative which aims to close the mental health treatment gap is Mental Health First Aid (MHFA). Modelled on physical first aid, MHFA seeks to provide the general public with first aid skills to support those experiencing a mental health problem or crisis until such a time that they can access professional help or the crisis resolves (Kitchener & Jorm, 2002). The programme was developed in Australia in 2000 and has since been delivered in 26 countries, to upwards of 2.7 million people (Jorm, Kitchener, & Reavley, 2019). MHFA was first launched in Ireland (MHFAI) in 2014. A partnership with the Health Service Executive (HSE) was announced in 2017 in order to make the training more widely available. Over 7,500 people have received the training in Ireland to date (MHFAI, 2020).

The current research came about when an initial plan to research a pilot of Youth MHFA was delayed. It emerged that MHFAI had received ethical approval and consent from Standard MHFA trainees in order to research the outcomes of the programme, however, such a project was yet to be completed. A plan was thus formulated to investigate the outcomes of MHFA training with the general public in Ireland. As MHFA had previously been researched on an international scale, it was important to identify aspects of the evidence base that required further evaluation. A review of the literature revealed a need for a more critical evaluation of MHFA training and its underlying assumptions, as well as research to examine the long-term, lived outcomes of MHFA. Combining these various positions, the following research aims were decided:

- To understand the impact of MHFA training with the general public and how useful MHFA skills are to participants.
- To examine the influence of MHFA training on helping behaviour and other MHFA outcomes at up to and beyond 12 months post-training.
- To explore how discourses constructing mental health influence the effectiveness of MHFA.
1.2 Thesis Structure

The following provides a brief overview of the structure of the present study, starting from Chapter two which discusses the existing literature and sets the scene for the current research.

1.3 Chapter 2: Literature Review

This chapter reviews the literature relevant to the present study. It firstly provides a background to the mental health treatment gap which MHFA seeks to address. This is followed by a critical discussion of previous attempts to close the mental health treatment gap, focusing on help-seeking and engagement, mental health literacy and helping behaviour. The theoretical framework that underpins the current study is then reviewed. Lastly MHFA and its evidence base is introduced, followed by an outline of the current study rationale and research questions.

1.4 Chapter 3: Methodology

Chapter three will provide a rationale for adopting qualitative methodology to address the current research questions. It will then explain the reasoning behind using qualitative thematic analysis. Ethical considerations and research procedures will be explained, and the study sample will be outlined. Finally, the process of thematic analysis (TA) will be described.

1.5 Chapter 4: Results

This chapter contains two sections: the first presents findings from analysis of the qualitative survey data and the second provides a more in-depth review of results from TA of individual telephone interviews. In particular, the 6 main interview themes will be presented in detail.

1.6 Chapter 5: Discussion

Chapter 5 provides a critical discussion of key findings from the present study, placing them in the context of existing literature and highlighting the original contributions of the current research. The strengths and limitations of the present study are considered. Implications and recommendations for clinical practice and policy, education, and future research are also outlined, as well as a critical reflection on the overall research process.
Chapter Two: Literature Review

2.1 Chapter Introduction

This chapter reviews the literature relevant to the present study. It firstly provides an overview of definitions of mental health and mental illness, along with mental illness prevalence rates. It then outlines the mental health treatment gap upon which the need for MHFA is founded. This background is expanded upon in a critical synopsis of attempts to close the mental health treatment gap. The focus here is on public attitudes towards giving and seeking help for mental health problems. Help-seeking and engagement, mental health literacy and helping behaviour are each appraised with a view to understanding why and how these factors may help to close the mental health treatment gap. The theoretical framework that underpins the current study, the Theory of Planned Behaviour (TPB) (Azjen, 1991) is then reviewed. Lastly MHFA and its existing evidence base is introduced, followed by an outline of the rationale behind the current study and its primary research questions.

2.2 Literature Search Strategy

In light of recent systematic reviews of the MHFA evidence base, it was decided that a scoping review was not required for the present study. Instead, relevant literature was first reviewed through the MHFA International website which holds an extensive repository of literature on MHFA training. Here, the evidence base is categorised into three core levels of research evaluating MHFA programmes: systematic reviews (n=3), randomised controlled trials (n=21) and other evaluations (e.g., pilot courses and uncontrolled trials) (n=61). The online database includes additional reviews that have addressed MHFA training as part of their analysis of relevant areas such as mental health training (n=14). A list of qualitative evaluations of MHFA (n=20) and research that provides evaluation of MHFA as part of another project (n=14) are also provided. A repository of MHFA discussion papers and commentaries was further appraised (n=22). Lastly, a review of additional articles on mental health literacy was carried out (n=9). Non-peer reviewed articles were excluded from this review and a focus on evaluations of Standard MHFA training was adopted. Studies dating from 2002 to 2020 were reviewed, however, an interest was taken in more recent research.

Key studies were used to condense and focus the current review. The most recent systematic reviews and meta-analyses of MHFA training were examined and core topics relevant to current research questions were identified: mental health literacy, helping behaviour, mental
illness stigma, and the theory of planned behaviour. Reference lists of key studies were used to direct a review of core topics and a screening of work by key authors was also carried out. PsycINFO, PubMed, Cochrane, and Embase databases were searched for any outstanding literature using combinations of the following search terms: “mental health literacy”; “MHFA / mental health training”; “the theory of planned behaviour”; “mental health / mental illness stigma”; “helping behaviour mental health / mental illness”; “help-giving mental health / mental illness; mental illness prevalence”. The titles and abstracts of identified articles were screened for relevance, with a focus on systematic reviews and the most recent literature. There was a particular interest in identifying further articles on helping behaviour for mental illness, which emerged as a less researched area. Throughout the review, an effort was made to source literature providing some critique or external perspectives on MHFA. This was based on the rationale that the majority of existing literature had been produced by those involved in MHFA, which could yield a biased assessment of the area.

2.3 Defining Mental Health and Mental Illness

The World Health Organisation (WHO, 2019a) defines mental health as a state of well-being in which an individual can realise their potential, cope with the normal stresses of life, work productively and contribute to their community. Mental health is thus not viewed as the absence of mental illness. It is instead viewed as existing on a continuum which ranges from mental well-being to mental illness, with varying levels of distress in between (WHO, 2019b). Figure 1 (WHO, 2019b) depicts the continuum of mental health, with individuals expected to fluctuate along this scale according to their life stage and experiences. Mental illness, on the other hand, is defined specifically as the presence of disorders classified in the International Statistical Classification of Diseases and Related Health Problems (ICD) or other diagnostic systems (WHO, 2013). The terms mental disorder, mental illness and mental health problem tend to be used interchangeably when referring to such experiences. As mentioned in the
introduction section, the term mental health problem (MHP) will be utilised in the current research.

Figure 1. Continuum of mental health and mental health conditions

WHO guidelines recognise the complex factors involved in mental illness. Alongside of individual characteristics, numerous social and environmental factors have been shown to influence MHPs (WHO, 2013). Most notably, across all European countries, it has been identified that mental illness prevalence rates are greatest amongst the most deprived (WHO, 2015). Contributing factors include childhood adversity, living standards, working conditions, social supports, poverty, physical illness, trauma and discrimination. Conversely, prevention and support with regard to such factors are found to aid in the promotion of mental well-being (McDaid, Hewlett & Park, 2018). Thus, mental health and mental illness are defined as two distinct but related experiences whereby many of the factors involved in mental health are also central to mental illness and vice versa.

Understandings of mental health and mental illness can be problematic. Chambers (2017) highlights the tension between these definitions and their implications for practice. He suggests that mental health policy adopts a narrow focus on mental illness at the expense of mental health. Furthermore, it has been argued that the conflation of mental health with mental illness serves to perpetuate biomedical understandings and models of care (DeFehr, 2016). There is a growing body of literature questioning the validity and reliability of such understandings, their related diagnostic categories and the utility of associated treatments (Carta & Angermeyer, 2015; Kinderman et al., 2012; Read, Kirsch & McGrath, 2020). There is also increasing scientific evidence to support these arguments (Marshall, 2020). More recently, alternative models which recognise the range of factors involved in the development and experience of mental illness have been put forward (Johnstone, 2017; Johnstone & Boyle, 2018). Chambers
(2017) advocates for greater transparency and diversity around the ways in which mental health is constructed, with important consequences for mental health care and engagement.

2.4 Mental Illness Prevalence

Mental health disorders affect around 25% of the population. Over 970 million people have a mental health problem according to Global Burden of Disease estimates in 2017 (WHO, 2019). In Europe, mental disorders are estimated to affect over one third of the population each year, with 84,000 deaths related either to MHPs or suicide in 2015 (OECD, 2018). According to OECD figures, Ireland is among the EU countries with the highest estimated prevalence rates of mental illness, with 18.5% or more of the population having at least one mental disorder. It is noted, however, that such figures may represent greater awareness and access to services for mental health problems in countries such as Ireland, relative to other EU countries (Coppens et al., 2013). Depression (4.5% EU population) and anxiety (5.4% EU population) are the most commonly experienced mental disorders at a global and EU level, followed by substance-use disorders (2.5% EU population) (OECD). Bipolar and psychotic disorders affect approximately 1-2% of the European population (WHO, 2015). Depression and anxiety disorders are found to be more prevalent amongst women, whilst substance-use disorders are more common amongst males. Chronic depression is also identified more frequently amongst the middle-aged, those with lower levels of education, income and employment, and those with physical health problems (OECD).

Mental illness presents a substantial public health challenge, identified as the greatest source of disability and the third ranked cause of disease burden (as measured by years lived with disability) in the European Region (WHO, 2019a). Mental health conditions have significant consequences for both the individual and society. Those with mental disorders are estimated to die 20 years earlier, often due to comorbid physical diseases that have been not been appropriately treated (WHO, 2013). Likewise, physical health problems are found to be associated with conditions such as depression. The economic burden of mental ill-health is great, accounting for more than 4% of GDP across Europe (OECD, 2018). Such costs often relate to employment, with 1.6% of this figure representing indirect labour market costs associated with lower employment rates among those with mental illness, together with greater absenteeism and lower productivity at work. As mentioned, unemployment is simultaneously associated with worse mental health and findings show that, whereas job losses are linked to suicide, employment can improve mental health (OECD). In spite of this, a high percentage of
Europeans who receive disability-related social welfare benefits cite mental illness as their main ailment (WHO, 2015). Such statistics represent the complex cycle of mental illness, whereby those with mental disorders are more likely to experience discrimination, inequality and other factors known to negatively affect mental health (Puras, 2018; Spandler & Calton, 2009).

2.5 The Mental Health Treatment Gap

According to recent WHO (2019c) statistics, despite the recognised prevalence and consequences of mental illness, more than 80% of those with a mental disorder do not have access to adequate mental health care. Globally, approximately two-thirds of those with a mental health condition receive no treatment, with this figure ranging between 35-50% for high-income countries (Thornicroft, 2007; WHO, 2013). Furthermore, for those who do access mental health care, it is often not appropriate or sufficient. Even in higher income countries, studies have revealed that the quality of mental health care is lacking, and resources are employed ineffectively (Jorm, Patten, Brugha & Mojtabai, 2017; Meadows et al., 2019). The WHO recognised the problems with access to evidence based and rights based mental health care and launched the Mental Health Treatment Gap (mhGAP) in response to this issue (WHO, 2008). This action plan encourages countries to move away from institutionalised care, towards community-based mental health services and equal access to a range of evidence-based treatments. It also advocates for multiple sectors in providing for mental health needs and for strategies that target mental health promotion and prevention. More recent aspects of mhGAP emphasise the role of the wider community in promoting and managing mental health, with importance given to non-specialised mental health care (WHO, 2019a). Figure 2 (WHO, 2019b) outlines the WHO model for best practice in mental health service provision.
The WHO thus places equal importance on strategies that address risk factors associated with mental illness, as they do on providing quality care. It is proposed that such an approach has important implications for reducing the economic and social burden of mental illness (McDaid, Hewlett & Park, 2017). In line with WHO directives, several European countries have developed mental health promotion and prevention policies. The OECD (2018) identified over 100 prevention and promotion activities in place across Europe. These activities seek to address priority areas across the lifespan including suicide prevention, the early years, young people aged 11-25 and workplace mental health; with these areas receiving the most input to date. Such strategies acknowledge the role of community settings in mental health service provision, with ‘community platform’ settings thought to better enable interventions to reach the general public (WHO, 2019b). As Figure 3 (WHO, 2019b) outlines, community platforms target priority areas for intervention such as schools, workplaces and community groups. Community interventions also address the spectrum of mental health, whilst community providers include individuals from a range of backgrounds and professions. Settings such as the workplace are thus viewed as platforms through which to: promote well-being and prevent mental health problems, raise awareness and intervene early, and support those with mental health problems.
so as to improve their outcomes. These strategies can be implemented with individuals, groups or organisations and strategy providers are determined by the level of expertise required (WHO, 2019b).

Figure 3. Dimensions of the community platform

There is evidence for the effectiveness of interventions provided through community platforms, with improved mental health outcomes, reduced risk of mental illness and economic benefits in areas such as the early years, schools and the workplace (McDaid et al., 2017; Petersen et al., 2016). It is also recognised, however, that inconsistent approaches, poor cooperation between sectors and limited resources are barriers to successful intervention in many countries (McDaid et al.). Insufficient focus on preventative initiatives has been posited as an explanation for sustained mental illness prevalence rates in several countries, despite increased mental health expenditure and service provision (Jorm et al., 2017; Meadows et al., 2019). In his critical analysis of Irish mental health policy, Chambers (2017) highlights the disparities between the narrative of core policy document A Vision for Change: Report of the Expert Group on Mental Health Policy (AVFC) (Government of Ireland, 2006) and its proposed actions. Chambers states that, whilst the document refers to mental health and well-being for all, its recommendations chiefly pertain to providing services for mental disorders. This critique further suggests that, by allowing disease models of psychiatry to dominate mental health discourses and practice, AVFC impedes the development of strategies for mental health promotion and prevention. This view is echoed by DeFehr (2016) who argues that strategies
seated in psychiatric discourse serve to maintain the factors involved in mental illness, doing so by constructing such experiences as individual rather than social or political problems.

2.6 Closing the Gap

Awareness raising and anti-stigma activities are identified as core strategies for addressing the mental health treatment gap in the community. These interventions acknowledge the role of public knowledge, attitudes and behaviour in maintaining the treatment gap. It has been recognised that many people with mental disorders choose not to engage with mental health services (MHS) (Thornicroft, 2008; WHO, 2015). People also delay seeking treatment, with many waiting a number of years to do so (Wang et al., 2005). In addition, those who do seek help often discontinue or do not fully comply with treatment. Whilst structural barriers such as cost and availability deter people from help-seeking, so-called attitudinal barriers have been found to be equally important (Thornicroft, 2008). Low perceived need and a preference to manage one’s own condition are common barriers to seeking treatment, whilst adverse treatment experiences and perceiving treatment as ineffective are associated with poor engagement (Andrade et al., 2014). As there are potentially significant consequences for untreated mental health problems, addressing these issues is a priority (Knapp, McDaid & Parsonage, 2011).

2.6.1 Help-seeking and engagement

Prejudice, poor understanding of mental disorders and their treatment, and perceived discrimination towards people with mental illness, all act as barriers to help-seeking for mental health problems (Henderson, Evans-Lacko & Thornicroft, 2013). Furthermore, better knowledge and attitudes towards mental illness are associated with increased willingness to disclose and seek help for MHPs among the general public (Rüsch, Evans-Lacko, Henderson, Flach, & Thornicroft, 2011). Public campaigns targeting these areas were found to increase intentions to disclose and seek help, however, effects on behaviour are yet to be determined (Henderson, Robinson, Evans-Lacko & Thornicroft, 2017). In people with mental disorders, interventions that address mental health literacy and personal stigma have been shown to improve long-term, formal help-seeking behaviours (Xu et al., 2018).

Individuals often internalise public attitudes about mental disorders (Corrigan, 2000). So-called self-stigma has been identified as strongly associated with lower help-seeking (Clement et al., 2015). In contrast, countries with less public stigma, greater help-seeking and better
access to mental health information, were found to have fewer reports of self-stigma and perceived discrimination amongst people with mental disorders (Evans-Lacko, Brohan, Mojtabai & Thornicroft, 2012). Reports of self-stigma were lowest in countries where the public felt comfortable talking to people with a mental illness. This may relate to wider findings that the most common stigma barrier to help-seeking is worry about disclosure (Clement et al., 2015). Whereas disclosure is associated with empowerment in people with mental disorders, self-stigma is linked to shame and low self-efficacy, which is in turn related to a range of poor outcomes (Corrigan & Matthews, 2003). Table 1 from Rüsch, Angermeyer & Corrigan (2005) provides an overview of public and self-stigma.

Table 1 Components of public and self-stigma (taken from Rüsch et al., 2005)

<table>
<thead>
<tr>
<th>Public Stigma</th>
<th>Self-stigma</th>
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<td><strong>Stereotype:</strong></td>
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<td>Negative belief about a group such as</td>
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<td>Incompetence</td>
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<td>Character weakness</td>
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<td>Dangerousness</td>
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<td><strong>Prejudice:</strong></td>
<td><strong>Prejudice:</strong></td>
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<td>Agreement with belief and/or</td>
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<td>Negative emotional reaction such as</td>
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<td>Anger or</td>
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<td>Fear</td>
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<td><strong>Discrimination:</strong></td>
<td><strong>Discrimination:</strong></td>
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<tr>
<td>Behavior response to prejudice such as:</td>
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<td>Avoidance of work and housing opportunities</td>
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National surveys have found that public knowledge of mental disorders is generally poor, and that people hold a range of biased attitudes towards people with mental illness (Angermeyer & Dietrich, 2006; Reavley & Jorm, 2011). Public ideas vary depending on type of disorder, with people discriminating against different disorders accordingly. For example, schizophrenia is associated with greater perceived dangerousness and unpredictability, along with a desire for social distance. Social phobia and depression, on the other hand, are more likely to be viewed as a sign of personal weakness and something that people can ‘snap out of’ (Coppens et al., 2013; Reavley & Jorm). Studies have also found that members of the public are often unable to correctly identify mental disorders and know little about their treatment (Jorm et al., 1997). Compared to mental health professionals, the public show a preference for psycho-social explanations of mental illness and view psychiatric treatment less favourably than self-help.
strategies, informal help or generic professional help (Riedel-Heller, Matschinger, & Angermeyer, 2005; Tay, Tay & Klainin-Yobas, 2018).

Anti-stigma programmes have been found to improve public attitudes towards mental illness in the short-term, as well as decrease discrimination experienced by people with mental disorders (Henderson et al., 2013; Morgan, Reavley, Ross, San Too & Jorm, 2018). Social contact interventions and contact-based education are identified as most effective at reducing stigma towards people with mental illness (Thornicroft et al., 2016). This finding is in line with evidence that contact is associated with less stigmatising attitudes (Maunder & White, 2019). Knowledge about MHPs and their treatment also appear to have improved as a result of public health campaigns (Schomerus et al., 2012). Increases in knowledge are thought to have led to improved attitudes towards mental health treatment and a greater willingness to seek professional help (Picco et al., 2018; Rüsch, Evans-Lacko & Thornicroft, 2012). The influence of increased knowledge on attitudes towards individuals with mental health problems is less clear, however. Population trends suggest that, despite increases in mental health literacy, attitudes towards people with mental illness have remained stable or possibly worsened (Schomerus et al., 2012).

The latter findings touch on wider ontological and epistemological debates about mental health problems and how they are understood. Research suggests that framing mental illness as a biomedical disorder, whilst reducing blame on people experiencing problems, serves to increase stigma in the form of social rejection, pessimism about recovery and perceptions of dangerousness and unpredictability (Longden & Read, 2017). This has been found to be the case for the public, those with mental health problems and mental health clinicians; with implications for the outcomes of people experiencing problems (Kvaale, Haslam, & Gottdiener, 2013; Larkings & Brown, 2018). Link and Phelan (2001) further highlight the potentially negative impact of mental illness ‘labelling’ in their theory of stigma. In contrast, psycho-social frameworks of mental distress have been found to be associated with more positive attitudes and outcomes (Longden & Read, 2017). Psycho-social perspectives recognize the significant role of adverse life experiences in the development of mental health problems. They frame distress as a normal response to these circumstances as opposed to reducing it to disordered, biologically determined symptoms (Johnstone & Boyle, 2018; Kinderman et al., 2012). Evidence indicates that, as with the general public, psycho-social
causal explanations are preferred by people diagnosed with a mental disorder (Carter, Read, Pyle & Morrison, 2018; Read, 2020).

### 2.6.2 Mental Health Literacy (MHL)

Mental health knowledge is frequently referred to as mental health literacy, with this term denoting a person’s knowledge of mental disorders and their treatment. In recognition of the gap in public mental health knowledge, Jorm et al. (1997) formally introduced the construct of mental health literacy. Mental Health Literacy (MHL) refers to “knowledge and beliefs about mental disorders, which aid in their recognition, management or prevention” (Jorm et al., 1997, p.182). MHL is based on the reasoning that individuals who experience mental health problems and those around them are often the first line of intervention for mental illness (Jorm, Griffiths, Christensen, Parslow & Rogers, 2004). Mental health literacy seeks to bring public views about mental disorders in line with that of psychiatric professionals, in order to provide knowledge to intervene early in mental health problems and support mental illness. Mental health literacy thus presumes the superiority of professional expertise (Jorm, 2000). The construct comprises the following components: knowledge of how to prevent mental health problem; ability to recognise mental illness; awareness of appropriate options for help or treatment; familiarity with self-help approaches; and first aid skills to assist those with a mental health problem or crisis (Jorm, 2012). It is proposed that increases in MHL should both improve engagement with evidence based mental health care and reduce the burden on mental health services by empowering the public with skills to support themselves and others.

Educational interventions designed to address the specific components of mental health literacy have been shown to improve knowledge, attitudes and behaviour towards mental health problems (Morgan, Ross & Reavley, 2018). Contrary to previous findings about mental health knowledge and stigma, this includes social distance measures of stigma. There is also evidence that MHL has increased in several countries following broader public health campaigns; with indications that the gap between pubic and professional opinion is reducing (Reavley & Jorm, 2014; Schomerus et al., 2012). Australian studies show that people are engaging more frequently with mental health services and that perceived need for help has increased (Jorm, 2018; Meadows & Irene, 2011). This is following a decade of initiatives to improve mental health literacy and access to services. Whilst rates of depression and anxiety in Australia increased over this period, specifically among young males and middle-aged females, male suicide rates declined (Jorm, 2011). Information on the extent to which better mental health
literacy leads to actual behaviour change and improves mental health is otherwise limited (Jorm et al., 2006).

Population statistics reveal that despite increases in mental health literacy, service provision and expenditure, mental illness rates have remained stable over time (Jorm et al., 2017). Goldney, Eckert, Hawthorne and Taylor (2010) identified an inverse relationship between MHL and depression in Australia, with increased mental health literacy accounting for 27% of the growth in major depression between 1998 and 2008 and poor MHL cited as a protective factor against depression. Furthermore, recent research has rebuffed the hypothesis that increased willingness to disclose mental illness is masking a fall in prevalence rates (Jorm, Mackinnon, Hart, Reavley & Morgan, 2020). There are, however, suggestions that increased mental health literacy has led to greater internalising and pathologizing of mental distress; whereby reports of life stress have decreased at the same time as perceived mental health needs and mood disorder diagnoses have increased (Simpson, Meadows, Frances & Patten, 2012). There is also evidence of the public incorrectly identifying themselves as having a mental disorder (Jorm et al., 2017). These findings may relate to wider issues around the expansion of diagnostic criteria for mental disorders and the implications of the same (Allsop, Read, Corcoran & Kinderman, 2019).

In Australia, those who accessed mental health services did not view the service as fully meeting their needs (Meadows & Irene, 2011). International research also highlights that mental health treatment is often insufficient and inappropriate (Jorm et al., 2017). Evidence shows that disadvantaged groups access services less and receive lower quality provision than those in more affluent settings, despite having a higher prevalence of mental illness (Jorm, 2018; Meadows et al., 2019). Clark et al. (2018) thus argue that how services are organized and dispensed is essential to mental health outcomes. There is also the suggestion that, in certain cases, mental health care may do more harm than good (Illich, 1976). Recent research provides support for the idea that, for some psychiatric treatments, harmful effects can outweigh any benefits particularly from the perspective of the recipient (Moncrieff, Cohen & Porter, 2013; Read, Grigoriu, Gee, Diggle & Butler, 2020; Read & Sacia, 2020). Furthermore, there are arguments that a focus on treating mental illness may come at the expense of activities that preserve well-being and prevent mental health problems (DeFehr, 2016; Goldney et al., 2010). This includes the idea that prioritising professional treatment might impact upon personal efficacy for self-help strategies (Meadows et al., 2019).
It must also be noted that the construct of mental health literacy has been questioned within the literature (Spiker & Hammer, 2018). Despite its scope, research into MHL tends to focus on limited components such as disorder recognition (Kutcher, Wei and Coniglio, 2016). There is thus considerable variation in how mental health literacy is defined. There is also variation in the range and quality of tools used to measure mental health literacy, with many tools failing to adequately demonstrate their psychometric properties (O’Connor, Casey & Clough, 2014; Wei, McGrath, Hayden & Kutcher, 2015; 2016). In particular, concerns are expressed about a reliance on diagnostic vignettes and their ability to provide a valid and reliable assessment of mental health literacy, as defined by Jorm and colleagues (1997). It is also argued that there has been no systematic measurement or definition of the elements contained within this concept, nor is there a quantitative tool which serves to reliably measure MHL across various settings (O’Connor et al., 2014). Some suggest that mental health literacy research would benefit from contextualising itself, as well as considering more pluralistic understandings of mental illness and treatment (Furnham & Hamid, 2014; Moll, Zanhour, Patten, Stuart, & MacDermid, 2017).

2.6.3 Helping Behaviour

Mental health literacy recognises the more active role that the general public can play in supporting the mental health of others. Help-seeking for mental illness can range from self-help to formal mental health care, with various forms of informal help and generic professional help in between. People have been found to follow a pattern whereby self-help strategies are adopted for milder mental health problems and professional help is recruited as symptoms become more severe (Andrade et al., 2014; Jorm et al., 2004). As mentioned, however, the public tend to favour self-help strategies and informal help over professional mental health care (Coppens et al., 2013; Tay et al., 2018). Research suggests that people with MHPs are more likely to seek help when it is suggested by others (Cusack, Deane, Wilson & Ciarrochi, 2004; Wong, Brownson, Rutkowski, Nguyen & Becker, 2014). There is also evidence that people thinking of suicide are more likely to seek help from family and friends (Barnes, Ikeda & Kresnow, 2002). Furthermore, positive social support has been found to aid in the management of and recovery from mental illness (Muldoon et al., 2019; Nasser & Overholser, 2005). Jorm (2012) thus argues that mental health literacy interventions should seek to provide the public with knowledge of effective self-help strategies, along with the ability to recognise and intervene appropriately with mental health problems or crises in others.
Australian studies have revealed that public behaviour towards people with mental health problems is largely positive (Reavley, Morgan, Rossetto & Jorm, 2018). However, self-reports of people engaging in discriminatory behaviour were fewer than instances of perceived discrimination reported by people with mental health problems. This finding may indicate a social desirability effect with responses to questions about mental illness stigma (Coppens et al., 2013; Henderson, Evans-Lacko, Flach & Thornicroft, 2012). For those who did report either experiencing or engaging in discriminatory behaviour, the most frequently described behaviour was avoidance in the form of shunning, reducing or cutting off contact (Reavley et al.). Problems with tolerating an individuals’ symptoms and needing space from the same were the main reasons for engaging in avoidance. Family members and partners of those with a mental health condition were most likely to engage in discriminatory behaviours.

Generic support and continuing or increased contact were the most frequently cited supportive behaviours (Reavley et al., 2018). Other research found that listening, offering information and support, and encouraging a person towards professional help were the most commonly reported actual and intended helping behaviours towards people with mental health problems (Jorm, Blewitt, Griffiths, Kitchener & Parslow, 2005; Rossetto, Jorm & Reavley, 2014a; 2014b). Overall, however, research judged the quality of helping behaviours among the general public to be poor. Many people failed to engage in appropriate actions or to recognise a need for professional help. Members of the public were also reluctant to assess or intervene in mental health crises, particularly with regard to asking about suicidal intent. Reactions differed according to the type of mental disorder, indicating the influence of prejudiced attitudes towards problems such as schizophrenia and social phobia. Jorm (2012) provides a summary of comparable research with young people, with similar reports of actual and intended behaviour towards people with mental health problems.

Research into the factors involved in helping behaviour identified that females were more likely to engage in helpful actions towards people with mental health problems (Rossetto et al., 2014b). Stigma in the form of viewing a person as ‘weak not sick’ and a desire for social distance, as well as a belief that recovery was possible without professional help were found to be associated with poor helping and harmful responses. Reports of harmful responses were infrequent, however. People were most likely to seek advice on how to support schizophrenia symptoms, suggesting a deficit of knowledge in this area. Interestingly, mental health literacy variables were not found to be consistently related to helping behaviour. Studies with both
adults and young people have found that intentions can predict helping behaviour, particularly with regard to the quality of behaviour (Mason, Hart, Rossetto & Jorm, 2015; Rossetto, Jorm & Reavley, 2016; Yap & Jorm, 2012). Past behaviour and confidence to help were identified as significant predictors for future help giving. The public were also found to have good knowledge of strategies to prevent mental illness (Jorm, 2012).

2.7 Theoretical Framework: The Theory of Planned Behaviour

The relationship between intentions and helping behaviour for mental illness is supported by the Theory of Planned Behaviour (TPB), which proposes that intention is a main predictor of behaviour (Azjen, 1991). There is evidence that interventions can bring about behaviour change for health-related behaviours, particularly when based upon strong theoretical assumptions (Davis, Campbell, Hildon, Hobbs & Michie, 2015). The TPB is one of the most frequently utilised and recognised behaviour change theories in the social and behavioural sciences. It has proved a useful model through which to develop behaviour change interventions and has been shown to successfully predict behaviour within a variety of contexts (Ajzen, 2002; Armitage & Conner, 2001; Steinmetz, Knappstein, Ajzen, Schmidt, & Kabst, 2016). Interventions based on the theory of planned behaviour have been shown to be particularly effective with the public and with groups. Further research has found intention to predict behaviour change across several settings (Webb & Sheeran, 2006). The current research will thus use the TPB to understand the way in which the public behave towards mental illness, particularly with regard to helping for mental health problems.

Developed out of the Theory of Reasoned Action (TRA), the theory of planned behaviour suggests that a person's performance of a behaviour is borne out of their intentions to engage in it (Azjen, 1991). Such intentions are directly influenced by the individuals’ attitudes, subjective norms and perceived behavioural control. Furthermore, each of the latter are said to be determined by a person’s salient beliefs. The TPB thus proposes that human behaviour is ultimately the function of one’s prominent underlying beliefs around any given behaviour. Attitudes are based upon underlying beliefs about the potential positive or negative consequences of engaging in a behaviour. Subjective norms refer to the person’s beliefs about the normative expectations of their environment and their desire to conform to these expectations. Such norms are transmitted through society and an individual’s social networks. Perceived behavioural control (PBC) refers to the extent to which a person is confident in their abilities to fulfil a behaviour, similar to the concept of self-efficacy (Bandura, 1997). It is
thought that perceived behavioural control can predict both intentions and behaviour, potentially moderating the effect of intention on behaviour (Armitage & Conner, 2001; Webb & Sheeran, 2006). Confidence that one has both the resources and ability to engage with a particular behaviour is thus seen as a necessary requirement to behaviour change. Figure 4. depicts the theory of planned behaviour framework.

By including perceived behavioural control alongside attitudes and subjective norms, the theory of planned behaviour attempts to give a comprehensive account of the individual and environmental factors involved in human behaviour (Azjen, 2002). Each of these three factors are conceptually independent predictors of intention and may have a greater or lesser influence on behaviour, depending upon the situation (Armitage & Conner, 2001). In relation to behaviour around mental health problems, public beliefs about the nature, course and treatment of mental illness will likely influence a person’s attitudes, subjective norms and perceived behavioural control (Jorm, 2000). For example, if it is believed that a person experiencing a mental disorder is dangerous, that they can’t be helped and that attempting to help might lead to negative consequences, intentions to help and the likelihood of helping will be low. On the other hand, if it is believed that mental health problems are a common experience, that recovery is possible and that a member of the public can offer effective help, helping intentions and behaviour will be higher. The same would be true for help-seeking for a mental health problem. The theory of planned behaviour thus gives further credence to mental health literacy and
treatment gap initiatives which seek to improve public knowledge, attitudes and behaviour towards MHPs (Jorm, 2012; WHO, 2019b).

The principles of the theory of planned behaviour have been applied to mental illness stigma and mental health literacy research (Griffiths, 2013; Riedel-Heller et al., 2005; Rossetto et al., 2014a). The theory of planned behaviour is thought to appeal within this area as it maps onto the attitudinal, normative and behavioural aspects of stigma towards mental illness. Griffiths emphasises the need for interventions not only to address attitudes and beliefs, but also to attend to the implementation of actions around mental health problems. The TPB delineates the motivational processes whereby a person’s intention to engage in a behaviour is increased and the implementational processes which encourage a person to act on their intentions (Azjen, 2015). Azjen proposes that attitude change will only result in behaviour change if the former can be readily transferred to the behavioural context and barriers to implementing intended behaviours are removed. Critics argue that both social structures and individual factors influence these processes beyond what the theory of planned behaviour accounts for (Manstead, 2011).

There are arguments which emphasise the role of wider social structures in preventing true behaviour change around mental illness (Stangl et al., 2019). These are supported by commentaries which address the function of power and political and cultural ideologies in the development and experience of mental illness (Chambers, 2015; DeFehr, 2016; Harper, 2014; Spandler & Calton, 2009). There are thus suggestions that public interventions should target specific behavioural outcomes such as social contact and equality, as opposed to changing knowledge and attitudes towards mental illness (Link & Phelan, 2001; Stuart, 2016). There are also arguments that mental health problems are the result of complex interactions between social and individual factors, whereby interventions that attempt to reduce these experiences are both invalid and unhelpful (DeFehr; Johnstone & Boyle, 2018). It is thought that the current research would benefit from considering these critical perspectives when attempting to understand the processes involved in behaviour change around mental health problems.

2.8 Mental Health First Aid (MHFA)

Mental Health First Aid (MHFA) is a standardised intervention designed to improve the mental health literacy of the general public (Kitchener & Jorm, 2002). Modelled on physical first aid, MHFA specifically seeks to provide people with first aid skills to support those experiencing
a mental health problem or crisis until such a time that they can access professional help, or the crisis resolves. This definition has since expanded to include help given to a person experiencing the worsening of a mental health problem (Kitchener, Jorm & Kelly, 2015). MHFA could be seen as a community platform intervention, designed to prevent mental health conditions and to support people with MHPs (WHO, 2019b). The programme was developed in Australia in 2000 and has since been adapted for various settings such as the workplace, schools and different cultures. It has been delivered in 26 countries, to upwards of 2.7 million people worldwide (Jorm, Kitchener, & Reavley, 2019). Devolved management allows different countries to adopt and roll out MHFA training, either through government agencies, private organizations or non-governmental organizations (NGOs).

Standard MHFA is a 2-day training, delivered face-to-face with those aged 18 years plus (Kitchener, Jorm & Kelly, 2015). MHFA follows a train-the-trainer model whereby instructors are trained to teach MHFA training to others, who are then considered to have the skills required to provide MHFA to individuals within their community (Morgan et al., 2018). MHFA participants are taught about the signs and symptoms of mental disorders and about evidence-based interventions for these problems. The course provides guidelines on difficulties including depression, psychosis, anxiety and substance abuse. It also addresses mental health crises: suicidal thoughts and behaviours, self-harm, panic attacks, trauma, severe psychosis, aggressive behaviour, severe effects of substance use. Participants are provided with knowledge on how to recognize mental health problems, how to offer initial support and how to direct a person towards professional help. They also learn a five-step action plan ‘ALGEE’: Approach the person, Assess and assist with any crisis, Listen non-judgmentally, Give support and information, Encourage the person to get appropriate professional help, and Encourage other supports.

As with mental health literacy, MHFA presumes the superior knowledge of mental health professionals (Jorm, 2000; 2012). MHFA guidelines are developed using the Delphi expert consensus method, which gathers expert knowledge around a particular topic (Jorm, 2015). Such ‘wisdom of crowds’ expertise should ideally be diverse and independent; however, diversity of expertise is not an essential requirement of the Delphi method. Jorm acknowledges that for Delphi studies in the area of mental health, experts are largely professionals and the type of experts depends on the question being posed. Problems with recruiting experts by lived experience have meant that varied expertise is lacking from many MHFA guidelines (Jorm &
Ross, 2018). As mentioned in previous sections of this review, medical perspectives of mental illness can be problematic and there are suggestions that MHFA inadvertently feeds into unequal medical, social and political structures that contribute to mental health problems (Chambers, 2017; DeFehr, 2016). Jorm and Ross acknowledge that the research and delivery of MHFA guidance is largely carried out by those involved in its development. There is, therefore, a recognised need for greater external involvement in the development, implementation and review of MHFA.

Reviews of the evidence-base for MHFA have found the training to improve knowledge of mental disorders, with moderate effects at up to 12 months post-training (Morgan et al., 2018; Malowski, LaCaille, LaCaille, Reich & Klinger, 2019). Small effects were identified for reductions in stigmatising attitudes towards mental illness, specifically social distance. The training was found to have greater effects on confidence and intentions to provide MHFA (moderate to large) than on actual behaviour (small). However, intentions were found to predict helping behaviour. These findings are in line with existing evidence about the role of confidence and intentions in subsequent MHFA helping behaviour (Rossetto et al., 2016). Overall training effects beyond 6 months were less clear, as were changes in the quality of helping behaviours, as many studies failed to assess these outcomes. Similarly, training effects for the mental health of both MHFA participants and recipients were not supported.

With regard to study quality, Morgan et al. (2018) carried out a meta-analysis and systematic review of randomised controlled trials of MHFA training with adults. Eligible trials used any comparison group and assessed one or more the primary MHFA outcomes: MHFA knowledge; recognition of mental disorders; treatment knowledge; stigma; confidence or intentions to provide MHFA; provision of mental health first aid; mental health of MHFA trainees or recipients. A total of 18 trials (5936 participants) were included. Previous literature has criticised the criterion validity and overall quality of measures used to assess mental health knowledge and other MHFA concepts, with the use of vignettes viewed as particularly problematic (Moll et al., 2017; Wei et al., 2016). Malowski et al. (2019) conducted a similar meta-analysis of MHFA training in an American context, analysing randomised and non-randomised controlled trials of youth and adult MHFA training with a total of 16 studies included. This study identified an inverse relationship between study quality and effect size. The review recommended that evaluation of objective behavioural changes required greater emphasis, as did MHFA effects on distressed recipients.
Greater investigation of MHFA helping behaviours has been advised, particularly with regard to effects on recipients (Morgan et al., 2018). Whilst there are clear challenges to collecting data of this kind, the need for such information has been flagged since the training’s inception (Kitchener & Jorm, 2002). Limited research has attempted to address this gap. MHFA-trained pharmacy students were formally observed in a simulated suicidal crisis role-play, with 50% implementing appropriate responses compared to 95.8% who expressed confidence in doing the same (El-Den, Chen, Moles, & O’Reilly, 2018). Overall, students were found to both over- and under-estimate their abilities relative to observed performance. Students were also found to have difficulty using suicide-specific terminology and their attitudes towards suicide varied, regardless of training (Boukouvalas et al., 2018; El-Den et al., 2018). In another study, long-term effects on adolescents whose parents had completed MHFA found no significant changes in either adolescent mental health or support provided by parents (Morgan et al., 2019). There were, however, improvements in parents’ knowledge, confidence and intentions including at 1- and 2-year follow-up. The authors speculate that parents’ changes did not readily transfer onto supportive behaviour, with other factors possibly affecting this link. This study also lacked power to identify its primary outcome effects of adolescent mental health and parent support.

Two studies have produced provisional models of MHFA helping behaviour. Research with graduates of MHFA-USA training identified that increased knowledge, empathy and strategies to deal with mental distress enhanced participants’ intentions to provide MHFA. Intentions were moderated by a sense of permission and responsibility to become involved, increased confidence to help, and reduced stigma around mental health problems (Lucksted, Mendenhall, Frauenholtz & Aakre, 2015). Whilst some behaviour change was illustrated by this study, the authors cautioned that confidence and intention did not inevitably lead to behaviour change. They thus identified a need to evaluate the process by which MHFA intentions lead to helping behaviour. They also proposed that stigma may be a central to MHFA effects, given their findings around the importance of reduced fear and increased empathy in trainees. A similar study with Australian MHFA graduates found that first aider and recipient relationship, first aider qualities, and recipient willingness to accept help were key factors affecting the link between MHFA intentions and actual helping behaviour (Rosetto, Jorm & Reavley, 2018). Such research emphasises the role of both individual and environmental factors in the implementation of MHFA helping behaviours.
Qualitative MHFA studies revealed increases in knowledge, empathy, and confidence to intervene with a mental health crisis as a result of the training (Svensson, Hansson & Stjernsward, 2015). Follow-up at up to 24 months post-training found that most participants had used their MHFA skills and that helping encounters increased with time (Hart, Jorm, Paxton & Cvetkovski, 2012; Jorm, Kitchener & Mugford, 2005). Participants stated that MHFA had given them a ‘toolkit’ for helping with mental health problems and referred to ALGEE skills. Whilst participants could not recall all of the skills they had learned, listening, providing empathy and offering information were cited as commonly used helping behaviours (Rodgers, Burns & Crawford, 2019). Participants also reported a change in their attitudes, with reduced stigma and avoidance of mental illness (Mendenhall, Jackson & Hase, 2013). Some trainees expressed improvements to their self-awareness and ability to manage their own mental health (Hung, Lam & Chow, 2019; Lucksted et al.). This reflection is in line with limited quantitative findings about training effects on participant mental health (Kitchener & Jorm, 2006).

With regard to barriers to using MHFA, few studies have addressed this issue. Ploper, Jones, Kraus, Schmidt and Corrigan (2015) found that participants were concerned about recalling their ALGEE skills and what do after administering this action plan. Individuals described difficulty helping people that they didn’t know, those of a different culture and those unwilling to accept help. Other research similarly identified others’ resistance and trainee discomfort as barriers to helping (Morawska, Fletcher, Pope, Heathwood, Anderson, & McAuliffe, 2013). Participants also expressed concerns about poor services to support MHFA. They were especially concerned about insufficient provision for low income and ethnic minority groups (Ploper et al.). Feedback on the training itself was generally positive, specifically regarding the use of real-life examples and good learning materials. The influence of the instructor on participants’ training experience was also highlighted. Similar to other findings, it was thought that the training was repetitive in places and there were conflicting opinions about the level and intensity at which the course was pitched (Morawska et al., 2013; Svensson et al., 2015). In this vein, Corrigan (2018) argued that MHFA is guilty of ‘education positivism’ or providing too much information.

MHFA research participants are often white, female, university educated professionals or students studying health-related subjects (Kitchener & Jorm, 2006; Rogers at al., 2019). This is in line with findings that mental health first aiders are predominantly educated white women.
of middle age. Women constitute 65-85% of MHFA trainees (Rossetto et al., 2018). Trainees frequently engage in MHFA for professional reasons, with many working in non-mental health professions that encounter people with mental health difficulties (Booth et al., 2017; Lucksted et al., 2015). Studies have identified an association between behaviour change and attending MHFA for work, whereby the work environment provides greater opportunity for implementing MHFA skills (Mendenhall et al., 2013; Morawska et al., 2013). Some participants stated that MHFA served more to reinforce their pre-existing understandings of mental illness, acting as a refresher and supporting previous attitudes (Svensson et al., 2015). Notwithstanding, the training’s usefulness has been echoed across participants. Those who participated for work reported using their MHFA skills in both personal and professional settings (Hung et al., 2019; Mendenhall et al., 2013).

Despite MHFA’s widespread dissemination and the findings presented above, Jorm & Ross (2018) acknowledge that there is limited evidence regarding training effects on public mental health outcomes. Richardson, Dale, Welby, McMillan and Churchill (2018) outline the deficiencies of the MHFA evidence base and put forward a protocol for comprehensive evaluation. This includes assessing the outcomes of MHFA recipients and gathering more detailed information about the implementation of MHFA skills. Most MHFA research continues to recommend further study into the long-term effects of MHFA and the nature and quality of MHFA helping behaviours (Morgan et al., 2018).

2.9 Current Study

The current study seeks to qualitatively explore the effects of MHFA training, particularly with regard to the nature and impact of helping for mental health problems. It also seeks to understand the long-term effects of MHFA by evaluating outcomes up to and beyond 12 months post-training. Previous research into MHFA training in Ireland found increases to trainee knowledge, confidence and competence around dealing with mental health problems, as well as improvements to trainees’ subjective well-being ( Shanahan, 2013). This research did not examine the quality or impact of actual helping behaviour, however. Similar to the wider literature, research within an Irish context has found poor mental health literacy and stigmatised attitudes towards mental illness among the general public (Byrne, Swords, & Nixon, 2015; Coyle, Lowry, Saunders, 2017). A converse relationship whereby greater mental health literacy was associated with negative attitudes towards mental illness was also identified (O’Keeffe et al., 2016). Irish studies have further highlighted the way in which structural inequalities and
discriminatory behaviour can maintain and be maintained by a focus on mental illness over mental health (Chambers, 2017; Coyle et al., 2017).

Lastly, as far as the present researcher is aware, there have been no prior studies examining MHFA in the context of discourses constructing mental health and their implications for MHFA outcomes. The present study will thus evaluate MHFA training in Ireland, using this critical lens to explore participants’ post-training experiences and helping behaviour.

More specifically, the current study poses the following research questions:

1. Since completing MHFA training, how useful have participants found the skills they learned?
2. Has completing MHFA training improved participants’ knowledge, attitudes and confidence with regard to dealing with mental health problems?
3. What factors are involved in the helping behaviour of MHFA trainees and how has MHFA training influenced this behaviour?
4. What can the experiences of MHFA trainees tell us about the nature and quality of MHFA helping behaviours?
5. What can the experiences of MHFA trainees tell us about the way in which discourses constructing mental health influence MHFA outcomes?
3 Chapter Three: Methodology

3.1 Chapter Introduction

The following chapter will firstly provide a rationale for adopting qualitative methodology to address the current research questions. It will then explain the reasoning behind using thematic analysis for examining the data collected. Ethical considerations and research procedures will be explained, and the study sample will be outlined. Finally, the process of thematic analysis will be described.

3.2 Positionality and Rationale for Qualitative Methodology

In addressing the research questions at hand, the present study is concerned with the experience and realities of MHFA trainees. It seeks to understand the ways in which MHFA training has influenced the helping behaviours of MHFAiders, how useful MHFA skills are in real-life settings and the impact of MHFA. Furthermore, the present enquiry looks to illuminate those factors effecting behaviour change around helping for mental health problems, with a particular focus on discourses constructing mental health. In doing so, this project seeks to provide a deeper and more contextual understanding of MHFA and its effectiveness. MHFA research to date operates under the assumption that mental health problems are measurable psychiatric disorders (Jorm, 2000). It therefore evaluates MHFA according to outcomes that correspond with such reductionist views of mental illness. This includes using narrow quantitative measures to assess mental health knowledge, attitudes and behaviours (Moll et al., 2017). Even qualitative studies of MHFA training have served to assess only the very specific themes set out within MHFA literature (e.g., Jorm, Kitchener & Mugford, 2005; Svensson et al., 2015).

In contrast, the current research adopts the stance that whilst mental health problems and related experiences are real phenomena, these phenomena are both individually experienced and socially constructed. This study will thus use an approach which recognises the full complexity of mental health problems and interventions attempting to address them. Qualitative research methods allow not only for rich description and deeper understanding of a topic but can also provide “a means to develop a context-rich description and understanding of phenomena” (Krahn & Putnam, 2003, p. 177). Likewise, qualitative approaches place value on gauging the individual experiences and interpretations of participants (Barker, Pistrang & Elliot, 2016).
By recognising the different levels at which mental health can be understood and experienced, the present research adopts a critical realist position. Critical realism acknowledges reality as it can be observed, but also recognises that such reality does not occur in isolation of individual interpretation or a wider context (Fletcher, 2017). The three levels of critical realist ontology are illustrated in Figure 5 by Fletcher (p.183). Critical realism suggests that, unlike purely positivist or constructionist positions, ontology cannot be reduced to epistemology and that there are several ways to understand reality. Given that the current study is particularly concerned with bringing to light the contextual factors influencing MHFA, the present approach could also be thought of as critical realist social constructionism (Harper, 2012). Harper (p.92) describes how this position looks to “go beyond the text” and to interpret data according to its “broader historical, cultural and social context”. Pilgrim and Bentall (1999) provide a thorough account of critical realism as applied to understandings of mental illness.

![Critical Realist Ontology](taken from Fletcher, 2017)

3.3 Thematic Analysis

Thematic analysis (TA), as proposed by Braun and Clarke (2006), was identified as the most appropriate means through which to examine the data for the current study. Unlike other methodologies, TA is designed to be independent of specific theory and epistemology and “is compatible with both essentialist and constructionist paradigms within psychology” (Braun & Clarke, p.78). TA thus provides a flexible approach through which to identify, examine and describe a data set, lending itself to the critical realist approach of the present study. In fact,
TA is often associated with a critical realist perspective and critical qualitative research (Braun & Clarke, 2019; 2014). TA is designed to deal with larger data sets and to address patterns of meaning across data (Braun & Clarke, 2006). Given its methodological flexibility, it can also simultaneously be used to analyse patterns beyond the surface level. Likewise, TA can be applied with several kinds of qualitative data (Joffe, 2012). The current research is concerned with providing an overall evaluation of MHFA, as well analysing training effects at multiple levels of understanding. A large sample size and different methods of data collection were therefore employed. There are examples of TA being used to effectively analyse similar data sets in the area of mental health (Murphy et al., 2017; Read, 2020).

As outlined, TA was deemed most suited to the positionality and research questions of the current study. Alternative qualitative methodologies were given due consideration, however. Other approaches were rejected due to their limited theoretical freedom and subsequent methodological constraints (Braun & Clarke, 2006). Interpretative Phenomenological Analysis (IPA) was deemed inappropriate due to its strictly phenomenological position, being more concerned with the idiographic experience of the individual (Smith, Flowers & Larkin, 2009). IPA is also more suited to small sample sizes and detailed interview data. Narrative Analysis (Reissman, 1993) was similarly rejected for its specific interest in the accounts of the individual participant. Grounded Theory (Glasser & Strauss, 1967) and its aim to produce a data-led theory of the subject was deemed unsuitable, as the current study is more interested in the impact of existing concepts. Content Analysis and other forms of coding reliability thematic analysis were rejected due to their positivist-oriented methodology (Boyatzis, 1998; Joffe & Yardley, 2004). Lastly, Discourse Analysis was judged to be inappropriate owing to its sole concern with language (Georgaca & Avdi, 2012). Whilst the present research is concerned with the function and construction of discourses around mental health, this is not the only aim of the project. It was therefore determined that critical TA would better allow for this aim to be addressed, whilst also fulfilling the other goals of the research (Braun & Clarke, 2012).

### 3.4 Ethical Considerations

Ethics approval for the current study was sought from the University of Limerick Education and Health Sciences Research Ethics Committee (Appendix A). Participants were fully informed of the nature of their participation and their right to withdraw from the study at any time (Appendix B). Respondents were also asked to provide informed consent by selecting this
option in the online survey and giving verbal informed consent prior to telephone interview (Appendix C). In line with General Data Protection Law (GDPR), participants were provided with a Research Privacy Notice (Appendix D) outlining how their information would be used and of their rights to withdraw and access their information. As further protection against data protection risks, a Data Protection Impact Assessment (DPIA) (Appendix E) was completed by the researcher and reviewed by Data Protection Officers at each the University of Limerick and MHFAI. Finally, the research project and its ethical considerations were reviewed by the board of management at Saint John of God Hospital which governs MHFAI (Appendix F). Understanding that distress may be caused by recalling experiences of MHFA and mental health problems, participants were fully debriefed following both the survey and interview and directed to mental health supports recommended by MHFAI (Appendix G).

3.5 Procedure

The current study was developed in collaboration with MHFA Ireland. Regular consultation with MHFAI, who deliver MHFA training and provided the research sample, was carried out throughout the design phase of the project. MHFAI’s approach to the research was further influenced by their governing organisation, Saint John of God Hospital Group. As a result, issues around ethical considerations, timelines and data protection law placed some constraints on the project. Most notably, this determined no face-to-face contact with participants. Data therefore had to be collected indirectly (online or over the telephone). MHFAI also provided input on the nature and content of survey and interview questions, including demographic items. Further information on the design process can be found in extracts from the researcher’s reflective memos (Appendix H).

Online questionnaires and telephone interviews had their merits for the purposes of the current study, providing ease of access to participants located around the country. This proved particularly useful when the onset of the Covid-19 pandemic occurred during data collection. The online survey had been completed prior to the pandemic; however, telephone interviews were conducted during lockdown and were facilitated by their remote nature. Utilising such indirect methods may also have led to a reduction in social desirability effects associated with questions about mental illness (Coppens et al., 2013; Henderson et al., 2012).
3.5.1 **Pilot Study**

During the design phase the survey and interview schedule were regularly piloted by 3-4 stakeholders at MHFAI, with several revisions made. The final online survey (Appendix I) was then piloted by 4 MHFAI staff in order to test for timing and ease of use. The telephone interview was piloted with one MHFAI staff member and changes made to interview questions in order to make them more open-ended (Appendix J). Given the number of participants who reported doing MHFA for work or professional development, a question addressing this area was added to the interview schedule. Details of revisions are documented in extracts from the researcher’s reflective memos (Appendix H).

3.5.2 **Mental Health First Aid Training**

All study participants had completed Standard MHFA training with MHFAI. Standard MHFA is a 2-day, 12-hour training that is delivered face-to-face with those aged 18 years and over. MHFA participants are taught about the signs and symptoms of mental disorders and evidence-based interventions for these problems. Participants are provided with knowledge on how to recognize mental health problems, how to offer initial support and how to direct a person towards professional help. They learn a five-step action plan ‘ALGEE’: Approach the person, assess and assist with any crisis, Listen non-judgmentally, Give support and information, Encourage the person to get appropriate professional help, and Encourage other supports (Kitchener et al., 2015). The sessions use a mixture of group work, video content, PowerPoint and group discussion to support participants’ learning. Courses are limited to 20 persons in order to maintain an optimal learning environment and are delivered by an MHFA approved trainer, who must have a background or experience in mental health. Participants are given a MHFA standard manual and a certificate of completion following the training. Some of the participants in the current study received Workplace MHFA training, which varies slightly from Standard MHFA in that it focuses on how MHFA skills can be applied in a workplace setting.

3.5.3 **Questionnaire**

An online questionnaire was developed using Qualtrics software. A direct link to the survey was embedded in an email and distributed to participants by MHFAI. The survey contained a volunteer information page, research privacy notice, consent page and debrief page (Appendices B, C, D and G), items gathering demographic and background information, and
qualitative questions about participants’ experience of MHFA (Appendix I). As part of their background, participants were asked about current or prior contact with people experiencing a mental health problem. Given that research has shown contact to have a significant effect on attitudes towards mental illness, it was thought such information would be useful (Maunder & White, 2019). Contact information was collected using items 1-4 of the Reported and Intended Behaviour Scale (RIBS) (Evans-Lacko et al., 2011). The RIBS is used to evaluate behaviour towards mental illness at the population level. It assesses behaviour across four domains: living with, working with, living nearby and continuing a close relationship with someone with a mental health problem. The first four items of the RIBS are designed to assess the prevalence of current or previous contact and are used as stand-alone items. Overall test–retest reliability of the RIBS is 0.75 (Lin’s concordance statistic). Overall internal consistency is 0.85 (Cronbach’s a).

As shown in Appendix I, participants were asked to provide qualitative details of their reasons for doing MHFA and their previous experience or training in mental health. They were also asked 3 open-ended questions, each allowing a maximum response of 200 words. The first question related to changes experienced as a result of MHFA training. A second open-ended question related to challenges in attempting to use MHFA skills. A final open-ended item offered room for participants to provide further comment. These questions were based upon the present research questions and items used in previous MHFA research (Jorm et al., 2005; Svensson et al., 2017). The aim of these items was to gain a greater overall understanding of trainees’ experience of MHFA and the factors influencing this. By using an anonymous online questionnaire, it was hoped to gather more concise information from a larger sample (Barker et al., 2016).

3.5.4 Telephone Interviews

Qualitative interviews are an established means through which to gauge participants’ experiences and to allow for a deeper examination of concepts being addressed (Kvale & Brinkmann, 2009). It was hoped that in-depth interviews would expand upon the questionnaire data, triangulating this information and comprehensively addressing the research questions at hand (Spencer & Ritchie, 2012). In order to attend to the current research questions, a semi-structured interview was utilised. Interview guides can help to generate open responses in relation to specific subjects (Kvale & Brinkmann, 2009). Such a format also allows for further probing of responses provided. The interview guide was again based upon the current research
questions and previous MHFA studies (Jorm et al., 2005; Svensson et al., 2015). Interviews covered three main topics: 1) Confidence dealing with mental health problems 2) Attitudes towards mental health problems and 3) Experience using MHFA skills (Appendix J). Within each section there was a series of probes designed to elicit or expand upon participants’ responses. There was also a fourth question allowing trainees to provide additional comment. As previously mentioned, questions and probes were adapted following pilot interview in order to ensure that they elicited more detailed and open responses (Barker et al., 2016).

Telephone interviews were conducted in a private room at the researcher’s home, as a consequence of Covid-19 restrictions. The researcher’s phone number was withheld, and participants’ telephone numbers were immediately deleted following interview. Interviews were recorded using a Dictaphone, having first received verbal permission from participants. Interviews lasted between 8-47 minutes (average 19 minutes). The researcher sought to be empathetic and non-judgemental throughout the interviews in order to build rapport and encourage trainees to freely express themselves (Barker et al., 2016). The researcher was also aware to avoid leading questions, to use the interview schedule flexibly and to adapt to participants’ responses. Lastly, as a psychologist in training, the researcher was conscious of the distinction between researcher and clinician; being careful not to step into a therapeutic role (Barker et al., 2016).

3.6 Participants

3.6.1 Questionnaire Participants

The online survey link was emailed to n=1373 MHFA participants by MHFAI. This sample comprised MHFA participants who undertook the training in the previous 18 months (approx.) up to end December 2019 and had given consent to be contacted for future evaluations of the course. The cohort was located across Ireland and was broadly made up of individuals from workplaces, community groups, voluntary organizations and other members of the general public. There were no exclusion criteria. By including individuals who had completed MHFA up to 12 months and beyond, it was hoped to gain greater insight into the long-term effects of the training, particularly with regard to helping behaviour. Previous MHFA studies found that helping encounters increased with time, suggesting that long-term trainees may offer greater insights into utilising MHFA and the quality of MHFA helping behaviours (Jorm et al., 2005). It is acknowledged, however, that such data does not address the need for robust quantitative investigation into long-term training effects.

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A total of 256 participants fully completed the online survey. The majority of respondents were female, university educated and aged between 31-59 (see Table 2 for sample characteristics). The majority of the sample stated that they had no previous training or professional experience in the area of mental health.

3.6.2 Interview Participants

Of those who completed the online survey, 46 individuals provided their number to be contacted for telephone interview. Attempts were made to contact all of this group, with a final total of 30 interview participants. The characteristics of the interview sample are also provided in Table 2. There were a higher proportion of males in the interview sample relative to the survey sample and a low representation of those aged 18-30. The interview sample reported slightly higher levels of previous experience in mental health and instances of using MHFA. Based on the differences between the survey and interview sample, it may be the case that the interview cohort were a more experienced group who had greater opportunity to apply their MHFA training. Such factors are worth considering when analysing and interpreting the interview data, as well as comparing this data to the survey sample. Qualitative details of interview participants’ reasons for doing MHFA and their previous training or experience are provided in Chapter 4 (Tables 4 and 5).
<table>
<thead>
<tr>
<th>Demographic Factor</th>
<th>Category</th>
<th>Frequency</th>
<th>Percentage</th>
<th>Demographic Factor</th>
<th>Category</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Male</td>
<td>69</td>
<td>27.49%</td>
<td>Gender</td>
<td>Male</td>
<td>12</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>179</td>
<td>71.31%</td>
<td></td>
<td>Female</td>
<td>18</td>
<td>60%</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>0</td>
<td>0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prefer not to say</td>
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<td>1.20%</td>
<td></td>
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<tr>
<td></td>
<td>(incomplete responses)</td>
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<td>1.56%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age Group</td>
<td>18-30</td>
<td>29</td>
<td>11.33%</td>
<td>Age Group</td>
<td>18-30</td>
<td>1</td>
<td>3.33%</td>
</tr>
<tr>
<td></td>
<td>31-44</td>
<td>115</td>
<td>44.92%</td>
<td></td>
<td>31-44</td>
<td>15</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>45-59</td>
<td>102</td>
<td>39.84%</td>
<td></td>
<td>45-59</td>
<td>12</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td>60+</td>
<td>10</td>
<td>3.91%</td>
<td></td>
<td>60+</td>
<td>2</td>
<td>6.67%</td>
</tr>
<tr>
<td>Highest Level of Education</td>
<td>School Education</td>
<td>17</td>
<td>6.64%</td>
<td>Highest Level of Education</td>
<td>School Education</td>
<td>1</td>
<td>3.33%</td>
</tr>
<tr>
<td></td>
<td>Professional Training</td>
<td>28</td>
<td>10.94%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diploma</td>
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<td>22.27%</td>
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<td>Diploma</td>
<td>9</td>
<td>30%</td>
</tr>
<tr>
<td></td>
<td>University Degree or above</td>
<td>152</td>
<td>59.38%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prefer not to say</td>
<td>2</td>
<td>0.78%</td>
<td></td>
<td>Prefer not to say</td>
<td>1</td>
<td>3.33%</td>
</tr>
</tbody>
</table>
Table 3. Survey and Interview Sample Characteristics

<table>
<thead>
<tr>
<th>Time Since Completion of Training</th>
<th>Survey Participants</th>
<th>Interview Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 3 months</td>
<td>46</td>
<td></td>
</tr>
<tr>
<td>3-6 months</td>
<td>78</td>
<td>3</td>
</tr>
<tr>
<td>6-9 months</td>
<td>28</td>
<td>13</td>
</tr>
<tr>
<td>9-12 months</td>
<td>52</td>
<td>3</td>
</tr>
<tr>
<td>&gt; 12 months</td>
<td>52</td>
<td>6</td>
</tr>
<tr>
<td>Time Since Completion of Training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 3 months</td>
<td>46</td>
<td></td>
</tr>
<tr>
<td>3-6 months</td>
<td>78</td>
<td>13</td>
</tr>
<tr>
<td>6-9 months</td>
<td>28</td>
<td>3</td>
</tr>
<tr>
<td>9-12 months</td>
<td>52</td>
<td>6</td>
</tr>
<tr>
<td>&gt; 12 months</td>
<td>52</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Previous Training or Professional Experience in Mental Health</th>
<th>Survey Participants</th>
<th>Interview Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>156</td>
<td>13</td>
</tr>
<tr>
<td>Some</td>
<td>83</td>
<td>13</td>
</tr>
<tr>
<td>A lot</td>
<td>17</td>
<td>4</td>
</tr>
<tr>
<td>Previous Training or Professional Experience in Mental Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>156</td>
<td>13</td>
</tr>
<tr>
<td>Some</td>
<td>83</td>
<td>13</td>
</tr>
<tr>
<td>A lot</td>
<td>17</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Use of MHFA skills since completing the training</th>
<th>Survey Participants</th>
<th>Interview Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>45</td>
<td>3</td>
</tr>
<tr>
<td>Sometimes</td>
<td>179</td>
<td>23</td>
</tr>
<tr>
<td>Frequently</td>
<td>31</td>
<td>4</td>
</tr>
<tr>
<td>(incomplete responses)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Use of MHFA skills since completing the training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not at all</td>
<td>45</td>
<td>3</td>
</tr>
<tr>
<td>Sometimes</td>
<td>179</td>
<td>23</td>
</tr>
<tr>
<td>Frequently</td>
<td>31</td>
<td>4</td>
</tr>
</tbody>
</table>
All participants were asked to provide quantitative reasons for doing MHFA training and could select more than one answer in response to this question. Reasons related to work or professional development was the most frequently selected option. Figure 6 illustrates participants’ reasons for doing MHFA training. Analysis of qualitative details provided in support of these reasons are presented in Chapter 4.

Figure 6. Participants’ Reasons for Doing MHFA Training

The entire sample were also asked about their current or previous contact with people experiencing a mental health problem as per items 1-4 on the RIBS (Evans-Lacko et al., 2011), with responses presented in Figure 7. As illustrated, the sample reported high levels of contact.
3.7 Thematic Analysis Process

Given the flexibility of TA, Braun & Clarke (2006) outline a number of important decisions before commencing data analysis. These decisions help to define the approach taken towards analysis. Whilst they remain flexible, making these choices explicit from the outset is an important part of the reflexive nature of TA (Braun & Clarke, 2019). As previously delineated, the current research adopted a critical realist stance towards understanding MHFA. It was therefore decided to investigate outcomes at different levels of understanding, paying particular attention to the subjective and socially constructed experience (Fletcher, 2017). The second decision was that, whilst the study does wish to explore overall patterns of meaning across the data, analysis will seek specifically to examine the topics set out by the research questions. The researcher will therefore employ a mostly deductive or ‘top-down’ approach to analysis, coding data for these pre-determined concepts (Braun & Clarke, 2006).

Lastly, analysis will be carried out at each the ‘semantic’ and the ‘latent’ level (Braun & Clarke, 2006; 2019). This is reflective of the researcher’s positionality and the area being studied. Data will be analysed for surface level themes around MHFA outcomes and experiences. It will also be analysed at the latent level in order to examine how discourses constructing mental health influence the data. The researcher will look to identify assumptions underlying MHFA outcomes, acknowledging that discourses both constitute and construct human experience.
(Sims-Schouten, Riley & Willig, 2007). More specifically, analysis will attempt to understand the impact of biomedical and psychosocial constructs of mental health on the outcomes of MHFA (Georgaca, 2014). Given the more prescriptive nature of the survey questions, survey data will be analysed mostly at the semantic level. For responses to these questions, themes will be deduced according to answers to specific items and adopt item terminology. In contrast, the more detailed and open answers obtained through individual interviews will allow for deeper analysis of underlying meanings and for some data-led theme production.

**Process**

Telephone interviews were transcribed verbatim by the researcher into a word document. Qualitative answers from the online questionnaire were downloaded and placed into individual documents. This data was separately uploaded to NVivo qualitative software. Computer software does not remove the position of the researcher from analysis, but makes it easier to code, group and keep track of data (Joffe, 2012). All qualitative data was then analysed using the six stages of Thematic Analysis outlined by Braun and Clarke (2006):

**Familiarisation and immersion:** The researcher familiarized themselves with the interview data by repeatedly listening to the audio of the interviews and then transcribing it verbatim. Transcripts were read and cross-checked for errors with the interview audio. They were then re-read for further immersion. In the case of the qualitative survey responses, the researcher read and re-read data collected from the qualitative items and open-ended questions. Initial analytic observations were noted during this process.

**Coding:** Interview transcripts were thoroughly coded, often using theory-led observations based on the research questions and concepts. Codes were named accordingly. The vocabulary of participants, as well as data-led observations were adopted when deemed a better fit. Sections of data were coded more than once if necessary. Data from qualitative survey items were coded separately and in a more deductive manner, mostly adopting question terminology.

**Identifying themes:** Following initial coding, themes were constructed by grouping and regrouping the data extracts. At the end of this stage, codes had been condensed into meaningful preliminary themes and sub-themes. All coded data extracts were integrated into a theme. Survey data was analysed separately, and survey items were each analysed for their own set of themes, which were more deductive in nature.
Revision of themes: The aim of this process was to ensure that the themes and sub-themes were representative of both the data set and the individual extracts within the theme. All data sets were reread and recoded using the themes that had been identified, reviewing the relationships between the extracts, themes, sub-themes and the entire data set.

Theme definition: The themes that had been decided were reviewed and refined once again with a view to creating concise and meaningful theme names and definitions. Greater consideration was given to interview themes which were more rigorously developed through deep engagement with the data. In contrast, survey themes tended to be predetermined by their associated questions and were more surface level in nature.

Reporting: The final step was to effectively report the thematic findings. This involved choosing the most pertinent extracts to represent and discuss themes, relating these findings back to the research aims and literature. More space was given to interview themes in order to deliver the detailed and meaningful analysis sought by the current research questions. Interviews themes and survey themes were reported separately, with greater emphasis on interview findings. Owing to the more concise and surface level answers elicited by survey items, this data was presented in a manner accordingly.

3.7.1 Reflexivity and Rigor

Braun and Clarke (2019) define their version of TA, also referred to as ‘reflexive’ TA, as organic, flexible and transparent. This form of TA views coding and theme development as an active and reflexive process between the researcher and the data, particularly when adopting a critical approach. The need for inter-rater reliability is refuted in this context, given that data analysis is viewed as something subjectively defined by the individual researcher (Braun & Clarke, 2014). Instead, the view is taken that:

“Quality reflexive TA is not about following procedures ‘correctly’ (or about ‘accurate’ and ‘reliable’ coding, or achieving consensus between coders), but about the researcher’s reflective and thoughtful engagement with their data and their reflexive and thoughtful engagement with the analytic process” (Braun & Clarke, 2019, p.594).

Using this framework, themes do not emerge from the data but are actively constructed by the researcher, using a reflexive process. Table 4 (Braun & Clarke, 2006) outlines the procedures for rigour that were followed by the current researcher. Thompson and Harper (2012) recognise
the importance of reflexivity in good qualitative research, stressing the need for both personal and epistemological reflexivity. The influence of the researcher’s personal position and the stance of current study were thus considered throughout the research process, particularly during analysis (Finlay & Gough, 2003). These considerations are logged in extracts from the researcher’s reflective diaries (Appendix H).

Table 3 Checklist of Criteria for Good TA (taken from Braun & Clarke, 2006)

<table>
<thead>
<tr>
<th>Process</th>
<th>No.</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transcription</td>
<td>1</td>
<td>The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for ‘accuracy’.</td>
</tr>
<tr>
<td>Coding</td>
<td>2</td>
<td>Each data item has been given equal attention in the coding process.</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Themes have not been generated from a few vivid examples (an anecdotal approach), but instead the coding process has been thorough, inclusive and comprehensive.</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>All relevant extracts for all each theme have been collated.</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>Themes have been checked against each other and back to the original data set.</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>Themes are internally coherent, consistent, and distinctive.</td>
</tr>
<tr>
<td>Analysis</td>
<td>7</td>
<td>Data have been analysed - interpreted, made sense of – rather than just paraphrased or described.</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>Analysis and data match each other - the extracts illustrate the analytic claims.</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>Analysis tells a convincing and well-organized story about the data and topic.</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>A good balance between analytic narrative and illustrative extracts is provided.</td>
</tr>
<tr>
<td>Overall</td>
<td>11</td>
<td>Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly.</td>
</tr>
<tr>
<td>Written report</td>
<td>12</td>
<td>The assumptions about, and specific approach to, thematic analysis are clearly explicated.</td>
</tr>
<tr>
<td></td>
<td>13</td>
<td>There is a good fit between what you claim you do, and what you show you have done – i.e., described method and reported analysis are consistent.</td>
</tr>
<tr>
<td></td>
<td>14</td>
<td>The language and concepts used in the report are consistent with the epistemological position of the analysis.</td>
</tr>
<tr>
<td></td>
<td>15</td>
<td>The researcher is positioned as active in the research process; themes do not just ‘emerge’.</td>
</tr>
</tbody>
</table>
4 Chapter Four: Results

4.1 Chapter Introduction

The following chapter presents the results from TA of the data collected for the current study. Given that the current project is interested in gaining an in-depth understanding of the experiences of MHFA trainees, a greater focus is placed on the findings from interviews with individual participants. It is hoped that these detailed accounts can offer deeper insight into the results of the broader survey data. This chapter thus contains two sections: the first presents the findings from analysis of the qualitative survey data and the second provides a more in-depth review of the results from TA of the interviews. Reflective boxes are used in both sections in order to give insight into the researcher’s decision-making process during analysis. Preliminary thematic maps, offering further evidence of the analysis process can be found in Appendix K.

4.2 Section 1: Questionnaire Findings

Findings from TA of survey data provides an overview of the experiences of MHFA trainees. Data is organised according to each online item, analysed separately. Analysis of participants’ qualitative details on each their reasons for doing MHFA training and their previous training or professional experience in mental health are presented first, followed by their responses to the 3 open-ended questions: Reasons for doing MHFA training; Previous training or experience in the area of Mental Health; Changes as a result of MHFA training; Challenges to using MHFA skills; Additional Comment. A description of themes is provided below, accompanied by illustrative thematic maps and text extracts. All extracts are taken directly from participants’ typed responses and are presented in italics. As answers were provided anonymously and participants could provide only 1 answer to each question, excerpts are not attached to an identifier. Whilst questionnaire analysis was mostly at the surface level, latent analysis of the overall survey data is presented at the end of this section. Additional text extracts in support of final themes can be found in Appendix L.

4.2.1 Reasons for doing MHFA training

Figure 8. illustrates the themes derived from trainees’ qualitative descriptions of their reasons for doing MHFA training. Overall responses were analysed using TA in order to develop a greater understanding of participants’ motivations for engaging in MHFA. Given the nature of
the question posed, themes are largely representative of the options that had been provided to participants.

Most participants stated work as their main reason for doing MHFA training. Respondents came from a wide range of sectors, from corporate settings to family resource centres. Many participants were self-motivated to complete MHFA and could see the value of the training for their professional role. This related to being able to support those that they came into contact with at work, both colleagues and clients.

*I am a rep on a vulnerable customer working group as part of my job in Financial Services and this course was a fantastic learning opportunity to support this.*

Respondents described coming across people with mental health problems in their work and a desire to be able to deal effectively with these issues. Non-mental health professionals whose work involved contact with people with mental health difficulties were common within the sample. The number of MHPs presenting in their work environment was also referred to by participants, with a subsequent need for them to develop skills in this area.

*As HR Manager I've come across employees with mental health issues. I wanted to be better educated and have a better understanding of how to support them and help them support themselves.*
Some respondents wrote specifically about a desire to help colleagues in distress. This was particularly the case for trainees in some form of management role. It also appeared to be part of a broader awareness of the stressors posed by the workplace and the commonplace nature of mental health struggles.

*I deal with a lot of new staff starting in my workplace and it’s overwhelming as they come to a new country, new culture and sometimes they find it hard to understand the situations. This can result in the staff giving up or getting stressed.*

Several participants reported that their engagement with the training was instigated by their organisation, who recognised a need for skill development in this area. For some, MHFA was used to upskill them for their professional role. Many trainees were also engaging as part of their company’s wider mental health and well-being strategy.

*As per MH agenda at work, we are training MH First Aiders across the business.*

Trainees expressed a desire to develop skills for addressing mental health problems. In particular, respondents described wanting to know how to help those experiencing a problem and how to spot the signs of mental illness. Some participants were looking for more specific skills, such as how to prevent suicide or handle a mental health crisis.

*I have come across suicide three times in my life. Most recently with a neighbour and previously with colleagues. I took this training to be able to recognise the signs of someone struggling with their mental health and to have the power to have that initial conversation with someone for early intervention.*

A number of respondents engaged in the training for reasons relating to roles in their local community. Similar to the workplace, responses here acknowledged the commonplace nature of mental health difficulties. Many community reasons referred to the mental health of young people, despite the fact that Standard MHFA training is not geared towards this age group. This may be explained by the fact that poor resources and high rates of mental health problems were also cited in relation to this cohort.

*I coach underage football and see on a day to day basis the pressures on young people and parents.*
A smaller number of trainees referred to personal reasons for doing the training. These participants either had direct lived experience of MHPs or indirect experience through others in their immediate environment. They expressed a desire to improve their knowledge and skills with regard to managing these experiences.

*On a personal level, I wanted to attend to learn how to handle certain situations that arise within my family around mental health.*

The final theme identified from analysis of participants’ reasons for doing MHFA was stigma and awareness. Challenging stigma and increasing awareness around mental health problems was cited as important among trainees. Participants stated a belief that current attitudes needed to be changed and expressed a desire to be part of this process.

*Part of a committee at work who tries to reduce stigma around mental health.*

### 4.2.2 Previous training or professional experience in mental health

As reported in Chapter 3, the majority of participants reported no previous professional experience or training in mental health. Those who did identify as having relevant training or experience provided qualitative descriptions of their backgrounds. Figure 9. illustrates the themes produced from analysis of trainees’ answers.

Figure 9 Participants' Previous Training or Experience in the Area of Mental Health
Most trainees who gave details had completed some form of suicide prevention or awareness training. For the most part, participants had done SafeTALK and ASIST courses provided by the HSE National Office for Suicide Prevention (NOSP). There were other suicide prevention and awareness courses that respondents had attended, such as “Mind our Men” training with suicide prevention charity Pieta House.

* * *

I have done ASIST and SafeTALK Suicide Awareness training, the HSE MindOut Programme training and some Mental Health First Aid sessions.

Respondents cited a range of professional experience which they deemed to be relevant to the area of mental health, from Life Coaching to Nursing. This experience often related to dealing with people in mental distress or intervening with mental health as part of their role.

* * *

I am a nurse. I have looked after patients with mental health who presented with medical problems. I have a large experience of looking after persons with mental health diagnosis, but I am not a mental health professional.

Several respondents reported having completed generic mental health and well-being courses, either through their work or out of personal interest. People cited training around specific skills or kinds of MHP, such as “Deliberate Self Harm” or “Addiction Studies”. Some participants had completed professional training or higher education in related fields of study. Trainees also had experience in the form of voluntary or community sector roles.

* * *

I trained as a social worker and did a masters in Family psychotherapy.

I have worked as a volunteer with Samaritans for many years.

There were reports of personal experience from some participants, having previously managed their own mental health problems or that of close others.

* * *

Spoken to mental health practitioners in relation to my own mental health in the past.

4.2.3 Changes as a result of MHFA training

Participants were asked to provide information about changes that they had experienced as a result of MHFA training. Specifically, respondents were asked to offer their thoughts on the following statement: “Research suggests that MHFA training can improve a person's
knowledge, confidence and ability to help those experiencing mental health difficulties”.

Figure 10 Thematic Map, Changes Experienced as a Result of MHFA

**ALGEE Skills**

The ALGEE action plan taught by MHFA featured prominently in participants’ responses to this question. Respondents broadly expressed changes in relation to: Approaching people experiencing a mental health problem; Recognising signs, Assessing and intervening with crises; Listening non-judgementally; Giving information and support; and Encouraging professional support and other supports.

*Most of all the skill to listen non-judgmentally. Not jump in and fix it, just allow the person to share their experience. Leave space for them to suggest what help they may need & only after this share the knowledge I have on other services available to them.*

Several people referred to skills around recognising and intervening with crisis situations, particularly the issue of suicide.

*Agree - good to get solid advice of what you should do/say and not be afraid to use the term suicide directly instead of "dancing" around the issues.*

**Confidence**

When speaking about changes achieved as a result of MHFA training, confidence was frequently referred to in participants’ narratives. Statements emphasised the role of knowledge
and skill development in improved confidence for helping with MHPs. Having the ALGEE framework for helping also appeared to increase confidence.

*With the MHFA training, I feel that I can offer a structured response, a process to follow, which helps my confidence.*

Participants’ narratives around confidence further revealed that they were comfortable in the knowledge that there were limitations to the help they could provide. Knowing that that they could encourage people towards professional help and other supports seemed to instil greater confidence.

*I feel more equipped to be in a position to offer support re the help a person might need. However, it is a situation which has to be handled sensitively. Important thing is for the person to get professional help.*

**Helping Behaviour**

Accounts of actual helping behaviour were also given in participants’ responses to this question. Trainees made reference to the fact they felt more equipped to intervene having done MHFA training and reported positive outcomes as result of their helping. Some cited that they had only recently completed training and so had little opportunity for helping.

*I have only had one incident since completing the course where I recognized that someone was having a mental health crisis and I was able to talk with them and guide them towards seeking support from Pieta House (which they did, and it was really successful).*

There were also some comments about the limitations to providing MHFA, such as when an individual does not want help or is reluctant to confide in the first aider.

*True but it can only help to recognise the signs, help can only go so far. The person has to want help and has to want to get better as well.*

**Understanding and Awareness**

Several respondents referred to the way in which MHFA had improved their awareness and understanding of mental health problems. Narratives here made a link between knowledge and
empathy, with increased knowledge leading to greater empathy and in some cases reduced stigma. Participants also referred to increased ability to recognise the signs of a mental health problem.

*Education is a key factor in understanding and breaking the stigma attached to mental health. The MHFA training covered areas of illness I had little knowledge or understanding of.*

4.2.4 **Challenges to using MHFA skills**

Trainees were asked to provide details about challenges they had encountered in attempting to use MHFA skills or help someone experiencing a MHP. Themes constructed from responses about challenges are illustrated in Figure 11.

![Figure 11 Thematic map, Challenges to using MHFA Skills](image)

**Confidence**

Confidence was referred to as a barrier and a facilitator when it came to the use of MHFA skills. For some, MHFA had helped them to overcome low confidence and made them more likely to intervene. For others, however, confidence remained a challenge. The need to practice or a lack of experience was a common narrative.

*Maybe a bit of uncertainty about if I was giving the right advice due to lack of experience.*
Pre-existing beliefs and external factors also appeared to influence trainees’ confidence to help someone in mental distress. Participants expressed a belief that broaching the issue of mental health was an inherently difficult task.

*It's not the most natural thing in the world to ask someone about their mental health...but that comes from the historical social stigma around mental health.*

**Help Not Taken**

People not accepting help was another challenge cited by respondents. Participants described individuals who were ‘unwilling’ either to accept a need for help or to seek professional help.

*The biggest challenge I have found with helping someone with mental ill-health is their own denial of the issue.*

Trainees’ narratives acknowledged some of the reasons why people might be reluctant to seek help, with stigma a prevalent concept.

*The only challenge I have found is in trying to get a friend to face that they needed professional help. Unfortunately, they had the common misconception that people with mental illness should be kept away from 'normal' people in case they are a risk to others.*

**Trust and Relationships**

Not unrelated to the previous theme, participants referred to the role of trust and relationships in being able to help others. Challenges around trust, familiarity and confidentiality were described within this theme. Close relationships were seen to both impede and facilitate helping, depending on the experience of the individual participant.

*In the workplace I think it is still very difficult to get colleagues to talk. Friends are easier as you have built trust over time.*

*It is harder to help people you are close to. It is hard to step back and not allow your fear/worry for them to take over rational mind.*
The environment in which help was taking place was also cited as effecting helping relationships. This particularly related to the workplace where issues such as culture, power relations and a lack of confidential space were described.

*Approaching someone who may be suffering from mental health is quite difficult in the workplace, especially if they are senior colleagues.*

**Training Limitations**

The limits of MHFA training were highlighted in participants’ narratives around challenges. For some, limitations related to difficulties remembering course material and a lack of opportunity to practice their skills. There were varied experiences depending on when people had completed training and their exposure to situations requiring intervention. A number of people wrote about referring back to their MHFA manual in order to seek guidance.

*The main challenge would be getting the initial experience to actually apply what I have learned.*

External factors, in particular poor resources and services for mental health, were also referenced as a limitation. Directing people to services with extensive waiting times was described as a notable challenge by trainees. Participants who had completed MHFA for work also cited resource issues such as insufficient time and support to implement their training.

*I think the biggest issue facing us today is the lack of resources available on a professional level.*

### 4.2.5 Additional Comment

The final survey question allowed participants to provide additional comment about their experience of MHFA training. The responses yielded here were broadly divided into two themes: *Positive Feedback* and *Mixed Feedback*.

**Positive Feedback**

Several respondents gave encouraging accounts of the training, highlighting positive experiences and recommending MHFA to others. A desire for the course to be more widely disseminated was expressed within these narratives. Participants wrote about knowledge
gained and stated that they had personally benefitted from doing the training. Comments also involved reflection on course delivery, with reference to skilled facilitators.

I am grateful for the skills MHFA has given me as it has helped me in my personal life as well as my professional career.

Some feedback described an affinity with the wider MHFA community. There were also examples of identification with MHFA concepts, whereby trainees adopted MHFA narratives through which to understand and describe their personal experiences.

I really enjoyed the training and am very happy to be part of the growing MHFA family.

Mixed Feedback

Mixed feedback involved trainees’ acknowledgment of the training’s strengths while simultaneously highlighting some of its shortcomings. Issues ranged from insufficient workplace supports to a need for ‘refresher’ training.

I think regular training annually or even more to keep up to date and to keep our confidence up would be useful.

Other responses referred to issues with the content and delivery of MHFA with recommendations around the information provided and the use of certain teaching methods, such as a desire for increased practical activities. Individual needs and preferences were expressed here, with varied ideas about the level at which the training should be pitched.

I feel, as I am not a Mental Health professional dealing with these issues regularly, the training was probably too in depth. Maybe a single day's training would be more relevant for professionals such as myself.

Reflective Box

The insights provided through participants’ responses to the survey surprised me. Trainees were quite candid in their answers and offered nuanced information about their experiences. The question about Challenges to using MHFA and the opportunity to provide Additional Comment gave greater insight into both the individual and external factors effecting trainees’ helping for MHPs. Although survey questions were designed to elicit more concise, surface level comments, depth of meaning could be witnessed throughout. It was therefore decided that a section dedicated to latent analysis of the data set would be useful.
4.2.6 **Latent Analysis of the Questionnaire Data**

Underlying assumptions in relation to mental health were identified throughout participants’ survey answers. Narratives could be seen to reflect the recognition of mental health problems in wider society. A medicalised language was present, demonstrating familiarity with diagnostic discourses around mental distress.

*Working with young people who experience suicidal ideation and engage in self injurious behaviours.*

Such discourses were evident in references to “*what to watch out for*” or the signs of mental health problems and the belief that mental health should be treated in a similar manner to physical health. This language is also part of MHFA dialogue about mental health and how to help people experiencing a problem. Accounts often involved the idea that mental distress requires professional help, with the trainees’ role being to direct people towards such supports. As mentioned, some trainees expressed identification with a medicalised understanding of their personal experiences.

*For me the training made me question my own mental health. As a result, I found myself recognising signs within myself and realised I was also suffering from anxiety and mild depression.*

National suicide prevention policy was reflected in participants’ references to SafeTALK and ASIST training. These courses were rolled out as part of the ‘Connecting for Life’ strategy to reduce suicide 2015-2020 (DoH, 2015). The number of mental health courses described were also in line with government policy to increase skills and awareness around MHPs (Government of Ireland, 2006). Previous experience reported by trainees demonstrated the varied approaches and kinds of help that people might access for mental health in this country, ranging from parenting support to psychiatric medication. It is also reflective of the array of narratives around mental health both in society and in a public health context.

There was evidence in participants’ accounts which depicted the normalisation and stigmatisation of mental health problems. Some people inadvertently referred to mental health difficulties in an ‘othering’ manner, whereas others endorsed normalising perspectives that they took from the training.
Importantly, the statistics and information shared helped me realise how prevalent mental health difficulties are and that really at the end of the day we are all the same.

The influence of socially constructed views was particularly apparent in trainees’ responses to the question about Challenges to using MHFA. Stigma around mental health problems could be witnessed, both in trainees’ explicit references and in the meanings underlying some of their comments. Stigmatized attitudes were discussed in the context of reluctance towards both help-seeking and help-giving for MHPs.

Same old story people do not want to accept the fact that they may be suffering from some level of mental health issues.

Responses also acknowledged the psychosocial factors involved in mental distress, with references to stress and trauma and their role in the prevalence of mental health issues. At a corporate level, it would appear that some organisations were attempting to change their culture around mental health, recognising the need for a more supportive approach.

Completed the course as part of an initiative to have MH Champions across the business to support our people and change the conversation surrounding MH in the workplace.

4.3 Section 2: Interview Findings

All interview participants completed the online survey prior to telephone interview. In order to provide further information about the characteristics of the interview sample and in support of interview themes, extracts from participants’ responses to the survey questions addressing ‘Reasons for doing MHFA’ and ‘Previous training or professional experience in mental health’ are presented in Tables 5 & 6 respectively (note: interview participants’ responses were also included in analysis of the survey data). The use of ellipses indicates the removal of superfluous text in order to provide a more precise account of trainees’ responses.
<table>
<thead>
<tr>
<th>Interview Participants’ Reasons for doing MHFA Training (Survey Responses)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am a rep on a vulnerable customer working group… I have also had experience of anxiety, panic attacks and depression so it was also for this reason I wanted to attend.</td>
</tr>
<tr>
<td>Work as a guidance counsellor and deal with students and staff with mental health needs.</td>
</tr>
<tr>
<td>Meeting clients daily who present with mental health issues or need urgent intervention.</td>
</tr>
<tr>
<td>I work in the 3rd level sector and wanted to have the standardized knowledge and resources to inform students regarding what mental health first aid is.</td>
</tr>
<tr>
<td>I am a member of the Consumer &amp; Carer Council in St. John of God. I was a patient at the hospital for 8 weeks…</td>
</tr>
<tr>
<td>Mental health problems in family and friends so wanted to learn more about it.</td>
</tr>
<tr>
<td>I am a Support Worker working with Participants with Mental Health Problems &amp; Mild Learning Difficulties. I did the Mental Health Training to up-skill.</td>
</tr>
<tr>
<td>I am a &quot;peer supporter&quot; in the Garda organisation and I knew this course would assist with my role.</td>
</tr>
<tr>
<td>This course was provided for us to do in work and appealed to me as I work in quite stressful environment. Also, I’ve personally had some tough life experiences I’ve had to face and felt this would be of a great benefit to my work and personal life.</td>
</tr>
<tr>
<td>I had a member of staff come to me struggling with mental health…I managed as best I could but felt that as a manager of a significant number of people that I needed to upskill in this area.</td>
</tr>
<tr>
<td>My company were keen to have Mental Health First Aiders trained up within the office.</td>
</tr>
<tr>
<td>I am an EAP in the company and it will be of help in work.</td>
</tr>
<tr>
<td>Completed as part of the Family Resource Centre Mental Health Promotions training.</td>
</tr>
<tr>
<td>Programme was initiated by our Company and I, as a people manager, was selected to attend.</td>
</tr>
<tr>
<td>Over 20 suicides in our area in Approx. 5 years</td>
</tr>
<tr>
<td>The company I work for wanted to introduce MHFAiders to the office in an effort to show they mental health is as important as physical health.</td>
</tr>
<tr>
<td>Working in the community meeting &amp; supporting residents I saw this as a great opportunity to gain knowledge &amp; skills to help me to identify residents showing signs of needing extra support…</td>
</tr>
<tr>
<td>I have family members who suffer from serious anxiety and depression &amp; I am also a volunteer in a youth group, so I thought it was important to educate myself further.</td>
</tr>
<tr>
<td>I would regard myself as an expert by experience needing to be hospitalised on six occasions with a diagnosed of Schizophrenia, Schizoaffective disorder and Bi-polar on the first three admissions.</td>
</tr>
</tbody>
</table>
Table 5 Interview participants’ Previous Training or Professional Experience in Mental Health

<table>
<thead>
<tr>
<th>Interview Participants’ Previous Training or Professional Experience in Mental Health (Survey Responses)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic work-related courses with regard to mental health and wellness.</td>
</tr>
<tr>
<td>In my general training as a guidance counsellor.</td>
</tr>
<tr>
<td>I am a mental health nurse, qualified 1985 and have worked in this area apart from brief departures all my life. I have also gone on to do further study in the area…I guess what is important is that I have never worked in crisis intervention where this training might most seamlessly transfer.</td>
</tr>
<tr>
<td>Safe Talk course and ASSIST course done. In addition, have completed diploma courses on Alison.com in the areas of mental health burnout and other mental health related issues.</td>
</tr>
<tr>
<td>Family Resource Centre Code of Practice in Suicide Prevention training. SafeTALK.</td>
</tr>
<tr>
<td>I teach a mindfulness and positive mental health program.</td>
</tr>
<tr>
<td>I have a Certificate in Counselling Skills and have completed a number of Mindfulness Courses.</td>
</tr>
<tr>
<td>I trained as a social worker and did a masters in Family psychotherapy. I have worked as a volunteer with Samaritans for many years. Presently my client group struggle with mental health problems and many also attend mainstream psychiatric and addiction services.</td>
</tr>
<tr>
<td>Assist /Dip in Social studies / Critical incident training/ deal with staff who are experiencing mental health issues on a regular basis.</td>
</tr>
<tr>
<td>Did a mental health short course in a centre I do voluntary work in.</td>
</tr>
<tr>
<td>Volunteered as a Samaritan for a couple of years.</td>
</tr>
<tr>
<td>Psychotherapy training.</td>
</tr>
<tr>
<td>Basic counselling training &amp; safeTALK.</td>
</tr>
<tr>
<td>ASSIST Training &amp; Safetalk.</td>
</tr>
<tr>
<td>ASSIST course.</td>
</tr>
</tbody>
</table>

Data from anonymous telephone interviews with 30 MHFA trainees was analysed collectively. TA produced 6 core themes and associated subthemes, illustrated in Figure 12. Subthemes were used to provide greater structure and to discuss specific elements of the large and complex themes within the data set. Given that analysis was carried out beyond the surface level, subthemes were also used to elucidate levels of meaning within the data. Illustrative quotes from participants’ narratives are provided in support of interview themes. Quotes are italicised. The use of ellipses indicates the removal of superfluous text in order to provide a more precise account of trainees’ experiences. Additional quotations in support of final themes can be found in Appendix L.
4.3.1 Overview of Findings

TA of interview data produced 6 core themes: Helping for Mental Health Problems; MHFA Narratives & Experiences; Resources & Services for Mental Health; Subjective Norms; Understandings of Mental Health; Covid-19. In constructing these themes, the researcher used the current research questions and their knowledge of the area as a guiding framework. The themes presented are thus reflective of the research questions posed and the concepts informing them.

Helping for Mental Health Problems describes participant experiences of helping people in mental distress and using their MHFA skills. This overarching concept is divided into 4 related subthemes: Helping Behaviour; Existing Skills & Experience; Perceived Behavioural Control; Boundaries & Self-care. These subthemes were viewed as requiring individual attention owing to their role in trainees’ experiences of helping for mental health problems and are discussed in more detail below.

MHFA Narratives and Experiences was derived from interpretation of participants’ discussion of their specific experiences of MHFA training and its impact upon them. Based around this central organising concept, 3 subthemes were used to provide further structure to understanding trainees’ MHFA experience: ALGEE Skills; Knowledge & Empathy; Teaching Methods.
Resources and Services for Mental Health provides a description of participants’ accounts of utilising professional support for mental health, as part of their overall experience of MHFA and the helping process. Interpretation of the data led to the construction of 2 connected subthemes which offer deeper insight into this overarching concept: Different Kinds of Help and Positive & Negative Experiences.

Subjective Norms discusses the impact of social norms in trainees’ discussion of attitudes and behaviour around mental health. This includes narratives around norms that impact upon both help-giving and help-seeking for mental health problems. TA led to the creation of 2 subthemes: Stigma and Social Support Systems. These subthemes describe in more detail the influence of subjective norms on the interpretation and application of MHFA.

Understandings of Mental Health is used to describe the discourses and meaning behind trainees’ understandings of mental health, along with the impact of these understandings. This theme is broadly divided into 2 subthemes: Biomedical Discourses and Psychosocial Discourses.

Covid-19 depicts the pandemic context during which interview data was collected. Participants spoke about the impact of the pandemic on both themselves and those they were helping, with examples of helping behaviour in response this experience.

4.3.2 Theme 1: Helping for Mental Health Problems

This first theme outlines participant experiences of helping for mental health problems. Four key subthemes were identified in relation to helping and are described in detail below. There is some overlap between subthemes, given their relationship to the overarching theme. Each theme, however, was deemed notable and of relevance to the research questions such that they required individual consideration.

Helping Behaviour

With regard to helping behaviours, all interview participants had some post-training experience of helping a person in mental distress. For some, help involved having a chat with a distressed colleague. For others, it took the form of assisting someone experiencing the onset or worsening of a mental health problem. The type of help given depended on the cases presenting to participants, which often related to their roles at work or in the community. Examples of
helping behaviour regularly involved the use of skills learned through MHFA training. Trainees’ detailed accounts can be used to examine the quality of their self-reported helping behaviours. Assessed through a MHFA lens, trainees described using the ALGEE skills outlined as best practice in MHFA training. Furthermore, MHFA guidance for specific problems such as psychosis and suicidal ideation can also be witnessed in participants’ accounts.

Participant 3 works in a community setting and gave an account of a helping experience in which she applied her MHFA training:

> Well one person produced to us where he had relocated, and we would support anyone who has an address in this area basically. He produced to me with severe anxiety and I knew there was something else there because he was saying he could hear voices, not necessarily voices, but he was saying there’s an awful lot of noise in his head and he wasn’t in control of his thoughts. That’s what he would produce saying to me. So, when I had a chance to sit back, I actually realised he had no services in place at all and so I contacted the Community Mental Health Team and I contacted Shine and asked them to meet with him.

Participant 20 describes by-proxy helping behaviour with a family member in a potential crisis situation:

> A very close family member, they had been showing signs of falling into a deep depression and someone close to them could see they were becoming very down. And you know, their mood had changed significantly. And they rang me and said look, ‘I'm really worried about him and I don't know what to do’. And I said, you need to go in and you need to ask him has he contemplated suicide? Has he got to that point where he's thinking of that? But they were like, ‘no I don't want to say that to him’. But I said you're not going to put that thought into his head if it's not already there. And I kind of learnt that from the course and I said, if anything, it will let you know where he’s at and we will know what type of help he needs... But it enabled us to realise what the level of severity was. So, I was able to get the contacts I have been given about the supports that are available and we made an appointment and he went to the GP and he did, he made a lot of changes and it seemed to help.
**Existing Skills and Experience**

Participants spoke about their existing skills and experience during their accounts of helping others. For some this involved personal knowledge gained through the experiences of friends or family members, or through their own lived experience. In fact, several participants identified themselves as having had some kind of mental health difficulty in the past and described using this understanding when helping others.

*I think it's being perceptive and just putting yourself back then and what did you want when you were in that situation kind of way. That's helpful.* (Participant 7)

Interviewees reflected upon how current or previous roles at work had given them skills and opportunities to intervene with mental health problems. This included a variety of professions such as HR, teaching, banking, psychotherapy and An Garda Síochána. They also referenced some training in mental health, often linked to their professional role. Participants identified the ways in which MHFA had reinforced their previous experience and training.

*I have a lot of experience. I'm 22 years in the guards so I've dealt with quite a lot over the years.* (Participant 16)

Narratives further addressed the ways in which MHFA training had augmented existing skills for helping with MHPs. Many trainees had previous knowledge and experience, however, MHFA added to this by providing a specific framework for helping.

*Again, a lot of stuff I would have kind of picked up through different bits and bobs over the years. I suppose by attending this training it kind of pulled it all together for me and put it in kind of a systematic approach rather than picking a little bit out of this and that, that I would have done over the years.* (Participant 1)

**Perceived Behavioural Control (PBC)**

The subtheme of perceived behavioural control (PBC) was constructed out of participants’ accounts of their confidence to help those experiencing a problem. Reflections addressed trainees’ perceptions about their capacity to deal effectively with people in mental distress. For many, MHFA training provided them with confidence and permission to intervene.
Trainees spoke, in particular, of greater belief in their ability to help with a mental health crisis. Learning that it is safe and appropriate to directly address the question of suicide / suicidal intent was referred to as important here.

Feeling they had the means to help encouraged participants to engage in helping behaviour. For some, confidence from previous experience had been reinforced by MHFA training. For others, the course had provided them with knowledge and a sense of competence for dealing with mental health issues.

Knowing what is expected of them, what good helping looks like and also the limits to their helping further enhanced participants perceived behavioural control.

Trainees also expressed that their confidence was lacking in certain areas. This seemed to relate to their own skills, but also to the situations that they might be faced with. For example, helping
strangers or people with “severe” MHPs. Trainees’ perceptions were affected by these seemingly unpredictable external factors, with fear playing a significant role.

_I hate to use the word but, around the more serious really severe mental health illnesses like some of the videos that we were shown. To be honest I felt well, if I had to deal with something like that, I would require more training._ (Participant 24)

**Boundaries and Self-Care**

The final subtheme within helping for mental health problems is around boundaries and self-care. Knowing their limitations and looking after themselves when helping others was viewed as important by trainees, a message reinforced by MHFA. Establishing boundaries in their helping relationships and engaging in self-care activities such as exercise and meditation were described in this context. Some participants spoke about instances whereby going beyond their limits or not practicing self-care had negatively impacted upon them.

_I suppose when you're dealing with mental health it's important to know what your limitations are. Because it's very easy to get sucked in and before you know it then you're swimming well out of your depth._ (Participant 4)

Participants further described experiences of recognising and dealing with their personal mental health needs, as a result of helping others. It seemed that MHFA training caused some trainees to reflect on their own mental health and to make changes in this regard.

_It's kind of made me, I suppose, recognise some things in myself that I need to look at and address for myself. To actually ask for help or not to be afraid to say, ‘actually do you know what, I'm not having a good day today’ as opposed to going ‘no I'm grand, I'm fine’._ (Participant 19)
4.3.3 Theme 2: MHFA Narratives & Experiences

Theme 2 specifically addresses participants’ experiences of MHFA and what they learned from the training. These narratives were divided into 3 subthemes: Knowledge & Empathy; ALGEE Skills; Teaching Methods.

Knowledge and Empathy

Trainees spoke about changes to their knowledge and empathy as a result of MHFA training. They articulated the way in which MHFA had improved their knowledge and understanding of mental health problems. A link between knowledge and empathy was described, whereupon increased understanding had led to greater empathy. Increased knowledge related to general knowledge about MHPs, but also to knowledge of specific experiences such as depression and anxiety.

*With the anxiety and depression, it definitely would have changed. I would definitely have more empathy towards them and in people I work with as well. Because I know it can be hard at work. You're like, you just want them to do a job. But I definitely would be more aware now of things going on.* (Participant 29)

Some participants explained how improved understanding had changed their approach with people experiencing mental health difficulties, resulting in more positive outcomes.

*Well I suppose prior to this, from a personal family situation, my patience may not have been as where they should have been and probably that was down to a lack of education on my behalf. However, I suppose the light has been shone on that for me personally and that has been the most beneficial part of the whole exercise.* (Participant 2)

When speaking about knowledge, trainees expressed that they had developed greater awareness of the “signs and symptoms” of mental health problems. They also referred to the importance of being able to recognise signs of MHPs in others. The language of diagnostic categories was used and MHFA narratives could be witnessed in participants’ accounts.
Basically, the signs to look out for would be (if it's somebody that you know) it's kind of there's been a change in their behaviour, how they’re dressing, their attitude to work and if they're not engaging really. (Participant 11)

**ALGEE Skills**

Participants referenced the various ALGEE skills in their narratives about MHFA. Listening, adopting a non-judgemental approach and signposting to relevant services were frequently cited. In particular, trainees spoke about the value of simply listening and providing empathy to someone in distress. Linked to the earlier subtheme of perceived behavioural control, trainees spoke about the value of having a “toolkit” or framework for helping and how this had improved their approach. Participants also reported improved skills with regard to assessing and assisting with a mental health crisis.

_Well the whole ethos is based around ALGEE. You know, so assess and seek to understand and be non-judgemental and all that. I use that kind of as the framework. And knowing that basically I'd be able to direct people towards services or direct them towards seeking supports. Whether it's professional support or family. Or whether it's GPs or then other support around that. I would be familiar with all of that._ (Participant 11)

Trainees’ accounts reflected a move towards MHFA understandings of MHPs and the idea that professional help is the gold standard of support. They expressed understanding that effective helping behaviour does not require “solving” a person’s problems, but instead directing them towards other supports.

_I suppose just with regard to the first aider point of view, you just being able to direct someone where to go as opposed to sort of you being almost a counsellor to them. Trying to separate those two things. Because you know you can't fix the problems that they're having you can only really direct them to get help._ (Participant 23)

**Teaching Methods**

Teaching methods featured prominently in participants’ accounts about their experience of the training. Reports highlighted the way in which the content and delivery of the training helped
to convey the MHFA philosophy. Particular mediums such as videos, role plays and the MHFA manual were referenced as helpful.

There was a lot of open discussion around different scenarios and how you might deal with them. So, you know, in that sense it was quite good. (Participant 4)

Some descriptions were given of course facilitators and their role in the participants’ experience of the training. Practical examples and facilitators with lived experience were valued by trainees.

The course was very well facilitated. I think that made a difference as well. Maybe what was relevant was the person acknowledged lived experience and that very much came through. (Participant 8)

There were also varied opinions when it came to some elements of the training. For some, the training proved problematic as it exposed them to experiences which they found distressing. For others, similar information was viewed as insightful and informative. Such diverse reactions convey the role of individual difference in how MHFA training is received.

I think was it the psychosis one, yeah gosh. I'll be honest with you...I actually found that quite overwhelming and it was a shock to me really. I had no idea. You know, I had read things about psychosis, but I really didn't know much about it...I think the suicidal part as well. I know some of us were a bit, after that particular day, we were kind of taken aback. We were a bit shocked you know. (Participant 7)

They did a great example of psychosis on the course where somebody was having a conversation and they have somebody else talking into their ear. You know, it was just a powerful demonstration. (Participant 10)

4.3.4 Theme 3: Resources and Services for Mental Health

Theme 3 discusses participants’ experiences with regard to resources and services available for mental health problems. Trainees referred to the different kinds of help available and gave accounts of positive & negative experiences with services. Participants’ accounts in this area often drew on their own personal experiences, as well as their experience of helping others.
Different Kinds of Help

Trainees’ dialogue around the kinds of help available once again highlighted the spectrum of interventions that can be used in support of mental health. Services mentioned included private counselling, community groups and psychiatry; whilst interventions ranged from mindfulness to in-patient care. The role of more preventative supports such as talking to a friend or getting regular exercise were also acknowledged. Participants described awareness of the range of supports available and understanding when such help is appropriate.

Some of those groups when we meet and talk that’s enough. But there’s a few that would just need some kind of external outside professional support, just to be able to talk. (Participant 9)

There were instances whereby participants referred to personal experience of accessing help for and managing their own mental health, discussing the kinds of intervention that worked for them.

I would have had a lot of stress obviously being a single parent and I would have never say taken a pill or went to the doctor to look for something like that. I would have always looked at exercise or stuff like that... (Participant 14)

Trainees’ discussion of the different kinds of help for MHPs showed an understanding of the process involved in accessing professional supports. Some trainees referenced how MHFA had provided them with this knoweldge. MHFA narratives can further be identified in participants’ accounts, with trainees following recommended steps to direct people towards professional help.

And the GP was brilliant. Spoke to him. Spoke to me. Did a referral then to the Department of psychiatry. And I think because I was able to say to her, look there's been x, y, z and I knew that these were the things that were ticking that box... (Participant 22)

Accounts also advocated for a greater range of services in response to mental distress, acknowledging that mental health is not a ‘one-size-fits-all’ experience and that supports currently available are often inappropriate or insufficient. A call for greater provisions to support mental well-being and protect against mental health problems was also expressed.
You know there's lots of other services around. Just like pieta house isn't the be all and end all in terms of suicide, the psychiatric unit isn't the be all and end all for people in a lot of distress. What we have to do is develop more options. (Participant 27)

**Positive and Negative Experiences**

Participants spoke about experiences of accessing mental health services for themselves or others. Personal accounts from individuals who had utilised services offered in-depth insights here. Descriptions conveyed positive experiences of professional support but also highlighted its shortcomings. Positive encounters involved services that were readily available, easy to access and provided a range of supports in response to a person’s needs. Negative encounters tended to fail in these respects.

*I found the psychiatric units can be very unreal kind of places and you're being observed all the time, you know. And really what's needed is a good relationship with staff, rather than observing all your abnormalities...* (Participant 27)

*I was able to go to my GP when things got bad and more recently say in the last 2 years was put on medication but then was put in touch with mental health services in Dublin and that was very accessible for me and you know it was life-changing really..* (Participant 23)

There was some contrast between the experiences of those who had accessed private compared to public mental health supports. Participants working in the corporate sector often gave reports of referring people to private services or workplace supports, with positive outcomes.

*I directed them for counselling...He went to look for help and he came back to me afterwards and thanked me for pointing that out to him. So, the advice aspect of it and introducing him to the professionals. He did go and speak to them and he got benefit from it and so I thought that was good. (Participant 2)*

There were several accounts of obstacles to accessing effective public mental health supports. Issues included long waiting times, navigation of complex systems and inappropriate services. Participants cited a need for improved services for children and young people, as well as other specific cohorts such as people with a dual diagnosis of addiction and mental health problem and those with an intellectual disability (ID) and co-morbid MHP. Trainees working or
volunteering in community settings referred to feeling under-resourced in their roles assisting people with mental health problems. Similar problems were expressed by some trainees in business settings.

They would go and try and access support from a mental health clinic or something like that and be put on a waiting list, where they really needed to be dealt with there and then... (Participant 1)

4.3.5 Theme 4: Subjective Norms

Theme 4 presents trainees’ narratives about the subjective norms influencing attitudes and behaviour around mental distress. Stigma and social support systems were viewed as significant in this context, with trainees’ illustrating the influence of these concepts on both help-giving and help-seeking for mental health problems. Overall, this theme highlights trainees’ perceptions of and need to comply with the expectations of others with regard to mental health. It also demonstrates the extent to which wider social norms impacted upon the interpretation and use of MHFA.

Stigma

The concept of stigma towards mental illness was referred to regularly. It appeared to be one of the most significant barriers that participants perceived in relation to providing help for MHPs. Accounts here referred to trainees’ own stigma about mental health, but also their experience of others’ attitudes towards mental illness and engaging in help. Explanations around others’ reluctance to seek or accept help for mental health problems were given, with discourses highlighting experiences of both public and self-stigma. Fear about the social consequences of being labelled as having a MHP was apparent.

I think a lot of it is fear and public ignorance. People don’t know and mental health is still a dirty word. It’s shocking how many people have such narrow perceptions of it...
(Participant 15)

Differences between males and females were addressed in this context, with males cited as being more reluctant to disclose mental health difficulties or seek help. Such reluctance was explained by the perception that it is not the norm for men to talk about their mental health and that disclosure may be seen as a sign of weakness. Similar references were made with regard
to disclosing mental health difficulties in the workplace, with a fear of being viewed as incapable. Some participants gave accounts of stigmatising experiences at work and in other settings.

*For your middle-aged guy or fellas my age, late 40s / 50s, there's still a bit of a stigma attached to going and trying to seek out help and support or even to admit that there is something wrong.* (Participant 4)

Some discourses illustrated stigma unconsciously in the way trainees spoke about or perceived MHPs. These unconscious attitudes were displayed by participants with and without personal experience of mental health problems.

*There's all different categories. And someone who just isn't feeling well and needs a bit of support, they don't want to see themselves as being mental- as having mental health...* (Participant 9)

There were instances where MHFA seemed to feed into stigmatising attitudes by reinforcing trainees’ perceptions of certain experiences as chronic, severe and outside of the norm. However, there were also reports from participants about how MHFA helped them to combat some of their own stigma towards mental illness and gave them the confidence to question others’ prejudices. Gaining a better understanding of MHPs and normalising these experiences was said to have helped in this respect.

*You would have seen people walking around the streets who were a bit demented and you would have thought, that's just crazy or whatever. And now you go, actually that person is having a psychotic break or is psychotic. You kind of realise it's not as terrifying once you know what it is.* (Participant 11)

**Social Support Systems**

In contrast to the previous subtheme on stigma, trainees referred to the importance of feeling socially supported when both seeking and providing help for mental health problems. Accounts were given whereby social support, or a lack thereof, influenced attitudes towards MHPs. Feeling validated and fully supported by peers was described as a facilitator to help-seeking and recovery. Conversely, feeling isolated and being treated differently as a result of disclosure were features of negative experiences. The effect of a supportive workplace culture was
illustrated in a number of examples, with the potential to either normalise or stigmatise mental health difficulties in this setting.

So, we’re very fortunate here that the leadership in this company are very much behind it. They preach that it is, you know, all about mental health and they’re very much about it and very much behind it. And no one would be, if they wanted to, blocked in coming forward or stigmatised... (Participant 10)

I work in nursing...both general and mental health and I don't know whether it's socially constructed or whatever, but there still is that reticence about disclosure of any mental health problem. (Participant 8)

Trainees gave examples of efforts to encourage a social support system for those in need, identifying the importance of this for helping with mental distress. Normalising and cultivating a feeling of shared experience was cited as key to building an effective support system. Participants also described ways in which a supportive help-giving culture had been fostered within their respective environments. Open conversations about mental health, peer groups for help-giving and practices that recognise and support mental health were referred to as successful strategies. Feeling equipped and well-resourced in their help-giving role was also seen as supportive by trainees.

I think a lot is to do with feeling judged by those around them. And definitely in groups where people would be open with each other and say, “you know what, actually I had a really bad anxiety attack at the weekend”. Somebody else will say “I have those” or “I have had those”. (Participant 22)

4.3.6 Theme 5: Understandings of Mental Health

Theme 5 addresses participants’ understandings of mental health and mental illness, examining the discourses and underlying meanings influencing these ideas. Understandings are broadly categorised into the subthemes of biomedical discourses and psychosocial discourses, analysing the implications of these narratives for the implementation of MHFA.
Biomedical Discourses

Biomedical discourses, or language which views mental health problems as a biological illness, was prevalent throughout participants’ narratives. MHPs were often referred to using diagnostic terms and as experiences that require professional or medical treatment.

At 22 or 23 they think they're fine and they come off their meds. People in their sixties do the same thing. They come off their meds and you're back to square one in a very short space of time. (Participant 17)

Such discourses are in line with MHFA dialogue about the nature of mental health problems and the ALGEE action plan for helping. As previously mentioned, a shift in trainees’ understandings towards a need to direct people towards professional help was also observed in their accounts.

The guidance is that you're directing them towards GP / medical help a lot of the time... (Participant 26)

Differences in meaning and understanding could also be seen according to type of diagnosis or ‘severity’ of MHP. ‘Less severe’ difficulties were viewed in a more normalising way. Experiences with labels such as schizophrenia or bipolar were referred to in a more pathologizing manner. Concepts such as perceived dangerousness, unpredictability and prognostic pessimism were evident in trainees’ discourses here. Behavioural consequences as a result of these attitudes were also described, mostly in form of avoidance towards disclosure, help-seeking and help-giving.

You're looking I suppose, within my job, at the impact on one's capability to perform. If you are disclosing, particularly a diagnosis of depression or a diagnosis of a psychotic disorder, I would definitely see that as a barrier... (Participant 8)

Underlying negative perceptions about diagnostic labels and medical treatment for mental health problems could be witnessed in participants’ stories. Fears about the chronic and severe nature of mental illness and associated treatments were evident in these accounts.

I engaged in CAMHS with my son a few years ago. He didn't engage with them at all. He had a questionnaire and he put down all the wrong answers...If he was to put down
the right answers, he said, he would have been institutionalized. They would have locked him up... (Participant 30)

The language of ‘labelling’ and the meaning that such labels held for people could be seen throughout the data. For some, having a language for MHPs was helpful. For others, labels appeared to be associated with a range of negative connotations.

...people are still lurking in the shadows. They're not able to kind of say I've got bipolar or I've got binge eating or I'm self-harming or have suicidal ideation... (Participant 6)

Just language around how people are feeling or there's a lot of conversation around medication, going to see a therapist. Just making mental health, I suppose, more accessible because you're hearing the words a lot more... (Participant 11)

**Psychosocial Discourses**

Psychosocial discourses were also present in trainees’ discussion. Narratives here recognised the role of psychosocial factors in the development and experience of mental health problems, constructing mental distress in a more normalising manner. At times, participants identified their own experiences of distress or reflected on how they too could experience a mental health difficulty. Those with lived experience and in community roles appeared to be more aware of psychosocial issues, however, those in corporate roles also showed understanding.

I was on a project for 9 months last year where I lost two people to long term mental health sick leave. I probably spent at least 3 days a week talking any number of people off the edge of a cliff with the project. Even my own mental health was quite screwed up... (Participant 18)

A range of factors including trauma, abuse, social disadvantage, relationship issues, financial problems and work stress were cited as potential reasons for developing a mental health problem.

Older women who would have suffered abuse, even domestic abuse, but just got on with it and you can see it affecting them now... (Participant 9)
There were references to ways in which MHFA training had helped to normalise MHPs and provide a better understanding of how mental health issues might develop. Conveying the role of trauma and stressors in the development of mental distress, as well as illustrating the way in which ‘normal’ people can experience mental illness were cited as important. Likewise, the ability to live a fulfilling life in spite of or following a mental health issue was also referred to as a significant learning.

*I can remember one of the videos showing how it was incremental, you know, it didn’t just happen in one day that somebody became very unwell. But there was a lead up to that and I remember a lot of people commenting on that...So, it helps people to understand that there is a context to all this. That there is a background and it made it less ‘madness’ and more understandable.* (Participant 8)

The need for more preventative intervention with regard to psychosocial issues was emphasised by some trainees, particularly those working in community settings. Several participants stated a requirement for greater supports for young people in this context. There were also references to optimism about recovery from mental health difficulties and endorsement of treatment or services that facilitate recovery. In contrast, other psychosocial narratives appeared to place blame and responsibility on the individual with regard to coping. In these cases, personal weakness was seen to explain distress in response to psychosocial stressors.

*We each have to get on with obstacles that are thrown our way... It's just how you deal with them and some are better dealing with them than others.* (Participant 14)

**Reflective Box**

I was struck by the similarities between the interview data and the findings from the survey questions. The more detailed accounts provided by interview participants often matched and expanded upon the answers given in the survey. I was also conscious of the extent to which the research questions and their guiding concepts shaped my interpretation of the data. By making this relationship explicit I hoped to facilitate a more reflexive and robust analysis. I was also intrigued by the prominence of interview participants’ understandings of mental health in their accounts. Whilst I had endeavoured to attend to underlying meanings throughout analysis, I felt that *Understandings of Mental Health* was a theme which required in-depth analysis in its own right. In relation to this topic, I was aware of my own bias towards psychosocial understandings and the potential to represent such understandings in a more favourable light. I therefore gave this due consideration, in particular during my interpretation and reporting of the findings.
4.3.7 Theme 6: Covid-19

The final theme from analysis of individual interviews addressed Covid-19. This theme reflects the pandemic context during which interview data was collected. Participants were aware of the way in which Covid-19 and associated factors were impacting both themselves and those they were helping. There were accounts of efforts to implement helping behaviours in this situation. Furthermore, it seemed that the pandemic had prompted increased incidence of trainees being approached for assistance.

"I suppose, a lot of people now are stressed and anxious at the minute you know. So, it's just trying to talk to them. Particularly from a work perspective, they're worried about what's going to happen in the longer term and I'm just trying to give them a bit of reassurance that at this stage..." (Participant 4)

Depending on their setting, trainees had different concerns. Those in corporate settings expressed challenges around issues such as working from home and job security. Those in community settings spoke about fears for the worsening of mental health problems and a loss of services. Increased anxiety was reported across both settings, however, with an underlying recognition that this was an understandable and shared reaction to the circumstances. There was also shared worry for vulnerable loved ones or those working on the front line, as well as for their own safety.

"I'm working from home at the moment so I'm trying to support them on the phone, but this thing does nothing for them now. With the fear and stuff around..." (Participant 3)

"Because everyone is working at home now for the minute and so we shifted the focus to how can we help people through this. Because you know people will get anxious, just in this whole scenario. If they're not getting anxious or worried at this time, then there's something wrong with them (laughs)." (Participant 10)
4.4 Summary of Findings

This chapter has outlined the findings of qualitative TA with data collected from MHFA trainees, with the purpose of understanding their post-training experiences and helping behaviour. These results provide a greater understanding of the extent to which MHFA training has changed trainees’ knowledge, attitudes and behaviour around mental health problems. In particular, 6 core interview themes offered in-depth insight into the nature and quality of trainees’ helping behaviours, along with the factors impacting this. Across both survey and interview findings, underlying discourses about mental health were examined in relation to their influence on MHFA outcomes. Issues including stigma and social support were identified to affect the understanding and use of MHFA skills. Other significant factors such as previous experience and resources to support MHFA were also described. Whilst MHFA was found to improve trainees’ confidence and helping behaviour, helping actions and their outcomes were clearly impacted by these individual and environmental factors. The following Chapter will discuss these findings in more detail and place them in the context of existing literature.
5 Chapter 5: Discussion

5.1 Chapter Introduction

The following chapter provides a critical discussion of key findings from the present study, placing them in the context of existing literature and highlighting the original contributions of the current research. Literature examined in Chapter Two will be discussed in relation to the principal outcomes of the study and the strengths and limitations of the present research will be considered. Implications and recommendations for clinical practice, policy, education and future research will be outlined. This will be followed by a critical reflection of the overall research process, including discussion of the researcher’s positionality. The chapter will conclude with a brief summary of the overall study.

5.2 Summary of Findings

The present research has provided an alternative lens through which to consider the effects of MHFA training, in particular the post-training experiences and helping behaviour of MHFA trainees. Individual interviews with trainees elicited detailed descriptions of help-giving actions and the factors that influence the application of MHFA skills. Alongside qualitative survey data these detailed accounts produced deeper insights into the changes produced by MHFA, specifically the quality and outcomes of MHFA helping behaviour. Qualitative investigation allowed for the impact of individual nuances in this context to emerge. A focus on discourses underlying trainees’ experience of MHFA elicited evidence of the contextual factors shaping MHFA outcomes.

The current study gathered information on trainees’ reasons for doing MHFA training, their previous experience in mental health, changes experienced as a result of MHFA, and challenges encountered in attempting to implement their training. Six main themes were formed subsequent to individual interviews with trainees: ‘Helping for Mental Health Problems’, ‘MHFA Narratives & Experiences’, ‘Resources & Services for Mental Health’, ‘Subjective Norms’, ‘Understandings of Mental Health’, and ‘Covid-19’. These themes and their associated subthemes illustrated how MHFA training improved trainees’ knowledge, confidence and skills for helping with MHPs. They also provided insight into trainees’ helping behaviour, highlighting the role of individual and external factors in determining the application and outcomes of MHFA. Discourses constructing participants’ understandings of
mental health, along with factors such as service provision and social norms, were found to impact MHFA effects.

With regard to the research questions and aims of the current study, the present findings have fulfilled the study’s aims to understand the utility of MHFA skills, to examine the influence of MHFA training on helping behaviour and other outcomes at up to and beyond 12 months post-training, and to explore how discourses constructing mental health impact MHFA effects. This research has also made preliminary steps towards addressing key gaps in the MHFA literature, as identified by MHFA International, namely: understanding the impact of MHFA in the workplace setting; evaluating MHFA effectiveness with recipients; and identifying which aspects of MHFA training have the greatest impact on MHFAider skills. Below is an overview of findings in relation to the current research questions. A more detailed discussion of each the survey and interview findings will follow.

*Research questions 1 and 2* queried how useful participants found MHFA skills and whether the training improved their knowledge, attitudes and confidence for dealing with mental health problems. Overall, trainees reported finding the training beneficial. Many trainees were non-mental health trained professionals who had engaged in the course for their professional role. They cited a need for MHFA training due to their exposure to mental health problems at work and described using their skills in these settings. The ALGEE framework, as well as specific tools to address suicide and other crisis situations were cited as particularly useful. Similar accounts were given by those using MHFA in personal settings. Participants described how changes to their knowledge of mental health problems and effective helping behaviours had improved their confidence to provide help to others. Greater empathy and improved attitudes towards people with mental health problems were also described, whereby normalising accounts and insights into lived experience were particularly enlightening.

Trainees further demonstrated the utility of MHFA skills by describing post-training instances of their helping behaviour. These descriptions simultaneously addressed *research questions 3 and 4 regarding the factors involved in trainees’ helping behaviour and the nature and quality of these behaviours*. Trainees mostly acted in line with the ALGEE framework and MHFA guidelines for specific presentations such as psychosis or suicidal ideation. They also referred to recognising different MHPs and using the skills of listening empathetically and directing people to professional supports. Many trainees engaged in helping as part of their professional role and cited this role as significant to their involvement and implementation of MHFA skills.
Professional roles and previous experience also provided trainees with an existing level of knowledge and confidence that was either enhanced or reaffirmed by MHFA training. It therefore appeared as though helping roles were as significant, if not more so, than time (since completion of training) with regard to opportunities to help others or practice MHFA.

Other factors found to impact helping behaviour were issues such as stigma, social support and mental health resources and services. Insufficient and inappropriate services, in particular, were identified as a barrier to the professional support advocated by MHFA thus hindering the MHFA process. Trainees and recipients who were better resourced, either in their workplace or community, appeared to experience better outcomes as a result of MHFA. Shared experience and cultures supportive of mental health were said to facilitate trainees in providing MHFA. There were similar descriptions of the benefits of supportive environments and relationships for individuals experiencing MHPs. The long-term nature of many trainees’ helping connections and their ability to follow-up with recipients, as well as the personal lived experience of some trainees, contributed to particularly useful insights with regard to the effectiveness of the MHFA helping pathway from start to endpoint.

Lastly, trainees identified stigma as a significant barrier to people accepting help and engaging in professional support for their mental health. Stigma was also evident in some trainees’ reasons for not helping others. These findings relate to research question 5 about the way in which discourses constructing mental health influence MHFA outcomes. Participants’ stories illustrated the ways different understandings of mental health can influence attitudes and behaviour towards help-giving and help-seeking for MHPs. Both biomedical and psychosocial explanations were referenced, with ideas of MHPs as chronic or dangerous often leading to prejudice and avoidance. Trainees discussed how MHFA had influenced their understandings and had both normalising and stigmatising effects. Social contact and prior experience were also found to influence participants’ perceptions of and behaviour towards MHPs. Together, these findings demonstrate the complex nature of discourses constructing mental health and highlight the limits to using knowledge to effect change in this area.

5.3 Questionnaire Findings

Survey findings identified a demographic similar to previous MHFA research. The majority of self-selecting respondents were female, university educated and aged between 31 and 59 years. This is in line with the profile of the average MHFA trainee (Rossetto et al., 2018). Similar to
previous reports, ‘Reasons related to work or professional development’ were the most commonly cited reasons for doing MHFA. Although previous studies were often carried out with those working or studying in health-related areas, details provided by this cohort indicated a variety of backgrounds ranging from the corporate sector to homelessness organisations (Rogers et al., 2019). A common thread among participants was exposure to mental health problems in their professional roles. This supports research by Booth et al. (2017) regarding training for non-mental health professionals who come into contact with people with mental ill-health. In the current study, training needs were commonly expressed among those from community-based roles such the disability sector and teaching. In corporate settings, mental health and well-being policies appeared to be the driving force behind engagement in the training.

The majority of survey participants reported no formal training or professional experience in mental health. For those who did deem themselves to have relevant training or experience, suicide prevention training was most commonly referenced. Exposure to mental health problems in professional or voluntary roles and training in support of these roles (e.g., WRAP training) was also cited. Professional experience ranged from HR to psychiatry training. Participants has also completed education or training in related areas such as social work, psychotherapy and addiction studies. These responses demonstrated the spectrum of interventions that can be applied with mental health, as well as the kinds of training promoted and delivered as part of the national mental health policy (Government of Ireland, 2006).

‘Personal reasons (e.g., for yourself, family or friends)’ and ‘Reasons for personal development’ were also cited by participants as reasons for doing the training. Trainees described their own experience of mental health problems, as well as that of others in their immediate environment. Previous MHFA studies have recorded similar experience among trainees (Jorm et al., 2005; Morowska et al., 2013). Current participants reported high levels of contact with people experiencing MHPs. This was highest in relation to friends or work colleagues. High incidence of current or previous contact was corroborated by participants’ qualitative descriptions of their background and experiences. Personal and professional reasons for engaging in MHFA have been linked to high contact in previous studies (Jorm et al., 2005; Lucksted et al., 2015). Given the retrospective nature of the current study, it must also be considered that increased recognition of mental health problems following MHFA training influenced participants’ reports of contact (Jorm et al., 2017).
In their comments about changes experienced as a result of the training, participants cited improvements in relation to the core MHFA outcomes of knowledge, attitudes and behaviour. Similar to previous qualitative and quantitative findings, the current trainees referred to increased knowledge in terms of their understanding and recognition of mental health problems (Svensson et al., 2015; Morgan et al., 2018). They also reported improved attitudes, describing how changes to their understanding had led to increased empathy and reduced stigma. Theories of stigma support the idea that greater knowledge can lead to improved attitudes towards mental illness (Corrigan, 2000). This cohort also described greater confidence to help a person in mental distress. The ALGEE framework was cited as contributing to this confidence, providing trainees with skills for helping. According to the theory of planned behaviour, the belief that one has the means to successfully carry out a behaviour (perceived behavioural control) increases the likelihood that this behaviour will occur (Azjen, 2002).

Eighty-two percent of survey participants reported using their MHFA skills post-training. Descriptions of help-giving further highlighted the ways in which participants felt equipped to help following the course. They outlined instances of recognising, approaching and intervening with MHPs, including crisis situations. Reports involved predominantly positive outcomes; however, trainees also provided details of challenges and limitations to using their MHFA skills. Akin to earlier studies, recipient resistance and inadequate services to support MHFA were cited by the current group (Ploper et al., 2015). Low confidence due to a lack of MHFA practice was also described. Previous MHFA research identified that helping encounters increased with time (Jorm et al., 2005). In the present study, trainees’ personal or professional contact with mental health problems was referred to as equally significant in providing opportunities and confidence for help-giving. Previous studies identified that past behaviour and confidence predicted future help-giving behaviour for MHPs (Mason et al., 2015; Rossetto et al., 2016).

Survey participants provided insights into the reasons why resistance to MHFA might occur. Denial of a mental health problem and reluctance to seek help were frequently attributed to stigma. This idea is supported by the existing literature on stigma and help-seeking (Clement et al., 2015). Participants also referred to their own stigma about approaching mental health issues, describing inherent challenges to addressing the subject. The relationship between help-giver and recipient was also cited as important. Similar to previous findings, trainees reported feeling less comfortable helping a stranger (Ploper et al., 2015; Rossetto et al., 2018). Lack of
trust and familiarity were further described as a barrier to engaging those in need of help, with research suggesting that people with MHPs are more likely to seek help from family and friends (Barnes et al., 2002). With regard to the training itself, trainees praised the course for its practical teaching methods, skilled facilitators and useful learning materials. Recommendations were made for increased practical activities, refresher training and tailoring courses to specific training needs. These insights are reflective of previous findings about trainees’ experience of MHFA courses (Svensson et al., 2015).

5.4 Interview Findings

5.4.1 Theme 1: Helping for Mental Health Problems

When probed, all interview participants had provided some form of help to someone in distress and used their MHFA skills. The nature and quality of the help provided, in most cases, could be seen to follow the ALGEE framework and MHFA guidelines for helping. These findings are supported by measures previously used to assess the helping behaviour of MHFA trainees (El-Den et al., 2018; Rossetto et al., 2018). MHFA guidance also provided interview participants with increased confidence to help, which corroborates the current survey findings and previous literature (Morgan et al., 2018). Viewed through a theory of planned behaviour lens, the current research demonstrates how confidence or perceived behavioural control can predict helping for mental health problems (Armitage & Conner, 2001). Trainees also referred to how MHFA had reinforced their existing knowledge and skills for helping. Previous research into helping behaviour for MHPs found that people who engage in help-giving tend to behave in line with ALGEE guidelines (Jorm, et al., 2005; Reavley et al., 2018).

Interview participants’ accounts further illustrated the influence of existing skills and experience on perceived behavioural control and helping behaviour. As outlined in Chapter 3, interview participants reported slightly higher instance of prior experience and using MHFA compared to the survey sample. Several interviewees were in professional or voluntary roles which involved exposure to MHPs (see Tables 5 & 6). Participants also had personal or family experience of mental health problems. In this context, their helping conveyed a sense of permission, responsibility or familiarity such that intervening was an automatic process. For instance, individuals in professions such as HR or An Garda Siochana described a sense of authority to provide help. Trainees also described feeling comfortable assisting those with whom they had close relationships. In corporate settings, individuals felt a sense of
responsibility associated with their organisation’s mental health policy and the adoption of a workplace ‘MHFAider’ role.

MHFA skills, combined with their personal or professional role, provided current trainees with a sense that they had the means to effectively engage in helping behaviour. Trainees’ environments also appeared to provide a context in which to implement MHFA. Azjen (2015) argued that, in order for a new behaviour to be adopted, the behavioural context must facilitate its implementation. This is supported by previous findings that people who completed MHFA for work were more likely to report behaviour change (Mendenhall et al., 2013). For those with less experience, however, MHFA was described as instilling a sense of confidence and permission to become involved. This is in line with existing findings that MHFA increases helping confidence and intentions and that these factors predict behaviour (Azjen, 1991; Morgan et al., 2018).

Boundaries and self-care were also described within current participants’ helping examples. Somewhat linked to perceived behavioural control, trainees spoke about the value of knowing the limits to their helping and the need to attend to self-care when helping others. Previous research found similar considerations among MHFAiders, with implications for the kind of help they provided (Rossetto et al., 2018). Instances of using MHFA to support their own mental health were also described by trainees. Existing research found MHFA to increase self-awareness and provide MHFAiders with skills to manage difficulties encountered in their own lives (Hung et al., 2019; Lucksted et al., 2015).

5.4.2 Theme 2: MHFA narratives and experiences

Interview participants’ discussion of MHFA training reiterated the current survey findings. Trainees referenced the various ALGEE skills and how they had supported their help-giving. In line with previous reports, listening non-judgementally and encouraging access to other supports were commonly utilised skills (Rogers et al., 2019; Rossetto et al., 2014b). Crisis intervention skills were also valued by trainees, as was MHFA’s impact on their ability to recognise signs of specific mental health problems. Overall increases in knowledge and empathy were outlined, with greater understanding of problems leading to improved behaviour towards people with MHPs. Improvements in empathy and relationships with people experiencing mental health problems were outlined in previous MHFA studies (Jorm et al., 2005; Lucksted et al., 2015).
MHFA teaching methods were cited as contributing to participants’ changes, whereby role plays, videos and practical examples had the most impact. The MHFA training manual was also described as a useful resource, often employed as an aide-memoire. Course facilitators with lived or practical experience of dealing with mental health issues were highly regarded. It has previously been proposed that MHFA training should place greater emphasis on practical teaching methods and the involvement of those with lived experience (Corrigan, 2018). The current survey and interview cohort expressed a desire for MHFA to be more widely disseminated and for ‘refresher’ training to made available, which has been echoed in previous research (Svensson et al., 2015).

Whilst MHFA was praised overall, there was some mixed feedback. This related to the level and intensity at which the course was pitched, a challenge identified in prior studies (Ploper et al., 2015). Current participants displayed differences of opinion with regard to some of the content and information shared on the course. This varied according to individual need and perception. There were accounts of trainees feeling overwhelmed by course content and expressing shock or fright at certain scenarios presented to them. This was particularly the case for ‘crisis’ situations such as psychosis or suicidal ideation, whereby people had not previously encountered this kind of experience.

Critical mental health commentators would argue that MHFA training feeds into stigma towards mental health problems by framing them from a biomedical perspective. The experiences described above could be seen to support this idea, with participants expressing fear and avoidance in relation to the severity and unpredictability of problems such as schizophrenia. Previous research has found biomedical explanations to increase stigma in the form of perceived dangerousness, unpredictability, and pessimism about recovery (Kvaale et al., 2013). Critical commentators would further argue that MHFA narratives of recognising, labelling and pathologizing mental health problems are thus experienced as unhelpful in this context (DeFehr, 2016). It has also been suggested that there are a range of individual factors involved in a person’s perception of mental health and their subsequent help-seeking or help-giving behaviour (Clement et al., 2015; Rossetto et al., 2018).

5.4.3 Theme 3: Resources and services for mental health

An area that has received less attention within the existing MHFA literature is resources and services to support MHFA. Whilst previous research has looked at the outcomes of MHFA, it
has tended to limit its focus to trainees’ recall of specific helping interactions (Rossetto et al., 2018; Svensson et al., 2015). Given that a significant aspect of MHFA is to encourage a person towards professional or other supports, it is important that the outcomes of seeking or engaging in such support are understood. A study by Ploper et al. (2015) identified that MHFA trainees were concerned about insufficient resources when referring a person for professional help, in particular minority or disadvantaged individuals. Long waiting times, low staffing, and poor-quality services were highlighted as issues.

Insufficient services to support MHFA were cited as a challenge within both the survey and interview findings from the current study. Many helping examples involved trainees directing people towards professional supports and sometimes assisting them to access these supports. Trainees cited feeling under-resourced in their help-giving roles, particularly those working in community settings. The current cohort often had ongoing contact with those they had helped and could therefore provide information on the longer-term outcomes of this intervention. In addition, some participants had personal experience of mental health problems either through themselves or loved ones. These individuals had utilised the mental health services to which they were directing others and provided details of the same.

Common issues were long waiting times, inappropriate treatment, poorly coordinated services and insufficient resources. Certain cohorts were referenced as particularly under-resourced. A lack of quality acute care and alternatives to psychiatric treatment were also highlighted. There were, however, accounts of positive experiences of using professional services. Such experiences were facilitated by well-resourced localities and knowing the steps required to access help. Differences were identified between those using public mental health services and those availing of private supports, with the later reporting more positive encounters. Trainees also described how MHFA training had given them greater awareness of supports available, and when and how to utilise them. The kinds of structural barriers outlined have widely been identified as contributing to the mental health treatment gap (Meadows et al., 2019; Thornicroft, 2008).

From a critical perspective, it is argued that MHFA feeds into inappropriate services (Chambers, 2017; DeFehr, 2016). Part of this argument is that alternative models of care are prevented by the biomedical labelling and treatment of mental health problems. It is also argued that MHFA feeds into neoliberal policies of individualising and pathologizing MHPs at the expense of addressing the social, economic and political inequalities underlying these
experiences (Spandler & Calton, 2009; Link & Phelan, 2001). Participants in the current study called for increased provision to prevent MHPs and more varied treatment options. There is evidence to suggest that a focus on mental illness and psychiatric care is occurring at the expense of promoting and improving mental health (Jorm et al., 2017; Meadows et al., 2019). Furthermore, the deficiencies in mental health services described in the current study are in line with findings from global and national assessments of mental health provision (WHO, 2013).

5.4.4 Theme 4: Subjective norms

This theme was constructed around trainees’ beliefs about the mental health norms in their environment and their desire to conform to these ideas. According to the theory of planned behaviour, is more likely to occur if it is considered in line with the expectations of an individual’s social network (Azjen, 1991). Trainees referred to the influence of stigma when discussing reluctance to accept help for mental health problems. They expressed a belief that mental health is stigmatised in Irish society and that people fear the social consequences of being labelled mentally ill. This was particularly the case for contexts such as the workplace or among males, whereby stigma was perceived to be more pronounced. Such accounts are supported by literature on public-stigma, self-stigma and their implications for help-seeking and disclosure of MHPs (Clement et al., 2015; Evans-Lacko et al., 2012).

Participants described their own experiences of having witnessed or been subjected to stigma in their social environments. Many examples were in the workplace, with discrimination following disclosure of mental health difficulties. At times, participants themselves displayed stigma in their narratives. They made attempts to distance themselves from more ‘severe’ mental illness and expressed prejudice towards experiences that did not match their norms or values. Trainees also reflected on how MHFA had made them aware of their prejudices, providing them with greater insight. These findings are in line with existing research on mental illness stigma and stigma-reduction interventions (Thornicroft et al., 2016).

In some cases, MHFA appeared to reinforce stigma and ‘othering’ of people with mental health difficulties, especially when these difficulties were perceived as chronic, severe and outside of the norm (Link & Phelan, 2001). These narratives add to arguments about the stigmatising effects of biomedical perspectives. They also support evidence that improved public mental health literacy has failed to reduce stigma towards people with MHPs (Schomerus et al., 2012).
MHFA research has identified only small effects on personal stigma and desire for social distance (Malowski et al., 2019; Morgan et al., 2018). There are also reports that mental health literacy training has little impact on perceived social stigma i.e. beliefs about others’ attitudes towards mental illness (Bond et al., 2016; Coppens et al., 2013). For the current cohort, it appears that these beliefs were mostly influenced by direct exposure to stigma in society.

Opposite to the concept of stigma, participants explained the perception that feeling supported and having one’s experience validated improved help-seeking and recovery from mental health issues. They also described promoting social support systems in their help-giving roles. Peer support groups and shared experience were particularly effective in this context. Participants in both corporate and community settings referred to the significance of a culture that values and supports mental health, including the MHFA process. Existing evidence attests to the role of social support in help-seeking and recovery from mental illness (Muldoon et al., 2019; Nasser & Overholser, 2005). There is also evidence for the importance of stigma-reduction in cultivating a supportive workplace and of a need to support those in help-giving roles (Hanisch et al., 2016; Hung et al., 2019).

Finally, there is evidence that social contact is most effective at reducing stigma towards people with MHPs (Maunder & White, 2019). The current cohort reported high levels of contact and the value of this can be seen in their narratives. Interestingly, participants who expressed stigmatised views towards people with severe mental illness reported having had no previous contact with such experiences. See Change, an Irish stigma reduction campaign, highlights the limits to using knowledge and attitudes to achieve behaviour change towards mental health problems (Coyle et al., 2017). This campaign advocates social justice models of stigma-reduction, emphasising social contact theory and steps that directly tackle discrimination and social inequality towards people with MHPs (Link & Phelan, 2001; Stuart, 2016).

5.4.5 **Theme 5: Understandings of mental health**

Biomedical language was frequently used by participants in relation to their understandings of mental health. This included labelling mental health difficulties using diagnostic terms and describing the ‘signs and symptoms’ that aid in this categorisation. The recognition of mental disorders is a core element of MHFA training, with participants’ accounts often reflecting MHFA narratives (Kitchener & Jorm, 2002). Trainees also demonstrated an understanding that
mental illness is best treated by professionals, using MHFA guidelines to direct people into the medical system via their GP.

In understanding mental health issues from a biomedical perspective, participants referred to ‘mild’ and ‘severe’ problems whereby severe problems (e.g. major depression, schizophrenia) were viewed as more pathological in nature. Stigmatised attitudes including perceived dangerousness, unpredictability and prognostic pessimism were associated with such problems. Stigmatised behaviours of avoidance and desire for social distance were also described. These findings corroborate existing evidence on the impact of biomedical understandings and public stigma towards specific mental health issues (Longden & Read, 2017; Schomerus et al., 2012). From a theory of planned behaviour perspective, these understandings can be seen to influence attitudes such that a fear of negative consequences leads to avoidance of helping behaviour (Azjen, 1991). Biomedical narratives were similarly associated with stigma towards help-seeking, as discussed earlier. This was not always trainees’ experience, however, with previous research indicating that mental health literacy interventions can reduce treatment stigma and increase help-seeking behaviour (Picco et al., 2018; Rüsch et al., 2012).

Trainees’ dialogues also featured psychosocial understandings of mental health problems. Participants referred to the various social, psychological and environmental factors involved in the onset and experience of mental health problems. Some trainees described how MHFA had given them insight into the psychosocial factors involved in mental illness and had a normalising effect on their understanding. Research supports the significant role of psychosocial factors in the development and experience of MHPs (WHO, 2015). This study’s findings are in line with existing evidence for the role of psychosocial explanations in reducing public stigma towards people with mental health problems (Kvaale et al., 2013; Longden & Read, 2017). There is also evidence to suggest that the general public and people with MHPs prefer such understandings (Tay et al., 2018). Current participants often used psychosocial causal explanations when providing accounts of mental health problems, particularly when describing their own lived experience.

Psychosocial understandings have been linked to more positive outcomes for people with mental health conditions, improving both their own and others’ attitudes towards their experiences (Rüsch et al., 2005). One caveat to psychosocial understandings is their potential to increase blame and attributions of personal ‘weakness’. Such attitudes were present in some
of the present cohort’s narratives. Attribution theory suggests that biogenetic explanations reduce blame towards people with mental health problems (Weiner et al., 1988). As outlined, however, such ‘genetic essentialist’ perspectives have also been found to provoke prognostic pessimism and fear towards mental illness, with important implications for the outcomes of people with MHPs (Larkings & Brown, 2018). The complexities outlined here lend support to interventions which instead focus on the behavioural outcomes of stigma, thus facilitating the conditions through which real understanding and attitude change can occur (Stangl et al., 2019; Stuart, 2016).

5.4.6 Theme 6: Covid-19

Telephone interviews took place in March 2020, during the first wave of the Covid-19 virus and the introduction of ‘lockdown’ measures. These issues were therefore at the forefront of many participants’ experiences. Participants referred to the impact of the pandemic in relation to their personal and professional lives, acknowledging the effect of the virus on both their own and others’ well-being. There were personal concerns about safety, financial and job security, and problems with working from home. These concerns were shared by individuals whom MHFAiders were supporting, particularly colleagues in corporate settings. Participants working in the community expressed concerns about issues such as the worsening of MHPs, loss of services and inappropriate living situations for their clients. Across both settings, trainees reported increased incidence of being approached for help in response to the pandemic.

The experiences described here have been echoed by preliminary research into the mental health impacts of the pandemic and previous research on similar public health emergencies (Javed et al., 2020). Covid-19 and its consequences have resulted in society being faced with the kinds of psychosocial stressors known to cause mental distress. MHFAiders expressed an awareness of this and gave examples of using their MHFA skills to support those around them. This helping behaviour could also be seen to model Psychological First Aid (PFA) or disaster mental health training (Vernberg et al., 2008). PFA has been employed during Covid-19 in an attempt to minimise the psychological impact of the pandemic. PFA acknowledges a person’s psychosocial trauma and seeks to intervene by providing connection, practical assistance, safety, social supports and other help known to protect against the impact of traumatic events (Muldoon et al., 2019). Many of the techniques involved in PFA are similar to MHFA, however, PFA recognises a person’s distress as a normal and shared response to an abnormal experience. In keeping with this narrative, participants in the current study recognised the
common reaction to Covid-19 and looked to validate and support this. It has been argued that MHFA should adopt an approach more in line with PFA, particularly in response to Covid-19 (Mei & McGorry, 2020).

5.5 Strengths and Limitations

The main strength of the current study is the lens through which it has examined MHFA. Unlike the majority of previous MHFA research, the present study was carried out by an individual with no connection to or vested interest in MHFA. MHFA research to date has largely been conducted by those involved in the development and delivery of the training (Jorm & Ross, 2018; Mei & McGorry, 2020). Secondly, the philosophical lens used by the current researcher is in contrast to existing MHFA studies. Ontologically, this study adopted a critical realist stance through which to analyse MHFA, acknowledging the complex nature of mental health-related experiences. Epistemologically, the current research sought to understand MHFA predominantly through the experience of individual trainees and their social context. Existing MHFA evaluations have mostly assumed a positivist approach, examining only specific, quantifiable outcomes seated in a medical essentialist framework (DeFehr, 2016; Morgan et al., 2018).

By adopting the above approach, the current researcher was able to examine MHFA from a critical angle and offer a perspective otherwise lacking in the literature. This study delivered a more comprehensive understanding of MHFA training and the individual and contextual factors impacting its outcomes. Conducting in-depth interviews with trainees and examining the discourses underlying their experiences facilitated this process. In line with a critical realist approach, the present study triangulated its findings by also assessing basic quantitative and qualitative MHFA outcomes with a larger cohort. Together, the survey and interview data provided a more robust set of findings. The size and characteristics of both the survey and interview samples, when compared with previous MHFA samples, is a representative cohort and possible strength of the current study.

Utilising Braun and Clarke’s (2006) ‘reflexive’ thematic analysis also aided the analytical approach of the current research. This allowed for analysis of both surface level MHFA concepts, as well as the underlying meaning of these ideas and their impact on behaviour. Remaining reflexive and aware of the researcher’s role in producing codes and themes was particularly useful and important, given the largely deductive nature of analysis. Ensuring that
codes, themes and theme definitions were truly reflective of the data set was difficult but essential, as was selecting quotes that most accurately represented themes. Applying TA with the two different data sets was a challenge, given the concise and prescriptive nature of the survey items relative to the more detailed individual interviews. The way in which TA provided the flexibility to adapt to this diverse data, however, was viewed as a strength of the current study.

Previously identified as an area requiring further research, the present findings delivered detailed insight into the actual helping behaviours of MHFA trainees. Moreover, the current cohort provided accounts of the ongoing outcomes of their helping behaviour. This generated information on the resources and services in support of MHFA and the complete MHFA process. Such information has largely been absent from previous MHFA studies (Richardson et al., 2018). Adding to this, some participants had personally availed of services to which MHFA directs people and were able to provide insight into these experiences. The current study also included those that had completed the training up to and beyond 12 months prior to data collection, allowing for examination of longer term MHFA outcomes. It would appear that the current study benefitted from participants’ opportunity to reflect on the use of MHFA in the long-term, providing insights into the ongoing outcomes of their helping relationships.

Lastly, the extent to which the theory of planned behaviour can fully explain the complex individual and environmental factors involved in MHFA outcomes could be questioned. Many of the current findings do readily map onto TPB concepts, however, with attitudes, subjective norms and perceived behavioural control often providing accurate explanations for trainees’ experiences. A particular strength of the TPB in relation to the current study, is the delineation of implementation processes relative to motivational processes (Azjen, 2015). Implementation processes account, at a very basic level, for some of the barriers and facilitators identified in the current study, whereby factors such as professional role and social support enabled the implementation of help-giving intentions. In contrast, factors such as stigma and poor resources were found to act as barriers to one’s intentions to provide MHFA. Despite this, the current study could still have benefitted from greater consideration of alternative theoretical frameworks to explain MHFA changes.

The findings of the current study must be interpreted with some caution owing to a few factors. The data collected in this study is entirely retrospective, with participants being asked to retrospectively recall their experiences of MHFA, reflect on changes as result of the training
and provide accounts of MHFA helping encounters. There are clear problems with this, particularly given the length of time since some participants completed the training. It is also likely that trainees’ accounts were influenced by MHFA and their post-training experiences, such that their reports were not an entirely accurate representation of the changes experienced.

The current cohorts’ accounts may also have been affected by the nature of the sample. The group were a self-selecting sample who had completed MHFA training, consented to be contacted for future research and opted to participate in the present study. It could therefore be assumed that this was a motivated and compliant group with an interest in MHFA. In particular, the interview cohort were a more experienced group who had prior exposure to the area of mental health and greater opportunity to implement their MHFA training. Recruiting a random sample may have reduced the potential for bias and produced a more representative group. As noted, however, the current sample are similar in profile to the ‘average’ MHFAider as identified by existing MHFA research (Rossetto et al., 2018). Previous studies have called for MHFA research with less experienced members of the general public, given that the average MHFAider is an educated, middle-aged female engaging in the training for professional reasons (Morowska et al., 2013).

Another potential caveat of the present research is its literature review method, which could have benefited from a more systematic approach. In order to achieve the aim of assuming a critical stance towards MHFA and its underlying concepts, the current review utilised somewhat of an exploratory approach. It was therefore broad in nature and encompassed a range of concepts. Based on the findings of the current research, comprehensive review of a specific area such as stigma may progress the evaluation of MHFA outcomes.

Finally, despite the insight that this study has offered into MHFA helping behaviours and their outcomes, MHFA effects still need to be examined with recipients. The current research would undoubtedly have benefited from exploring this angle. Similarly, whilst the present study provided a more comprehensive understanding of MHFA outcomes and experiences, it could have gone further in doing so. In order to provide full insight into the subjective and contextual factors involved in MHFA, an interpretivist stance could have been adopted. In this case, IPA or discourse analysis would have provided a better means through which to examine trainees’ experiences. Whist TA from a critical realist perspective allowed for depth of analysis, it should be acknowledged that it does not offer the depth of exploration of either of these approaches (Harper, 2012).
5.6 Implications for Clinical Practice and Policy

The current study offers important insights for mental health policy and clinical practice. Collectively, participants’ accounts add to existing evidence about the effects of stigma on help-seeking and help-giving for mental health problems. The current findings demonstrated that, whilst biomedical explanations of mental illness can reduce blame and increase empathy towards people with MHPs, they can also be associated with stigmatising effects in terms of fear, avoidance and prognostic pessimism. In contrast, narratives that normalised mental health problems and improved awareness of psychosocial causal explanations appeared to produce fewer stigmatising attitudes and behaviours. These findings are in line with existing literature on mental illness stigma, with consequences for people with MHPs in terms of treatment and recovery. Whilst no strong conclusions can be drawn from the current data alone, it is does serve to highlight the potential pitfalls of mental health policy and practice which frames mental health problems as a biomedical issue.

The current data more clearly illustrates the limitations to interventions that use knowledge to reduce mental illness stigma. In line with social justice models of stigma-reduction, the present findings demonstrate the role of individual and socio-structural factors in perpetuating stigma towards mental health problems. These findings validate the need to address the behavioural outcomes of stigma (i.e., discrimination and social inequality) in order to produce true behaviour change. The current study also lends support to social contact as a means of reducing stigma towards people with mental health difficulties and encouraging help-giving behaviour. Such findings are reinforced by the theory of planned behaviour, which recognises the role of subjective norms and behavioural setting in translating attitude change into behaviour. Furthermore, the present research showed the benefits of fostering a normalising and supportive culture towards mental health, with positive implications for help-seeking and help-giving. Open conversations, peer support and practices that actively support mental health were referred to as facilitating this culture. Mental health policy and practice should therefore prioritise inclusion and equality for people with MHPs, ahead of strategies that seek purely to change public knowledge.

The current insights in relation to ‘resources and services’ highlighted some of the deficiencies of public mental health services. The need for better in-patient services and improved provision for specific cohorts were referenced by participants. Better resourced, recovery-oriented services and varied treatment options were also recommended, as were preventative measures...
with regard to psychosocial causes of mental health problems. These issues were recognised in a review of outcomes from the *Vision for Change* mental health policy (Government of Ireland, 2006). Proposals to address these factors were outlined in a new mental health policy *Sharing the Vision: A mental health policy for everyone* (Government of Ireland, 2020). This document details plans for services which recognise the role of trauma in the experience of mental illness. There were also proposals for specialist services for both dual-diagnosis and mental health ID populations, as well as an expansion of mental health services for children and young people up to the age of 25. Likewise, a greater variety of options for people requiring acute or in-patient mental health care was outlined.

Should these proposals be implemented, the service needs identified by the current cohort would be fulfilled. Unfortunately, however, many of these proposals were also made in the *Vision for Change* document in 2006 and failed to be enacted. The current policy promises a human rights and recovery-based approach, which promotes social inclusion, improves access to services and gives equal weight to mental health prevention and promotion as to mental illness. MHFA could be an important conduit to accessing these services and promoting mental well-being and recovery. As the current research illustrates and critics would argue, however, it is important that policy translates into practice and that MHFA does not continue to feed into systems and narratives that invalidate and perpetuate the negative experiences of those with MHPs (De Feher, 2016; Chambers, 2017).

### 5.7 Implications for Education and Training

MHFA is an educational intervention designed to provide the general public with training on how to help people experiencing mental health problems. The results of this study have reinforced previous findings that MHFA training generally improves knowledge, attitudes and helping behaviour towards MHPs. This research has also highlighted the individual and contextual factors involved in these outcomes. Based on the current findings it would appear that a person’s existing skills and experience, including their professional or voluntary role, contributes to their sense of confidence and use of MHFA skills. Similarly, reported contact with people experiencing mental health problems also influenced participants’ MHFA attitudes and behaviour. Providing formal helping opportunities and exposure to lived experience of mental health problems may therefore improve training effects for individuals without such levels of contact. Recognising the limitations of attempting to change behaviour through knowledge alone is thus also an important implication for education and training.
As mentioned previously, the current study highlighted the potentially stigmatising effects of different MHFA narratives. One suggestion is that similar to Psychological First Aid, MHFA training focuses on normalising and supportive behaviour, as opposed to delivering complex understandings of mental health problems. Presenting trainees with information about biomedical and psychosocial debates may be helpful if such information continues to be provided. Another implication supported by the current findings, is the inclusion of people with lived experience in the design and delivery of MHFA training. The voices of those with lived experience should be represented in a similar manner to that of medical experts. Experts by experience could increase social contact and the normalising of MHPs, as well as better represent the views of those whom MHFA is intended to serve. Such strategies may carry similar implications for any mental health training, including that of mental health professionals.

The majority of current participants came from non-mental health professional roles that involved exposure to mental health problems, highlighting a particular demand for mental health training among this cohort. Listening and providing empathy were valued skills among participants, with many also benefitting from skills to address the issue of suicide or other mental health crises. Participants recommended refresher training, increased practical activities and role plays during training. These comments are a reiteration of previous recommendations, with further suggestions that MHFA should be pitched at different levels depending on the needs and experience of the audience.

5.8 Recommendations for Future Research

In light of the findings and limitations of the current study, it is recommended that future research seeks to add to understandings about the lived outcomes of MHFA helping behaviours. As recommended by previous studies, there is a continued need to explore MHFA effects on recipients. The manner in which current participants with lived experience shared their stories, highlights potential avenues for exploring this area and refutes some of the ethical barriers flagged in relation to such investigations. Research questions with a recipient population should seek to understand recipient conceptualisations of their own mental health and how MHFAiders addressed their difficulties. It would also be helpful to learn about recipients’ experiences of MHFA in comparison to previous support, particularly if help had been provided by the first aider prior to training. Accounts of implementing MHFA advice
with regard to accessing services, seeking professional support, using self-help strategies etc. would also add to the knowledge base around MHFA outcomes.

Another area emerging as worthy of further research is that of workplace experiences. Many current participants engaged in MHFA training for work and described applying MHFA in the work environment. Examining the effects of workplace culture on MHFA and vice versa would be particularly interesting in light of the present data about subjective norms and PBC. Exploring these factors in specific work settings would also be of interest, with potentially different experiences in corporate compared to community-based settings. Assessing previous exposure to MHPs through a person’s profession, as well as existing skills developed through this role, would be useful in understanding the true impact of MHFA in this context. Some of the current cohort reported having completed other MH training through their role, with suicide prevention training most commonly cited. Training of this kind might provide a useful comparison for MHFA, with participants describing similarities between skills gained from both courses.

As flagged in the limitations section, assessing trainees’ experiences pre and post MHFA would be useful in order to accurately understand changes experienced as result of the training. Similarly, using a random sample of participants might reduce any potential bias associated with a self-selecting group. Research through a purely interpretivist lens, using IPA or discourse analysis, would likely produce an even deeper understanding of the individual and environmental factors involved in MHFA experiences. Lastly, given the impact of different understandings of mental health on attitudes and behaviours in the current study, it may be helpful to measure these understandings and their associated outcomes with regards their influence on MHFA effects. Standardised measures of different causal explanations and stigmatised attitudes could be applied. Participants’ previous contact with people experiencing MHPs, based on the current findings, would be another useful variable to assess in order to determine its influence on MHFA outcomes.

5.9 Critical Reflection

As the primary researcher in the study and in light of the reflexive TA approach adopted, it is important to recognise my central role in the current research. My own positionality influenced the study from the outset, including the research questions and the design of the study. Whilst
these decisions were made in collaboration with MHFAI and influenced by factors within the organisation, my own interpretation was always applied.

Early on in the research process, conflict between my positionality and the research area emerged. This initially came in the form of debates with MHFAI about the design of the research. As someone who believes that our experiences are a product of both our subjective interpretation and our social context, I am interested in the individual and environmental factors that impact phenomena being studied. I would therefore tend towards qualitative means of understanding experiences and seek to gather as much nuanced information as possible. For the current study, however, I had to compromise on this due to concerns about data protection and research impact. Most notably, I could not conduct in-person interviews. In addition, demographic items relating to issues such as lived experience and ethnicity were also excluded. It was not until these issues arose that I recognised my need to gather information in particular ways and learned the value of being able to compromise on my approach.

My second hurdle related to the existing literature and the concept of MHFA itself. I found that when I started examining the evidence for MHFA, I experienced a mixture of shock and confusion with regards to the surface-level nature of this research. Having been aware of MHFA as an intervention and the widespread nature of its dissemination, I had made certain assumptions about the research base upon which it was founded. What I discovered, however, was that evidence regarding the lived outcomes of the intervention was very sparse. I often found myself coming out of my reading with more questions than answers about the nature and utility of MHFA and the concepts on which it is founded.

Part of my reaction to the MHFA evidence base relates to my own position on mental health. My previously mentioned psychosocial bias is based on my own lived experience of trauma, mental health issues and recovery, as well as my clinical experience in mental health settings. At times I found myself confronted when reading about the psychosocial causal explanations preferred by the general public and how MHL interventions sought to bring peoples’ views in line with mental health experts. I thus experienced somewhat of an existential crisis about my role in researching an intervention such as MHFA. Such was this dilemma that I brought it to personal therapy during the project in order to resolve my impasse.

I resolved my issues here by reminding myself that I do understand and respect the value of psychiatry. I also believe in the importance of people being able to understand and address
MHPs from the perspective which they find most helpful. This influenced me to attempt to balance the biomedical foundations of MHFA with my more critical psychosocial stance. Being aware of my own preferences was imperative throughout the research process and was something that I regularly reminded myself of. I found, however, that during the course of data collection and analysis I was pleased to witness positive experiences as a result of biomedical approaches. I was also surprised to learn of the extent to which MHFA promoted psychosocial explanations and the normalising of MHPs among participants. My efforts to remain impartial during data collection and analysis were facilitated by the varied, detailed and honest accounts provided by trainees.

Overall, I feel that teaming my positionality with the concept of MHFA generated positive outcomes. For my part, I was forced to consider and challenge some of my own positionality around mental health. With regard to MHFA, I feel that bringing a critical lens to analysing the programme has highlighted both its strengths and areas that require some consideration if it is to achieve its desired aims of helping people with MHPs. Importantly, in adopting this approach, the current research has expanded the current MHFA evidence base by providing preliminary understandings of the lived outcomes of MHFA helping behaviour.

5.10 Study Conclusion

The primary aim of the current study was to understand the post-training experiences and helping behaviour of MHFA trainees. This research was particularly interested in learning about the nature and quality of trainees’ helping behaviour and the factors influencing these outcomes. Qualitative analysis involving online survey questions and in-depth individual interviews gave a comprehensive understanding of the experiences and behaviours of participants, as well as providing individual and social context to these accounts. Findings confirmed the utility of MHFA training in improving general knowledge, attitudes and behaviour towards mental health problems. In line with the aims of the current research, MHFA was found to influence helping behaviour and trainees’ confidence to provide such help. Factors such as stigma, social support, previous experience and resources to support of MHFA were also found to impact these outcomes. Important implications for clinical practice and policy, education, and future research were outlined, along with the strengths and limitations of the current study. The present research provides support for mental health training that uses diverse and inclusive understandings of mental health. It also highlights the limits to using knowledge to change behaviour towards mental health problems. Lastly this study suggests
that, in order for MHFA to be effective, it should be reinforced by contexts which promote inclusion and equality for people with mental health problems.
6 References


Appendixes

Appendix A: Ethics Approval Letter

Dear Barry

Thank you for your amended Research Ethics application which was recently reviewed by the Education and Health Sciences Research Ethics Committee. The recommendation of the Committee is outlined below:

Project Title: 2019_06_42_EHS Evaluating Mental Health First Aid training in Ireland: A study of participants’ experiences.
Principal Investigator: Barry Coughlan
Other Investigators: Jennifer McMahon, Janine O’Gorman.
Recommendation: Approved until April 2020.

Please note that as Principal Investigator of this project you are required to submit a Research Completion Report Form (attached) on completion of this research study.

Yours Sincerely

Anne O’Brien

Anne O’Brien
Senior Administrator, Education & Health Sciences
Research Ethics Committee
Ollscoil Luimnigh / University of Limerick
Guthán / Phone +353 61 234101
Facs / Fax +353 61 202561
Ríomhphost / Email: anne.obrien@ul.ie
Gréasán / Web: http://www.ehs.ul.ie
Appendix B: Participant Information

VOLUNTEER INFORMATION

(SURVEY)

Dear Participant,

You have been invited to participate in the current study, as you have completed Mental Health First Aid (MHFA) Ireland training and gave your consent to be contacted for ongoing evaluations of the programme.

This study is being carried out by a student on the University of Limerick Doctorate in Clinical Psychology, as part of their doctoral thesis. The findings of this evaluation will be made available through publications on the MHFA website, in academic journals and other MHFA Ireland materials.

The purpose of this evaluation is to hear your views on the MHFA course. By taking part in this study you are helping MHFA Ireland to understand the impact of the course and how useful the skills taught have been to participants. The following survey will ask questions about your experience of the course, as well as your use of MHFA since completing the course.

Your participation is entirely voluntary and the information you provide is confidential. In order to protect your own and others’ anonymity, we ask that you do not give any names or personal details in the answers that you provide. Given that MHFA training is designed to help with adults experiencing mental health difficulties, we also ask that you only refer to experiences concerning those over the age of 18 years.

This research study has received Ethics approval from the Education and Health Sciences Research Ethics Committee 2019_06_42_EHS. If you have any concerns about this study and wish to contact someone independent, you may contact:

Chairman Education and Health Sciences Research Ethics Committee
EHS Faculty Office
University of Limerick
Tel (061) 234101
Appendix B: Participant Information

VOLUNTEER INFORMATION

(INTEVIEW)

Telephone interview script:

You have been invited to participate in the current study, as you have completed Mental Health First Aid (MHFA) Ireland training and gave your consent to be contacted for ongoing evaluations of the programme. You also recently completed the MHFA evaluation study and gave consent to be contacted for a follow-up telephone interview.

The following interview will ask you some additional questions about the MHFA course and your experiences of using MHFA. The interview will take a maximum of 20 minutes to complete.

We ask that you provide no identifying or personal information during the interview in order to protect your own and others’ anonymity.

This interview will be recorded, immediately transferred to a password protected computer file and deleted from the recording device. The audio will be transcribed and again held on a password protected computer. This information will be held for 7 years and then deleted. As with the survey you completed, you can opt out of this interview or contact the researcher to withdraw or access your information at any time.

Do you have any further questions?
Appendix C: Consent

PARTICIPANT CONSENT

(SURVEY)

Evaluating Mental Health First Aid training in Ireland: A study of participants’ post-training experiences and helping behaviour.

PLEASE READ THE STATEMENTS BELOW AND IF YOU AGREE TO THEM, SELECT CONTINUE TO CONSENT TO TAKING PART IN THIS RESEARCH STUDY.

- I have read and understood the Participant Information.
- I have read and understood the Research Privacy Notice.
- I understand what the project is about, and what the results will be used for.
- I understand that what the researchers find out in this study may be shared with others but that my name will not be given to anyone in any written material developed.
- I am fully aware of what I will have to do, and of any risks and benefits of the study.
- I know that I am choosing to take part in the study and that I can stop taking part in the study at any stage without giving any reason to the researchers.

PLEASE CLICK CONTINUE IF YOU WISH TO PROCEED WITH THE SURVEY
Appendix C: Consent

PARTICIPANT CONSENT

(INTERVIEW)

To be read to participant before proceeding with telephone interview

Evaluating Mental Health First Aid training in Ireland: A study of participants’ post-training experiences and helping behaviour.

PLEASE LISTEN TO THE FOLLOWING STATEMENTS AND, IF YOU AGREE TO THEM, PROVIDE YOUR CONSENT TO TAKING PART IN THIS RESEARCH STUDY.

- I have received and understand the Participant Information and Research Privacy Notice.
- I understand what the project is about, and what the results will be used for.
- I understand that what the researchers find out in this study may be shared with others but that my name will not be given to anyone in any written material developed.
- I am fully aware of what I will have to do, and of any risks and benefits of the study.
- I know that I am choosing to take part in the study and that I can stop taking part in the study at any stage without giving any reason to the researchers.

(The below statements are to be read aloud by the researcher in order to gain participants’ verbal consent)

This study involves audio recording.

- I am aware that my participation in this study may be recorded (audio) and I agree to this. However, if I feel uncomfortable at any time, I can ask that the recording equipment be switched off. I understand that I can ask for a copy of my recording.
- I understand what will happen to the recordings once the study is finished.
- I agree to the statements above and I consent to taking part in this research study.
Appendix D: Research Privacy Notice

RESEARCH PRIVACY NOTICE

This Privacy Notice governs the use and storage of your personal data by the University of Limerick. The processing of this data is carried out in accordance with the General Data Protection Regulation (GDPR) / Data Protection Acts 1988-2018 (“Data Protection Law”) and in accordance with this Data Protection Privacy Notice. The University is the Data Controller for personal data we process about you.

The purpose of this Data Protection Privacy Notice is to explain how the University uses and processes personal data we collect and hold about you as a research participant. This notice extends to all your personal data as defined under Article 2(1) of the General Data Protection Regulation (EU) 2016/679.

1. Title and Purpose of the research project

Evaluating Mental Health First Aid training in Ireland: A study of participants’ post-training experiences and helping behaviour.

The purpose of this evaluation is to hear your views on the MHFA course. By taking part in this study you are helping MHFA Ireland to understand the impact of the course and how useful the skills taught have been to participants.

1.2 Potential benefits that may arise from the research project

It is hoped that the findings of this study will inform quality improvement and contribute to the evidence base for the effectiveness of MHFA in Ireland, as well as adding to the wider MHFA literature.

2. Research Ethics Committee

2.1 Ethical approval was granted by the Education and Health Sciences Research Ethics Committee on the 11th of November 2019.

3. Identity of the Data Controller(s)

3.1 University of Limerick, Plassey, Limerick.
4. **Identity and Contact Details of the Data Protection Officer of the Data Controller(s)**

4.1 You can contact the University of Limerick’s Data Protection Officer at dataprotection@ul.ie or by writing to Data Protection Officer, Room A1-073, University of Limerick, Limerick.

5. **The Identity of the Principal Investigator**

5.1 The Principal Investigator for this Research Project is Janine O’Gorman, Postgraduate Student, Doctorate in Clinical Psychology, University of Limerick.

6. **Why the University Holds Your Personal Data**

6.1 The University must process your personal data in order to undertake research relating to Mental Health First Aid Ireland training, it’s impact and use among the general public.

7. **Research Participant Personal Data held by the University**

7.1 You provide us with your personal data to enable us to undertake the research project. Participation in this research project is voluntary and participants may withdraw without giving any reason. Should you wish to withdraw you may do so by contacting the Principal Investigator at 16032438@studentmail.ul.ie or writing to him/her at Department of Psychology, University of Limerick, Limerick.

7.2 The categories of personal data collected/recorded may include:

- Mobile numbers (if provided)
- Age
- Gender
- Voice recordings (if provided)
- Questionnaires obtained from research subjects (on-line)
- Research subject consent forms
- Qualifications/Education Details
- Details of Employment and Volunteering or Community experience
- Special Category data (g) data concerning Mental Health

8. **Lawful Basis for University Processing Personal Data**

8.1 Data Protection Law requires that the University must have a valid lawful basis in order to process personal data.
8.2 The University will rely on your explicit consent in order to process your personal data for research purposes. Consent must be freely given, specific, informed and an unambiguous indication of your wishes by which you (by a statement or by a clear affirmative action) signify agreement to the processing of personal data relating to you. Your decision not to consent will have no adverse consequences for you.

8.3 You are free to withdraw this consent and you can do so by contacting the Principal Investigator at the following email address 16032438@studentmail.ul.ie.

9. Protecting Your Personal Data

9.1 Reasonable appropriate administrative, technical, personnel procedural and physical measures are employed to safeguard Personal Data against loss, theft and unauthorised uses access, uses or modifications.

9.2 All researchers of the University must adhere to the University’s Data Protection Policy when processing Personal Data on behalf of UL (available at www.ul.ie/dataprotection). Nonadherence to the University’s Data Protection Policy may lead to disciplinary action. Researchers of the University shall undertake Data Protection Training before they engage in the research project.

9.3 Personal data collected for this research project will be pseudonymised upon collection and will fully be anonymised within 12 months. Truly anonymised data is not Personal Data. Once data is anonymised for the purposes of this research project, the terms of this Privacy Notice will no longer apply.

10. Sharing Your Personal Data with Third Parties

10.2 The only Third Party with whom data will be shared is Mental Health First Aid Ireland and any data that is shared will be fully anonymous.

12. Retention of your Personal Data

12.1 All Personal Data collected for this research project will be retained in accordance with the University’s Records Management and Retention Policy. The Retention Policy (July 2019) currently states a retention period of 7 years.

13. Your Rights

13.1 Depending on the legal basis which we rely on to process your Personal Data, you may have the right to request that we:

- provide you with information as to whether we process your data and details relating to our processing, and with a copy of your personal data;
- rectify any inaccurate data we might have about you without undue delay;
- complete any incomplete information about you;
- under certain circumstances, erase your Personal Data without undue delay;
• under certain circumstances, be restricted from processing your data;
• under certain circumstances, furnish you with the Personal Data which you provided us within a structured, commonly used and machine-readable format.

13.2 Requests for any of the above should be addressed by email to the Principal Investigator at 16032438@studentmail.ul.ie AND the Data Protection Officer at dataprotection@ul.ie. Your request will be processed within 30 days of receipt. Please note, however, it may not be possible to facilitate all requests, for example, where the University is required by law to collect and process certain personal data including that personal information that is required of any research participant.

13.3 It is your responsibility to let the Principal Investigator know if your contact details change.

14. Queries, Contacts, Right of Complaint

14.1 Further information on Data Protection at the University of Limerick may be viewed at www.ul.ie/dataprotection. You can contact the Data Protection Officer at dataprotection@ul.ie or by writing to Data Protection Officer, Room A1-073, University of Limerick, Limerick.

14.2 You have a right to lodge a complaint with the Office of the Data Protection Commissioner (Supervisory Authority). While we recommend that you raise any concerns or queries with us first at the following email address 16032438@studentmail.ul.ie, you may contact that Office at info@dataprotection.ie or by writing to the Data Protection Commissioner, Canal House, Station Road, Portarlington, Co. Laois.

15. Review

15.1 This Privacy Notice will be reviewed and updated from time to time to take into account changes in the law and the experience gained from the Notice in practice.
Appendix E: DPIA Approval

12 December 2019

Dear Sir/Madam

A Data Protection Impact Assessment (DPIA) has been undertaken by the Ms. Janine O’Gorman in relation to the research project “Evaluating Mental Health First Aid training in Ireland: A study of participants’ post-training experiences and helping behaviour”. The University of Limerick’s Data Protection Unit has reviewed and provided advice on the DPIA.

The Department of Psychology shall retain overall responsibility for and ownership of the DPIA assessment, the consideration and minimisation of all potential data protection risks and the implementation of any recommendations of the Data Protection Unit.

Yours sincerely

Derval Howlett
Data Protection Officer
Appendix F: MHFAI / SJOG Approval

27 January 2020

To Whom it May Concern

Saint John of God Hospital fully supports the purpose and title of the Research Proposal “Evaluating Mental Health First Aid training in Ireland: A study of participants’ post-training experiences and helping behaviour”. We are reassured in consistency of the Data Protection Impact Assessment and Risk Assessments in relation to the accountability for Data Protection. We confirm that we wish to commence the Research.

Emma Balmaine
Chief Executive

Joe Kelly
Head of Operations, Quality and Data Protection
Appendix G: Debrief

Debrief (Survey)

Thank you for taking the time to complete this survey, your feedback will make a valuable contribution to the future of MHFA.

We are aware that participating in this survey may have brought up experiences that are emotionally distressing for you. We would like to remind you of the importance of caring for yourself when providing mental health first aid to others and refer you to pages 20-21 in your MHFA training manual, which provides contact details of resources and services should you require support.

Following on from this survey, we are looking for individuals to participate in a brief telephone interview (approximately 15-20 mins) in the coming weeks. This interview will ask further questions about your experience and subsequent use of MHFA training. If you would be happy to participate, please select the option below and provide an appropriate contact number, as well times or dates when it would be best to contact you. Your number will be used solely to contact you for the purposes of the interview and deleted thereafter.

I would like to be contacted for telephone interview:

Contact number:

Dates and times that would be best to call (options provided):

END OF QUESTIONNAIRE.
Appendix G: Debrief

MHFA Evaluation Telephone Interview

Debrief Script

Thank you for taking the time to complete this interview, your feedback will make a valuable contribution to the future of MHFA.

We are aware that participating in this study may have brought up some difficult experiences and would like to remind you of the importance of caring for yourself when providing mental health first aid to others. Following our conversation, for your own self-care and wellbeing, it might be good to do something relaxing or enjoyable today such as going for a nice walk or having a cup of tea with a friend. If you feel that you require further support, pages 20-21 in your MHFA training manual provides contact details of mental health resources which I can talk you through now if this would be helpful?

As mentioned at the start of the interview, the audio from our conversation will be transcribed and kept on a password protected computer. This information will be held for 7 years and then deleted. As with the survey you completed, you can contact the researcher to withdraw your information at any time.

My sincere thanks once again for your valuable contribution.

END OF INTERVIEW.
Appendix H: Extracts from Reflective Memos / Diaries

22/05/2019

Email feedback from MHFAI regarding initial survey and interview schedule drafts. MHFAI expressed concerns about ‘Ethnic Background’ and ‘Highest Level of Education’ items, due to potential impact on participants. Further refinement of qualitative questions needed. Hone down questions according to research aims and questions.

23/07/2020

Supervision session today. Agreed to focus on MHFAI behaviours and outcomes, as per research aims and questions. Remove survey and interview questions that relate specifically to training i.e. training evaluation questions. Need to be careful not to end up doing a surface-level ‘service evaluation’.

26/07/2019

Meeting with MHFAI. Discussed changes to qualitative survey and interview questions, which are now taking shape. MHFAI happy to remove training evaluation type questions and focus on in-depth MHFAI experiences and outcomes. MHFAI informed me that, due to GDPR procedure, face-to-face interviews would be problematic. We discussed getting around this by conducting anonymous telephone interviews. This is not how I had pictured qualitative data collection going; however, telephone interviews will provide access to participants in order to gather more detailed accounts of their experiences. Also agreed that we would limit sample to ‘up to approx. 12 months’ since completion of training, as the cohort would otherwise be too large for MHFAI to collate and contact participants.

11/09/2019

Feedback from MHFAI on final draft of the online survey schedule. MHFAI expressed concerns about ‘Highest Level of Education’ item. Whilst I understand that this could be an off-putting question, education has been identified as a significant factor in previous MHFA studies and I feel that it is therefore important information to gather. I will discuss this in supervision in order to make a final call on retaining this item. Some helpful feedback from MHFAI regard to phrasing of qualitative questions e.g. change “barriers” to “challenges”.

13/03/2020

Pilot telephone interview. Upon using the interview schedule, I found it quite superficial or surface-level. Also found the questions leading in terms of assessing desired MHFA outcomes i.e. improved knowledge, attitudes and helping behaviours. I was getting ‘yes’ answers to a lot of questions without getting much meaning or detail behind them. Decision to add to / amend line of questioning in order to be less leading and use open questions to elicit detailed and
meaningful responses. Decision to probe for more detail about individual and personal experiences whilst maintaining the bounds of GDPR and confidentiality.

19/03/2020

First day of telephone interviews. 8 interviews today. I became aware of the fact that participants thought that I was part of the MHFAI team and was conscious of the effect that this was having on their responses. In some cases, participants seemed reluctant to provide any negative feedback and felt compelled to emphasise the benefits of the training. I therefore started to clarify my position at the outset and will do this going forward. I was somewhat anxious around the ‘cold calling’ process, not knowing the person’s name etc prior to calling. The changes made following the pilot interview worked well, encouraging more detailed responses and requiring less probing. Noticed difficulties due to absence of non-verbal signals over the telephone and disconnect at times between my line of questioning and the person’s interpretation.

20/03/2020

Day 2 of telephone interviews. 6 interviews today. Stating my impartial role at the outset has definitely had an effect in terms of trainees providing more open and honest accounts. I was less anxious about cold calling people and managing the interview process today. A few people have been ruled out either by choice or through not answering scheduled phone calls – 4 in total. Workplace culture and environmental influences coming through in participants’ accounts. Decided to add this as a probe to the interview schedule, for use when appropriate.

27/03/2020

A couple of longer phone calls today. I am pleasantly surprised by the positive experiences some have had with the medical model of treatment. Some participants are providing accounts of their own lived experience and I feel very privileged to hear their stories. It has been easier than anticipated to be an impartial interviewer. Whilst not adopting a therapeutic role, utilising my therapeutic skills of being non-judgemental and non-directive have been helpful here. Participants have provided open and honest accounts for the most part and I found greater openness from my own perspective through listening to them.

April 2020

During transcription and early analysis, I started forming preliminary themes in my mind. These related to different understandings of mental health and their influence, the impact of trainees’ professional role and environment on their helping behaviour, lived experience, and stigma. There are similarities between the interview data and the qualitative survey data, such that at times I struggle to recall which data set a particular extract belongs to. I also have to be careful not to place too much importance on specific accounts to which I am drawn, ensuring that I am considering the entire data set when constructing my themes.
Appendix I: Online Survey Schedule

Demographic and Background Information

Age

| 18-30 | 31-44 | 45-59 | 60+ |

Gender

| Male | Female | Other | Prefer not to say |

Highest Level of Education

| School Education | Professional Training | Diploma | University degree or above | Prefer not to say |

Time since completion of MHFA training

| < 3 months | 3 – 6 months | 6 - 9 months | 9 – 12 months | 12 months + |

Reasons for doing MHFA training *(can select more than one answer here)*

| Reasons related to work or professional development *(Please give details)* | Reasons related to volunteering / community *(Please give details)* | Personal Reasons (i.e. for yourself, family or friends) | Reasons related to Personal Development | Other *(Please give details)* |

Have you had any previous training or professional experience in the area of Mental Health?

| None | Some | A lot |

Please provide details of any experience or training
Since completing MHFA training, have you used MHFA skills to support somebody with a mental health problem?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Sometimes</th>
<th>Frequently</th>
</tr>
</thead>
</table>

A reminder that in order to protect your own and others’ anonymity, we ask that you do not give any names or personal details in the following answers that you provide. Given that MHFA training is designed to help with adults experiencing mental health difficulties, we also ask that you only refer to experiences concerning those over the age of 18 years.

1) Research suggests that MHFA can improve participants’ knowledge, confidence and ability to help those who may be experiencing mental health difficulties.

   What do you think about this statement? (200-word limit)

2) Have you found any challenges to you using MHFA skills or to helping someone with a mental health problem? (200-word limit)

   (please do not provide any personal or identifying information in your examples here)

3) Any other comments? (200-word limit)
**Reported and Intended Behaviour Scale (RIBS)**

**Instructions:** The following questions ask about your experiences and views in relation to people who have mental health problems (for example, people seen by healthcare staff). For each of questions 1–4, please respond by **ticking one box only**.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong></td>
<td>Are you currently living with, or have you ever lived with, someone with a mental health problem?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2.</strong></td>
<td>Are you currently working with, or have you ever worked with, someone with a mental health problem?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>3.</strong></td>
<td>Do you currently have, or have you ever had, a neighbour with a mental health problem?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>4.</strong></td>
<td>Do you currently have, or have you ever had, a close friend with a mental health problem?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix J: Interview Schedule

Interview Schedule

1. **How confident do you feel about dealing with people who may be experiencing a mental health problem?**

   - Compare this to how you felt before the training.
   - Has your knowledge about signs and symptoms of mental health problems increased?
   - Do you think you would know how to help someone?
   - Would you know where to signpost someone who needs help?

2. **Do you think your attitude towards mental health problems has changed as a result of participating in MHFA training?**

   - If yes, please explain?
   - How would you view a person with mental health problems now compared to before training?

3. **Have you experienced a post-course situation where someone seemed to have a mental health problem? (please do not provide any personal or identifying information in your examples here)**

   **If no:**
   1. How would you handle such a situation? How well prepared would you feel to help?
   2. Were you surprised not to have encountered such a situation?

   **If yes:**
   1. Can you tell us about the situation and the problem you think that person had?
   2. Could you help them?
   3. Did you help them?
   4. If not, why so?
   5. What was your main reason for becoming involved?
   6. Can you say more about what you said or did?
   7. How do you think your support impacted that person?
   8. How did you feel afterwards?

4. **Is there anything else that you would like to say about MHFA training, its value and/or this research study?**
Interview Schedule: Additional Probes

(revised following Pilot Interview)

- How confident are you in helping someone who may be in mental distress or experiencing a mental health problem?
- How confident are you in dealing with mental distress in general?
- What can you tell me about your knowledge of the signs and causes of mental distress?
- How do you view mental distress or mental health problems?
- What are your attitudes or beliefs about mental distress / mental health problems?
- What are your attitudes or beliefs about people who experience mental health problems?
- How would you view a person who may be experiencing mental distress?
- Have you ever helped someone who is in mental distress / has a mental health problem?
- What kind of problem did they have?
- How did you help them?
- What was your reason for becoming involved?
- Did it help?
- How did your help impact upon the person?
- How did this experience impact upon you?
- If you haven’t helped somebody, why do you think that is?
- How would you help someone if you had the opportunity?
- Has your knowledge about the signs and causes of mental distress / mental health problems changed as a result of the training?
- Have your beliefs about mental health problems and people experiencing them changed as a result of the training?
- Has the way you help someone in mental distress changed as a result of the training?
- What problems have you come across in trying to help someone?
- What do you think might stop someone accepting or seeking help?
- What do you think might stop or encourage you from seeking help if you were in distress?
- Is there anything about workplace environment or other environments that you think contributes to this process (if relevant)?
- Are there any particular skills or tools that you learned on the training that you find yourself referring back to or using most?
- Is there anything else that you would like to add?
Appendix K: Preliminary Thematic Maps and Codebooks

First Aider Outcomes
- Positive Outcomes
- Mixed Outcomes
- Time Since Completion of Training

Understanding of Mental Health
- Psychosocial Discourses
- Biomedical Discourses
- Labelling

Helping for MH Problems
- Helping Behaviours
- Help-seeking
- Existing Skills and Experience
- Perceived Behavioural Control
- Lived Experience
- Role at Work

Subjective Norms
- Stigma
- Support System

Different Kinds of Help
- Resources & Services
- Mental Health Treatment

ALGEE Skills
- Approach
- Assess and Assist with any Crisis
- Encourage towards professional help & other supports
- Give support and information
- Knowledge
- Empathy
- Listen Non-Judgementally
Appendix K: Preliminary Thematic Maps and Codebooks

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<th>Description</th>
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### Appendix L: Quotations & Text Extracts in Support of Themes

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<th>Survey Themes</th>
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<td><strong>1. Reasons for doing MHFA</strong></td>
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<td><strong>2. Previous training or professional experience in mental health.</strong></td>
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<tr>
<td><strong>3. Changes experienced as a result of MHFA.</strong></td>
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</table>
| **3. Challenges experienced in using MHFA.** | I find it challenging at work, as people often do not want to disclose what MH issues they are having as it can impact their job (managers perceptions, promotion, review and bonus).

The mental health system is not working, and if they can access the right service the follow-up service is very poor.

The challenges are that when you are not dealing with it regularly. It did not come automatically. Needed time to remember the cues. The handbook is very useful to remind you.

Sometimes people clam up and withdraw as they might feel you could be judging them, or they feel that talking is a sign of weakness.

We also have issues with senior mgmt. paying lip service to our MH agenda - they are "bought in" but when it comes down to it, they are only interested in people putting in a high performance. |
| **4. Additional comment.** | Course was a good learning opportunity and was very interactive with participants sharing their own experiences with family / friends and then we had an opportunity to reflect and express our view on these.

For workplace, it may be useful to include a brief section on stress and burnout as this is very prevalent. Catching this at earlier stages may prevent more serious issues from developing. This course should be mandatory in all customer facing employment and schools/colleges.

It is a very worthwhile programme and would be good to have bite-size refresher training or learning material issued to attendees post the programme. |
Appendix L: Quotations & Text Extracts in Support of Themes

<table>
<thead>
<tr>
<th>Interview Themes</th>
<th>Helping Behaviour</th>
<th>Existing Skills &amp; Experience</th>
<th>Perceived Behavioural Control (PBC)</th>
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<td><strong>1. Helping for mental health problems</strong></td>
<td>Recently I had somebody say to me they were concerned that a member of their family was getting really paranoid and she was afraid that by calling over she would make her more paranoid and I was like look, you're doing the right thing. Your intentions are good. You just need an excuse to call over for something else and just be mindful not to participate in it. You know, don't go along with it or don't chastise her for being, for having... Don't tell her she's stupid or being ridiculous. Just say “God, it sounds really difficult or that sounds really scary. How long has this been going on for and have you talked to anybody?” That's kind of good stuff, so... (Participant 11)</td>
<td>I would be an EAP you know. They would come to you or you're making contact with them because colleagues are worried about them, you know that kind of scenario. (Participant 4)</td>
<td>I suppose the other thing then would be the directness of approach. So, where somebody indicates that suicide is their intention, that I don't have a fear anymore about actually asking them, “well, do you have a plan?”...(Participant 19)</td>
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<td>On a local level in my own office, I've instigated a couple of really important things. So, we do like a ‘wind down’ at the end of the day, because we can deal with some quite challenging clients. So, for me it's about making sure that by the time my team leaves the office, they've offloaded as much as they can of the day. (Participant 19)</td>
<td>You know instinctively I sort of knew the stuff but it's great to have a set of guidelines or a flow to follow because you feel that you are at least sort of adhering to a set of guidelines that are universally accepted. (Participant 18)</td>
<td>One thing that I took from the training was that if you show that you're confident and not intimidated by the idea of somebody with a mental health issue, that they are more likely to respond to you...you know, if somebody feels that you can cope with what they're going to say to you, that they are more likely to open up or seek advice at another point with you. (Participant 22)</td>
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### Boundaries & Self-Care

Before she used to drain me, and every time I spoke to her it was misery, misery, misery and I found it draining. Whereas now I’m being more upbeat for her and it’s working for me as well. And I don’t feel like... I don't own it. I don't own her misery. (Participant 15)

This course made me very aware also, of issues that I have myself...I was aware of them, but I was like ‘ah, sure it’s grand’...I'll work it out. But you don't work these things out without help. (Participant 30)

### 2. MHFA narratives and experiences

#### Knowledge & Empathy

I was actually surprised that I have anxiety. I would never have put down how I am, and I act to anxiety, but it is. I think people don’t realise that they’re actually more susceptible to anxiety. (Participant 20)

I kind of look at people differently... If their behaviour changes rather than going ‘they’re in an awful bad mood lately’, looking at, maybe is something going on and actually asking them... (Participant 15)

#### ALGEE Skills

Well I think mainly it was just listening without, you know, without judging... Really it was just listening and maybe advising them to go and speak to a medical professional...the doctor really was the first thing, would be the first port of call. And just listening in some cases, as they don’t all need the doctor. (Participant 10).

My job is to direct somebody to the people that can help them from a professional perspective. To be the conduit rather than the solution. and that, I suppose, changed the way that I engage with people. (Participant 18)

#### Teaching Methods

There were a lot of videos. They were very good takes on different scenarios of people in different situations: in work, at home etc. They were very good. They were eye openers because you're looking in from the outside and you could be any one of those people. The person that is helping or the person that's receiving help... (Participant 21)

The guy who did it on the day was really good. He had a lot of experience to bring to the table and that's what I liked about him. (Participant 4)

### 3. Resources & services for MH
**Different Kinds of Help**

The medication can do this that and the other but really, you're getting your mind into a healthy place by eating well exercising, you know, practicing mindfulness and just being aware of what's going on inside. I think it's just as important... (Participant 23)

I think myself there should be something, that they are engaging from an early age. From maybe 10 or 12 years old that they get into self-awareness. They start doing a bit of meditation. That they start doing a bit of self-care and all that kind of stuff. And when they do meet a crisis or when they do get something...that they actually have some skills and tools to deal with it. (Participant 30)

**Positive & Negative Experiences**

She actually expressed a wish to kill herself. But I was aware, also, that hospitals won't deal with that if there's alcohol involved. And I stayed with her all night and then waited until the next morning...I wanted to get her through to maybe 8am the next morning where she could then make the appropriate phone calls. You know, she couldn't phone a GP at that time and it was clear that if we took her to hospital that wasn't going to be effective. (Participant 18)

We had a huge amount of suicides there about 6 or 7 years ago over a 2-year period and we tried every avenue to get somebody to talk to our group of youths, because we would be dealing with up to 120 youths in a voluntary capacity. And obviously that does affect them when something massive happens in a community...And we couldn't get anyone to come talk to them. (Participant 17)

**4. Subjective norms**

**Stigma**

I had a burnout at work and just actually calling it a burnout, it's very challenging and you don't want people to think that you can't do your job or that you won't get a promotion. So, it's a terrifying thing for people. (Participant 11)

The biggest thing is the stigma around mental health. Particularly around men I think, where men don't want to show their weakness to anybody else. You know, the stigma that's there. They want to stay strong... they don't want to be seen as weak in front of their family, their friends, their colleagues. (Participant 26)

**Social Support Systems**

Now I know a lot of women would talk to their friends and get support, but I know a lot of men would not...I suppose some of the different programs like men's shed and other clubs and things like that men can go to are a possible way that things could happen outside of the workplace, but I don't know. (Participant 5)
We have a good system at work. We have an employee assistance program as well, where people can get free counselling sessions and we have a couple of groups so people can talk about stuff and the more you talk about it, just the more people open up and talk about their experiences as well... (Participant 20)

5. Understandings of mental health

<table>
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<tr>
<th>Biomedical Discourses</th>
<th>I mean my father is an alcoholic but has been sober for coming up 50 years this year. So, I would be fairly sympathetic to the concept that it is a disease. You know, people don't do these things for no reason... (Participant 18).</th>
</tr>
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<td></td>
<td>I'd like to think that I was always very open-minded about it anyway. Like I have a few friends and family members that would have had problems over the years... So, I know that it is an illness like, you know... I wouldn't be blaming them. (Participant 15).</td>
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<table>
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<tr>
<th>Psychosocial Discourses</th>
<th>You know you can see the cycle... the same cycle of homelessness, hostel accommodation and imprisonment. That's the revolving door that we have now...people are discharged from those psychiatric units as well into homelessness. (Participant 27).</th>
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<td>I suppose it really depends on the individual. Whether it's stressful factors at home and they bring them into work or whether it's stuff they're dealing with in work that they're finding challenging. (Participant 1).</td>
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6. Covid 19

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<th>And as well because of the housing crisis you could have 12 people living in a house... And that's fine if you can all go out during the day. But now if they're all in the house and you know it's not a functional house... No disrespect to any families, but if there is quite a lot of high dysfunctionality, that causes, like, a timebomb. (Participant 9)</th>
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<td>Like last week when all the madness happened and we all had to work remotely, I sent an email to the entire team just to share my experience of how it felt. Because my husband's job is at risk and it's all a bit mental. And overall, I'm very positive but one of the mornings I actually woke up, I had nightmares, I felt very anxious... I had, not a full panic attack, but I know how to recognise them. I get a feeling of Deja-vu and I get a little bit of a racing heart... So, I shared that with the team, and I said look, overall this is how I feel. (Participant 20)</td>
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