Aboriginal & Torres Strait Islander
Mental Health First Aid (AMHFA)
National Pilot Program

2008 Evaluation Report

for the Department of Health and Ageing, Office for Aboriginal and Torres Strait Islander Health

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Executive Summary

Background

In 2007, the Mental Health First Aid Training and Research Program based at ORYGEN Research Centre, University of Melbourne, was granted funding by OATSIH to finalise the cultural adaptation of the Aboriginal and Torres Strait Islander Mental Health First Aid (AMHFA) course and teaching materials. A key component of the OATSIH grant included an evaluation of the major aspects of the training course and program. This report the presents the methodology and results, and makes a number of recommendations for the further development and evaluation of the program.

Methods used

Quantitative data were collected to measure course uptake and predictors of conducting courses. Quantitative questionnaire data were used to investigate changes in mental health literacy from before to after training. Qualitative data were collected in a series of evaluation workshops to ascertain the perceptions of various stakeholders about the strengths, weaknesses and possible future directions of the AMHFA program.

Results

As of November 2008, 199 Aboriginal AMHFA Instructors have been trained in the 5-day Instructor Training Program. These Instructors have so far run 155 14-hour AMHFA courses, which have reached 1,115 people. Only 40% of Instructors had run at least one course, but this will continue to increase over time as more have the opportunity to do so. An examination of the characteristics of instructors who ran courses, compared to those who did not, showed few differences. Those who ran courses tended to have more prior teaching experience and to have made contact post-training with an AMHFA Trainer of Instructors.

Questionnaires given pre- and post-training showed that both Instructors and 14-hour course participants became more confident that they could assist someone with a mental health problem and that they felt they had greater mental health knowledge.

Analysis of qualitative data from Instructors and 14-hour course participants indicated that the AMHFA 5-day Instructor program and 14-hour course are culturally appropriate, empowering for Indigenous people, and provided information that was seen as highly relevant and important in assisting Aboriginal people with a mental illness. Some themes that emerged suggested recommendations for change.

Recommendations

Five recommendations were made based on consistent findings in the evaluation:

1. Potential AMHFA Instructors should be asked to do the 14-hour AMHA course first before applying to be an Instructor. This would give them a clearer idea of what the Instructor’s role involves and allow them time to prepare for

instructor training. It would also reduce the intensity of the instructor training week.

2. There is a need for on-going support of AMHFA Instructors to assist their preparation for running a course and to deal with issues that arise during courses. An AMHFA Trainer needs to be employed to take on this role.
3. Materials need to be developed for teaching the course to people with lower levels of English literacy
4. A revision of the AMHFA manual and teaching materials is needed to update relevant statistics and services and to incorporate the new Mental Health First Aid Guidelines for Aboriginal and Torres Strait Islander People.
5. An exploratory trial needs to be carried out on the impact of the 14-hour AMHFA course on the knowledge, attitudes and helping behaviour of course participants. This trial needs to be carried out using an approach that is culturally acceptable to Aboriginal people.

Background to the AMHFA Program

The idea of modifying the Mental Health First Aid course developed by Kitchener & Jorm (2002) was born in Canberra in 2004. The Commonwealth Department of Health and Ageing (Mental Health Branch) provided funding via an Indigenous Strategies Working Group and Indigenous Writers Group to culturally adapt the course to better meet the needs of Aboriginal and Torres Strait Islander people. Mr Alan Sambono, an Indigenous man from the Northern Territory, was assigned by the Commonwealth to work with MHFA Instructor Len Kanowski on the project.

Whilst some progress was made on the cultural adaptation during 2005, it was not until the establishment in 2006 of an Aboriginal and Torres Strait Islander MHFA Reference Group, comprising a small body of Aboriginal people and Len Kanowski, that significant cultural adaptations were made. Funding for this initiative was provided by the MHFA Training and Research Program and the Australian Government Department of Health and Ageing (Suicide Prevention Section). The work was overseen by Auseinet, Flinders University, South Australia.

In 2007 the Mental Health First Aid Training and Research Program based at ORYGEN Research Centre, University of Melbourne, was granted funding to finalise the cultural adaptation of the course and teaching materials. This work was overseen by an OATSIH Expert Reference Group comprising Aboriginal health professionals as well as non-Aboriginal health professionals specialising in Aboriginal and Torres Strait Islander mental health and wellbeing. OATSIH funding also provided for the development of two culturally appropriate DVDs for use in the Aboriginal MHFA course; the employment of an Aboriginal Trainer-of-Instructors and an Aboriginal Administrative Assistant; the development of teaching materials and scholarships to support Aboriginal and Torres Strait Islander Instructors to undertake the 5-day Aboriginal Mental Health First Aid Instructor Training Course.

A key component of the OATSIH grant included planning, conducting and reporting on an evaluation of the key aspects of the training course and program.
This report the presents the methodology and results, and makes a number of recommendations for the further development and evaluation of the program.

Evaluation of the AMHFA Program

Aims of the Evaluation

The aims were:

- To evaluate the uptake of the 14-hour AMHFA course by counting the number of courses conducted, and the number and characteristics of first aiders trained.
- To investigate changes in mental health literacy in a sample of AMHFA Instructors following the 5-day training course, and in a sample of participants following their attendance at the 14-hour AMHFA course.
- To evaluate the perceptions of the trained AMHFA Instructors and Trainers of Instructors on the following:
  1. The 5-day AMHFA instructor training course and the 14-hour AMHFA course in terms of its mental health content, cultural content, community relevance, teaching approach and course uptake in Aboriginal community controlled health services and communities.
  2. The aspects of the 5-day AMHFA instructor training course and the 14-hour AMHFA course that worked well and aspects that could be improved.
- To obtain course feedback from a sample of 14-hour AMHFA course participants from Aboriginal community controlled health services and Aboriginal communities to determine course strengths, weaknesses and areas where the AMHFA course can be improved in terms of content and cultural relevance.

Originally, it was planned to carry out a more detailed evaluation of the effects of the program on 14-hour AMHFA attendees. However, this was dependent on additional resources for the evaluation which would be provided by a partner organisation, beyondblue. Because agreement was not reached between beyondblue and OATSIH, beyondblue did not proceed to provide the additional funding and the aims had to be restricted accordingly. Appendix 1 gives the revised proposal for the evaluation which was approved by OATSIH.

Methods Used

Quantitative data were collected to measure course uptake and predictors of conducting courses. Quantitative questionnaire data were used to investigate changes in mental health literacy from before to after training. Qualitative data were collected to ascertain the perceptions of various stakeholders about the strengths, weaknesses and possible future directions of the AMHFA program.

Measuring uptake of the instructor training course and the 14-hour AMHFA course

Number of Instructors trained and courses run was ascertained using the Instructor Database which is associated with the MHFA website (www.mhfa.com.au). After completing their training, Instructors are recorded on this database. The database then allows Instructors to record details of all courses they teach. To encourage entry of data, all AMHFA Instructors were contacted during the months of August to October

2008 by the AMHFA training team and assistance was provided if the Instructor had not entered information on all the courses they had taught. The data were then taken from the database on 1 November 2008, which was the census date for this component of the evaluation. The data were plotted to show the percentage of Instructors running a course as a function of time since training. To provide some perspective on the rate of uptake, a similar analysis was carried out for Instructors who trained in the standard (non-Aboriginal) MHFA course over the same period. This allowed a comparison of the percentage offering courses for Aboriginal and non-Aboriginal Instructors.

Some non-Aboriginal people also trained to be Instructors so that they could work as a team with an Aboriginal person to run courses in Aboriginal communities. Data on the number of these Instructors were also taken from the database.

A final source of data was the number of AMHFA Instructors who attended the inaugural AMHFA Instructor Forum which was held in Melbourne from 15-16th May 2008.

Analysis of predictors of conducting courses

Because many Instructors had not run courses by the census date, a statistical analysis was carried out to find characteristics of Instructors who had run one or more courses compared to those who had not. One obvious predictor is the time since training as an Instructor—the more months available to run a course, the greater the probability that an Instructor will do so. However, we were interested to find predictors additional to the time available. These predictors might give clues to better selection of Instructors or better support that could be provided post-training. The following predictors were examined:

Instructor characteristics:

- Gender of Instructor
- Type of employer
- Type of position of employment
- State in which the Instructor resided
- Remoteness of the Instructor's home town according to the RRMA categorization of the Australian Bureau of Statistics
- Number of years experience in mental health prior to Instructor training
- Highest qualification achieved
- Number of years experience in teaching or training prior to Instructor training
- Did the Instructor identify as a consumer of mental health services for a mental illness?
- Did the Instructor identify as a carer of a loved one with a mental illness?
- Did the Instructor indicate on their application form that they would like to become an Instructor to improve their mental health knowledge?
- Did the Instructor indicate on their application form a desire to teach, educate, present, deliver or train?

Post-course support provided:

- Had the Instructor had any form of contact with a Trainer?
- Had the Instructor had phone contact with a Trainer?
- Had the Instructor had email contact with a Trainer?
- Had the Instructor met face-to-face with a Trainer?

- Had the Instructor attended an evaluation workshop?
- Had the Instructor attended the Instructor Conference?

The predictors were examined using logistic regression analysis. The analysis was carried out in two steps. In the first step, each predictor was examined individually, with time since training as a covariate. In the second step, any predictor that was significant at the $p<.10$ level was entered into a simultaneous regression analysis, again with time as a covariate. Predictors significant at the $p<.05$ level were interpreted.

Assessment of changes in mental health literacy

To assess changes in mental health literacy, printed questionnaires were given to participants who attended evaluation workshops. Each questionnaire contained two items designed to assess aspects of mental heath literacy. Each item was a question about how the level of the participant's knowledge of mental health issues or confidence in assisting someone with a mental illness. Participants ranked their level of knowledge and confidence both before and after their AMHFA training on a 5-point scale from *Extremely knowledgeable/confident* to *No knowledge/confidence*. Any increase in participant's rating after attending AMHFA training was considered an indication of change in mental health literacy.

Analysis of changes in mental health literacy

In total, 33 Instructors and 20 14-hour course participants completed the printed questionnaires. Ratings on the two items were scored on a scale from 1 to 5, where a higher score represents greater confidence in providing help and greater knowledge of mental health problems. For both the Instructors and the 14-hour course participants, paired sample t-tests were carried out comparing the means before and after training. Differences significant at the $p<.05$ level were interpreted.

Workshops to gather qualitative data on perceptions of Instructors, course participants and the AMHFA Training Team

Accredited AMHFA Instructors were invited to attend regional evaluation workshops. Instructors were asked to comment on their perceptions of both their 5-day training program, as well as the structure and materials of the 14-hour course they were to present in their communities. The workshops were conducted in New South Wales, Queensland, Northern Territory, and Western Australia. Kara Eddington, Aboriginal MHFA Coordinator, facilitated these forums, while Laura Hart audio-recorded the proceedings and typed a summary of the points raised on a laptop. Immediately following each workshop, Laura Hart and Kara Eddington reviewed the points that were recorded on the laptop and reached a consensus that these were correct and that there were no omissions.

Several evaluation workshops were offered to community members and staff from Aboriginal community controlled health services who participated in the 14-hour AMHFA course. Workshops were offered within specific Aboriginal community controlled health service sites. Participants were invited to attend the workshops by the Aboriginal Instructors who conducted the course. Workshops were held in New South Wales, Queensland, South Australia and Western Australia. These workshops were also facilitated by Kara Eddington and Laura Hart recorded the points made. The discussion dealt with how they found their course, the information presented, and how

confident they felt about providing mental health first aid to an Aboriginal or Torres Strait Islander person. Following each workshop, the information gathered was reviewed by Kara Eddington and Laura Hart, as described for the Instructor workshops.

Individual interviews were carried out with Kara Eddington (AMHFA coordinator), Len Kanowski (Deputy Director, MHFA) and Rhys Kinsey (AMHFA administrative assistant). The interviews were carried out by Prof Tony Jorm, with Laura Hart recording the points made. Members of the training team were asked to talk about what they saw as the strengths and weakness of the program and suggestions for future improvements. For Rhys Kinsey, the interview focussed on administrative aspects only.

Analysis of the qualitative data

There were a large number of points made across the various workshops and interviewers. These were grouped into three broad categories by Laura Hart: (1) Perceived strengths (2) Areas for improvement and (3) Future directions. Some points emerged consistently across the different workshops and interviews, whereas others were idiosyncratic. In order to find the most consistently mentioned points, Laura Hart selected out those that were mentioned in at least 3 of the 4 Instructor workshops, in at least 3 of the 4 course participant workshops, or by at least 2 of the 3 AMHFA training and administrative team. These consistently mentioned points formed the basis of conclusions reached about strengths, weaknesses and future directions.

Ethics approval

Ethics approval was provided by the Melbourne Health Mental Health Research Ethics Committee. The committee carried out consultation with an expert in Aboriginal health research when making its decision. Appendix 2 gives the application that was submitted and the letter of approval.

Results

Uptake of the Instructor Training Program

The inaugural 5-day AMHFA Instructor Training commenced on 5th March, 2007. Since that time, 199 Aboriginal Instructors have been trained in 17 5-day courses, which were held across the country (see Table 1).

Table 1: *Instructor Training courses 2007/2008*

Location	State	Start Date	Scholarship Holders	Instructors Trained
Orange	NSW	5-Mar-07	1	10
Cairns	QLD	21-May-07	7	12
Brisbane	QLD	27-Aug-07	3	14
Broome	WA	17-Sep-07	6	12
Sydney	NSW	22-Oct-07	9	13
Alice Springs	NT	12-Nov-07	11	13
Melbourne	VIC	19-Nov-07	8	10
Adelaide	SA	11-Feb-08	5	16
Perth	WA	10-Mar-08	7	11
Hobart	TAS	31-Mar-08	7	12
Darwin	NT	14-Apr-08	5	9
Cairns	QLD	28-Apr-08	3	12
Melbourne	VIC	23-Jun-08	0	7
Kempsey	NSW	14-Jul-08	3	8
Toowoomba	QLD	18-Aug-08	1	8
Echuca	VIC	27-Oct-08	7	15
Canberra	ACT	24-Nov-08	11	17
Total		**17**	**94**	**199**

In addition, the AMHFA Training Program has run two 3-day training courses for non-Indigenous, previously accredited, MHFA Instructors. There are currently 8 accredited non-Indigenous AMHFA Instructors. Acceptance into this training program required participants to meet strict criteria, including previous experience as an accredited MHFA Instructor presenting the 12-hour Adult version of the course, experience in working in the field of Aboriginal mental health, ongoing work within Aboriginal communities and a commitment to involving Aboriginal people as cultural experts within the 14-hour AMHFA courses they present in the future.

On 14th May 2008, an inaugural AMHFA Instructor Forum was held. This was a full-day event held in conjunction with the two-day MHFA Instructors' Conference, which took place on 15th -16th May in Melbourne, 2008. 21 accredited AMHFA Instructors attended the forum and addressed issues relating to the presentation of the 14-hour course in their communities.

Uptake of the 14-hour AMHFA courses

The implementation of the AMHFA 14-hour course began in 2007 when the first 14-hour course was run in Newcastle, on June 25th by two Instructors who attended the Orange training course held in March 2007.

Between March 2007 and August 30th 2008, 155 14-hour AMHFA courses have been run across the country. Table 2 shows how many courses have been run in each state and territory. To date 1,115 people have attended a 14-hour course across Australia.

The analyses presented here include the 14-hour courses that were run between June 25th 2007 and November 30th 2008.

Table 2: *14-hour AMHFA courses run between June 25th 2007 and November 30th 2008*

State	Number of Courses
ACT	0
NSW	36
NT	2
QLD	37
SA	15
TAS	0
VIC	11
WA	14
Total	**115**

Of these 115 14-hour AMHFA courses, 58 (50%) were presented in a co-facilitation format, where two or more instructors shared the presenting. 14 courses (12%) involved a co-facilitator who was a non-Aboriginal person. Four of those 14 courses involved a co-facilitator who had completed the 3-day AMHFA Instructor course, while the other 10 courses involved a co-facilitator who had completed the 5-day Adult MHFA Instructor course only. There was one 14-hour AMHFA course that was presented by two non-Indigenous AMHFA accredited Instructors, with no Aboriginal Instructor present.

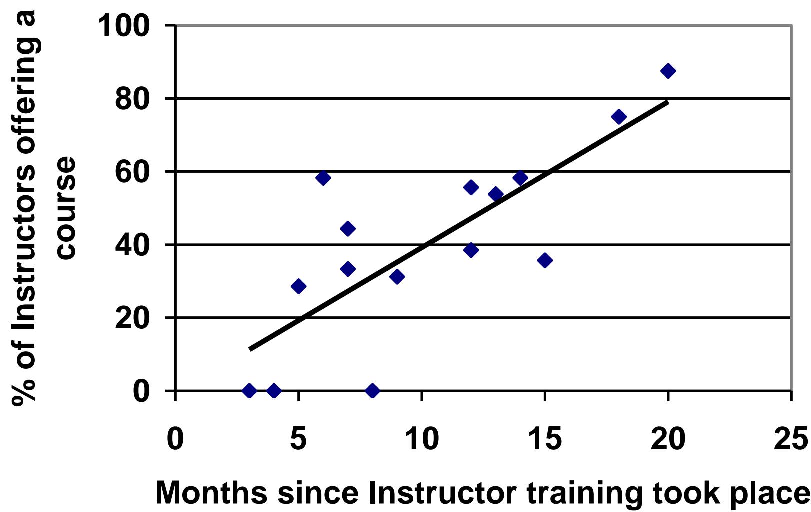
Predictors of conducting courses

The analyses of predictors of conducting a course included only the 165 Instructors who were trained between March 2007 and the end of August 2008. The 32 Instructors who were trained in Echuca and Canberra in October and November of 2008 were excluded from these analyses because they had not had sufficient time to have prepared for and presented a 14-hour course in their communities. The inclusion of their data would have disproportionately inflated the proportion of Instructors who had not yet presented a course.

Of the 165 Instructors who were trained between March 2007 and August 2008, 67 (40%) had run one course or more. While the percentage of trained Instructors who have run courses appears lower than might be expected, it is not substantially different to the percentage who had run courses from the group of Instructors who attended the 5-day Adult (non-indigenous) MHFA training between March 2007 and August 2008 (320 trained, 188 or 59% have run courses).

The main factor associated with whether or not a course was taught was time since training. Figure 1 shows the percentage of Instructors who have run a course as a function of when their training took place. It can be seen that the percentage is quite high for those instructors who attended the earliest instructor training courses.

Figure 1: *Percentage of Instructors offering a 14-hour course following each of the 5-day Instructor training courses. (A regression line has been fitted to the data points).*



In order to assess if there were any characteristics of Instructors that may have predicted whether or not they presented a course, a series of logistic regression analyses was performed to determine whether any of the following factors predicted running a course: Instructor's gender, type of workplace, type of work position, state of residence, rural-remote classification of home town, number of years experience in mental health, level of qualification, teaching or training experience, consumer or carer status, amount of contact had with a Trainer of Instructors(Len Kanowski or Kara Eddington), or whether or not the Instructor had mentioned a desire to increase their mental health knowledge or to educate, train, deliver or facilitate AMHFA courses on their application forms. A summary of findings is presented in Table 3. Appendix 3 presents the full results of the regression analyses.

The length of time Instructors had between completing their 5-day training and the cut-off date of November 30th 2008 was the most reliable predictor of whether or not an Instructor had run a course. For each week since their 5-day training, an Instructor was 1.04 times more likely to have run a course.

A set of further analyses were performed, controlling for time since Instructor training, to see if any other variables could increase the likelihood that an Instructor would run a course. These further analyses found that an Instructor's level of teaching experience significantly increased the likelihood of presenting a course. For each increase in level of teaching experience, an Instructor was 1.3 times more likely to present a course. The only other variables that predicted course presentation was whether or not an Instructor had had contact with a Trainer (either Len or Kara). If an Instructor had made any form of contact with Len or Kara, they were 2.7 times more likely to have presented a course. Having face to face contact with a Trainer was the strongest predictor of course presentation, with those Instructors who arranged to meet with Len or Kara 3.5 times more likely to have presented a course.

It was also found that an Instructor's level of teaching experience and carer status impacted on the likelihood of presenting a course, although these analyses only approached significance, and should be interpreted with caution.

The set of predictors that were significant at the $P<.10$ level, were next included in a simultaneous multiple logistic regression analysis. The only predictors which remained significant when all other predictors were adjusted for were time since training and the instructor having had face-to-face post-training contact with one of the trainers of instructors.

Table 3: *Characteristics of Instructors which predict course presentation*

Characteristic Analysed	Explanation	Did belonging to one particular category make an Instructor more likely to run a course?
Gender	Sex of Instructor	No
Weeks since Instructor training	Date of Instructor training completion	Yes Odds ratio = 1.042, p<.001
Workplace	Type of employer	No
Work position	Type of position of employment	No
State	State in which Instructor resides	No
RRMA	Classification of home town according to RRMA categories (ABS)	No
Years in MH	Number of years experience in mental health prior to Instructor training	No
Qualification	Highest level of qualification achieved	No
Teaching / Training	Number of years experience in teaching or training prior to Instructor training	Yes Odds ratio = 1.392, p=.017
Consumer	Did the Instructor identify as a consumer of mental health services for a mental illness	No
Carer	Did the Instructor identify as a carer of a loved one with a mental illness	Approaching significance Odds ratio = 1.955, p=.082
MH knowledge	Did the Instructor indicate on their application form that they would like to become an Instructor to improve their mental health knowledge?	No
Mention: teach, educate, present, deliver, train?	Did the Instructor indicate on their application form a desire to teach, educate, present, deliver or train?	No
MADE contact?	Had the Instructor initiated any form of contact with a Trainer	Yes – Odds ratio = 2.746, p=.007
Phone Contacts	Had the Instructor phoned a Trainer	Yes – Odds ratio = 3.311, p=.003
Email Contacts	Had the Instructor emailed a Trainer	Yes – Odds ratio = 2.128 p=.038
Face-face	Had the Instructor met face-to-face with a Trainer	Yes – Odds ratio = 3.523 p=.001
Evaluation	Had the Instructor attended the Evaluation Workshops	No
Conference	Had the Instructor attended the Instructor Conference	No

Changes in mental health literacy of Instructors and participants

A quantitative analysis of level of knowledge and confidence found that both Instructors and 14-hour course participants showed a significant increase in their level of mental health knowledge and their confidence in helping someone with a mental illness, as measured by a 5-point rating scale on the participant questionnaires. Figures 2 and 3 show the means before and after for each group. It can be seen that, as would be expected, Instructors had greater knowledge and confidence than course participants. The changes in both groups were highly statistically significant, $p<.001$.

Figure 2: *Change in Instructor Mental Health Literacy*

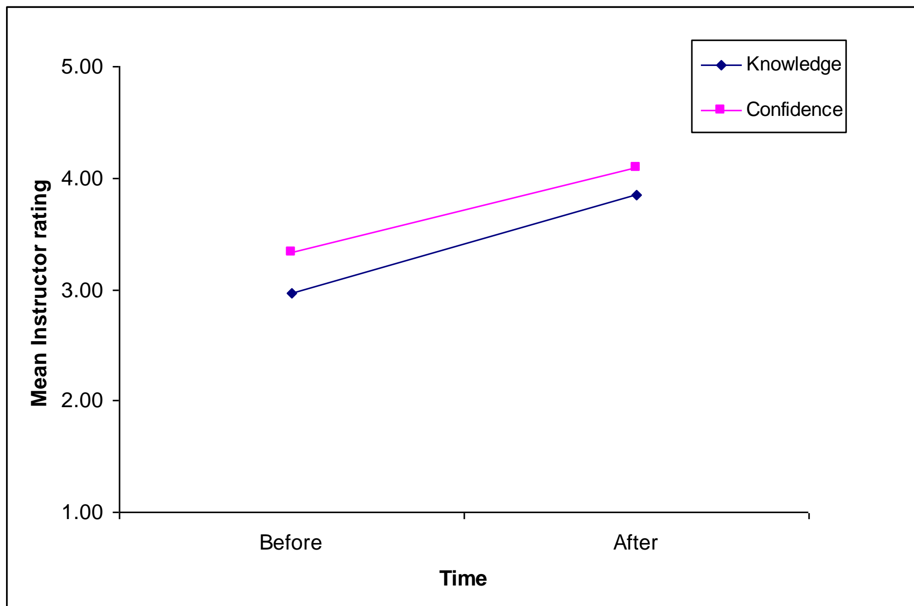
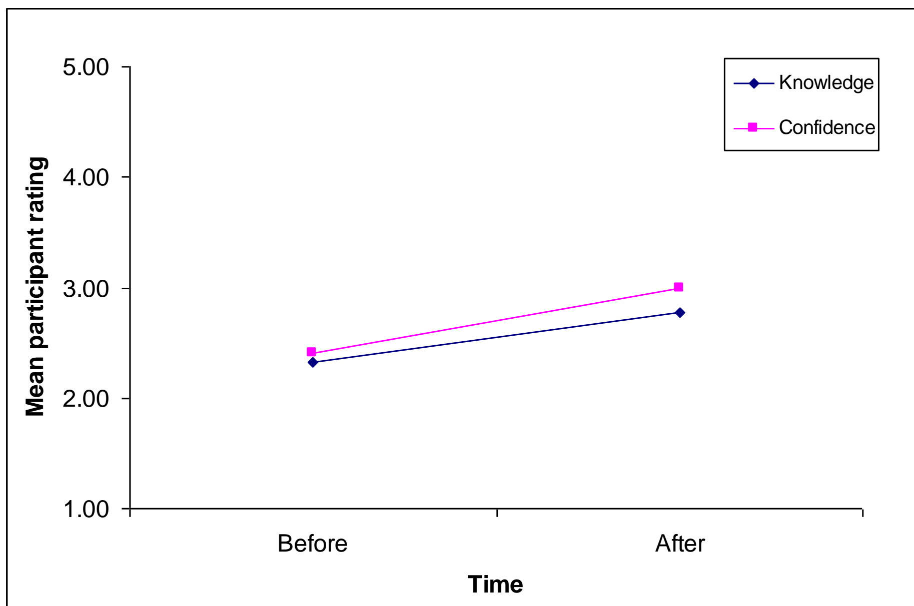


Figure 3: *Change in 14-hour Course participant mental health literacy*



Perceptions of Instructors, course participants and the AMHFA training team

The first evaluation workshops were held in December 2007 in Orange NSW. Subsequently, six further workshops were held in locations across Australia, with a total of 56 participants: 34 instructors and 22 course participants (see Table 4). Instructors were asked to comment on their perceptions of both their 5-day training program, as well as the structure and materials of the 14-hour course they were to present in their communities. Course participants were asked to comment on how they found the course, the information presented, and how confident they felt about providing mental health first aid to an Aboriginal or Torres Strait Islander person.

Table 4: *Number of Instructors and Participants Attending Evaluation Workshops 2007/2008*

Location	Instructor Workshop	Participant Workshop
Orange	7	4
Cairns	14	9
Alice Springs	7	-
Port Augusta	-	3
Perth	6	6
Total	**34**	**22**

In addition, interviews were conducted with AMHFA staff (Len Kanowski, Kara Eddington, and Rhys Kinsey) to evaluate staff attitudes towards the program.

A collation of themes discussed by all post-implementation review participants is displayed in Tables 5 - 8 below. Issues that were independently discussed by two or more AMHFA staff, three or more Instructor Evaluation Workshops, or three or more 14-hour Course Participants are presented in the Tables below.

The overwhelming response from all Staff, Instructors and 14-hour course participants was that the AMHFA 5-day Instructor program and 14-hour course are culturally appropriate, empowering for Indigenous people, and provided information that was seen as highly relevant and important in assisting Aboriginal people with a mental illness.

Table 5: *Perceived Strengths of the 5-day Instructor Training*

Trainers of Instructors	**Involvement of Aboriginal people -**	High level of interest from amongst Aboriginal communities & organisations, diverse range of people trained, including those who live in remote communities and from the Torres Strait. Also having Indigenous staff members in AMHFA Training and Admin team
	Materials -	▪ AMHFA Manual - artwork, liaison with Aboriginal and Expert Reference Group, was perceived as culturally appropriate ▪ DVDs - Indigenous content well received ▪ Feedback loop used to develop materials where AMHFA Instructors would give information/opinions on materials and Trainers would adapt appropriately
	Training model -	Style of training was appropriate for Aboriginal people as it contained culturally appropriate information and was presented with humour, knowledge and sensitivity
Instructors	**Sharing**	Instructors felt the 5-day training created a positive learning environment which was culturally safe and encouraged Instructors to share their personal experiences. They also reported that the sharing of personal experiences enhanced their learning and allowed a sense of support and rapport to develop
	Empowerment	Instructors reported that the 5-day training was empowering for Aboriginal people because it taught them skills and gave them information/knowledge that not only improved their personal abilities but also improved the capacity of their communities in relation to recognising and assisting in mental health problems
	Culturally appropriate	Instructors reported that a particular strength of the training was that it included Aboriginal people only in the 5-day course, was taught by (at least one) Aboriginal person, and was designed for Aboriginal people and their mental health issues. Instructors also reported that the training model, materials and information presented were all sensitive to Aboriginal culture and its diversity.
	Trainers	All Instructor groups reported that the professionalism, cultural safety and sensitivity, knowledge and expertise of Len Kanowski and Kara Eddington were strength of the program. Instructors liked that Len and Kara had different strengths, Len in the area of clinical knowledge, Kara in the area of community/cultural and counselling knowledge.
	Information	Instructors reported that the 5-day training presented a large volume of information that was all culturally relevant and important to understanding Aboriginal Mental Health.
	Resources/Materials	All Instructor groups reported that the resources given to the Instructors were a great strength of the program. The teaching resources helped them to learn more about mental health after the training finished and allowed them to feel confident when preparing for their courses. In addition the Instructors felt the class exercises were a fun way to engage their audience and the manual was a particular strength, especially its information on SEWB and the artwork.
	Confidence	Instructors noted that the 5-day training allowed them to build confidence not only as presenters but also as Mental Health First Aiders. After finishing the training, Instructors reported feeling more confident in teaching their communities about mental health problems, and also in intervening when those with mental illness required assistance.

Table 6: *Areas for Improvement and suggestions for the future in the 5-day Instructor Training*

		Areas for improvement	Future directions
Trainers of Instructors	**Materials development -**	The manual and DVDs took a long time to develop and involved an extensive consultation process. While consultation with a reference group is appropriate, the amount of modifications that were requested from different parties was extensive and time consuming.	A more efficient consultation process for material development is needed for the future. Existing, experienced AMHFA Instructors need to be part of this consultation process, as they are the key stakeholders in the development of new materials and have the most relevant knowledge in relation to cultural appropriateness, participant needs and course content.
	Training program schedule -	During early 2008 there were many 5-day training weeks scheduled back-to-back. This made it difficult for the admin team and didn't allow for Trainers to prepare sufficiently for each course. For instance, courses were not extensively promoted and classes were not always full because the admin team had insufficient time to advertise and promote each training course.	The training schedule needs to be less prescriptive and allow more time before each 5-day course for promotion, advertisement, participant selection and administrative preparation.
	Application process -	Trainers felt that the application process was not well understood. Many of the course applicants did not fill out the forms correctly or completely. Applicants also took a long time to submit the required documentation prior to attending the training. They needed to be followed up multiple times by both administration staff and the Trainers. The application process for scholarships in particular was very time consuming. There needs to be modified in the future to make it more user-friendly and less daunting for the applicants	Suggestions: 1.Incorporate a follow up phone call from a Trainer in the assessment process. Less emphasis on written application and more emphasis on a verbal interview. 2. Streamline application paperwork into one document. Allow it to be sent electronically, via fax or post. Incorporate the scholarship and Instructor training applications so that there are not two distinct sets of forms to complete.
	Selection criteria and assessment of Instructors -	Instructors often commented that the application process was daunting and confusing. Many Instructors commented that the statement, which appeared in the acceptance letter, stating that "There are 5 steps to becoming an accredited AMHFA Instructor. Step 2: You are re-assessed as suitable by the Trainer of Instructors for your course at the end of Day 3 of the Instructor Training Course. This assessment is based on observation of your communication skills, knowledge and attitudes." caused much anxiety amongst applicants.	Delete the statement from the acceptance letter. Have the Trainer perform a formal review of the person's ability to meet the selection criteria via a phone interview prior to commencing the 5-day training course.

	Knowledge of the Instructors prior to the 5-day training	Most Instructors reported feeling overwhelmed by the volume of information presented in the 5-day training course. However, the Trainers felt that all the information presented was crucial to the development of the Instructors skills	There are a number of suggestions for overcoming a lack of knowledge: 1. Change the criteria for Instructor acceptance to be more strict; 2. Require that Instructors attend the 14-hour AMHFA course before attending the 5-day training, so they are familiar with the material that will be discussed; 3. Change the structure of the 5-day training course, so that it is either longer, or includes a weekend break before the assessments begin, so that participants have time to review and analyse the information presented in the first 3 days of the training course before being required to present themselves.
	Pastoral support -	A high level of pastoral support was demanded of the Trainers by Instructors, both personally (because the AMHFA course discusses difficult mental health issues) and also professionally (around issues of planning, preparing and advertising courses). Trainers felt they lacked sufficient time to support the Instructors post-training.	A structured system of follow-up needs to be implemented where Trainers call and speak to Instructors after their training. This will allow Instructors to canvass any problems/issues they may be facing which are preventing them from presenting courses.
	Networking support -	Trainers encouraged Instructors to co-facilitate and support each other. Often Trainers needed to facilitate this process because Instructors required support to approach management personnel, often within their own organisation, but also to approach other Indigenous and non-Indigenous Instructors in their region, to create a roll-out plan.	Trainers need to have more time to support Instructors in developing regional and organisational support for the AMHFA program.
Instructors	**Presenting**	All Instructor groups reported that they felt insufficiently prepared as presenters. Although they felt confident about presenting the information in the 14-hour course, because it was sufficiently discussed in the training, they felt topics like group management, handling difficult class members and using different teaching styles, were not given enough emphasis or time. They would have liked more information about techniques and tools for effective presentation and group management.	There were a number of suggestions that were directed at overcoming this shortfall: Allow Instructors more time to develop their presentation before their assessments. This would involve a one-day or weekend break after Day 3 of the training course.
	Selection criteria and assessment	Instructors noted that the acceptance letter stating that "There are 5 steps to becoming an accredited AMHFA Instructor. Step 2: You are re-assessed as suitable by the Trainer of Instructors for your course at the end of Day 3 of the Instructor Training Course. This assessment is based on observation of your communication skills, knowledge and attitudes." caused Instructors to fear being sent home because they were inadequate. This made them anxious about attending the course and about being assessed. Instructors felt fearful of being sent home "shamed" to their community because they had not passed.	Remove this statement from the acceptance letter and have Trainers perform more thorough screening of applicant prior to attendance at the course.

Insufficient discussion about communities with low literacy	Instructors noted that although they appreciated the opportunity to present using the manual and PowerPoint resources in the 5-day training, in many situations, they would not use those resources back in their communities. Instructors felt there needed to be more time spent on developing different styles of presentation so that Instructors were prepared to use all the resources and very few.	There were a number of suggestions that were directed at overcoming this shortfall: Allow Instructors more time to develop their presentation before their assessments. This would involve a one-day or weekend break after Day 3 of the training course. Develop a second workshop that is shorter and takes place independently, which looks at designing a presentation specifically for the needs of the Instructors community.
Requirements of being and AMHFA Instructor	Instructors reported that they felt under-prepared when it came to understanding the exact amount of time required to prepare for and run a course, promoting, advertising and scheduling courses, liaison with community groups and their employer, in order to roll out the 14-hour course.	Instructors would like a section within the 5-day training that specifically looks at the steps that need to be taken to prepare for, organise, schedule and run a course, including who needs to be involved and how to liaise with employers to gain support for the course. Instructors also mentioned that they would like to see MHFA play a larger role in advocating for Instructors to have time offline (away from regular duties) to prepare for and present courses.
Duty of Care	Instructors felt that they would like more information about what duty of care they have as Instructors over the actions of first aiders they teach and the information they are presenting. They also wanted more information and guidelines around how much the information can be adapted to suit the community.	Develop guidelines on Duty of Care for Instructors and on presentations to low-literacy communities.
Volume of Information	Although Instructors saw the volume of information presented as a challenge, they also commented that they would not like to see any information lost from the 5-day training course.	Instructors suggested the following ideas for overcoming being overwhelmed by the amount of information present in the 5-days: 1. Require the Instructors to attend a 14-hour course before they attend the Instructor training so they have some familiarity with the material. 2. Set some pre-reading so that Instructors can become familiar with the AMHFA program. 3. Extend the 5-day program so that there is a weekend break in between the first three days and the last two, allowing Instructors a break to review and analyse the material.

Table 7: *Perceived Strengths of the 14-hour AMHFA Course*

Instructors	**Empowerment**	Instructors reported that course was empowering for Aboriginal communities because it taught their people skills and gave them information/knowledge that not only improved their ability to recognise when and assist someone who is having a mental health problem; it also made their attitudes to people with a mental illness more positive.
	Adaptability	Instructors appreciated that the course model allowed them to tailor the information presented to the audience's needs. For instance, Instructors could choose to use PowerPoint slides, to use the manuals, to use workbooks or to base the learning on more activities and discussion of artwork and culture.
	Culturally appropriate	Instructors reported that a particular strength of the course was that it provided an opportunity to share personal experiences of mental illness in a culturally appropriate way. Instructors liked that the course included information on social and emotional wellbeing and talked about mental illness within that context.
Community Members	**Information about mental illness**	Participants reported that the course gave them useful information about the mental illnesses, their symptoms and treatments. Many participants reported feeling more positive about mental illness and towards people with mental illness as a result of doing the course. Many noted that before the course they thought of people with mental illness as behaving "silly" or inappropriately or being affected by black magic. After the course, participants reported being able to understand people's behaviour as a symptom of their illness and this stopped them from being dismissive or avoidant.
	Skills in how to assist someone with a mental illness	All participants commented that the course, and in particular the ALGEE action plan, gave them more confidence in interacting with and assisting someone who was developing a mental illness or experiencing a mental health crisis. Many participants said that before the course they would avoid people with mental illness, put them in the "too-hard basket" and expect someone else to assist. After the course participants reported being more confident in offering assistance and more understanding of what the person might be going through.
	Model of the course	All participants reported that the model of the course was a great strength. Participants particularly liked the role plays, the activities and the ability to share personal stories. Participants commented that the active way in which the information was taught helped keep them interested, helped them to learn and remember the information and was a culturally appropriate way of presenting the information.
	Culturally appropriate	All participants reported that a particular strength of the course was that it was presented by Indigenous Instructors who were known to them and contained lots of information that was specific to Aboriginal people. Participants also liked that the information they learned was applicable to their own experiences in their community. A particular strength of the course, the participants reported, was the ability to talk about mental health in a culturally safe environment with people from their own community.
	Manual	Participants reported that they liked the manual. They liked the way the mental illnesses were described, in language that was easy to understand and not judgemental. They liked the artwork and the format of the book and felt it was a good resource to hang-on and come back to.
	Sharing	All participants noted that the format of the course allowed participants to feel safe enough to share personal stories about mental illness. This sharing of stories was seen as very important to de-stigmatising mental illness and to helping each other learn.
	Relevance and importance	Many participants commented that they liked that the information presented in the course was not only relevant to their experience in Aboriginal community, but also very important for understanding mental illness, their own mental health and feeling confident in being able to assist others who might need help for their mental health problem.

Table 8: *Areas for Improvement and suggestions for the future in the 14-hour AMHFA Course*

		Areas for improvement	Future directions
Instructors	**Need more materials for groups with low literacy levels**	Some Instructors were presenting to Aboriginal communities who do not have English as their first language. Instructors reported that they would have liked to have more pictorial and basic language materials for presenting to these communities. Also, in remote communities, there were no facilities for using PowerPoint slides or showing DVDs. In this scenario, Instructors requested that they are provided with some culturally appropriate materials that don't require technology.	A pictorial flip-chart should be developed for remote communities or groups with low literacy levels. Some discussion of presenting to participants with English as a second language should be incorporated into the 5-day Instructors training.
	Great amount of time needed for course preparation	Instructors noted that in order to present at an appropriate level and in a culturally respectful way, Instructors needed to spend time getting to know their audience and understanding their needs before presenting the course. Instructors reported that they felt it was particularly challenging to present "outside country" or to a community that was not their own, or when presenting to a group whose members had different levels of literacy.	Instructors wanted more time spent (in 5-day training) on discussing how to develop community awareness of the course, engage the community in the course, prepare for and present to community in a culturally respectful way.
	Course content	The statistics presented in the course were based on surveys of non-Aboriginal Australians. Instructors reported that they would like to present statistics that are relevant to Aboriginal and Torres Strait Islander people. Instructors also noted that they would like to see more Aboriginal content in the course, especially more DVDs telling Indigenous stories of mental illness, treatment and recovery.	Instructors suggested that a statistics bank be started by AMHFA so that when Instructors found good state or regional-based statistics, they could send them in to AMHFA to be distributed to other Instructors where relevant.
	Cultural Information	Instructors reported feeling a pressure from their audience to provide more information on culturally based treatment. They felt that this was a topic that was not discussed by the course and a demand of their audience that they could not meet.	These comments were made prior to the production of the AMHFA DVDs sponsored by OATSIH.
	Personal support	Instructors felt they needed a lot of support initially to have the confidence to begin presenting. They then reported that they often needed to debrief after presenting a course, because of the sensitive and emotional nature of issues discussed. Furthermore, Instructors often felt they need to contact their trainers for advice on managing group dynamics and issues around self-care.	Instructors reported that when co-facilitating courses, the pressures to respond to all demands of their audience were reduced and the emotional impact was lessened. Instructors should be encouraged, wherever possible, to co-facilitate.
	Workplace barriers	Many Instructors noted that a big challenge in presenting a 14-hour course was obtaining support from their managers and employers to have time "offline" (away from their usual duties) to prepare and present. Some Instructors reported being very frustrated at not being granted authorisation to take time away from their normal workload, or being restricted by workplace policies which made it difficult to release both the Instructor and participants to do the course.	Instructors requested the AMHFA play a role in liaising with their employers to negotiate sufficient "offline" time to prepare and present courses. They also suggested that AMHFA provide more detail about the amount of time and work involved in preparing for and presenting a course, in the training application procedures.

Community Members (14-hour Course participants)			
	Materials	Participants reported that they would like to see more Aboriginal content in the course, especially more DVDs specifically about Aboriginal Mental Health and more statistics about Aboriginal mental illness. While participants appreciated the DVD with Gary McDonald talking about depression was helpful, they felt it would be more relevant if there were Aboriginal and Islander people shown on the DVDs telling their stories of mental illness, treatment and recovery.	These comments were made by groups who had received their training prior to the production of the AMHFA DVDs sponsored by OATSIH.
	Activities	Some participants mentioned that they would like to see more opportunities to role play first aid scenarios so that they could practise the skills taught in the course and prepare for situations they may face in the community. Other participants noted that they would like to have more active involvement throughout the course as sometimes they felt there was too much reading from the manual and not enough explanation given of the language used.	Instructors could be given more activities to use throughout the course, especially for groups who have low levels of literacy and prefer to learn by doing rather than investigating text.
	Local Service Information	Some participants reported that they would like more information and time spent on learning how to contact local mental health services and who to speak to.	Participants mentioned that constructing a flow-chart in class, which depicted the contact numbers of different people and services within the community that a person could call when developing a mental illness or when experiencing a crisis would be a good way to learn and remember this information.

Recommendations for future directions of the AMHFA program

This evaluation has used three principal data sources: (1) quantitative data on the number of courses conducted, the number and characteristics of the instructors trained; (2) questionnaire data on changes in mental health literacy of Instructors and course participants; and (3) qualitative data from workshops with Instructors and course participants, and individual interviews with AMHFA staff. The recommendations below are based on findings that emerged consistently across sources of data.

Selection and preparation of Instructors

Most Instructors were found to offer AMHFA courses if given sufficient time to do so. However, there are a significant number of Instructors who do not. To place this in perspective, a comparison was carried out with Instructors who were trained to deliver the regular MHFA course over the same period. While the proportion offering courses was lower for the AMHFA Instructors than for the regular MHFA Instructors, the difference was not so large considering the less developed Aboriginal mental health workforce and the practical difficulties in delivering the course in some Aboriginal communities. Even if some Instructors never run a course, it is arguably still a good investment in workforce development because of the additional training that was received during the 5-day course. Nevertheless, it would be better use of resources to focus the training on people who are more likely to deliver courses. We attempted to find predictors of Instructors who were successful in running a course in the follow-up period. We found some indication that successful Instructors were better educated, had more teaching experience and more likely to be a carer. However, the predictors were not strong enough to recommend any additional selection criteria than those already used. There were Instructors with a wide variation in backgrounds who were successful in running courses. It seems more sensible to make the Instructor training available as at present and let the best people self-select afterwards by demonstrating that they can run courses successfully.

The qualitative data supported the idea of spreading the Instructor training over more days with a break in between. One suggested way of implementing this idea was to require Instructors to do the 14-hour AMHFA course first before applying to become an Instructor. This would give potential Instructors a clearer idea of what an Instructor is expected to do. If there was a gap between the 14-hour course and the Instructor training week, it would also allow more time for them to absorb the material and space out the learning of the large amount of information that Instructors are presented with.

Recommendation 1: Potential AMHFA instructors should be asked to do the 14-hour AMHA course first before applying to be an instructor. This would give them a clearer idea of what the instructor's role involves and allow them time to prepare for instructor training. It would also reduce the intensity of the instructor training week.

Post-training support for Instructors

The analysis of predictors of whether or not an Instructor offered a course found that post-training contact with AMHFA staff, particularly, face-to-face contact was associated with a greater likelihood of being a successful Instructor. Unfortunately, it is not possible to be certain what is cause and what is effect here. It is possible that post-training support helped the Instructors to run a course. It is also possible that Instructors who intended to run a course were more likely to make contact for support. Either way, it appears that Instructors wanted support. In the qualitative data, Instructors mentioned

that they needed support initially to give them confidence to begin and that there were sometimes workplace barriers that had to be overcome. They also reported the need to debrief and to seek specific advice on issues that arose following teaching a course.

Recommendation 2: There is a need for on-going support of AMHFA instructors to assist their preparation for running a course and to deal with issues that arise during courses. An AMHFA trainer needs to be employed to take on this role.

Improvements to training materials

There was widespread support in the qualitative data for the cultural appropriateness of the training approach and the training materials. Nevertheless, some areas were identified as needing strengthening. A particular need is more adaptations of the materials to suit less literate course participants and those who learn by doing rather than by reading. While the AMHFA workbook was developed with this in mind, it is evident that it has not met this need. One idea put forward was for a pictorial flip-chart. There were also suggestions for greater use of role playing.

Recommendation 3: Materials need to be developed for teaching the course to people with lower levels of English literacy

Other areas for improvement that were suggested were developing DVDs involving Aboriginal people, incorporating more Aboriginal statistics and incorporating more local information on services etc. The issue of DVDs has already been covered by the development of AMHFA films involving Aboriginal people. These were unfortunately not available for use at the time the training took place. Now that they are available, their suitability needs to be evaluated. There were also suggestions about incorporating more Aboriginal statistics and information on local services. While the availability of Aboriginal statistics is limited, there may be more information that has become available since the course materials were written. The issue of local services may best be dealt with by Instructors when they adapt the material for a particular community. However, there may be merit in assisting Instructors to compile and share this sort of information.

Another development that is relevant to the revision of the manual and materials is the project funded by the beyondblue Victorian Centre of Excellence to develop mental health first aid guidelines for Aboriginal people using consensus of Aboriginal mental health experts. This project has developed expert consensus guidelines on:

- Cultural Considerations and Community Techniques
- Trauma and Loss
- Suicidal Thoughts and Behaviours
- Deliberate Self-Injury
- Depression
- Psychosis

Additional guidelines are currently being developed on first aid for problem alcohol use and problem drug use. These guidelines give a strong basis guiding the content of the AMHFA course. However, because they have only gradually become available during the period of course development and rollout, they have yet to be incorporated.

Recommendation 4: A revision of the AMHFA manual and teaching materials is needed to update relevant statistics and services and to incorporate the new Mental Health First Aid Guidelines for Aboriginal and Torres Strait Islander People.

Future evaluation of the program

This evaluation has examined how the AMHFA program could be improved in terms of its uptake, content, training approach and support for Instructors. It has not dealt with the effects of the program on the knowledge, attitudes and first aid behaviours of course participants. Until the course has been polished and reached a stage of relative stability, this would be premature. These more specific goals are appropriate for the next stage of research on the program.

This evaluation of the AMHFA program can be usefully considered using the framework of Campbell et al. (2000) for the design and evaluation of complex interventions to improve health. These authors point out that "Problems often arise in the evaluation of complex interventions because researchers have not fully defined and developed the intervention. It is useful to consider the process of development and evaluation of such interventions as having several distinct phases….Progression from one phase to another may not be linear. In many cases an iterative process occurs - for example, if an exploratory trial finds that a complex intervention is unacceptable to potential recipients, the theoretical basis and components of the intervention may have to be re-examined. Preliminary work is often essential to establish the probable active components of the intervention so that they can be delivered effectively during the trial. Identifying which stage of development has been reached in specifying the intervention and outcome measures will give researchers and funding bodies' reasonable confidence that an appropriately designed and relevant study is being proposed."

These authors propose that evaluation of complex interventions proceed through 4 phases:

- Phase I. Modelling (identifying the components of the intervention which are likely to work);
- Phase II. Exploratory trial;
- Phase III. Definitive randomized controlled trial; and
- Phase IV. Long-term implementation.

The present evaluation corresponds to Phase I of this framework. It provides a basis for improving and refining the intervention before a formal trial is carried out. After these improvements have been carried out, the AMHFA program will be reading for a Phase II exploratory trial. This would focus on measuring the impact of the training on the knowledge, attitudes and behaviour of 14-hour AMHFA course participants. The methods of measuring these outcomes need careful consideration to ensure that they are acceptable and culturally appropriate for Aboriginal people. Past research on the main MHFA program has used written questionnaires. However, this method may not be appropriate for Aboriginal participants who vary in literacy and may prefer oral approaches to assessment. The low uptake of the mental health literacy questionnaire in the present evaluation suggests that written questionnaires are not optimal for maximizing response. One possibility would be to use the method of systematically gathering and analysing stories of providing mental health first aid that was used for an evaluation of the standard MHFA course in a rural area by Jorm et al. (2005).

Recommendation 5: An exploratory trial needs to be carried out on the impact of the 14-hour AMHFA course on the knowledge, attitudes and helping behaviour of course participants. This trial needs to be carried out using an approach that is culturally acceptable to Aboriginal people.

References

Campbell, M., Fitzpatrick, R., Haines, A. et al. (2000). Framework for design and evaluation of complex interventions to improve health. *British Medical Journal*, 321, 694-696.

Jorm, A.F., Kitchener, B.A. & Mugford, S.K. (2005). Experiences in applying skills learned in a Mental Health First Aid training course: a qualitative study of participants' stories. *BMC Psychiatry*, 5, 43.

Kitchener, B.A. & Jorm, A.F. (2002). Mental health first aid training for the public: evaluation of effects on knowledge, attitudes and helping behaviour. *BMC Psychiatry*, 2, 10.

Appendix 1. Revised proposal for the evaluation which was approved by OATSIH

DEED OF VARIATION No 2

Between

The Commonwealth of Australia
as represented by
the Department of Health and Ageing (the Commonwealth)
ABN: 83 605 426 759

and

ORYGEN Research Centre
ABN 95 098 918 686

RECITALS:

A. The Parties wish to vary the agreement relating to adapting the existing Mental Health First Aid Program into a training project to increase Aboriginal and Torres Strait islander health workers' awareness of mental health problems, and to provide participants with skills in responding to early signs and symptoms of mental health problems, dated 9 February 2007.

(“the **Principal Agreement**”)

B. Clause 1.4 of the Principal Agreement states that no variation to this contract is binding unless it is agreed in writing between the Parties.

OPERATIVE PART:

1. The Parties vary the Principal Agreement as follows:

A. Services and Subcontractors

4. Courses (Instructor Training)

The eleven (11) MHFA Instructor Training courses will be offered in a range of sites nationally. The sites will be determined in conjunction with OATSIH and the following locations have been agreed:

-

LOCATION
Orange, NSW
Cairns, QLD
Brisbane, QLD
Broome, WA
Sydney, NSW
Alice Springs, NT
Melbourne, VIC
Adelaide, SA
Perth, WA
Hobart, TAS
Darwin, NT

2. Deliverables

e) 120 Aboriginal and Torres Strait Islander Instructors trained in the MHFA Train-the-Instructor course by 30 June 2008.

h) Produce an evaluation report of the participants' satisfaction with the course and changes in mental health literacy, with tables summarizing data analysis, by 31 December 2007.

Agreed changes to the evaluation process are as follows:

Workshops

- Will aim at eliciting qualitative data for analysis about participants' perception of and experience with Aboriginal Mental Health First Aid (AMHFA).
- Four evaluation workshops will be offered to trainers who have attended the 5-day AMHFA course. The locations of the Trainer Evaluation workshops are:
    - Orange
    - Broome
    - Alice Springs
    - Cairns
- A smaller community trainee evaluation workshop will be offered to community members who have attended a 14-hour (2-day) course. These workshops will be held in each location (Orange, Broome, Alice Springs and Cairns) in conjunction with the instructor evaluation workshop. However, they may be held at a different location to the instructor workshops, in order to access communities who have benefited from the course.
- Workshops will collect data on trainers' and trainees' perception of the AMHFA program, its strengths and weaknesses, as well as their perceived changes in knowledge of mental health, and confidence in assisting members of their community who may be experiencing mental illness.
- ORYGEN will pursue ethics approval through the University of Melbourne, as appropriate.

Dates

- The evaluation workshops are designed to be run six (6) months after the 5-day trainer's workshop has taken place in each region.
- All evaluation workshops and data collection to be finalised by 30 June 2008.
- Evaluation report to be submitted to OATSIH by 31 December 2008.

Questionnaires

- Will be provided to all trainers who have attended the seven (7) 5-day instructor training programs conducted in 2007 and the four (4) in 2008.
- Will aim at eliciting quantitative data for analysis.
- Will include a rating scale about changes in knowledge and confidence surrounding mental health, mental illness and first aid.

Mental Health Literacy

- The evaluation shall attempt to measure the possible change in trainers' knowledge of mental health and confidence in helping others with their community who may be experiencing mental illness. In order to measure this, two rating scale questions will be included on the Trainers' questionnaire, and during the evaluation workshops trainers will be encouraged to talk about their experience before and after their training.
- The evaluation will lead an attempt to gain a better understanding about people's knowledge of mental illness

D. Time-frame (see clause 2.1)

The contractor will perform the contract according to the following timetable:-

Activity	Completion Date
Research and evaluation strategy plan.	27 April 2007
MHFA Manual, Train-the-Instructor Course, and Workbook.	28 February 2007
Two (2) MHFA DVDs.	31 May 2007
Advertise the course, select suitable participants, and liaise with OATSIH State Offices, NACCHO and its affiliates regarding the advertisements.	28 February 2007
First Interim Project Progress Report.	29 June 2007
Establish a database of participants' contact details. Second Interim Project Progress Report.	31 December 2007
Completion of eleven (11) instructor training programs.	30 April 2008
Third Report - Interim Evaluation Progress Report.	15 August 2008
Final evaluation report of providing mental health first aid.	31 December 2008
Final Report.	31 December 2008

E. Fees (see clauses 3.1 and 19.5)

The Commonwealth agrees that the total Fees for the Contract payable to the Contractor shall be a maximum of $1,560,414.00 (GST inclusive), paid in the following instalments after the successful completion of each activity and the acceptance by the Commonwealth of a correctly rendered Tax Invoice.

3rd Payment:
Upon completion of eleven (11) Instructor (30 April 2008),
$238,937 (GST inclusive)

4th Payment:
Upon provision of the preliminary evaluation report of the training course participants' satisfaction gained (15 August 2008), $218,583 (GST inclusive).

5th Payment:
Upon completion of final report of the project as well as a final evaluation report
(31 December 2008),
$476,103 (GST inclusive)

2. The Principal Agreement, as amended by this Deed of Variation, constitutes the entire agreement between the Parties.

EXECUTED AS A DEED

SIGNED, SEALED AND DELIVERED

for and on behalf of the COMMONWEALTH OF AUSTRALIA

By

-- (Print name)	)))))	-- (Signature)
-- (Print the position held)	)))	Date: …../…………../200…..

in the presence of

-- (Witness's name)	)))))	-- (Signature)

SIGNED, SEALED AND DELIVERED

for and on behalf of

(Print the Contractor's / Participant's name)

By

-- (Print Director's name)	))))))	-- (Signature of Director) Date: …../…………../200…..

and

-- (Print the 2nd Director's or Company Secretary's name)	))))))	-- (Signature of Director or Company Secretary) Date: …../…………../200…..

Appendix 2. Ethics application and letter of approval

MODULE ONE:
CORE APPLICATION FORM AND CHECKLIST

BEFORE YOU BEGIN

This Application Form is for use by researchers proposing to conduct a research project involving humans. **All researchers must complete Module 1** and may have to complete other Modules (see checklist at Question 1.6).

Before you start this application, please read the **Module One: Core Application Guidelines** and the National Health & Medical Research Council's *National Statement on Ethical Conduct in Research Involving Humans* (1999).

Please do not delete the version date in the footer e.g. July 2006.

Office Use Only:

HREC Ref. No. 2007.36 MHREC		**Date of Approval:** / /	
Approval Period:	**From** / /	**To** / /	
Approval signature:			

SECTION A: PROJECT OVERVIEW

1.1 Application Date:

Monday 17th September 2007

1.2 Full Project Title

Evaluation of the Aboriginal Mental Health First Aid (AMHFA) Program

FOR CLINICAL TRIALS ONLY:

Company/Sponsor Protocol Number (if applicable):

Version:

Date:

1.3 Brief Lay Summary of the Project

Briefly describe the project. Refer to the Guidelines for the type of information and level of detail required in your response *(no more than one page)*

Mental Health First Aid (MHFA) is defined as the help provided to a person developing a mental health problem or in a mental health crisis. The help is given until appropriate professional treatment is received, or the crisis resolves (Langlands et al., 2007).
In 2002 a Mental Health First Aid (MHFA) course was developed in order to overcome the lack of sufficient public knowledge about mental illness and first aid skills that family, friends, or colleagues of people who may be developing a mental disorder, could use.
There are now two versions of this course; a 5-day MHFA Instructors course, which is undertaken by people with a background in mental health service in order to become an

accredited MHFA trainer; and a 12-hour MHFA course which is designed for anyone interested in proving first aid to someone who may be developing a mental illness or suffering from a mental health crisis.

Several trials have been carried out to evaluate the effects of the course. The first trial was uncontrolled, but two subsequent trials have involved randomized comparison with wait-list controls (Kitchener & Jorm, 2006). These trials showed benefits in knowledge (improved agreement with health professionals about treatment), in behaviour (improved helping behaviour), in intentions (greater confidence in providing help to others), and in attitudes (decreased social distance from people with mental disorders). One trial even produced an improvement in mental health of participants, even though this is not an aim of the course. The Mental Health First Aid course has been widely disseminated in Australia and has spread to a number of other countries, including the UK, Hong Kong, USA, Canada, Ireland, Singapore and Finland. There are currently over 500 instructors in Australia.

Although the evaluation of the MHFA program was very encouraging, it is acknowledged that the existing MHFA course may not be fully applicable in different cultures. For this reason, culturally adapted versions of the MHFA courses have been developed, including one for Aboriginal Australians. The Aboriginal Mental Health First Aid (AMHFA) program involves a 14-hour course, taught by suitably qualified Aboriginal instructors, who themselves have been trained in a 5-day AMHFA training program.

The development of the AMHFA course work initially involved cultural adaptation of the MHFA manual which was overseen by the Indigenous Strategies Working Group (ISWG) set up under the National Suicide Prevention Strategy and an Editorial Sub-Committee with Aboriginal mental health experience. Since the completion of the AMHFA adaptation in early 2007, there has been a cohort of Aboriginal instructors running the culturally adapted 14-hour courses in their own communities; by the middle of 2007 there were 36 Aboriginal instructors trained.

The present application involves an evaluation of both the 5-day training program for Trainers and the delivery of the 14-hour course to community members. The evaluation involves completion of written questionnaires and information from focus groups by both instructors and 14-hour course trainees. The research aims to evaluate whether or not the adaptation of the MHFA course for Aboriginal Australians has been effective in training Aboriginal and Torres Strait Islander people in a culturally respectful way. In addition, this research aims to evaluate whether as a result of their AMHFA training, the Aboriginal Trainers and their 14-hour course Trainees, feel that their knowledge of mental illness has increased and their confidence in helping someone within their community, who may be experiencing a mental illness, has improved.

References

Kitchener BA and Jorm AF (2006) Mental health first aid training: review of evaluation studies. *Australian and New Zealand Journal of Psychiatry.*40:6–8

Langlands R, Jorm AF, Kelly CM and Kitchener BA (2007) First aid for depression: A Delphi consensus study with consumers, carers and clinicians. *Journal of Affective Disorders* (in press; accepted 7 May 2007)

1.4 Relationship to Other Projects

Indicate whether the project is

☒ a new stand-alone project

☐ a sub-component of a previously approved project

☐ related to other previously approved projects (e.g. a follow-up study)

If the project is a sub-component of, or in some other way related to, a previously

approved project, provide project numbers for the other project(s). Also indicate which HREC(s) approved the other project(s).

1.5 Broad Category of Research

Tick the category which best fits the application:

☐ Social Science ☐ Clinical Research

☐ Psychological ☐ Clinical Drug or Device Trial ⇨ CTN ☐ or CTX ☐

☒ Public Health ☐ Other (please specify) ……………………………

1.6 Project Summary

Does the project involve

- Participants? Yes ☒ No ☐
  If yes, please complete section D of Module 1
- Collection, use or disclosure of information? Yes ☒ No ☐
  If yes, please complete section E of Module 1
- Drug or device trial? Yes ☐ No ☒
  If yes, please complete Module 2
- Use of human tissues? Yes ☐ No ☒
  If yes, please complete Module 3
- Human genetic research? Yes ☐ No ☒
  If yes, please complete Module 3
- Use of radiation? Yes ☐ No ☒
  If yes, please complete Module 4

1.7 Multi-Site Projects

Is the project a multi-site project? That is, does the project involve recruitment of participants at more than one site and/or collection of information from more than one organisation?

Yes ☒ No ☐

Does the project have to be reviewed by other HRECs?

Yes ☐ No ☒

Name **all Australian HRECs** to which this project has been or will be submitted. For each HREC, list all Australian sites involved in this project that are covered by the application to that HREC. If the number of sites for a particular HREC is very large (or unknown), such that listing

individual sites is not feasible, indicate the number of sites covered by that HREC (*e.g. 50 primary schools or 20 out of 60 child care centres, etc*). Indicate the status of the application to other HRECs.

HREC	**Site**	**Status of application** (*e.g. not yet applied/approved/ rejected/pending*)

SECTION B: RESEARCHERS AND CONTACT INFORMATION

1.8 List all researchers involved in this project

*Copy this table and repeat for each **Principal Researcher**.*

Title and Name	Prof. Anthony Jorm BA(Hons)(Qld), MPsych, PhD(NSW), GDipComp(Deakin), DSc(ANU) FASSA
Appointment	Professorial Research Fellow
Department	ORYGEN Research Centre
Institution	Dept. of Psychiatry, University of Melbourne
Mailing address	ORYGEN Research Centre Locked Bag 10, PARKVILLE VIC 3053
Describe what this researcher will do in the context of this project	Take responsibility for the methodology of the evaluation and contribute to the writing of a report.
Include a brief summary of relevant experience for this project	Tony Jorm has been a full-time researcher in the mental health area since 1984. He has been involved in 3 published evaluations of mental health first aid training. He has qualifications in psychology and public health.
Phone	(03) 9342 3747
Fax	(03) 9342 3745
Mobile/pager	0401 449 672
email	ajorm@unimelb.edu.au

*Copy this table and repeat for each **Associate Researcher**.*

Title and Name	Len Kanowski RN(Psych), MSc Mental Health (Wgong), M Int MH (Melb)

Appointment	Deputy Director, Mental Health First Aid
Department	ORYGEN Research Centre
Institution	Melbourne Health
Mailing address	ORYGEN Research Centre Locked Bag 10, PARKVILLE VIC 3053
Describe what this researcher will do in the context of this project	Provide expertise on the evaluation questions to be asked and how this information should be sought in a culturally appropriate way.
Include a brief summary of relevant experience for this project	Len Kanowski has developed the ATSI Mental Health First Aid training program and has trained ATSI instructors. He is a mental health nurse with training in transcultural mental health.
Phone	(03) 9342 3767
Fax	(03) 9342 3745
Mobile/pager	0412 909 803
email	len.kanowski@mh.org.au

Copy this table and repeat for each ***Associate Researcher****.*

Title and Name	Kara Eddington BA(Psych), GDipEd(School Counselling), GDip (Counselling Psych), MA(Indig Health)
Appointment	Program Co-ordinator, Aboriginal Mental Health First Aid
Department	ORYGEN Research Centre
Institution	Melbourne Health
Mailing address	ORYGEN Research Centre Locked Bag 10, PARKVILLE VIC 3053
Describe what this researcher will do in the context of this project	Provide expertise on the evaluation questions to be asked and how this information should be sought in a culturally appropriate way. Facilitate focus groups with ATSI trainers and trainees.
Include a brief summary of relevant experience for this project	Kara Eddington is an Aboriginal Mental Health First Aid trainer of instructors and a Psychologist. Together with Len Kanowski, she has trained the ATSI instructors.
Phone	(03) 9342 3768
Fax	(03) 9342 3745

Mobile/pager	0413 904 034
email	karae@unimelb.edu.au

*Copy this table and repeat for each **Associate Researcher**.*

Title and Name	Laura Hart BA(Hist), BSc hons (Psych)
Appointment	Research Assistant, Mental Health Literacy
Department	ORYGEN Research Centre
Institution	Dept. Psychiatry, University of Melbourne
Mailing address	ORYGEN Research Centre Locked Bag 10, PARKVILLE VIC 3053
Describe what this researcher will do in the context of this project	Assist with the development of the methodology, record the data from the focus groups and do a qualitative analysis of the themes which emerge.
Include a brief summary of relevant experience for this project	Laura Hart has an Honours degree in psychology and has worked as a Research Assistant during 2007. Her research experience has been in ATSI mental health first aid.
Phone	(03) 9342 3761
Fax	(03) 9342 3745
Mobile/pager	0401 266 246
email	lhart@unimelb.edu.au

1.9 Training

Will any of the researchers require extra training to enable their participation in this project?

Yes ☐ No ☒

If *Yes*, list the researchers, describe the training that is required and who will provide this training.

Researcher	**Training required**	**Who will provide training?**

1.10 Person to whom the HREC may also direct correspondence:

Title and Name	Laura Hart
Appointment	Research Assistant
Department	Research Assistant, Mental Health Literacy
Institution	ORYGEN Research Centre
Mailing address	Dept. Psychiatry, University of Melbourne
Phone	ORYGEN Research Centre Locked Bag 10, PARKVILLE VIC 3053
Fax	(03) 9342 3761
Mobile/pager	(03) 9342 3745
email	0401 266 246
	lhart@unimelb.edu.au

SECTION C: PROJECT DETAILS

1.11 Anticipated duration of project: ____14 months

1.12 Anticipated commencement date at this site: 01 / 10 / 2007

1.13 Anticipated completion date at this site: 31 / 12 / 2008

1.14 Detailed Project Proposal

If the project is a clinical drug or device trial DO NOT complete question 1.14, but move directly to question 1.15. The detailed project proposal for clinical drug or device trials is completed in Module 2.

(a) Project Checklist

Major Proposal Components	**Page and/or section number in the proposal**	**Not Applicable**
Literature review		☒
Rationale for project	*Protocol_HREC_2007.36* (attachment) Page 1	☐
Hypothesis/research questions	*Protocol_HREC_2007.36* (attachment) Page 3 & 4	☐
Aims	*Protocol_HREC_2007.36* (attachment) Page 3	☐
Methodology	*Protocol_HREC_2007.36* (attachment) Page 4	☐
Inclusion/exclusion criteria	*Protocol_HREC_2007.36* (attachment) Page 4 & 5	☐
Randomisation procedures		☒
Statistical or other analyses	*Protocol_HREC_2007.36* (attachment) Page 5	☐

(b) Project Proposal

Every application must be accompanied by a detailed proposal. You may type (or "paste") your detailed proposal directly into the text box below and/or you may attach pre-printed document(s) immediately following this page. Attachments should include brochures/pamphlets, questionnaires or surveys and any other relevant documents. **Ensure that all attachments are page numbered throughout.**

You should consult the Guidelines about the type of information that should be included in the detailed proposal.

Please see attached documents:

Protocol_HREC_2007.36

Protocol_Questionnaire1_HREC_2007.36

Protocol_Questionnaire2_HREC_2007.36

Protocol_Workshop1_HREC_2007.36

Protocol_Workshop2_HREC_2007.36

1.15 Registration and Reporting

(a) If your study is a clinical trial (see 'Module One Guidelines' for definition), is the trial registered with a clinical trials register that fulfils the ICMJE criteria?

Yes ☐ No ☐ Study not a clinical trial ☒

If *Yes*, please provide the name of the register, date of the registration and indicate who undertook the registration:

Name of register: ____________________

Date of registration:_________________

Researcher ☐
Sponsor ☐
Other ☐ Provide details:_________________________

Please provide the registration number (if known): ________________

If you answered *No* to 1.15(a), please justify your response in detail.

(b) Are there any limitations or restrictions on the publication of results by researchers?

Yes ☐ No ☒

If *Yes*, explain the nature of the limitations or restrictions.

(c) Will a report of the project outcomes (for example, group data) be publicly accessible at the end of the project?

Yes ☒ No ☐

If *Yes*, give details of the type of report and how it will be made available.

If *No*, explain why not.

A summary of the findings will be made available on the MHFA website (mhfa.com.au). The data may also be included in a journal article describing the development, roll-out and evaluation of the AMHFA program.

(d) Will a plain English summary of the project outcomes (for example, individual or group data) be made directly available to participants at the end of the project?

Yes ☒ No ☐ N/A ☐

If *Yes*, give details of the type of report and how it will be made available.

If *No*, explain why not.

A short summary of the findings will be sent to all participants by mail or e-mail.

1.16 Adverse or Unforeseen Events

What procedures are in place to manage, monitor and report adverse and unforeseen events? Consider adverse events in relation to all aspects of the project, including (where applicable) participants, researchers and management of information.

We are not anticipating any adverse events. While the topics covered in the focus groups concern the Mental Health First Aid course, rather than the participants themselves, it is possible that some participants could describe emotionally charged events during the meetings. Kara Eddington will be available to talk to anyone who wishes. She is a psychologist and has worked as a counsellor, including with Aboriginal communities.

SECTION D: PARTICIPANTS

Researchers should consult the Guidelines under Section D for a definition of "participant" for the purposes of this application.

If the project does NOT involve participants, do NOT complete this section, but go directly to Section E. If you are not completing Section D, you may delete it from your application to avoid unnecessary paper usage.

1.17 Number of participants

(a) Total number of participants in the project (at all sites combined)

150 (approx)

(b) Break down the number of participants for each site for which this HREC is responsible

Site	No. of participants
Orange Trainers Evaluation workshop	10
Orange Trainees evaluation workshop	10
Broome Trainers Evaluation workshop	13
Broome Trainees evaluation workshop	10
Alice Springs Trainers Evaluation workshop	15
Alice Springs Trainees evaluation workshop	10
Cairns Trainers Evaluation workshop	12
Cairns Trainees evaluation workshop	10
Trainers evaluation questionnaire (by mail)	60

(c) If the project involves more than one project group (e.g. control and experimental groups), how many participants will be in each group?

Trainer group n=110 (approx)
Trainee group n=40 (approx)

1.18 Participants - Details

(a) What categories of people will be recruited? *(e.g. cancer patients, children, people with learning disabilities, pensioners, etc)*

There will be two: (1) Aboriginal and Torres Strait Islander people who are accredited Aboriginal Mental Health First Aid Trainers; (2) both Aboriginal and non-Aboriginal people who have completed the 14-hour AMHFA course.

(b) Will Aboriginal and Torres Strait Islander people be targeted for recruitment to this project?

☒ Yes ☐ No

If *No*, are people of Aboriginal and Torres Strait Islander origin likely to be significantly represented in the cohort of participants recruited?

☐ Yes ☐ No

(c) What will be the age range of participants?

18+ years

(d) What ethical issues do the criteria for inclusion or exclusion give rise to?

Given that this project is an *evaluation* of the AMHFA program, the inclusion of both trainers and trainees in the research is not thought to give rise to any ethical issues.

1.19 Recruitment of Participants

(a) Describe the procedure for recruitment of participants. Include information about

- Source of participants
- Exactly how potential participants will be identified
- Exactly how potential participants will be contacted and by whom, including whether the person making initial contact has any relationship to potential participants
- The method(s) by which information is provided to potential participants (*e.g. verbally, information sheet, fliers, posters, etc*)
- The setting in which information is provided (*e.g. over the telephone, in a clinic or doctor's surgery, through the mail, etc*)

Trainers.
Trainers will be recruited for research participation from the list of accredited AMHFA Instructors that is held by the AMHFA. The trainers will be mailed a *Participant Information Sheet* with attached consent form and evaluation questionnaire. Participants will be encouraged to contact any member of the research team, via phone or email, should they have any questions regarding their participation in the research. The participants will be familiar with the researchers Len Kanowski and Kara Eddington, who were the facilitators of the AMHFA 5-day course which all participants attended to become accredited trainers.

Trainees.
Trainees will be recruited *via* the Trainers. Trainers will have run 14-hour AMHFA courses in their own community, once they became accredited. Trainers will be asked to send via mail, or deliver in person, a *Participant Information Sheet to* those who have attended their courses. Trainees will be invited to attend the

short-evaluation workshops in the presence of their Trainers. Once present at the short-evaluation workshops, the Research Assistant and workshop facilitator will discuss the details on the *Participation Information Sheet* before requesting that the participants sign a consent form.

() Will any follow-up procedures be used to improve the rate of participation?

Yes ☐ No ☒

If *Yes*, describe the procedures.

(c) Will any dependent or unequal relationship exist between anyone involved in the recruitment and the potential participants (e.g. counsellor/client, teacher/student, doctor/patient, warder/prisoner, etc)?

Yes ☒ No ☐

If *Yes*:

(i) What is the nature of the dependent or unequal relationship?

The recruitment of the Trainees will occur via Aboriginal or Torres Strait Islander people who will have trained them in AMHFA 14-hour course. This means that there will be a student/teacher relationship between participants within this project.

(ii) How will ethical issues arising from the unequal relationship be addressed?

Both groups of participants (Trainers/Trainees) will be given their own forum to discuss their views of the AMHFA program. Although the Trainers may be present at the short-evaluation workshops for the Trainees (Stage 2), the discussion will focus on the stories of the Trainees and their perceptions of the 14-hour AMHFA course, its presentation and content.

The *Participant Information* Sheet notes that grievances can be directed to Prof. Anthony Jorm who is independent of the training process. Contact details for the Melbourne Health HREC will also be provided to all participants should they wish to discuss ethical issues of this research, independent of the researchers.

(d) Will a dual relationship exist between any researcher and participants (e.g. will any of the researchers also be responsible for project, program or administrative oversight within the organisation where it is proposed to recruit participants and carry out the research)?

Yes ☐ No ☒

If *Yes*:

(i) What is the nature of the dual relationship?

(ii) How will ethical issues arising from the dual relationship be addressed?

(e) Will reimbursement, payment or other offers be made to participants?

Yes ☒ No ☐

If *Yes*, provide details.

Travel and meal expenses for the trainers travelling long distances to attend the workshops will be reimbursed.

1.20 Information to Participants

(a) Does the project design involve deliberate deception of participants?

Yes ☐ No ☒

If *Yes*, explain why the real purpose of the research needs to be concealed.

(b) Will information about the project be given to participants in the form of a **written** Participant Information?

Yes ☒ No ☐

If *No*, give reasons.

1.21 Consent

(a) Will any of the participants have the capacity to give voluntary and informed consent? Yes

☒ No ☐

If *Yes*, how will consent be obtained?

☒ Written consent form

☐ Verbal – explain below how consent will be recorded

☒ Implied consent (*e.g. by completing a questionnaire*) – give details

In the first stage of the evaluation, questionnaires will be sent to all trainers who undertook the 5-day AMHFA course in 2007. Consent to participate in this part of the research will be implied by the completion and mailing of the questionnaire back to ORYGEN.

In the second stage of the research, all Trainers who intend to participate in the evaluation workshops will be asked to complete a written consent form. Trainers will be sent a consent form via mail, in conjunction with their Participant Information Sheet regarding the evaluation workshops. Trainers will be required to read the Information sheet, sign the consent form, and return it to ORYGEN, *before* they travel to the workshops. The consent procedure will therefore not be done in person for the Trainers.

In the Trainee Community Evaluation Workshops, the consent procedure will be done in person. All participants will receive a Trainee Participant Information Sheet, and a verbal explanation of research procedures from the Research Assistant before being asked to complete their consent forms. The consent procedure will occur before the commencement of the Evaluation workshop.

(b) Will any of the participants **not** have the capacity to give voluntary and informed consent? Yes ☐ No ☒

If *Yes*, who will be asked to provide consent *(tick as many as apply)*?

☐ Parent/guardian

☐ Person responsible (as defined by the *Guardianship and Administration Act* 1986)

☐ Procedural authorisation (as defined by the *Guardianship and Administration Act 1986*). ***Please make sure you also answer question 1.21d below***

☐ Other – give details

How will consent be obtained?

☐ Written consent form

☐ Verbal – explain below how consent will be recorded

(c) How will competence to give consent be determined and who will make this determination?

The participants must be over the age of 18, and have completed either the AMHFA 5-day trainers course or 14-hour AMHFA course

(d) If this research project is likely to involve procedural authorisation (see question 1.21(b) above), provide details of the following:

- Justify the potential use of procedural authorisation in the research project - that is, provide details regarding how this research project may satisfy the requirements for procedural authorisation;
- Provide details of the steps to be taken to identify and contact a 'person responsible' prior to, and following, the use of procedural authorisation.

ATTACH A COPY OF PARTICIPANT INFORMATION AND CONSENT FORM(S) AT THE END OF MODULE ONE.

1.22 Consequences of Participation

(a) What are the potential or actual harms of participation (if any)?

None are anticipated.

(b) Is there any possibility of inconvenience to participants?

Yes ☒ No ☐

If *Yes*, please describe.

Participants will need to arrange to travel to the workshops and have time taken out of their normal employment routine in order to participate.

(c) Is there a need for special counselling?

Yes ☐ No ☒

If *Yes*, describe the form of the counselling: how it will be conducted, when and by whom?

(d) Will participants be denied access to other treatments, therapies or services as a result of participation? Yes ☐ No ☒ N/A ☐

Give details.

(e) Are there any potential benefits to the participants?

The results will be used to improve the training of AMHFA instructors and the content of the AMHFA course.

1.23 Other Ethical Issues

Does the project present any other ethical issues with respect to participation? *(e.g. Issues related to illegal activities; indigenous or other special community or cultural groups; risks to third parties, collectivities; etc)*

The project involves Aboriginal and Torres Strait Islander participants. The project has involved extensive indigenous consultation and has been funded by the Office of Aboriginal and Torres Strait Islander Health (OATSIH). One of the investigators (Kara Eddington) is Aboriginal.

SECTION E: COLLECTION/USE/DISCLOSURE OF INFORMATION

Researchers have a legal as well as an ethical obligation to consider privacy issues. The following questions assist both the researcher and the HREC to fulfil their obligations under State and Commonwealth privacy legislation.

You may delete questions or parts of questions that you are not required to answer, in the interests of reducing paper usage.

1.24 Collection of Information Directly from Individuals

(a) Does the project involve collection of information directly from individuals about themselves?

☐ No - **go to Question 1.25**

☒ Yes – answer the following questions:

(b) What type of information will be collected? (*Tick as many as apply*)

☒ personal information

☐ sensitive information

☐ health information

(c) Does the Participant Information and Consent Form explain the following:

The identity of the organisation collecting the information and how to contact it?	Yes☒	No☐
The purposes for which the information is being collected?	Yes☒	No☐
The period for which the records relating to the participant will be kept?	Yes☒	No☐
The steps taken to ensure confidentiality and secure storage of data?	Yes☒	No☐
The types of individuals or organisations to which your organisation usually discloses information of this kind?	Yes☒	No☐
How privacy will be protected in any publication of the information?	Yes☒	No☐
The fact that the individual may access that information?	Yes☐	No☒
Any law that requires the particular information to be collected?	Yes☐	No☒
The consequences (if any) for the individual if all or part of the information is not provided	Yes☒	No☐

If you answered "*No*" to any of these questions, give the reasons why this information has not been included in the Participant Information and Consent Form.

These items are not applicable to the present project.

1.25 Do Other Questions in this Section have to be Completed?

(a) Does the project involve the collection, use or disclosure of **identified or potentially identifiable** information from sources other than the individual whose information it is?

(see Module One Guidelines for definitions)

☒ No – **Go to Question 1.30 and do not answer the remainder of question 1.25, 1.26, 1.27, 1.28 or 1.29**

1.30 General Issues

(a) How many records will be collected, used or disclosed? Specify the information that will be collected, used or disclosed *(e.g. date of birth, medical history, number of convictions, etc)*

Number of records: 3 Protocol Questionnaire1 (see attachment) Protocol Questionnaire2 (see attachment) Protocol Workshop1 (see attachment) Protocol Workshop2 (see attachment) **Type of information:** Age, gender, DOB, qualifications in the mental health field, location of residence, perceptions of the AMHFA course.

(b) Does the project involve the adoption of unique identifiers assigned to individuals by other agencies or organisations?

☐ Yes ☒ No

If *Yes*, give details of how this will be carried out in accordance with relevant Privacy Principles (e.g. HPP 7, VIPP 7 or NPP 7).

(c) Does the project involve trans-border (i.e. interstate or overseas) data flow?

☒ Yes ☐ No

If *Yes*, give details of how this will be carried out in accordance with relevant Privacy Principles (e.g. HPP 9, VIPP 9 or NPP 9).

This is an evaluation of a national program and will collect data across several states/territories.

(d) For what period of time will the information be retained? How will the information be disposed of at the end of this period?

All data files will be held under password protection, retained for 5 years after publication, then deleted from our records.

(e) Describe the security arrangements for storage of the information. Where will the

information be stored? Who will have access to the information?

Information on paper questionnaires will be coded into an electronic format and saved as a software file either in MSExcel, MSWord or SPSS. The paper questionnaires will be shredded. During data collection and coding the paper questionnaires will be held in locked filing cabinets and will be stored separately from other documents that contain identifiable data (such as the consent forms).

Identifiable data on consent forms will be digitally scanned and stored electronically in a computer file then the paper will be shredded. During data collection and coding the paper forms will be held in locked filing cabinets and stored separately from other documents that contain participant responses.

The Research Assistant will be responsible for the filing of the hardcopy documents and the Principal Researcher will hold the keys to access the cabinets in which they will be stored.

The verbal contribution to discussion at the workshops will be coded, entered in electronic format and saved as a software file either in MSExcel, MSWord, or NVivo7.

All electronic documents will be held under password protection and will only be accessible by the Principal Researcher and the Research assistant.

(f) How will the privacy of individuals be respected in any publication arising from this project?

All data and findings published as a result of this research will be in non-identifiable, statistical summary form or as anonymous quotations.

1.31 Other Ethical Issues

Discuss any other ethical issues **relevant to the collection, use or disclosure of information** proposed in this project. Explain how these issues have been addressed.

In Question C.2 of the Trainers' evaluation questionnaire, participants are asked to identify themselves by name. However, this information has been requested for the purpose of matching the courses that have been run in conjunction with other AMHFA trainers. If the participant has not run a course in conjunction with another trainer, they will not be asked to identify themselves. If the trainer has run a course with another trainer, then course information will be paired, so that the number of courses run is not incorrectly inflated, and then names will be erased from the document to render it non-identifiable data.

SECTION F: FINANCIAL AND RELATED ISSUES

1.32 Potential Conflict of Interest

Do any researchers have any financial interests in this research or its outcomes, or any relevant affiliations?

Yes ☐ No ☒

If *Yes*, give details

If you have declared a potential conflict of interest, you should include an appropriate comment on the Participant Information and Consent Form.

1.33 Indirect Costs

Will there be payments over and above the direct costs of this project (e.g. conference and travel, recruitment incentives, equipment)?

Yes ☐ No ☒

If *Yes*, please provide details of payments and justification for them.

1.34 Project Budget

Attach a detailed project budget to this application.

Have you included:

- Salaries with on-costs ☒
- Administration costs ☒
- Research consumables (for example, bed-day costs) ☒
- Participant reimbursement ☒
- Departmental charges (e.g. Pharmacy, Pathology, Radiology) ☐

If a detailed budget is not being provided, give reasons.

This project has already been funded as part of a consultancy from OATSIH to roll out the AMHFA program. There are no costs to Melbourne Health.

1.35 Source of Funding

How will this project be funded? List all sources of funds (*e.g. commercial sponsorship, grant,*

departmental funds etc).

Source	Amount in $	Status of Funds	
		Application pending	**Funds Available**
OATSIH (total for consultancy, including evaluation)	$1,560,414		

1.36 Funds Coverage

Do the funds presently available or applied for cover all requirements to conduct the project?

Yes ☒ No ☐

If *No*, explain how the shortfall will be made up or dealt with.

1.37 Claims through Medicare

Will any charges be incurred by Medicare as a result of patient screening or participation?

Yes ☐ No ☐ N/A ☒

If *Yes*, has the Health Insurance Commission been notified and have they given permission?

Yes ☐ No ☐

1.38 Declaration by Researchers

Project Title:

I/WE, the researcher(s) agree:

- To only start this research project after obtaining final approval from the Institution's Human Research Ethics Committee (HREC);
- To conduct this research project in accordance with the protocols and procedures as approved by the HREC;
- To only carry out this research project where adequate funding is available to enable the project to be carried out according to good research practice and in an ethical manner;
- To provide additional information as requested by the HREC;
- To provide progress reports to the HREC as requested, including a final report and a copy of any published material at the end of the research project;
- To maintain the confidentiality of all data collected from or about project participants;
- To notify the HREC in writing immediately if any change to the project is proposed and await approval before proceeding with the proposed change;
- To notify the HREC in writing immediately if any adverse event occurs after the approval of the HREC has been obtained;
- To agree to an audit if requested by the HREC;
- To only use data and any tissue samples collected for the study for which approval has been given;
- To only grant access to data to authorised persons; and
- To maintain security procedures for the protection of privacy, including (but not restricted to): removal of identifying information from data collection forms and computer files, storage of linkage codes in a locked cabinet and password control for access to identified data on computer files.

I/we have read the NH&MRC *National Statement on Ethical Conduct in Research Involving Humans* 1999 and will observe the principles set out in that document and in the *Declaration of Helsinki*.

Name of principal researcher
Prof. Anthony Jorm

Signature **Date**

Name of researcher
Mr. Len Kanowski

Signature **Date**

Name of researcher
Ms. Kara Eddington

Signature **Date**

Name of researcher
Ms. Laura Hart

Signature **Date**

1.39 Certification by Principal Researcher and Head of Department

Project Title: Evaluation of the Aboriginal Mental Health First Aid (AMHFA) program

Certification By Principal Researcher

I accept responsibility for the conduct of this research project according to the principles of the *National Statement on Ethical Conduct in Research Involving Humans* published by the National Health & Medical Research Council (June 1999).

I certify that all researchers and other personnel involved in this project are appropriately qualified and experienced or will undergo appropriate training to fulfil their role in this project.

As principal researcher, I will take responsibility for the confidential maintenance of records for 7 years after completion of the project (15 years in the case of drug trials).

Name of principal researcher:
Prof. Anthony Jorm

Signature **Date**

Acceptance by Head of Department/Divisional Director/Authorised Institutional Official*

I certify that I have read the research project application named above.

My signature indicates that I support this research project.

Name of Head of Department (or appropriate person):
Prof. Patrick McGorry

Name of Department (or relevant section):
ORYGEN Research Centre

Signature **Date**

*Where an investigator is also Head of Department, certification must be sought from the person to whom the Head of Department is responsible. Investigators, who are also Department Heads or Divisional Directors, must not approve their own research on behalf of the Institution.

1.40 Declaration by Head of Supporting Department

This form is to be completed by the Head of any Department that is providing support or services to the research project, but which does not have any member(s) on the research team.

NA

MODULE ONE: CHECKLIST

Please satisfy each of the following before submitting the application. Failure to do so will delay review of the application.

Include a copy of this checklist (completed & signed) with the application.

Full Project Title

Evaluation of the Aboriginal Mental Health First Aid (AMHFA) Program

Have you answered all relevant questions in Module 1?	☐
Is a staff member from the Institution listed as a co-researcher?	☐
Have you defined all technical terms and abbreviations used?	☐
Have you included all questionnaires or surveys to be used?	☐
Have you completed all financial details in Module 1, Section F?	☐
Have you included a detailed project budget?	☐
Have you declared all potential conflicts of interest?	☐
Have you included any other site-specific modules or documentation specifically required by the Institution(s) at which you intend to conduct your research?	☐
Do the Participant Information and Consent Form(s) show the name of the Institution, with pages numbered & dated in the footer?	☐
Are all relevant modules stapled separately, in order? *Note: Attach attachments for each module at the end of that module*	☐
Are all pages (including attachments) numbered in the footer?	☐
Have you provided an original and the required number of copies?	☐
Have you completed the form "Declaration by Researcher(s)?	☐
Have you completed the form "Certification by Principal Researcher and Head of Department"?	☐
Has a completed "Declaration by Head of Supporting Department" been included for each supporting department (if applicable)?	☐

Name of principal researcher
Prof. Anthony Jorm

Signature **Date**

PO Royal Melbourne Hospital
Parkville Victoria 3050
Telephone: 61 3 9342 8530
Facsimile: 61 3 9342 8548
Email: research.directorate@mh.org.au
Website: www.mh.org.au/research
ABN 73 802 706 972

Mental Health Research and Ethics Committee Approval Certificate

Telephone: 9342 7215 Facsimile: 9342 8548

This is to certify that

MHREC Project No: 2007.36 **Approval date:** 7/11/07 **Expiry date:** 31/12/2008

Project Title: **Evaluation of the Aboriginal Mental Health First Aid (AMHFA) Program**

Principal Investigator: Professor Anothony Jorm
Professorial Research Fellow
ORYGEN Research Centre

Sponsored by: N/A

Protocol No: N/A

Participant Information and Consent Form: Version 7 dated August 2007 (Trainer Evaluation Workshop Information Sheet, Trainee Questionnaire and Workshop Information Sheet and Trainer Questionnaire Information Sheet)

Investigator Brochure: N/A

Conducted at: Evaluation workshops to be held in Orange, Broome, Alice Springs and Cairns **have been approved.**

It is now your responsibility to ensure that all people conducting this research project are made aware of which documents have been approved.

This approval is subject to ongoing, current and valid insurance coverage throughout the duration of the conduct of the study.

You are required to notify the Manager of the Mental Health Research and Ethics Committee of:

- Any change in the protocol and the reason for that change together with an indication of ethical implications (if any) by submitting an amendment to the study;
- Serious adverse effects on subjects and the action taken to manage them, including an amended Patient Information and Consent Form where appropriate;
- Any unforseen events;
- Your inability to continue as Principal Investigator, or any other change in research personnel involved in the study;
- A delay of more than 12 months in the commencement of the project; and
- The actual date of commencement of the study.

You are required to submit the following reports to the Mental Health Research and Ethics Committee:

- An Annual Report every twelve months for the duration of the project; and
- A detailed Final Report at the conclusion of the project.

The Mental Health Research and Ethics Committee may conduct an audit at any time.

An extension of the project beyond the stated conclusion date should be sought from the Mental Health Research and Ethics Committee.
Signed:

Michelle Clemson
Manager
Mental Health Research and Ethics Committee

Appendix 3. Results of logistic regression analyses predicting whether or not instructors ran a course

Characteristic Analysed	Categories	Odds ratios (and p-values) adjusting for time since training	Odds ratios (and p-values) adjusting for time since training and other predictors[1]
Gender	Male Female	Odds ratio = .376 p=.293	
Weeks since Instructor training	15 possible end dates (see Table 1)	Odds ratio = .041 p<=.001	Odds ratio = 1.027 p= .025
Workplace	Data missing Aboriginal Medical Service Government health service Mental health service Health service not otherwise specified Legal service Community service (eg. family, youth, Centacare, Relationships Australia etc) Education (school/university) Government (eg. DHS, Docs) Other	Odds ratio = .992 p= .902	
Work position	Data missing Health Worker / AOD Counsellor SEW / Support/ Youth/ Protection worker Mental Health Worker/Counsellor/Psychologist Education officer / Teacher Development/Project officer Manager/ Coordinator / Director Other (eg. consultant)	Odds ratio = .996 p= .929	
State	7 possible states or territories	Odds ratio = .863 p=.153	
RRMA	Capital city - M1 Metropolitan centre - M2 Large rural centre - R1 Small rural centre - R2 Other rural areas - R3 Remote centre - Rm1 Other Remote centre - Rm2	Odds ratio = 3.388 p= .119 Odds ratio = 4.054 p= .194 Odds ratio = 5.291 p= .040 Odds ratio = 2.731 p= .218 Odds ratio = 1.529 p= .642 Odds ratio = 3.787 p= .149	
Years in MH	Data missing/none 5 years or less 6 – 10 years experience More than 10 years Experience mentioned but length of time not determined	Odds ratio = 0.886 p= .899 Odds ratio = 4.168 p= .168 Odds ratio = 0.645 p= .667	

Qualification	Data missing Senior Secondary Certificate of Education, Certificate Level or Diploma, Bachelor Degree, Graduate Certificate or Graduate Diploma Postgraduate degree	Odds ratio = 1.391 p= .373	
Teaching / Training	Missing data No experience Some experience Experienced Qualifications in teaching/training	Odds ratio = .375 p= .128 Odds ratio = .276 p= .028 Odds ratio = .587 p= .257 Odds ratio = .940 p= .910	Odds ratio = .572 p = .418 Odds ratio = .347 p = .085 Odds ratio = .631 p = .357 Odds ratio = .843 p = .773
Consumer	Missing data Instructor has a mental illness Instructor does not have a mental illness	Odds ratio = .799 p=.725	
Carer	Missing data Instructor is carer of loved one with mental illness Instructor not a carer	Odds ratio = .670 p= .082	Odds ratio 2.090 p= 0.81
Scholarship	OATSIH Scholarship awarded No scholarship	Odds ratio = 1.089 p= .804	
MH knowledge	Missing data Instructor mentioned desire to increase their mental health knowledge Instructor did not mention	Odds ratio = 1.397 p=.105	
Mention: teach, educate, present, deliver, train?	Missing data Instructor mentioned desire to teach, educate etc Instructor did not mention	Odds ratio = 1.032 p=.884	
MADE contact?	No Yes	Odds ratio = 1.01 p= .007	Odds ratio = 2.446 p = .023
Phone Contacts	No Yes	Odds ratio = 1.197 p=.003	Odds ratio = 1.623 p = .386
Email Contacts	No Yes	Odds ratio = .755 p= .038	Odds ratio = 1.197 p = .708
Face-face	No Yes	Odds ratio = 1.259 p= .001	Odds ratio = 2.738 p = .020
Evaluation	No Yes	Odds ratio = .819 p= .099	Odds ratio = 1.598 p = .405
Conference	No Yes	Odds ratio = .912 p= .121	

[1]The predictors adjusted for in the simultaneous regression were all those significant at the p<.10 level in the preceding column