

University of Brighton

MSc in Public Health

MDM 96 Dissertation Module

**How are the skills learnt on Mental Health
First Aid training used to help people with
mental health problems?**

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Abstract

The aim of this study was to better understand how attendance on the Mental Health First Aid course affects the help and support given by health professionals to patients or members of the public living with mental health problems.

The study applied a generic qualitative approach using phenomenology and grounded theory. Semi-structured interviews were conducted with three participants, once before they attended the MHFA training and then again three months following. All participants were health trainers and had no prior training in mental health.

Analysis of pre and post MHFA attendance interview data using a structured coding process produced distinct themes. Comparisons between the pre and post data under these themes enabled a better understanding of how skills and knowledge learnt on the MHFA training are used to help people with mental health problems.

MHFA training appears to increase the help and support provided by health trainers to clients living with mental health problems, through the provision of a more comfortable environment for clients to discuss mental health problems and the provision of help and guidance towards appropriate support. Other contextual factors, notably good relationships with and awareness of mental health service providers appear integral to the extent to which health trainers were able to offer such help.

In light of national policy on reducing the stigma attached to mental health problems and the importance of early intervention, consideration should be given to MHFA as a training need for health trainers and other front line health professionals who have had no previous training in mental health. The small sample size in this study limits the reliability of the results. Whilst the study has made a start to addressing research gaps, more research is required using the methodology developed in this study and a larger sample size to strengthen the meaning of the results and further understand how the skills learnt on the Mental Health First Aid training are used to improve the help and support given by health professionals to patients or members of the public living with mental health problems.

Contents

STUDENT ASSIGNMENT DECLARATION FORM	2
ACKNOWLEDGEMENTS	3
ABSTRACT	4
CONTENTS	5
TABLE OF FIGURES	7
LIST OF ABBREVIATIONS	8
1.0 INTRODUCTION	9
2.0 BACKGROUND	11
2.1 PREVALENCE AND ECONOMICS OF MENTAL HEALTH PROBLEMS	11
2.2 EARLY INTERVENTION AND STIGMA	11
2.3 MENTAL HEALTH STRATEGY IN ENGLAND	12
2.4 MENTAL HEALTH FIRST AID	13
2.5 WHERE DOES MHFA FIT WITH NATIONAL STRATEGY?	14
3.0 LITERATURE REVIEW	15
3.1 SEARCH STRATEGY	15
3.2 MHFA RESEARCH GAPS	16
3.3 MHFA LITERATURE TO INFORM STUDY METHODOLOGY	17
3.4 OTHER RELEVANT LITERATURE TO INFORM STUDY METHODOLOGY	20
3.5 HOW THE LITERATURE INFORMS THIS RESEARCH	21
3.6 RESEARCH QUESTION	22
3.7 RESEARCH OBJECTIVES	23
4.0 METHODOLOGY	24
4.1 STUDY DESIGN	24
4.1.1 <i>Deciding on an approach - phenomenology</i>	24
4.1.2 <i>Epistemological and ontological influences</i>	25
4.1.3 <i>Deciding on an approach – grounded theory</i>	26
4.1.4 <i>Chosen approach – generic qualitative research</i>	27
4.2 TRANSLATING THE DEFINED APPROACH INTO APPROPRIATE DATA COLLECTION	27
4.3 DEVELOPING INTERVIEW QUESTIONS, CHECKING VALIDITY AND DETECTING AND COMPENSATING FOR ‘RESEARCHER EFFECTS’ AND ‘RESEARCHER BIAS’	28
4.4 PARTICIPANT INCLUSION AND EXCLUSION CRITERIA	29
4.5 REGULATORY APPROVAL	30
4.6 ETHICAL ISSUES	30
4.7 SAMPLING	31
4.8 SAMPLE SIZE	32
4.9 PARTICIPANT REQUIREMENTS	32
4.10 RECORDING EQUIPMENT	33
4.11 CONFIDENTIALITY AND DATA HANDLING	33
4.12 RESEARCH TIMELINE	33
5.0 ANALYSIS	34

5.1	TRANSCRIBING THE DATA	34
5.2	APPROACHES TAKEN	34
5.3	THEMATIC DEVELOPMENT	36
5.4	DATA COMPARISON	38
6.0	RESULTS	40
6.1	CATEGORY ONE: THE HEALTH TRAINER SERVICE	41
6.1.1	<i>The core role of health trainers</i>	41
6.1.2	<i>Case finding</i>	41
6.1.3	<i>Impact of health trainer role on mental health</i>	41
6.1.4	<i>Impact of wider social determinants on mental health</i>	42
6.1.5	<i>Summary of category one - the health trainer service</i>	43
6.2	CATEGORY TWO: DISCUSSING MENTAL HEALTH PROBLEMS WITH CLIENTS	43
6.2.1	<i>Language used</i>	43
6.2.2	<i>Recognising mental health problems</i>	44
6.2.3	<i>Bringing mental health problems into the discussion</i>	45
6.2.4	<i>Comfort with conversations on mental health problems</i>	47
6.2.5	<i>Providing empathy and the opportunity to talk</i>	47
6.2.6	<i>Summary of category two – discussing mental health problems with clients</i>	48
6.3	CATEGORY THREE: LINKS WITH MENTAL HEALTH SERVICES	49
6.3.1	<i>Awareness of mental health services</i>	49
6.3.2	<i>Relationship with mental health services</i>	50
6.3.3	<i>Referrals to mental health services</i>	50
6.3.4	<i>Summary of category three – links with mental health services</i>	52
6.4	RESULTS SUMMARY	52
7.0	DISCUSSION	53
7.1	COMPARING THE DATA	53
7.2	LINKING THE THEMES	55
7.3	HAS THE STUDY MET THE RESEARCH OBJECTIVES	57
7.4	STRENGTHS AND WEAKNESSES OF THE STUDY	59
7.4.1	<i>Validity</i>	59
7.4.2	<i>Reliability</i>	60
7.4.3	<i>Generalisability</i>	61
7.5	WHAT DOES THIS STUDY ADD TO CURRENT KNOWLEDGE AND WHAT RESEARCH IS STILL NEEDED?	62
7.6	RECOMMENDATIONS FOR FUTURE RESEARCH	62
7.7	DISCUSSION SUMMARY	63
8.0	CONCLUSION	64
9.0	REFERENCES	65
10.0	BIBLIOGRAPHY	68
11.0	WEBSITE RESOURCES	69
APPENDICES		70
APPENDIX A:	INTERVIEW QUESTIONS USED IN OTHER RESEARCH	70
APPENDIX B:	BRIGHTON WEST RESEARCH ETHICS COMMITTEE RECOMMENDATIONS	71
APPENDIX C:	CONSENT FORM	72
APPENDIX D:	PARTICIPANT INFORMATION SHEET	73

APPENDIX E: ANALYTICAL PROMPTS	76
APPENDIX F: ELEMENTS OF THE AXIAL CODING MODEL (STRAUSS AND CORBIN 1998)	76
APPENDIX G: EXAMPLE OF CODING	77
APPENDIX H: THE ROLE OF HEALTH TRAINERS	78
APPENDIX I: RESEARCH TIMELINE	79
APPENDIX J: INTERVIEW MATRIX	80

Table of figures

Figure 1: Thematic hierarchy developed from pre and post MHFA interviews	1
Figure 2: Thematic links	1

List of abbreviations

MHFA	Mental Health First Aid
PCT	Primary Care Trust
NHS	National Health Service
NIMHE	National Institute for Mental Health in England
ASSIA	Applied Social Sciences Index and Abstracts
CINAHL	Cumulative Index to Nursing and Allied Health Literature
IBSS	International Bibliography of the Social Sciences
NICE	National Institute for Health and Clinical Excellence
NSF	National Service Framework
RSPH	Royal Society of Public Health
ASIST	Applied Suicide Intervention Skills Training

1.0 Introduction

In any one year, 1 in 4 British adults experience at least one diagnosable mental health problem (Singleton 2000). Stigma and discrimination around mental health limits understanding, creates unnecessary fear and can be detrimental to recovery (Department of Health 1999). Standard One of the National Service Framework for Mental Health states that health and social services should promote mental health for all, by working with individuals and communities, combating discrimination against individuals and groups with mental health problems, and promoting their social inclusion (Department of Health 2004).

Mental Health First Aid (MHFA) was introduced to England in 2007 by the National Institute for Mental Health in England (NIMHE). MHFA is a 12 hour training course that hopes to contribute towards mental health policy in England, and aims to:

- Preserve life where a person may be a danger to themselves
- Provide help to prevent mental health problems developing into a more serious state
- Promote recovery of good mental health
- Provide comfort to a person experiencing mental ill health
- Raise awareness of mental health issues in the community
- Reduce stigma and discrimination

To achieve these aims, MHFA teaches participants to:

- recognise distress
- recognise the difference between Therapy and First Aid
- be confident in administering help in a First Aid situation
- provide initial help and guide a person towards appropriate support

Whilst MHFA has been seen to increase participant knowledge of mental health problems, confidence in providing help and agreement with health professionals about appropriate interventions (Kitchener

2002, Kitchener 2004, Jorm 2004), published studies have had large conflicts of interest, where the researchers have also been the developers of MHFA.

Further qualitative research is required in order to better understand the behavioural changes undergone by participants who attend the MHFA training, and how these changes might have enabled participants to provide help to someone experiencing a mental health problem and to guide a person towards appropriate support. In other words, do participants apply the skills they have learnt on the MHFA training to help people with mental health problems?

This study seeks to develop an understanding of the practical application of MHFA skills to help people with mental health problems. The term 'practical application' is used to help to distinguish this study from previous research, which has tended to focus on participant knowledge and confidence in providing help, rather than on 'real life', or 'practical application' of the skills learnt.

2.0 Background

2.1 Prevalence and economics of mental health problems

In England, at any one time, one adult in six suffers from a mental health problem (Department of Health 1999, 2009). Mental health problems range from more common conditions such as depression, which affects between 8 to 12% of the population per year (Singleton 2000), to schizophrenia, which affects around one person in every hundred (Department of Health 1999). Close to 9% of the UK population live with mixed anxiety and depression. Half of all women and a quarter of all men will be affected by depression at some period during their lives, and between 10% and 15% of women have postnatal depression after childbirth (Department of Health 1999).

Those in unemployment are twice as likely to have depression as people in work. People who have been abused or have been victims of domestic violence, those with drug and alcohol problems and people with physical illness have higher rates of mental health problems (Department of Health 1999).

In 1998, mental illness costs were estimated at £32 billion in England each year, including almost £12 billion in lost employment and £8 billion in benefit payments (Patel 1998). In 2009, revised figures suggested the financial and economic costs to be in the region of £77 billion, mostly attributable to lost productivity (Department of Health 2009).

2.2 Early intervention and stigma

Research indicates that a large proportion of people living with mental health problems do so without treatment (Gillinson 2010). Studies have suggested that as few as 29% of women and 17% of men living with a mental health problem have received treatment (Singleton 2003), roughly 1 in 4 people who suffer from depression or chronic anxiety receive any kind of treatment (Layard 2006) and people who do not get help are likely to experience more acute mental ill health (Kohn 2004).

Early intervention (accessing help at an earlier stage) has been seen to enable people to recover from mental health problems more quickly and for mental health problems to have less of an impact on people's lives (Altamura 2008, Woodward 2001, Hafner 1998). As well as the individual

benefits of early intervention, economic benefits include the potential to significantly reduce the number of people living on incapacity benefits (Layard 2006).

Lack of knowledge around mental health problems leads to stigma and prejudice which discourages help seeking behaviour (Boorman 2009). Those suffering with mental health problems often identify the stigma associated with mental health as the greatest barrier to their recovery (Corrigan 2004, Ertugral 2004).

2.3 Mental Health Strategy in England

Mental health policy has shifted rapidly in England over the last 15 years, with increasing emphasis towards early intervention. The National Service Framework for Mental Health (Department of Health 1999) identified that many people living with mental health problems had not been receiving the care they required as services were focused on those living with more acute mental health needs. The Framework set standards in five areas:

- Standard One addressed mental health promotion and social exclusion associated with mental health problems. It identified that health and social services should promote mental health for all, combat discrimination against individuals and groups with mental health problems, and promote their social inclusion.
- Standards Two and Three focussed on primary care and ensuring access to services for anyone living with a mental health problem. It emphasised a shift towards increasing support in primary care, in response to mental health problems accounting for one quarter of GP consultations and around 90% of people with mental health problems not progressing beyond this setting.
- Standards Four and Five covered effective services for people with severe mental illness.
- Standard Six related to individuals who care for people with mental health problems.
- Standard Seven focussed on the action necessary to reduce suicide.

In 2004, the Department of Health published the National Service Framework for Mental Health: Five Years On. Again, a significant focus was given to reducing the social exclusion of people with mental health problems, improving their employment prospects and opposing stigma and discrimination.

Using the same standards, Standards One and Two further focussed on increasing the availability of mental health services in primary care. This was reflected by a significant national increase in spending on psychological therapies and National Institute for Health and Clinical Excellence (NICE) guidance on the treatment of anxiety related disorders and mild to moderate depression by psychological therapies in a primary care setting.

New Horizons, the national mental health strategy published in 2009 (Department of Health 2009), built on the work of the National Service Framework for Mental Health from the previous ten years. New Horizons placed greater emphasis on the impact of the wider social determinants on mental health, including physical health, education, housing and employment. New Horizons grouped actions to be taken under six key themes:

- Prevention of mental ill health and promoting mental health
- Early intervention
- Tackling stigma
- Strengthening transitions
- Personalised care
- Innovation

Having a positive impact on stigma through the provision of socially and culturally competent services based on people's needs rather than their diagnostic category was identified as an essential step towards more inclusive, recovery-based approaches to care.

2.4 Mental Health First Aid

MHFA was launched in Australia in 2000. MHFA is a 12-hour course designed to give ordinary people the skills to help someone who is developing a mental health problem or who is already in mental health crisis. MHFA works on the principles that early intervention prevents mental health problems from developing into something more severe and that informed dialogue and knowledge about correct referrals helps to support people already in crisis.

Mental Health First Aid England is a Community Interest Company, providing the MHFA and Youth MHFA instructor training programmes. The training has been translated and developed to the English version and accredited by The Royal Society for Public Health (RSPH). MHFA does not train people to become therapists, but is designed to provide non mental health professionals with the knowledge of mental health problems and the confidence to intervene early when a mental health problem is identified.

2.5 Where does MHFA fit with national strategy?

MHFA aims to provide help at an early stage to prevent mental health problems developing into a more serious state, promote recovery, provide comfort to a person experiencing mental ill health, reduce stigma and discrimination, and preserve life where a person may be in danger to themselves.

MHFA has the potential to contribute to:

- Standards One, Two and Seven identified in the National Service Framework for Mental Health (Department of Health 1999)
- New Horizons (Department of Health 2009) strategy themes around prevention of mental ill health and promoting mental health, early intervention, and tackling stigma.

3.0 Literature Review

The literature review allows the researcher to demonstrate how a research proposal will deliver new findings that have not previously been available in the field and provides a strong foundation for the argument that this piece of research needs to take place (Flick 2006). There are three elements to this literature review:

- A review and critique of current research on MHFA to identify where the gaps exist with regards to developing an understanding of the practical application of MHFA skills to help people with mental health problems.
- A review and critique of approaches taken in previous MHFA research to collect meaningful data on how participants apply the skills they have learnt to help people with mental health problems, in order to inform an effective methodological approach in this study.
- A review and critique of approaches taken in previous research (which does not relate to MHFA but is of a similar construct and context) to collect meaningful data on how participants who attend such training courses apply the skills they have learnt to help others, in order to further inform study methodology.

To reflect these elements, this section will include the following three headings: 'MHFA Research Gaps', 'MHFA Literature to Inform Study Methodology' and 'Other Relevant Literature to Inform Study Methodology'.

3.1 Search Strategy

A literature search was undertaken using a cross database search engine using the terms 'MHFA', 'Mental Health First Aid' and 'Mental Health Training' within the title. The search, which was open dated, returned results in ASSIA, BioMed Central, CINAHL, EMBASE, IBSS, ProQuest Medical Library, PsycINFO, PubMed, PubMed Central, SAGE Premier 2010, ScienceDirect, Social Sciences Citation Index and Web of Science. Due to the limited publications on MHFA research, to enhance the literature review a search for grey literature was conducted. This was done by reviewing non-published evaluation studies posted on national MHFA websites and the person responsible for the

evaluation of the Scottish MHFA course was contacted in order to review the Scottish national evaluation (Reid 2005).

Whilst the literature review into MHFA identified research gaps, due to the small number of available studies for review, it was felt that critiquing research into the outcomes of other similarly constructed training would further inform the methodological approach needed in this study. Applied Suicide Intervention Skills Training (ASIST) was identified in this respect. ASIST is a two day course which aims to develop participant verbal communication skills and identification of correct referral routes with regards to helping a person who may be experiencing thoughts of suicide. A further literature search was undertaken in Medline (1996 to 2007), using 'ASIST' and 'suicide intervention training' as key terms.

Physical health first aid training is used as an analogy for the MHFA training, but the physical health first aid outcomes are measured in a very different way and are much more tangible in terms of actions taken and effect of actions. For this reason, literature on physical health first aid was discarded from the literature review.

3.2 MHFA Research Gaps

Research reliability into MHFA has improved (Kitchener 2006) since the first uncontrolled evaluation study in 2001 (Jorm 2005), to a more recent randomised control trial (Kitchener 2004) and cluster randomised control trial (Jorm 2004). Research has indicated personal mental health benefits to participants (Jorm 2004), although this was not originally a planned benefit and aim of the course.

Questionnaires and vignettes used with participants at pre, post and follow up stages of MHFA attendance have consistently recorded an increase in skills and confidence in discussing mental health (Sartore 2008, Kitchener 2002, Hussain 2009), a reduction in attitudes associated with mental health stigma (Minas 2009, Lam 2010, Sartore 2008), an improved knowledge of mental health problems (Minas 2009, Lam 2010), an increased knowledge of appropriate ways to assist someone with a mental health problem (Minas 2009, Lam 2010), and a convergence of participant beliefs about treatment with those held by health professionals (Lam 2010, Kitchener 2002, Kanowski 2009). More research is required to develop a better understanding of the practical application of MHFA skills to help people with mental health problems (Lam 2010, Sartore 2008, Kitchener 2002). Studies that

have attempted to do so have not applied strong methodological approaches and are critiqued in Section 3.3 (Jorm 2005, 2010, 2004).

To define the gaps in MHFA research, it is useful to return to the aims of the training and the skills it intends to provide people with. These are highlighted in the Introduction Section. Current literature provides a good evidence base to support the following course aims and outcomes:

- that it raises awareness of mental health issues in the community
- that it reduces stigma and discrimination
- that it teaches participants to recognise distress
- that it teaches participants to recognise the difference between Therapy and First Aid
- that it enables participants to be confident in administering help in a First Aid situation

The remaining aims and teaching outcomes are not supported by a good evidence base. Therefore, the gaps and research opportunity for this study lay in developing a better understanding of the practical application of MHFA skills to help people with mental health problems, with regards to:

- preserving life where a person may be a danger to themselves
- providing help to prevent mental health problems developing into a more serious state
- promoting recovery of good mental health
- providing comfort to a person experiencing mental ill health
- providing initial help and guide a person towards appropriate support

3.3 MHFA Literature to Inform Study Methodology

Three seminal MHFA studies (Jorm 2004, 2005 and 2010), which attempted to develop an understanding of the practical application of MHFA skills to help people with mental health problems, will now be critiqued to identify the methodological challenges they faced when attempting to capture this information. Their approaches will help to inform the methodology for this research.

Jorm (2005) used quantitative and qualitative approaches to research subsequent participant experience in providing first aid for mental health. A questionnaire was sent to participants nineteen

to twenty-one months post-MHFA training. 94 responses were received, from the 131 questionnaires sent. The questionnaire was designed to ascertain whether the respondent had, or had not, experienced a post-course situation where someone seemed to have a mental health problem, and for those that had, further probing questions were used to explore what type of help was given (see Appendix A). 73 of the 94 respondents said that they had experienced a post-course situation involving a mental health problem, with 44 of these 73 reporting that they were definitely able to help, a further 10 saying they thought they had been helpful, 4 people said they were unsure and there were 15 non responders. Responses to the questions were analysed on an individual basis and presented as stories reflecting two different settings: the social network of friends and family, and the work place. In addition, responses to open ended questions (Appendix A) were translated into emerging themes, including 'Calming the distressed person and listening to them', 'Actively referring someone to more specialist help', 'Competence' and 'Empathy', 'Knowledge gained on the course', 'Confidence in providing help' and 'Making contact with other people with similar concerns about mental health problems'.

This research was useful to the developing research field around MHFA to reinforce, with an open qualitative approach, previous findings around knowledge and confidence, that had previously been collected with more closed questions and using simulated scenarios (Kitchener 2002, Hossain 2009). The research discusses the risk of self-selecting participants in that they may lack true representation, but highlights that the qualitative data collected had enabled a better understanding of the practical application of MHFA skills to help people with mental health problems, referred in the paper as 'reported direct experience'. The discussion also identifies that the course benefits people seen by a wide range of participants, attending in professional and non-professional capacities.

Questions used in the study were not widely tested and their reliability can be challenged, but they should be used to inform further qualitative research in developing an understanding of the practical application of MHFA skills to help people with mental health problems. Flexible semi structured interviews using approaches more deeply rooted in phenomenology would have produced more rich and informing data on relevant participant experiences than that provided through the questionnaire used in this study. Failure to collect pre-attendance data made it more difficult to relate the MHFA course to the inferred improvements in the help given to people with mental health

problems and so future methodology should consider pre and post measures, and the use of a control group.

Jorm (2010) evaluated a youth version of the MHFA course in a cluster randomised control trial. 16 schools were randomly allocated to when they received the training, with an average of 30 participants (teachers) per school. Pre, post and six month follow up questionnaires were used with 327 out of the 560 participants to assess knowledge about mental health problems ($P < 0.001$ at post test and at follow up), recognition of depression in a vignette, stigma towards students, beliefs about treatment of depression which are like those of health professionals, confidence in providing help ($P = 0.005$ at post test and $P = 0.008$ at follow up), intentions to provide help to a depressed student, help provided to students, first aid provided to colleagues, school practices and policy and teacher psychological distress. Pre and post questionnaires were used with students to assess stigma towards a depressed peer, beliefs in the helpfulness of school staff for a depressed student, help received from school staff members, information received from teachers and student mental health.

In order to measure help provided to students, teachers and students were asked questions on frequency and type of help provided from and to them respectively, with regards to mental health problems (Appendix A). Outcomes showed that students under teachers trained in MHFA reported receiving more information about mental health problems in the form of lesson content, posters, pamphlets, brochures and books. There was no reported difference in specific help received from teachers on mental health problems or in the student's mental health.

The methodological strength of this study lay in the collection of pre, post and follow up MHFA attendance data, allowing a comparison and associations to be made between changes in participant behaviour and attendance on the MHFA course. The study also attempted to collect first-hand information from the target members of the population, i.e. the students, on help they received around mental health. The study weakness in terms of developing an understanding of the practical application of MHFA skills to help people with mental health problems lay in the use of very brief closed questions leaving little room to explore how the MHFA course really changed behaviours and outcomes for the students. As such, the data lacked a richness which phenomenological, ethnographical or grounded theoretical approaches can provide.

A controlled cluster randomised trial with 753 participants measured outcomes before the course started and 4 months after in terms of knowledge of mental health problems, confidence in providing help, actual help provided and social distance towards people living with mental health problems (Jorm 2004). A scripted telephone interview was used to record outcomes, with questions relating to practical application of the training looking at contact in the last six months with someone experiencing a mental health problem (yes/no response), how many people, whether any help was offered (yes/no response) and what type of help (open ended question). With regards to the open ended question which explored the type of help given to people with mental health problems, a significantly higher percentage reported offering help in the group receiving MHFA compared to the control group ($p = 0.031$). The research does not discuss in great depth the details of the help provided by participants to people with mental health problems, i.e. what was discussed and whether the person that participants were helping access more specialist support.

3.4 Other Relevant Literature to Inform Study Methodology

The ASIST course has been subject to a small number of published evaluation studies (Guttormsen 2003, Tierney 1994) and other evaluation studies have been written to inform ASIST delivery in countries including Canada (Crookall 1986), Australia (Turley 1998) and the United States of America (Cornell 2006). These studies suggest ASIST is beneficial in knowledge gains around suicide and ability to talk about suicide. Similar to MHFA, there is very little research that focuses on the practical application of the ASIST skills in order to help someone who may be at risk of suicide. The following provides a review and critique of the methodology used in those that attempt to do so.

The Suicide Intervention Field Trial Australia (Turley 1998) aimed to assess the change in helping behaviours, as well as learning outcomes, changes in participant suicide assessment, intervention knowledge, assessment of participant attitude towards intervention and belief in the possibility that suicide intervention could be effective. Subjects were selected at random from 2870 workshop participants. There was a good rationale for the choice of subjects, which included key gatekeepers, such as teachers, healthcare professionals and volunteers. The characteristics of a gatekeeper were clearly defined as any person in a position of trust who has potential contact with a person at risk of suicide. Subjects completed pre, post and four month follow up qualitative measures. A retrospective

self-report measure was applied to assess the change in helping behaviours. It is likely that the follow up group showed a bias towards the most committed to ASIST, or the most contactable. The selection of participants as 'gatekeepers' should be considered in the sampling for the research into MHFA.

An independent ASIST evaluation was conducted as part of West Dunbartonshire's Choose Life Action Plan (Sleven 2002). Open-ended questions were sent to 72 participants, with a 63% response rate. 12 people completed a one-to-one, fully transcribed interview. Although the study led to rich ethnographic qualitative data and reported increased knowledge, confidence, skills and that the ASIST model had been used in interventions, there was no pre-post comparison. However, the collection of rich ethnographic data demonstrated a good approach to collecting data on the real-life application of skills learnt on the training in order to provide help.

An evaluation of a suicide prevention training programme in the Atlantic Region in a prison studied the effect of the training on staff intervention skills and importantly on numbers of suicide interventions and referrals to psychologists concerning potentially suicidal inmates (Crookall 1986). Following the training, 70 staff and 12 inmates were formally interviewed. As well as a positive response indicating increased knowledge and improvement in intervention skills, increased referrals to psychologists were also reported, and a reduction in suicide over the following year was seen. This study did not conduct interviews before and after participants attended the ASIST training, but it did use pre-post measures in the form of numbers of referrals and suicide rate. These were good indicators for developing a better understanding of the application of skills learnt on the ASIST training to help people at risk of suicide and similar proxy measures should be considered in data collection for future research into MHFA.

3.5 How the literature informs this research

The research gap lies in developing a better understanding of how the skills learnt on the MHFA training are applied to help people with mental health problems.

Whilst this study is not concerned with ASIST research gaps, it was useful to broaden the literature review to include both MHFA and ASIST research, as there were different methodological approaches used in their attempts to better understand the help provided by participants to the target beneficiaries of the training. Broadening the literature review in this way has better informed the methodology in this research, and the learning from these approaches are summarised below.

Quantitative approaches using closed questions have not been able to clearly demonstrate how the skills learnt on MHFA training have been used to help people with mental health problems (Jorm 2005, 2004). More effective approaches to understanding the impact of applying the skills learnt on such training have included qualitative approaches applying structured interviews using open questions (Jorm 2004, Crookall 1986). However, such approaches have failed to apply pre-post analysis, and so it is difficult to make strong associations between help given by participants and attendance on the training (Jorm 2004, Crookall 1986). The use of a control group has been applied to both qualitative and quantitative approaches, but then only used in the analysis of quantitative data (Jorm 2004).

In this study, a phenomenological, ethnographical or grounded theoretical approach should be taken and analysis should demonstrate a systematic development of themes. Structured or semi structured interviews with MHFA participants should be used to collect rich pre and post MHFA attendance data. Questions developed in previous MHFA research (Appendix A) should inform future interview development. A control group should be used to allow for possible effects of the interview and consideration should be given to available 'indicators', i.e. numbers of referrals made to specialist mental health services, that can further illuminate the application of mental health first aid interventions. Research participants should possess 'gatekeeper' characteristics – they should be in a position of trust and have contact with people who might need additional help for a mental health problem.

3.6 Research question

How are the skills learnt on the MHFA training applied to help people with mental health problems?

3.7 Research Objectives

- To explore and interpret how attendance on the MHFA training might change interaction between participants and patients/members of the public.
- To explore and evaluate any change in the support, advice and help that MHFA participants provide to people experiencing mental health problems.
- To illuminate national practice around the delivery of MHFA training to help people with mental health problems and inform national policy.
- To identify future research implications with regards to exploring and evaluating how the skills learnt on the MHFA training are applied to help people with mental health problems.

The Methodology will now follow and will be informed by the key points drawn out in this literature review. It will identify which approaches will best enable achievement of the research objectives.

4.0 Methodology

The literature review identified the need for rich qualitative data in order to better understand the practical application of MHFA skills to help people with mental health problems. Qualitative research is unlikely to be representative of the entire population due to smaller sample size, but more time allocation and in depth study of participants offers the opportunity to explore, interpret and obtain a deeper understanding (Greenhalgh 2001). In this section, I will present an argument for the chosen qualitative approach, considering the research question and objectives identified in the literature review. The chosen approach and learning points from the literature review will then inform and influence the methods used to sample participants, collect data and perform data analysis.

4.1 Study design

The following presents an argument for the chosen methodological approach and the factors which influenced this decision.

4.1.1 Deciding on an approach - phenomenology

When attempting to develop a better understanding of the practical application of MHFA skills to help people with mental health problems, it would be important to explore the experience of MHFA participants in providing such help. This reasoning led itself to a phenomenological approach. Phenomenology is the study of conscious human experience in everyday life (Bowling 2002), adopting the notion of multiple realities (Polgar 2001), where in order to obtain a greater understanding of an individual's experience, the researcher must be able to demonstrate great empathy with the participant. Phenomenological approaches are strong in drawing out experiences and perceptions of individuals from their own perspective (Lester 1999). Interpretation of phenomenological data can develop practical theory which can inform, support or challenge policy and action (Lester 1999). Indeed, a phenomenological approach appeared powerful and relevant to achieving the first three research objectives.

4.1.2 Epistemological and ontological influences

Phenomenological research is influenced and affected by epistemological and ontological disciplines. Epistemology is concerned with the nature, sources and limits of knowledge (Klein 2005). Epistemologically speaking, qualitative approaches must recognise that individual knowledge and perspective are powerful factors in interpretation of subjective experience (Lester 1999). In this study, qualitative data would be provided by participants who attended the MHFA training. From an epistemological stance, responses given by participants in relation to interview questions would be based on their knowledge about the subject matter and surrounding environment, and on their interpretation of the impact of any help they felt they had given to someone living with a mental health problem.

Ontological discipline with regards to this study considers the 'security' or 'position' of the researcher within the study, or the meaning that the researcher attaches to social reality (Boeije 2010). In other words, what did I as the researcher bring to the study? As a researcher and a public health specialist with a background in public mental health, I held beliefs about cultural approaches that can help to improve mental health literacy in England and the types of practice that can help people with mental health problems. These beliefs were strongly shaped by national policy, strategy and evidence on which these documents are based. I had previously been a participant on the MHFA training and I had considered how MHFA can be applied to help people with mental health problems, the types of situations that could lend themselves to providing mental health first aid and whether or not I believed MHFA to be an effective training course in enabling participants to help people with mental health problems. From an ontological stance, my beliefs required consideration in research validity and bias, although there were ontological benefits as well as disadvantages. With beliefs shaped by national policy and evidence base, it was reasonable to assume congruence with professionally accepted and evidenced approaches in this field, and this could aid with understanding and interpreting epistemological phenomenon presented by participants. In an attempt to limit ontological impact, which might prevent realisation of subjective experience, bracketing would be required in as far as was possible to separate what belonged to the researcher (myself) and what truly belonged to the data, thus retaining focus on the remaining subjective perception.

4.1.3 Deciding on an approach – grounded theory

It was important to limit as much as was possible ontological impact on research validity and bias. Whilst the research initially identified with a phenomenological approach, I also intended to minimise pre-conceptions and external influences, and so I became aware that the study also strived to reflect grounded theory, with the formation of theories and explanations based strictly on analysis of the data (Barbour 2001). This would not have meant that previous knowledge was discarded, but seemed to give greater credibility to theory that would be contained within the data. Gomm (2000) points out that grounded theory offers ecological validity, whereas pre-conceived theories serve as the foundations of an artificial structure for data analysis, possibly distorting the truer picture offered by the qualitative approach.

Developed by Glaser and Strauss (1967), grounded theory attempts to develop a theory using systemic analysis of the data. In grounded theory, there is no hypothesis attached to the research in advance. This was true of this study, which looked to develop a better understanding of the practical application of MHFA skills to help people with mental health problems, and did not hypothesise that there was or was not an application of the skills learnt on the training. The literature review had identified that this study would need to identify similarities or differences between pre and post MHFA attendance data and that the systematic development of themes would form part of the analysis. Research objectives would frame and maintain the research focus, but the theory generated would be rooted within the data. In grounded theory, induction and deduction drive the analytical process. Induction tends to generalise repeated, particular observations within the data (via a systematic cataloguing of subjective experiences), and deduction considers that a particular situation is explained by deduction from something that is said (considering analysis of the all forms of data collection, such as transcriptions, audio recordings and memos).

Structured review, consideration of and immersion in the data applying inductive and deductive approaches leads to the development of codes, themes and categories. It is not until the data has been thoroughly analysed and compared, or until an in depth exploration of the interweaving codes, themes and categories has been completed, using all available data sources collected, that the analysis can be said to have reached 'saturation point', at which point Glaser and Strauss (1967) suggest that the grounded approach to the data has been sufficient to validate the theory. In

grounded theory it is possible for changes to be related to an intervention, which can inform social action and change.

4.1.4 Chosen approach – generic qualitative research

Generic qualitative research uses methodology clearly defined as qualitative research, and yet is not bound by one approach, or method to qualitative research, such as phenomenology or grounded theory (Meriam 1998). Generic qualitative research uses some or all methodologies to achieve greater understanding or knowledge of an event, and yet does not place its allegiance to an established set of assumptions or technique (Caelli 2003). Whilst researchers are often discouraged from combining approaches due to philosophical incompatibility (Creswell 1998), to be bound by one approach has been seen to be inhibitive of research potential (Probert 2006). The consideration of factors outlined in my decision making above left me favourably considering and ultimately adopting generic qualitative research, applying phenomenological and grounded theoretical approaches, thus enabling the recording and exploration of participants lived experiences with regards to providing help for people with mental health problems, and a structured thematic analysis grounded in the data collected.

4.2 Translating the defined approach into appropriate data collection

Three common options for data collection were considered – questionnaires, focus groups and interviews, or a combination of these options. It was felt that questionnaires would not be able to explore participant experience of providing help for people with mental health problems in sufficient depth. Previous research using questionnaires suggested that participants have provided some help to people with mental health problems (Jorm 200, 2010), but they have not been able to explore in any great depth the participant experience of providing this help or been able to infer how this help potentially benefitted people with mental health problems. Even with open questions in questionnaires, it is difficult to generate the type of information that is required as participants often interpret questions differently and questionnaires which have not been previously tested for reliability are subject to academic criticism (Dantzker 1958).

Focus groups typically range from 2-25 people. They can generate conversation which enables participants to collectively explore experiences and the observed interaction on a topic can

provide clear similarities and difference between participant experiences. They are at a disadvantage when attempting to explore experiences which may be sensitive or confidential, can inhibit quieter members of the group from providing feedback, and are not effective at providing depth and detail on the experiences of individual participants (Morgan 1997).

The literature review identified that the qualitative approach must allow for the exploration and illumination of participant experience so that rich and informative data could be collected to better understand the research gaps identified. One to one interviews offer an advantage over focus groups in this respect, as they enable the extraction of rich data on participant experiences in relation to the research objectives and provide the time required to achieve this (Morgan 1997, Bowling 2002). In order to maintain the flexibility needed within the interview to be able to explore wide ranging participant experiences of providing help, a semi structured interview matrix would be required. One to one interviews are subject to researcher bias and the reliability of the questions used can be challenged in a similar way to questionnaires, but it was felt the requirement of an in depth exploration of participant experience placed one to one interviews as the preferred method. There would be less risk of technical (audio recording) difficulties with face to face interviews than phone conducted interviews, and body language is useful to consider when exploring participant experience.

Semi-structured interviews are at risk of expense, time consumption and interviewer and interpretation bias (Bowling 2002), and a less structured approach can make it more difficult to conduct and manage an analysis of the data (Polgar 2001). These factors would require careful consideration when determining sample size and data analysis.

4.3 Developing interview questions, checking validity and detecting and compensating for ‘researcher effects’ and ‘researcher bias’

The questions used in the interview matrix (Appendix J) were predominantly open, inviting participants to describe events, experiences and outcomes with regards to the research objectives. The interview questions were developed using questions that had been seen to be successful in developing a better understanding of the practical application of MHFA skills to help people with mental health problems in previous research (Appendix A). The questions used in previous research were considered against the research gaps, the research aim and objective, i.e. did the questions

relate closely to what this study was trying to achieve. Those that did relate were used to inform the interview matrix. Additional questions and prompts were added to this matrix in order to more fully reflect the depth of the data required on participant experience and to ascertain clarity on participant responses where required.

Prior to entering the field, the questions used to form the structure for the interviews were tested with a front line professional in order to check for reliability with regards to the purpose of the study, i.e. was the data produced relevant to the research objectives? The front line professional used for this checking procedure was a manager at a nursery school, who manages a team of nine people. The test participant was known to the researcher and the data provided was not included as part of the data within the analysis. This exercise further informed the interview matrix.

Whilst interview questions were informed by those used in previous research, their reliability should be challenged as the extent to which they may have led participant response was not tested for and eliminated.

4.4 Participant Inclusion and Exclusion Criteria

The research aimed to develop a better understanding of the practical application of MHFA skills to help people with mental health problems. The literature review identified 'gatekeepers' as an appropriate participant group. A decision was therefore made to recruit front line health professionals as research participants, as their field of work presents regular interaction with patients or members of the public, giving good opportunity to extract rich qualitative data on help provided for mental health problems. The following inclusion criteria applied to research participants:

- Participants must have no previous training in mental health
- The participants must be front line health professionals
- For the purpose of this research, the term health professional refers to anyone who has a professional role in providing health care or providing a preventive health and wellbeing service, and can include physiotherapists, community nurses, pharmacists, health/fitness instructors, health visitors and health trainers.

The principle exclusion criteria for the study included people who had had previous training in mental health, as the MHFA course is not appropriate for trained mental health professionals.

4.5 Regulatory approval

Prior to approaching any participants, research undertaken through the NHS must have NHS Research Ethics Committee (REC) approval and the approval of the host NHS Trust. The research sponsor or care organisation has responsibility for providing safety and scientific quality (Kerrison 2003). The Research Proposal was accepted by the Brighton and Sussex Medical School Institute of Postgraduate Medicine. Following submission of the NHS Research Ethics Committee Form and attendance at an ethics interview with the West Brighton NHS Research Ethics Committee, changes were suggested to the research protocol by the committee (Appendix B), a second version of the NHS REC form was duly submitted and accepted. In order to enable research to be carried out with front line NHS staff in Sussex, a Research and Development application was submitted to and accepted by the Sussex NHS Research Consortium. Eventual participants were not NHS front line staff. Following email and phone call discussions with the corresponding NHS Research Consortium (not named to maintain participant confidentiality), it was agreed that participants could be approached following agreement from their line manager. This agreement was gained via further email and phone conversations.

4.6 Ethical issues

Participation in the research was entirely voluntary, and participants had the option to leave the research at any time and without having to justify the reasons why. Withdrawal from the research would not have affected participant registration on the MHFA training.

With the phenomenological element of research methodology, an emphasis was placed on a probing exploration of participant experience with regards to providing help for people with mental health problems. Discussing mental health problems can be an emotive subject, and the research provided participants with an opportunity to reflect on their role in this respect. Available support mechanisms to the participants, i.e. local support services and debriefing, were identified before entering the field

so that they could be offered to the participant following the interview. Similar support mechanisms were identified for the researcher, who was also able to discuss any matters arising with the Chief Investigator.

4.7 Sampling

In order to recruit participants, information on the research was sent out by MHFA England on behalf of the researcher to all MHFA instructors across London and the South East, asking that they offer research enrolment to the participants registered on their upcoming courses, and that they distribute the Participant Information Sheet (Appendix D). At the time of advertising for participants, six MHFA instructors offered to advertise research participation to people enrolled on upcoming MHFA courses. On further discussions, two of the instructors were not providing MHFA training to groups defined as health professionals (in this respect the sampling was purposive as these professional groups did not fit the particular research profile and were therefore discarded), one MHFA course was planned for a future date outside the timescale of this research, and one set of MHFA courses had not yet been confirmed. One of the remaining courses was scheduled with front line NHS health professionals from mixed professional backgrounds. An application was submitted to the relevant Research Consortium. This consortium were not able to process the application due to different rules on sponsorship, to those which had meant successful Research and Development clearance in Sussex. The remaining course which was being delivered to health trainers was the only opportunity for recruiting participants. Following discussions with the local Research Consortium and the health trainer's line manager (see 4.5 Regulatory Approval), it was agreed that the Participant Information Sheet could be sent to the health trainers registered on the MHFA training to see if they would like to participate in the research. This was done through the MHFA trainer and through the health trainer's line manager.

Interested health trainers (the eventual participants) contacted the researcher directly and a clear explanation of the time and emotional commitment that the research was asking from them was provided. The Participant Information Sheet was thoroughly discussed to help interested participants to make a decision on taking part. Each participant received the same amount of information on the research. The participants were not blind to the study, although not fully aware of the aims and objectives. All correspondence was through NHS communication routes, using NHS headed paper and from an NHS email account. The health trainer role is defined in Appendix H.

4.8 Sample size

The initial target sample size was sixteen participants, with the expectation that a minimum of four complete sets of data would be collected after attrition, and that this sample size would provide a richness of data to enable achievement of research objectives. It was assumed that some participants would leave the study before the initial interview and that some would attend the pre interview and leave the study before the post interview. Such attrition rates were seen in the literature review (Turley 1998). Reasons anticipated for non-completion included changes to MHFA course running times, changes to participant personal circumstance and an unwillingness to complete the second stage interview.

Following attrition, a total of three complete sets of data were collected. Whilst this was enough to provide rich qualitative data, it was one set less than was planned for during participant recruitment and as such weakened the strength and reliability of the data analysis, comparison and conclusion.

4.9 Participant requirements

Participants attended two interviews of approximately 15 to 25 minutes in length. Pre MHFA attendance interviews took place in the two months prior to the training, with post MHFA attendance interviews occurring three months following. It was felt, based on previous studies (Jorm 2004, 2010), that three months would be sufficient time to record changes to help giving behaviour, resulting from the MHFA course.

To minimise the participant requirements, the researcher travelled to a suitable venue chosen by the participant, where they felt most relaxed and were able to talk openly about their experience of providing help for people with mental health problems. Interviews were held in a meeting room at the participant's headquarters where it was appropriate for sound recording equipment. Interviews were conducted on a one to one basis without external interruptions. Valid consent forms were signed prior to conducting the interviews (Appendix C), in compliance with the Data Protection Act (1998). Following each interview, researcher interpretation of some of the main participant experiences based purely on a basic analysis of the data, were discussed over the phone with research participants two

weeks following the interview. The purpose of this was to minimise data pre-conceptions and ontological impact, to focus and align researcher empathy and thinking to the subjective view of the participant and to achieve appropriate epistemological perspective.

4.10 Recording equipment

Interviews were recorded using an Olympus VN6800PC Dictaphone and an Olympus VN5500PC Dictaphone as a backup sound recording device. These sound recording machines were selected because they were portable, easy to operate and produced a high level of audio replication. The researcher was competent in using both pieces of equipment. Following the audio capturing, the sound files were transferred to an encrypted IT system for transcription and analysis.

4.11 Confidentiality and data handling

Person identifiable information was stored on an encrypted and password protected IT system. The research write up has no person or patient identifiable data and results are discussed in terms of categories and themes. Participants, employers and other individuals are not named within the research, and other key information, such as place names which may lead to identification are not included. Participants were given a number prior to data analysis so that they were not identifiable during this stage of the research. Data was accessed by the researcher and data interpretation was supervised by the Academic Supervisor, by which stage the data was presented in themes and participant numbers, and not person identifiable. Participants had access to their individual data on request.

4.12 Research timeline

To enable the reader to develop more of a 'feel' for the research, Appendix I reflects the research timeline. The timeline includes data analysis, the approaches to which will be described in the next section.

5.0 Analysis

Analysis of qualitative data involves two aspects; data handling, which involves sorting and searching the data to create consistent grounded analysis, and interpretation, which emphasises that analysis must look at both subject matter and the way in which people frame their communications (Gibbs 2010). This section will describe the structured approach taken to analysing the data and how themes were developed. Continuing on from a carefully considered methodology, a strong approach to data analysis will strengthen the validity of the results.

5.1 Transcribing the data

Each of the six interviews (three pre and three post MHFA attendance) were manually transcribed into six Microsoft Word documents. The transcriptions were carried out by the researcher to enhance data immersion and meant that analysis started at this transcription stage. This approach helped the researcher to more fully understand the context and subject matter that they were transcribing. This was a preferred option to employing transcribers, who would have needed training to ensure subject matter familiarity and are costly.

Verbal ties such as 'er' and 'um' were removed and repetitions such as, 'what I mean', 'you know', 'my view is' and 'this is a challenge' remained. Abbreviations such as 'I'd', 'I'm', and 'isn't' also remained, so as not to lose meaning behind what was said, and because these were helpful for analytic coding.

5.2 Approaches taken

Analysis used induction and deduction to find patterns and explanations within the data. Induction tends to generalise repeated, particular observations, and deduction considers that a particular situation is explained by deduction from something that is said (Gibbs 2010).

Whilst induction and deduction are concerned with patterns in general statements, nomothetic and idiographic approaches to analysis consider the dimensions surrounding individuals and specific individual factors, respectively (Gibbs 2010). To elaborate, analysis of the data used a nomothetic approach in consideration of how events and settings surrounding participants might have played a role in the help they provided to people with mental health problems, and an idiographic approach

was used in considering the factors surrounding the individual participant. With a small participant sample size, care was needed when considering a nomothetic approach.

Data driven and concept driven approaches were used in the analysis. A data driven, or open coding, approach meant that analysis of the data was approached with as limited preconceptions as possible. Such an approach is advocated in research steeped in phenomenology and grounded theory (Gibbs 2010, Giorgi 2003), and important to establishing a fair framework to the analysis. As the study design, questionnaire development and analysis were carried out by the main researcher, elements of a concept driven approach also impacted – the researcher would have had an understanding of what themes were likely to develop prior to data collection and analysis. With concept driven coding, or framework analysis, it should be recognised that codes and themes need adjusting during and following data immersion (Gibbs 2010, Ritchie 2003, King 1998). Whilst open-coding was the primary approach in the data analysis, elements of a concept driven approach impacted on the resulting themes. Transfer between these two approaches is widely accepted and practiced (Gibbs 2010). Ensuring that the coding process remained reflective and responsive to the data remained paramount, so that new themes and emerging evidence from the data were not inhibited by preconceptions or researcher bias. To achieve this, bracketing was applied to help separate what belonged to the researcher and what truly belonged to the data, thus retaining focus on the remaining subjective perception. Bracketing required the development of themes strictly relating to the data, with clear analytical methods which were more synonymous with grounded theoretical than phenomenological analysis.

Additionally, realism and constructivism were considered in data analysis. Realism considers that there is a material world of objects that exists in isolation to us and independently to our actions. Constructivism considers that existence of objects and the world which we experience is a human construct, and so our interpretation of our experience of the world, no matter how material is individual and unique. Constructivism is therefore synonymous with minimising ontological impact and allowing for epistemological influence in order to faithfully reflect subjective data.

It is easy to assume that when attempting to minimise pre-conceptions, that constructionist, inductive, idiographic and data driven approaches should be used purely in qualitative analysis. Indeed, they are very important and justify the recognition that grounded theory is an essential approach within this study. However, to isolate these approaches would not be possible, and to do so

would have been unhelpful to achieving the study aim and objectives. This research related to understanding the experiences of participants, and what the experiences did or did not have in common before and after MHFA attendance. Whilst it is important to minimise pre-conceptions in qualitative research, it is also necessary to have a starting point (Glaser and Strauss 1967). To this extent, this study also applied deductive and nomothetic approaches to the analysis, justifying that phenomenology was also an essential approach within this study.

5.3 Thematic development

In response to the research question, this study collected rich qualitative data on participant experience of providing help for people with mental health problems, both before and after attendance on the MHFA training. Coding, in terms of qualitative analysis, refers to the process of organisation and management of large volumes of data (Gibbs 2010). In this study, the coding process led to the development of themes. Themes reflect the spirit of the things that are said by participants when describing their experience of the world (Gibbs 2010, Smith 1995, King 1998). The themes were carefully considered to most accurately reflect the outcome of the analytic process, which developed a rich tapestry of information to reflect participant experience. The following provides a description of thematic development.

Throughout the thematic development two sets of 'prompts' were used to enhance the structured approach to analysis. The first set of prompts (Appendix E) relate to specific patterns within the text, including significant words, key phrases and specific narrative. The second set of prompts (Appendix F) relate to the Structured Six Model Elements Table defined by Strauss and Corben (1998), which encourage the researcher to think about elements surrounding the participant experience, such as the causal conditions (i.e. what were the influences on the event or experience), the context (i.e. what were the locations of the event or experience) and the consequences (i.e. what were the outcomes of any actions).

During the initial stages of data transcription (from audio to transcript), memos were used to start to form descriptions around potential patterns in the data. These memos were just a sentence or two in length and were initial representations and thoughts (belonging to the researcher) reflective of

participant experiences. Memos are seen to be useful to help to give clarification and direction during the development of themes (Gibbs 2010).

Following transcription, a structured analysis of pre and post MHFA attendance data began. The first step was line by line coding of the text contained in all six transcripts (three transcripts from pre and three from post MHFA attendance). In this process, the lines of the transcripts were numbered. Key words and phrases were identified, extracted and grouped together under possible headings. Codes were attached to the extracted data which allowed the researcher to easily return to the transcript and line from which the data came. The line by line approach was by nature very blinkered on the words contained within a single line, and not necessarily reflective of the sentence or wider paragraph / narrative. However, this initial approach was felt necessary to ensure a data driven approach to the coding.

The next stage of analysis was to revisit the data to consider wider passages of text which related to the data that had been extracted and placed under the initial headings in line by line coding. Revisiting the wider passages of text helped to develop the broader picture of participant experiences under these headings. The titles of these headings were adapted to suitably reflect this broader picture. Some of the experiences were no longer relevant to their initial heading, and so were placed under new headings or moved to ones which reflected the experience that they conveyed. Induction, deduction, nomothetic and ideographic approaches were applied to wider passages of text which often meant that any one passage of text was relevant to and grouped under more than one heading. Again, passages of text were coded to allow the researcher to return to the relevant section of the transcript, and to identify which participant and to which interview (pre or post) the data related.

The initial memos developed during the transcription further annotated the picture developing under these headings. Finally, the audio recordings were revisited, this time from the perspective of the headings, in order to consider whether audio inflections added emphasis or gave a different meaning. This added further depth and perspective to the headings, and minor alternations were made to their wording to reflect this.

Only at the point when memos, line by line coding, wider passages of text and revisits to the original audio files from all six transcripts had been considered, did the headings turn into themes. At this point, epistemology inevitably played a part, as ultimately it was the researcher's interpretation of

what this collective data 'was saying' that influenced how the themes were titled. It was apparent that some themes could be grouped together under an overarching theme and these overarching themes were termed categories. Thus, a thematic hierarchy developed (see Figure 1 in the results section). The end product of the data analysis was an overarching thematic hierarchy that reflected and represented the data collected at both pre and post MHFA attendance interviews.

Glazer (1978) identified the development of a central theme as the final part of the systematic approach taken to analysing qualitative data. The discussion will describe how a focus on the causal links between the themes provided greater illumination to the research objectives, rather than an attempt to identify one central systematic theme. It was only upon full exploration of the causal links between the themes that data saturation was felt to have been achieved.

Participant data was carefully coded throughout the development of the thematic hierarchy and each stage of thematic development was saved as separate computer files. This meant that under any one of the final themes or categories, one could review all the codes and return to the raw data on which the thematic heading had been chosen to reflect. This could be done for participants on an individual or collective basis, and in terms of pre and post MHFA attendance. These codes and data could then be used to illuminate the Results and allow comparisons between pre and post MHFA attendance. Appendix G provides a demonstration of coding under one of the themes.

5.4 Data Comparison

Comparison of the codes and data under the themes between pre and post interviews occurred on three levels; on that of the individual participant (descriptive comparison), on that of the collective participants (collective comparison) and on that of analytic development (analytical comparison).

Descriptive comparison directly reflected anything that appeared to have changed for individual participants, thus applying inductive, deductive, ideographic and data driven approaches. Collective comparison reflected anything that appeared to have changed for the participants when considered as a whole, thus applying mainly inductive, to a lesser extent deductive, nomothetic, mainly data driven and to a lesser extent concept driven approaches. Analytical comparison made inferences about descriptive and collective analysis, applying an interpretation that went beyond

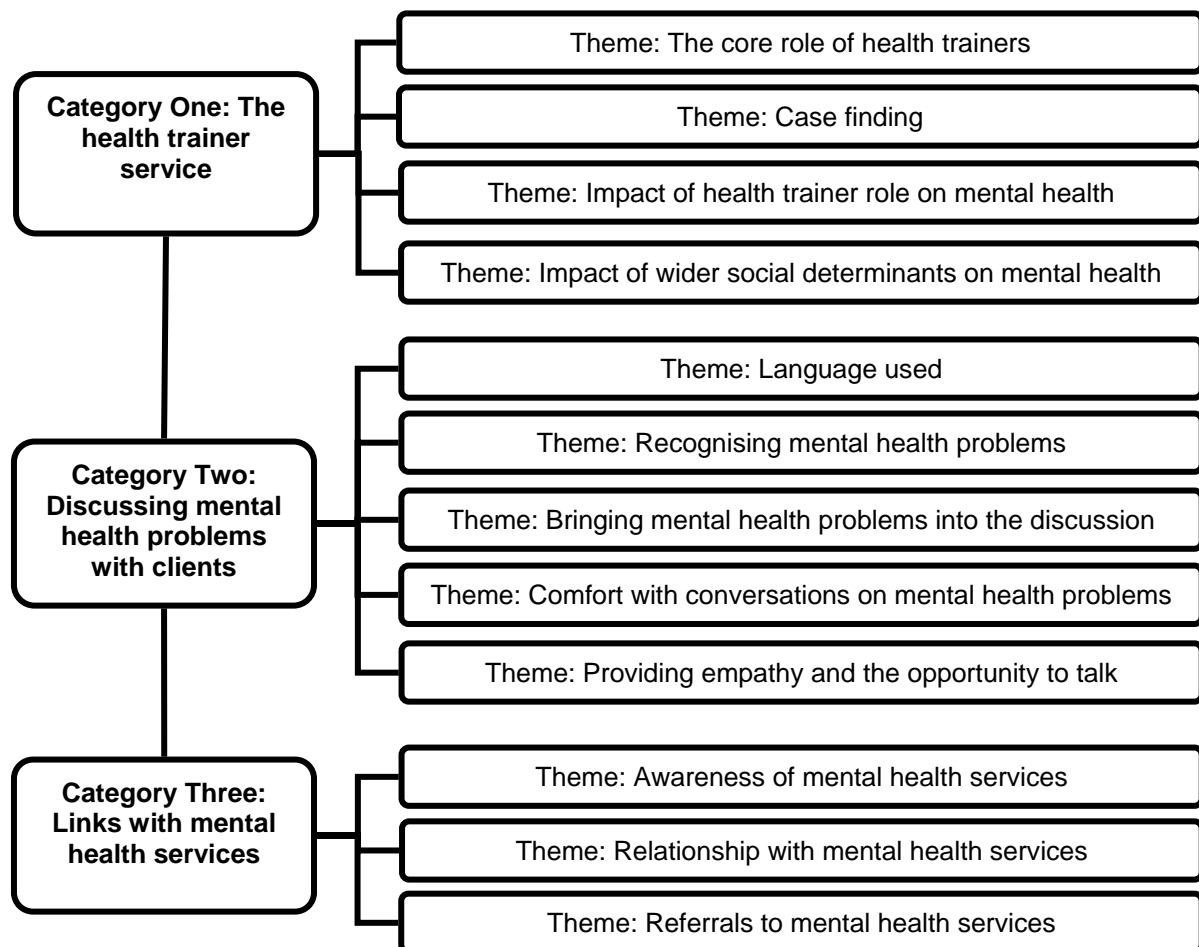
experiences conveyed purely based on the text and audio recording, thus applying inductive, deductive, ideographic, nomothetic, elements of a data driven, but mainly concept driven approaches. Analytical comparison required the greatest care as this type of interpretation was subject to researcher interpretation (considering ontological perspective) and therefore error and bias.

The Results section presents the analysis of the data collected, with the thematic hierarchy providing clear structure.

6.0 Results

King (1998) defined the presentation of qualitative results as a structured account around the categories and themes identified, drawing illustrative examples from the raw data or other text as required. The results are structured to reflect the thematic hierarchy in Figure 1, and presented in terms of pre and post stages of participant attendance on the MHFA training. A brief summary is provided after each of the three categories have been presented to add context to the health trainer service in relation to the research objectives. However, the results reflect a predominantly data driven analysis and it is not until the Discussion that the results will be interpreted and compared in connection with the objectives. To reflect and give life to the themes, participant quotes have been selected. Selected quotes are often reflective of more than one theme and this is suggestive of links and relationships between themes. In order that the results remain subjective, deductive links between themes are also not explored until the Discussion.

Figure 1: Thematic hierarchy developed from pre and post MHFA interviews



6.1 Category One: The health trainer service

6.1.1 The core role of health trainers

At pre and post MHFA attendance interviews, participants consistently described their role as one which helps and supports members of the public to make healthy lifestyle choices with regards to healthy eating, physical activity, alcohol use and smoking. This is achieved through up to eight, free, one to one sessions, helping to motivate and empower people by providing choice, setting goals and personalised health plans .

6.1.2 Case finding

During the pre-MHFA interview, finding clients and receiving referrals (case finding) into the health trainer service was at the development stage as the health trainer service was relatively new and had been seeing clients for two months. At the post MHFA interview, participants had identified and started to receive referrals from a range of settings, included talking therapies, community settings, children's centres, community centres, GP surgeries and sports centres.

Participant One: *Now that I know the staff that work there (primary mental health care service), and they know me now, we might be referring clients either way. I've arranged and put my posters up in the resource centre and some leaflets, they've got rooms there, that if one of their clients did want to see me, I could actually meet them there.*

6.1.3 Impact of health trainer role on mental health

Participants described their experiences of how the health trainer service can impact on client mental health. This was in relation to mental health and not mental health problems, although the two do impact on each other. During the interview, the following definition of mental health was given to participants in order to make the distinction: Mental health is the emotional and spiritual resilience which allows us to enjoy life and survive pain, disappointment and sadness. It is a positive sense of wellbeing and an underlying belief in our own, and others', dignity and worth (Health Education Authority 1997).

Participant responses in both pre and post interviews referred to the relationship between lifestyle and mental health and the mental health benefits associated with a healthy lifestyle. Links in both interviews were also made connecting the relationship between mental health, weight and nutrition. For example, clients reported being overweight as a barrier to socialising and partaking in activities such as swimming, which impacted on self esteem and social inclusion.

Participant One: *We (participant and client) had a discussion about the fact that alcohol, depression and anxiety are all tied in together.*

Participant Two: *We try and look at why they are feeling this (mental health related), any sort of behaviour that has made them feel like that and we have these behaviour change diaries ... sometimes you know the alcohol comes into it where (clients) are depressed after a heavy session drinking. Exercise and certain foods can improve mood, the alcohol doesn't – it's a depressant.*

It was recognised that by achieving personal goals, clients would invariably experience a positive impact on their mental health, although their ability to achieve their goals would also depend on current life events through which they were passing, for example, bereavement, employment and relationships being integral elements to a client's emotional wellbeing.

Participant Three: *All those things (lifestyle factors) have an impact on people's mental wellbeing, and the outcome of the whole process is that by the time they achieve their goals, they then begin to see their results and invariably they then become happier, they then feel more confident and more self assured, and it also affects other areas of their lives.*

6.1.4 Impact of wider social determinants on mental health

The post-MHFA interview data reflected how other socially contributing factors impact on mental health and mental health problems, such as unemployment, the importance of routine and feeling part of society (one participant had explored volunteering with a client not currently in employment). Collectively, participants also placed emphasis on significant life events having an impact on a client's mental health, with events such as bereavement and relationship breakdown having a tremendous impact on mental wellbeing and mental health problems, as well as on client likeliness to adopt lifestyle changes.

Participant One: *Obviously the client's weight is affecting her self esteem, and that is stopping her enjoyment of life and participation in social events. Other things I think of to refer people to would be something like health walks, because people want to get out and about, if they can't*

stand being in the house all the time. I've another client who is unemployed, so I'm encouraging them to keep on with that (courses through New Directions).

Participant Two: *I suggest volunteering (with regards to the impact that unemployment had on a client's mental health).*

Participant Three: *People who have the support of friends and family are more likely to achieve their goals, rather than those who are having difficulty in their relationships.*

6.1.5 Summary of category one - the health trainer service

The health trainer services is one which focuses on client's lifestyles and has an impact on physical and mental health – the two are strongly linked. Health trainers have to consider all the factors that affect a client and their likeliness to adopt lifestyle changes.

6.2 Category Two: Discussing mental health problems with clients

6.2.1 Language used

Collectively, in the pre and post MHFA attendance interview, participant experiences of the type of language and words used by clients to reflect mental health problems tended to be non medical and participants took the lead from clients in terms of adopting terminology regarding mental health problems.

Participant Two: *A couple have mentioned feeling down and not motivated and sort of fed up, you know, sort of bordering on depression, but they don't use those words.*

Participant Three: *You hear people who mention how they're feeling and their emotions at that particular time affect how they're feeling. In the long-run you might see people who could tell you things just as simple as they was feeling bored, or actually telling you that they were feeling really depressed.*

In the post MHFA data, the length of relationship with a client possibly influenced the terminology used. Use of the word 'stress' was common, although it was unclear as to whether this related to general life stress, or if it was being used, by the participant or their clients, to refer to a symptom of a mental health problem.

Participant One: *Sometimes people aren't that specific about what their actual diagnosis is. I would say that the ones I've seen in general, it's been depression. One person said she was bipolar, but apart from that people have just told me that, you know, they've been seeing a therapist, or that they're on tablets.*

For me, I take the lead from the client. If they tell me the diagnosis then they can talk about that. I think people often talk about these things in a very general way themselves. The words they use to me: 'I've been feeling a bit down' or 'I've been seeing a therapist', 'I'm on medication'. So they don't, not too specific about their problems. Obviously it depends how much I've seen them, obviously as time goes on people often start to open up and tell me a bit more about the past problems they've had, but I would say the language is very much general and very non medical.

Participant Two: *They (clients) say they're stressed and they're depressed – nearly all of them – I think it's just part of life now isn't it! It just comes up into conversation naturally, even if it's not on the first one.*

Participant Three: *Some people might tell that because of what's going on in their life they are a bit stressed.*

6.2.2 Recognising mental health problems

Collectively, pre-MHFA attendance data reflected limited participant experience of recognising that a client is living with a mental health problem. There appeared to be a shared concern about not correctly recognising a mental health problem and this seemed to contribute to a hesitation in terms of discussing mental health problems with clients.

Participant Three: *I'm no expert, so I can't just off hand diagnose somebody*

In the post-MHFA interview, with regards to recognising that clients may be living with a mental health problem, participants appeared to recognise that mental health problems are common among clients and the general population. Participants tended to focus on discussing how clients are feeling and what's happening in their lives rather than being concerned about defining the mental health problem.

Participant One: *About a quarter of my clients so far that I've seen have had some mental health issues, either for themselves or they're telling me that someone else in their family has mental health issues and that's had a knock on effect on them*

Participant Two: *I'll maybe give them a prompt, but I don't say 'Are you depressed' or 'Are you down'.*

Participant Three: *When a client starts to repeat one thing, and starts to stress something, then you obviously know that there is a problem (mental health) ... when somebody's bringing something forward then you know, you have to pay attention to it.*

There are little triggers, little issues, that if left unattended could result into something much more serious. It (being aware of such 'triggers') makes me pay more attention and look more critically at some of the signs, the suggestions and some of the points that clients raise ... makes it easier for me to identify them (mental health problems).

Particularly in the post-MHFA interview, the participants collectively spoke about the importance of not losing focus during appointments on the benefits of the health trainer service for people living with mental health problems.

At post MHFA attendance, one participant felt that having increased confidence, competence and feeling at ease about discussing mental health problems is very valuable and that it enables the health trainer to know immediately what the clients are talking about should they start discussing mental health problems. The participant also felt that these traits increased the client's confidence in the participant".

Participant One: *Feeling confident, competent and at ease discussing things with people, I would say that is very valuable. I wasn't all that clear on what it could mean previously (when clients discuss mental health problems). Knowing immediately what the client said they were being treated for, I thought 'oh yes, I've heard of that', and otherwise you might look a bit blank, and then they think 'oh, what sort of health trainer is this, she doesn't know anything'.*

6.2.3 Bringing mental health problems into the discussion

This theme represented participant experiences and reflections on how discussions about mental health problems with clients were brought into appointments. To clarify, this theme was separate to recognition of a mental health problem, or the provision of help in relation to it. Collectively, the pre-MHFA attendance data under this theme was not comprehensive to the extent of providing a clear description of experience, but an analytical description of the data suggested that discussions around mental health problems were brought into conversations by the client and not by the participant.

- Participant One: *Someone told me they'd been signed off work with stress. But that was as far as it went – it was only a casual conversation.*
- Participant Two: *They're brought it into the conversation (mental health problem) ... but it's been quite positive (related to lifestyle changes).*
- Participant Three: *It's something that you anticipate will happen, so you're not really shocked or taken unawares when it happens (discussing mental health problems).*

Analytically, post-MHFA attendance data suggested that discussions on mental health problems were client led, and the participants did not appear to discuss the specifics of a mental health problem:

- Participant One: *Sometimes people aren't that specific about their actual diagnosis.*
- Participant Two: *If they start talking, I'll maybe give them prompts, but I don't say "are you depressed" or "are you down", I don't actually ask that, but if it comes up into conversation, we can talk about it.*
- Participant Three: *You train to take everything that the client says seriously. Sometimes ... you find out a bit more, explore possibilities, find out where the client is going with it (when discussing mental health).*

In the post-MHFA interviews, participants described a wide range of examples where mental health problems had been discussed. Specific examples of discussions with clients around mental health problems were relayed during the post-MHFA interview.

- Participant One: *I would say that the ones I've seen in general, it's been depression. One client said she was bipolar, but apart from that people have just told me that, you know, they've been seeing a therapist, or that they're on tablets. I've got another client who is currently suffering from postnatal depression, she's seeing her GP about that. One client had previously been for some therapy on a course called 'Blues Be Gone'.*
- Participant Two: *I've got one (client) who's really depressed, who tried to commit suicide. A lot of clients are quite happy to tell you, go quite in depth.*
- Participant Three: *Clients do raise some mental health issues – some people might tell you that because of what's going on in their life they are a bit stressed, some people will tell you that they are worried.*

The range of mental health problems discussed in the health trainer appointments tended to reflect where they received referrals, or case found, from. For example, one of the participants who saw clients sourced through children's centres had discussions on postnatal depression.

6.2.4 Comfort with conversations on mental health problems

This theme developed to reflect participant experiences of speaking with clients about a mental health problem and their comfort with such conversations. Collectively, responses in the pre-MHFA interview reflected a reticence in terms of discussing mental health problems with clients:

- Participant One: *I think I'd be reluctant to explore it (mental health) too much.*
- Participant Two: *I don't really want to overstep the mark and go down that route (in terms of discussing mental health problems).*
- Participant Three: *It's not something you're very comfortable in (discussing mental health problems).*

Responses post-MHFA attendance varied across participants in terms of their experiences about discussing mental health problems and their comfort with such conversations and there was no collective representation of experiences. To give descriptive examples:

- Participant One: *I'm quite happy to discuss these things with them (mental health problems).*
- Participant Two: *I'm not really trained to talk about depression.*
- Participant Three: *Everything the client says is taken seriously. In terms of mental health issues being anything different, no it's not really different (with regards to discussing lifestyle changes).*

Post MHFA, there was consistency across participants with regards to emphasising the importance of maintaining a focus on the health trainer role and lifestyle changes when discussing mental health problems. Collectively, participants expressed the importance of not losing sight of the lifestyle changes that clients have identified. Participants identified that it was a challenge to ensure that the core elements of the health trainer service were provided, whilst processing and considering how to incorporate additional information around mental health problems. For example:

- Participant Two: *It (the conversation) can just end up going off track (if it's not focussed on lifestyle changes).*

6.2.5 Providing empathy and the opportunity to talk

Empathy has been described as the ability to understand another person's inner experiences and feelings and a capability to view the outside world from the other person's perspective (Hojat 2001).

In the pre-MHFA attendance interview, participants collectively discussed providing empathy and the opportunity to talk, mainly in relation to lifestyle changes that clients are attempting to make and the challenges they faced.

Participant One: *You think about how you might have dealt with things yourself and I think you can relate to people and empathise with them about their problems.*

Participant Two: *I think a lot of this role is actually letting the person talk, then they feel better. And just encouraging and (providing) empathy and positive feedback really (with regards to physical health and lifestyle changes).*

Participant Three: *You do try to sympathise and empathise with the person. It's something you anticipate will happen (discussing mental health problems), so you're not really shocked or taken so much unawares when it happens. I don't usually try to have a pre-conceived idea about anything, I just really like to have an open mind which really helps me because it means that I'm not surprised (in terms of general discussions).*

Analytically, in the post-MHFA interview, participants connected providing empathy and the opportunity for non-stigmatised and barrier-free conversations around mental health problems.

Participant One: *That's not a problem for me (discussing mental health problems), I'm quite happy to discuss these things with clients, and you know, let them see that I can empathise with their problems. I don't see it as a barrier and I've got no stigma attached to people with mental health problems, but I think people are a bit anxious about telling you about it in case it sort of puts you off working with them.*

Participant Two: *Maybe it helps just talking and getting it (a significant life event) off their chest. I think maybe they (clients) feel better after that, after talking.*

Participant Three: *A lot of the time when you hear 'mental health issues', you (public perception) think someone's gonna go, you know, berserk on them and stuff like that. Everybody gets/has at one time or another a mental health issue, so you know, it's not something that's unheard of.*

6.2.6 Summary of category two – discussing mental health problems with clients

There is no clear approach to discussing mental health problems with clients applied by the health trainer service. Providing the opportunity to talk is a key 'tool' used by health trainers to better understand a client's needs and barriers to lifestyle change. This opportunity is important for improving physical and mental health.

6.3 Category Three: Links with mental health services

6.3.1 Awareness of mental health services

A theme developed based on participant awareness of local services that could provide support for mental health problems. In the pre-MHFA attendance interview, two of the participants were aware of the mental health service provided in the primary care setting and whilst participants were aware that other services were available in the community, they did not know how they provided help to people with mental health problems.

- Participant One: *I'm aware of the local mental health services part of the local Primary Care Trust and I've met one of the ladies that's responsible for that, but I don't really have enough contacts. I've heard of charities like Mind that help people with mental health problems, but I think I need to have more information.*
- Participant Two: Not really no (in terms participant feeling they have a good knowledge or understanding about what might be available locally).
- Participant Three: *I do feel I'm quite knowledgeable about what's out there – relatively, yes, but understanding the context of exactly what those services offer could be a different issue altogether. I know that within the local community we have a mental health team, and then you have talking therapies, and other emotional and mental health resources that are available, but what exactly they do, you know, it's a bit out there for me.*

During the post-MHFA interview, all participants demonstrated a strong awareness of the local primary mental health care service and the Improving Access to Psychological Therapy (IAPT) programme. In terms of other mental health support services, one participant had also developed an understanding of an organisation called Rethink, and had developed good networking links with staff from the primary mental health care services. These links were developed through a promotional event in the town centre which was co-run. This networking opportunity led to the sharing of resources between the health trainer service and the primary mental health care service, and the option to use a room for health trainer appointments within the primary mental health care setting.

- Participant One: *I've actually discovered quite a lot in the last couple of weeks. I was involved in a promotion, it was to do with the Time To Change (National Campaign), in my local community. By doing that I've got to know ... talking therapies ... and there's a drop in centre for people who have been (previously) hospitalised with mental health problems. They have colleagues who help (with) education (and) employment following mental health problems. I met some people*

who work for an organisation called Rethink. I've suddenly over the last couple of weeks made a lot of new contacts, all to do with mental health services.

Participant Two: *The talking therapies, or I would refer them to their doctor (in terms of awareness of other services).*

Participant Three: *Our first port of call would always be the NHS provider services. I'm sure that there would be (other mental health services), but I can't say that I'm actively aware of any.*

6.3.2 Relationship with mental health services

At the time of the pre-MHFA attendance interview, none of the participants had developed relationships with staff within mental health services. In the post-MHFA interview, two of the participants gave examples of how relationships had developed with mental health service providers. The participants emphasised the importance of and challenges with regards to these relationships.

Participant One: *I've suddenly over the last couple of weeks made a lot of new contacts, all to do with mental health services, so that has given me lots more opportunities to get in touch with the right person. I know that these people are there, services I didn't know existed. I think it's better to have actually met them and have a chance to explore what they can actually offer to people, because then I can sort of talk to my clients and say 'this is what they do, is that really what you want?' Because if people are a bit vulnerable then you don't really want to send them off on a wild goose chase, and they might say, you know, 'she said try this and I did, it didn't work, it wasn't for me'. I think knowing more about it personally, having met people face to face and exchanged email addresses and phone numbers is important. Getting the referral right is important to maintaining the client's trust.*

Participant Three: *It's cordial (the dialogue with the primary mental health service) in the sense that the focus is always on the clients welfare. They're trying to get information from us, trying to find out exactly how we feel that the client needed their support, but obviously they have demands on their time and resources, so they're trying to really ascertain how much they feel the client would need their help, so we are then trying to convey the gravity of the seriousness of the client's concerns, and stress that their service is something that the client would need.*

6.3.3 Referrals to mental health services

At the pre MHFA interview, participants had made no referrals to mental health services. Two of the participants felt that there had not been the need to make a referral yet and one participant had felt there had been one occasion where a client would benefit from accessing a mental health professional. One participant had recommended to a client that they access a family intervention

centre and this was welcomed by the client, and the participant also suggested a self-help book from the library that was perhaps relevant to the client. When followed up at the next appointment, the client was pleased that the self help material had been discussed, although had not necessarily followed up on the suggestion.

Participant One: *With one client we've discussed stress and it was a case of maybe me suggesting that she could get a self help book from the library, that sort of thing, but I haven't suggested to anyone that they be referred to the mental health services – not yet.*

Participant Two: *Not yet (in terms of feeling the need to make a referral). No doubt I think it probably will.*

Participant Three: *(I've) not presently (made a referral). I have felt that it would be important (for one particular client) to access other, better qualified mental health professionals.*

There was a mixed response with regards to referrals to other services at the post-MHFA interview. One participant felt that they did not have enough knowledge to make a referral and mentioned that a leaflet would be useful as a prompt, but trying to remember everything is difficult and that it was important not to get sidetracked from the health trainer role. One of the participants spoke about one specific example of a referral they had made to primary care mental health services after recognising a clear need for more specialist support with the client. This was the first contact with mental health services that the client had had and the participant was the first person with which the client had discussed accessing mental health services. In the interview, the participant relayed the conversations and links that were needed in order for this referral to take place (this is reflected by Participant Three in 6.3.2). In a separate example, the same participant gave information to a client on what support was available through the Improving Access to Psychological Therapies (IAPT) programme.

Participant Two: *I don't know if I've got enough knowledge on that (making a referral). Maybe if I had a leaflet it would sort of prompt me a bit more maybe.*

Participant Three: *One of the cases was to give the client the information that there is on the support out there, talking about support like the Improving Access to Psychological Therapy, the IAPT, then another has actually been to refer the person on to the local mental health service.*

6.3.4 Summary of category three – links with mental health services

Awareness of, relationships with and referral routes to mental health services are not things that are automatically in place at the outset of the health trainer service. For them to exist, they must be developed by individual health trainers.

6.4 Results Summary

Every effort has been made to minimise the ontological impact of the researcher in how the themes have been represented in this section. This is to ensure that in the Discussion, where comparisons and links between themes will be made, any theory that arises in relation to the research aim and objectives is grounded within the data.

7.0 Discussion

The collection of data demonstrated an approach reflective of phenomenology, with grounded theory used to inform a thematic approach to data analysis. This section will compare the data presented under the thematic headings defined in the previous section. Comparisons made between pre and post interview data provided by an individual participant are referred to as descriptive comparisons. Comparisons between the pre and post collective data provided by participants (i.e. considering all three participant's responses as a whole) are referred to as collective comparisons. Comparisons that are based on assumptions and inferences extracted from analysing the data and following data saturation are referred to as analytic comparisons. By comparing the data in these ways and developing an understanding of the links between the themes, it will be possible to better understand how the skills learnt on the MHFA training are applied to help people with mental health problems. The ultimate purpose and focus of the Discussion will be to relate the data collected to the research objectives, to consider how well these objectives have been achieved and to identify where improvements in research could be made.

7.1 Comparing the data

Following attendance on the MHFA training, participants did not feel that the **core role of the health trainer** changed, and it remained focussed on supporting people to be motivated to make lifestyle changes regarding diet, weight, physical activity, alcohol and smoking. Between the pre and post MHFA interviews, the **case finding** routes through which participants received referrals developed, mainly to reflect the catchment group of the participant (health trainers tend to focus on specific groups within the community). One participant had started to receive referrals from the primary mental health care team following the MHFA training, although it is unclear if this referral pathway had developed as a reflection of the participant's catchment group or as a result of attending the MHFA training, or both. Collectively, participants recognised the positive **impact of the health trainer role on mental health** in both pre and post MHFA interviews. There was a clear difference in a collective comparison where in the post-MHFA interview, participants recognised and reported frequent experiences of discussing with clients the **impact of wider social determinants on mental health**, such as relationships, employment and social inclusion.

Participant experience of the **language used** by clients was consistently non medical when referring to mental health problems and participants adopted similar terminology to that used by clients during discussions on mental health. This did not appear to change following attendance on the MHFA training. Collectively, participant experience of **recognising mental health problems** in clients was more apparent in the post-MHFA attendance data. Participants were less concerned about the need to precisely identify the mental health problem in the post data compared to the pre data, and were more at ease with **bringing mental health problems into the conversation**, recognising that mental health problems were something that they could discuss with clients as part of the health trainer focus on lifestyles. Analytically, participants appeared to take the lead from clients in terms of bringing mental health problems into the conversation, although comparatively, the post-MHFA attendance data reflects a much richer vein of examples of participant experience of discussing mental health problems. Analytically, the depth and number of these conversations indicates a willingness to discuss mental health problems with clients that was not as apparent during the pre attendance interview. A comparative difference was recorded descriptively for two of the participants when considering **comfort with conversations on mental health problems**, with both participants describing experiences where they were consistently more at ease when discussing mental health problems with clients after attending the MHFA training. It is not possible to infer that participants provided more **empathy** to clients experiencing mental health problems from the post MHFA attendance data, although the post MHFA data is analytically suggestive that participants identified empathy with providing non-stigmatised conversation around mental health problems and the importance of non stigmatised discussions in removing the barriers to recovery faced by people living with mental health problems.

In the post-MHFA attendance interview, participants appeared to be more **aware of mental health services** and what these services provide, although this awareness only extended outside of NHS mental health services (to voluntary sector mental health organisations) in one descriptive example. There were clear descriptive examples from two participants of significant improvements in **relationships with mental health services** compared to pre-MHFA attendance data. In the three months following attendance on the MHFA training, collectively amongst the participants, there had

been one **referral to mental health services** compared to none prior to attending the training. In the post-MHFA attendance data, two of the participants had established clear contacts and referral routes for clients who would potentially require a referral to a mental health service.

7.2 Linking the themes

Themes within categories had clear links with each other but had been kept separate in the analysis due to the data driven approach, bracketing and a greater focus on induction. However, with a more deductive consideration for the data, it is reasonable to suggest that the themes that emerged are strongly linked both within and across categories. For example, it is reasonable to suggest a participant's comfort with conversations on mental health problems will play a part in how likely they are to refer a client to mental health services or provide empathy. By mapping probable links between themes, it is possible to consider whether a central themes exists, which Glaser (1978) identifies as the final part of the systematic approach to analysing qualitative data. This is done in Figure 2. There are two layers to this figure. First, the figure shows the likely links that exist between the themes based on induction and deduction from participant data. Second, the two themes which most strongly relate to the gaps in MHFA research (which were to preserve life where a person may be a danger to themselves, provide help to prevent mental health problems developing into a more serious state, promote recovery of good mental health, provide comfort to a person experiencing mental ill health and provide initial help and guide a person towards appropriate support) are highlighted in bold, as are the links that stem from these two themes.

Figure 2: Thematic links

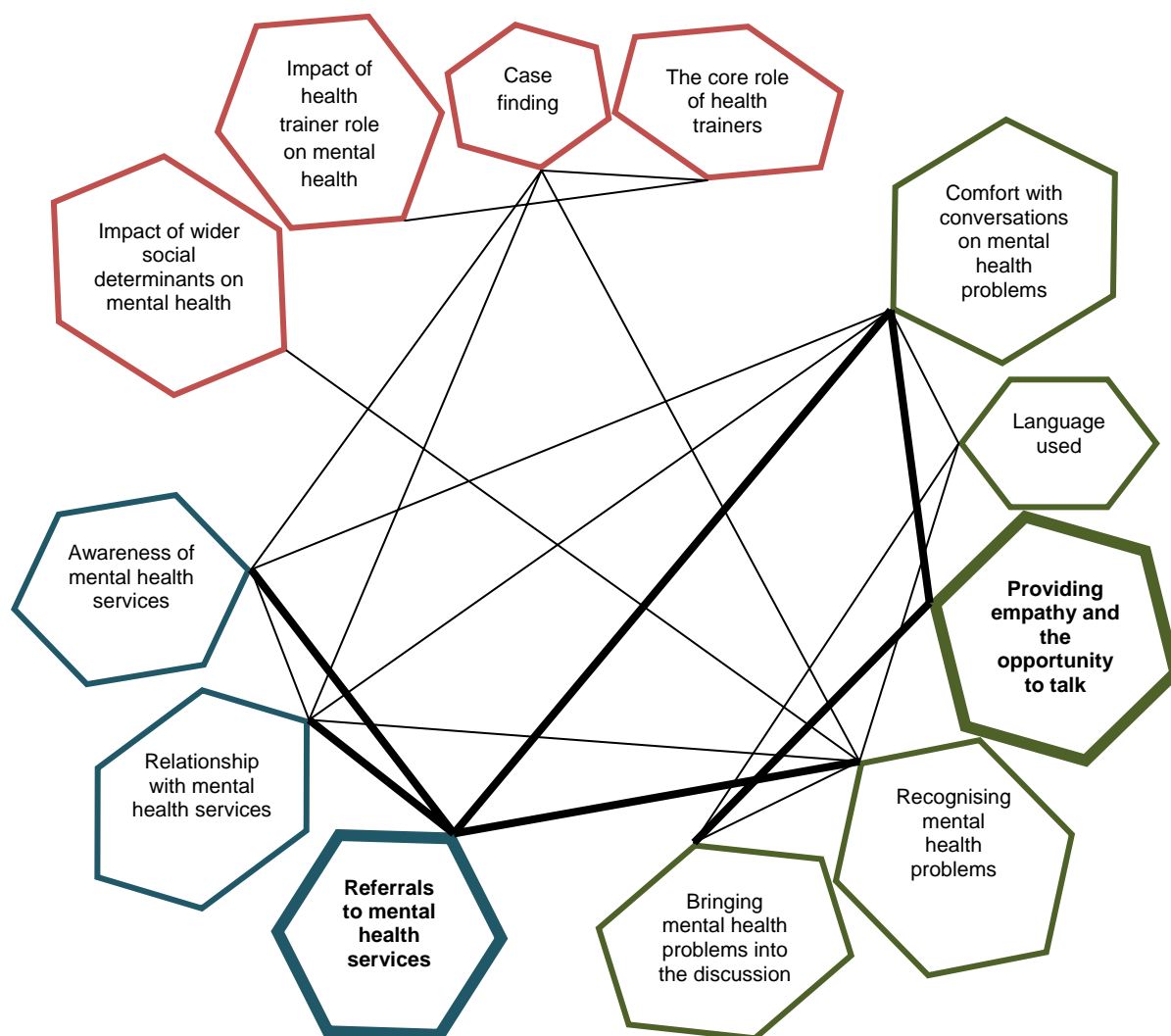


Figure 2 shows that the themes, and in particular the two themes that reflect the research gaps (which I will refer to as key themes), are linked to and affected by many other themes to a greater or lesser extent. It is likely that the themes attached to the two key themes are instrumental to developing an understanding of the practical application of MHFA skills to help people with mental health problems. Post MHFA data appeared to have a positive effect on the key themes, although it has not been possible to identify any one central, systematic theme which is connected to all others. However, it is important to note that 'relationship with mental health services' appears to be an important influencing factor connected to many other themes, and that this theme is outside the teaching outcomes of the MHFA training.

MHFA training appears to increase the help and support provided by health trainers to clients living with mental health problems, through the provision of a safer environment for clients to discuss mental health problems, the provision of help and guidance towards appropriate support and increased awareness of wider social determinants on mental health. Other contextual factors, most notably good relationships with and awareness of mental health service providers appear integral to the extent to which participants were able to offer such help, and by proxy, one could argue, the extent to which MHFA is able to affect the help and support given by health professionals to patients or members of the public living with mental health problems.

7.3 Has the study met the research objectives

The first research objective was to explore and interpret how attendance on the MHFA training might change interaction between participants and patients/members of the public. The descriptive, collective and analytic comparison between pre and post MHFA attendance data appears to suggest that participants were more able to recognise mental health problems, welcomed mental health problems into conversations more often and were more comfortable with conversations on mental health problems following attendance on the training. It proved difficult to interpret how and whether the provision of empathy had changed between interviews. However, it was apparent that participants had experienced discussing mental health problems more frequently and in greater depth with clients post MHFA attendance, and it is logical to assume therefore that participants will have provided a more comfortable and inviting environment to do this.

The second objective was to explore and evaluate any change in the support, advice and help that MHFA participants provide to people experiencing mental health problems. The post MHFA interview suggested increased advice (in terms of available mental health services) and referrals made into appropriate mental health services for clients with mental health problems, although there was only one example of a referral and it is not possible to say with certainty whether it was a direct consequence of MHFA attendance. These first two objectives relate to four of the research gaps identified with regards to the purpose of the MHFA training which were identified in the literature review. These were to promote recovery of good mental health, to provide comfort to a person experiencing mental ill health, to provide help to prevent mental health problems developing into a

more serious state and to provide initial help and guide a person towards appropriate support. There was no evidence to suggest achievement of the fifth research gap; to preserve life where a person may be a danger to themselves.

The third objective was to illuminate national practice around the delivery of MHFA training to help people with mental health problems and inform national policy. It appears that the skills learnt on the MHFA training are applied to help people with mental health problems, although other key factors, especially the development of good working relationships with mental health service providers, are key to the MHFA training goals achieving their full potential. MHFA has an apparent place in equipping front line health professionals with relevant skills to increase the help they give to people with mental health problems, although the delivery of the course should be considered with reference to the need for establishing strong professional relationships with relevant mental health service providers.

Referring to the Background given at the start of this research, the national mental health strategy New Horizons places emphasis on the impact of wider social determinants on mental health, including physical health, education, housing and employment, and grouped actions to be taken under six key themes: prevention of mental ill health and promoting mental health, early intervention, tackling stigma, strengthening transitions, personalised care and innovation. This research suggests that MHFA does play a role in increasing early access to appropriate mental health services for people with mental health problems, which they may not otherwise have accessed until a later point. MHFA participants appear more comfortable in discussing mental health problems and do so more frequently, which potentially relates to the New Horizons theme tackling stigma. The participants identified the role of wider social determinants on mental health more frequently in the post MHFA interview with increased experiences of discussions on relationships, social interaction and employment. No inference can be made about these conversations on wider social determinants in terms of additional help provided for people with mental health problems, although inclusion of wider social determinants in discussions reflected a more holistic consideration of factors impacting on a client's health in general, which included their mental health. New Horizons identified the provision of socially and culturally competent services based on people's needs rather than their diagnostic categories as an essential step towards more inclusive, recovery based approaches to care.

Given the results and comparisons made in this Discussion, MHFA does appear to have a role in supporting the delivery of national policy, including the New Horizon themes of prevention of mental ill health and promoting mental health, early intervention and tackling stigma. However, there were limitations to this research that should be addressed by future research in order to further illuminate and clarify the role of MHFA in delivering national policy.

The forth research objective was to identify future research implications with regards to exploring and evaluating how the skills learnt on the MHFA training are applied to help people with mental health problems. These are considered in the rest of the Discussion, which considers the strengths and weaknesses of the study, what research is still needed and what this study has added to current research.

7.4 Strengths and weaknesses of the study

To make inferences and draw conclusions about how the skills learnt on the Mental Health First Aid training are used to improve the help and support given by health professionals to patients or members of the public living with mental health problems, one must consider the validity, reliability and generalisability of the results. It is useful to consider these separately.

7.4.1 Validity

Doubts can be cast over any interview as to its ability to produce ecological validity and researchers can only learn from interviews what it is that participants tell them (Gomm 2000). That said, the stronger the methodology and analysis, the more likely the validity of the results. Validity refers to the extent to which explanations are truly reflective of what is actually happening. Considering realism, recognising the strengths and weaknesses of research validity is an essential component of assessing the strength of the research methodology and its results. Even from a pure constructivist or idealist viewpoint, that would question the point to challenging validity (if there are multiple views of reality then how can data interpretation prove meaningful to others), it would still be accepted that interpretation of data by researchers is vulnerable to bias or error.

This study attempted at every stage to capture and reflect what is happening in reality based on participant experience. This is demonstrated by the rich collection of data on participant

experience of providing help for people with mental health problems and an approach to analysis that is firmly grounded in the data. Interviews were conducted on a one to one basis and in privacy which added to participant comfort and allowed participants to describe their experiences in confidence and in their own time. In these respects, validity was possibly the strongest quality to this research. However, those considering the validity of this research should identify that elements of reflexivity and reflection weaken the validity. The most significant reflexive impact is that of the position and influence of the researcher upon the collection of the data and the interpretation of the results – in essence the ontological impact. As highlighted in the methodology section, interviews and data analysis were carried out by the researcher whose beliefs around MHFA and approach to discussing experiences of providing help for people with mental health problems with participants is likely to have impacted on these processes. A recommendation for future research would be to employ a researcher who had not participated themselves on the MFHA training.

The entire research process (literature review, development of methodology, data collection, analysis and data interpretation) was conducted by one researcher. Reflection relates to the ability to stand back from the research process to consider ideas (such as themes and categories) from different perspectives and to examine ontological impact. Whilst the approach to analysis was steeped in grounded theory, driven by the data (as opposed to a concept driven approach) and discussed regularly with an academic supervisor, the immersion of the researcher in the data, and indeed the entire research process, will have limited the researcher's ability to reflect. A recommendation for future research would be to employ more than one researcher, and to conduct facilitated reflection for the researchers at various stages of data collection and analysis, to align and manage their perspectives and ontological stance.

7.4.2 Reliability

Reliability is concerned with the extent to which the study results would be consistent across repeated investigations and with different researchers. The reliability of this study is strongly related to the participant recruitment and it is here that the study experienced important limitations. Weaknesses and limitations included:

- A small number of participants were recruited. More participants were hoped for in this study, but a combination of factors limited recruitment, including the timescales involved in the research, achieving ethical clearance from Research Consortia and small numbers of MHFA courses being delivered during the recruitment phase.
- Lack of a control group meant that the study could not allow for the effect of the interview on participants. It is likely that the interview would have had an impact, as the questions were focussed on learning more about participant experience with regards to the identified gaps in research. Therefore, participants will have reflected on their approach to helping people with mental health problems as a result of attending the interview.
- The recruitment of participants relied on participants expressing a desire to partake in the research. The risk of self-selecting participants is that they may lack true representation (Jorm 2005). In this case, participants may have been front line health professionals who desired to improve the help that they gave to people with mental health problems, although this could be said of anyone enrolling on the MHFA training.

7.4.3 Generalisability

Generalisability is concerned with the extent to which results are true for a wide, but specified, range of circumstances beyond those studied in the research (Gibbs 2010). This research set out to develop a better understanding of how the skills learnt on the Mental Health First Aid training are used to improve the help and support given by health professionals to patients or members of the public living with mental health problems. Ultimately, all participants were health trainers. Caution must therefore be given to inferences made about the data, firstly with regards to health professionals, and secondly with regards to health trainers. This study defined health trainers as health professionals, but health trainers are not representative of all health professionals. One can only talk about the potential difference that MHFA could make to health professionals as a result of this research. To understand the impact that MHFA is likely to have for health professionals who are not health trainers, such as physiotherapists, one would require participants whose profession is physiotherapy. As seen in the study, the participants brought with them their own interpretation of the use of the skills learnt on the MHFA training in relation to their role as health trainers. Other professions would likely do the same. In addition, care should be taken around generalising the study results for all health trainers.

This is due to the small sample size, and the fact that health trainer roles are influenced by individual catchments area, target groups and population need at a local level.

7.5 What does this study add to current knowledge and what research is still needed?

In addition to the interpretation of the data comparison, discussed at the beginning of this section, this study suggests that exploration of MHFA participant experiences using qualitative interviews can develop a better understanding of the practical application of the skills learnt on MHFA training to help people with mental health problems. Future research into MHFA is needed with the learning and recommendations from this study used and considered in research approaches.

7.6 Recommendations for future research

Despite limitations, the development of themes and comparisons between pre and post MHFA attendance data in this study should be viewed as a legitimate interpretation of how the skills learnt on the MHFA training might relate to the provision of help for people with mental health problems. Methodological strengths to this included a clearly identified research gap, defined approaches to data collection and analysis, employment of the most reliable methods within the confines of the research (considering cost and timescales) and consideration of the learning from previous research. Based on the discussion on validity, reliability and generalisability, future research should consider:

- An increased timescale for collecting the data.
- A greater catchment area for participant recruitment (this study only covered London and the South East).
- Recruitment of a larger number of participants.
- Introduction of a control group in order to allow for and detect for the impact of the interview.
- Completely independent researcher(s) to conduct future interviews.
- The employment of more than one researcher, considering the need for larger scale research, and to improve reflexivity and reflection.
- Further thematic validation with participants at the later stages of data analysis.

- It is desirable for this research project to be used as a template for future larger studies into the practical application of the skills learnt on MHFA to help people with mental health problems. The questions used in this study as part of a semi structured interview process have been successful in collecting meaningful data on the help provided by participants to people with mental health problems. The interview matrix in this study should inform and be used in future research into MHFA with a wider group of participants.

7.7 Discussion Summary

This section has compared the pre and post MHFA attendance data presented in the results and considered how the themes that developed from the data link and to some extent rely on each other. The comparison has been considered against the research objectives and a description was given to reflect how the objectives have been met. Finally, the strengths and the weaknesses of the study were discussed with the purpose of recognising, and informing those reading this research of, the validity, reliability and generalisability of the results, and informing future research into the practical application of the skills learnt on the MHFA training to help people with mental health problems. The next section will summarise the research, considering the aim of the research and the key discussion points that the reader should take away.

8.0 Conclusion

The aim of this study was to better understand how attendance on the Mental Health First Aid course affects the help and support given by health professionals to patients or members of the public living with mental health problems. The research methodology was informed by previous research and applied phenomenological and grounded theoretical approaches to data collection and analysis.

MHFA training appears to increase the help and support provided by health trainers to clients living with mental health problems, through the provision of a more comfortable environment for clients to discuss mental health problems and the provision of help and guidance towards appropriate support. Other contextual factors, notably good relationships with and awareness of mental health service providers appear integral to the extent to which health trainers were able to offer such help.

In light of national policy on reducing the stigma attached to mental health problems and the importance of early intervention, consideration should be given to MHFA as a training need for health trainers and other front line health professionals who have had no previous training in mental health.

The sample size in this study of three participants limits the reliability of the results. Whilst the study has made a start to addressing research gaps, more research is required and it is hoped that this study serves as an important precursor to larger studies into how the skills learnt on Mental Health First Aid training are used to improve the help and support given by health professionals to patients or members of the public living with mental health problems.

Future research into MHFA would enlighten policy makers as to how the training can best deliver mental health strategy and inform commissioners and providers of services as to whether MHFA should be delivered to staff.

It could be that the other contextual factors regarding relationships with and awareness of mental health services, which appeared integral to helping someone to access appropriate support, are considered in future developments of the MHFA training.

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Appendices

Appendix A: Interview questions used in other research

Taken from Jorm, AF. et al. 2005 *Experiences in applying skills learned in a mental health first aid training course: a qualitative study of participants' stories*. BMC Psychiatry 2005; 5:43

For those who could help a person experiencing a mental health problem:

- “Could you tell us something about the situation(s) and the problems you believed the person(s) was experiencing?”
- Were you able to do anything specific to help the person(s) you believed was suffering the mental health problem(s)?

For those who could not help a person experiencing a mental health problem:

- What was the reason(s) that you were not able to help that person(s)?
- Can you give us any examples of something you did?
- What do you think were the effects on that person/s of what you did?
- Can you give us any examples of how your relations with that person/s, or your feelings towards them, have changed?
- Do you think this change had any effect on the person/s, either good or bad?
- How (if at all) has doing the MHFA course changed how you relate to or feel about the person(s) suffering from that mental health problem?”

Jorm, AF. et al. 2010 *Mental health first aid training for high school teachers: a cluster randomized trial*. BMC Psychiatry 2010; 10:51

Questions asked to MHFA participants (the teachers):

- During the last month, did you talk with a student about their mental health problem (Never, Once, Occasionally, Frequently)?
- If yes, did you do any of the following: spent time listening to their problem, helped to calm them down, talked to them about suicidal thoughts, recommended they seek professional help, anything else?

Questions asked to those potentially receiving help (the students):

- Over the past month, have you talked with a school staff member about any mental health problem you may have (never, once, occasionally or frequently)?
- Over the past month, have you received any information about mental health problems from your teachers (Yes, No, and if Yes, how was this information presented)?

Appendix B: Brighton West Research Ethics Committee Recommendations

Further information or clarification required

1. The final research report should state that a perfect study would ideally consist of one interview before the course and one after.

Amendments required to supporting documentation:

Participant Information Sheet

2. The participant information sheet was overworked as it followed the model information sheet as recommended by NRES. The NRES template was more suitable for large scale clinical research and therefore it needed to be simplified for your type of study. The committee advised that you re-read the document and make it much more user friendly.
3. Parts 1 and 2 needed to be put together.
4. Under the paragraph relating to confidentiality, it needed to guarantee confidentiality as opposed to stating you would do your best
5. It needed to state that the research was being undertaken as part of an educational qualification
6. Acronyms needed to be explained fully in the first instance and then could be used afterwards
7. The paragraphs complaints could be removed. (The committee thought that service users could not complain if taking legal action)

Invitation Letter

8. The letter of invitation also appeared too busy. It needed to be simplified.
9. It needed to refer to Brighton West LREC as opposed to West Brighton LREC.
10. Any personal mobile telephone number being used as a contact number needed to be removed (also wherever it appeared on any other document)

Consent Form

11. Consent was required to conduct audio recordings and publish anonymous quotations.

Additional supporting documentation required:

12. A schedule or topic guide for the interviews was required for the committee to see an indication of the kind of questions that participants would be asked.

Recommendations

13. Should the research recruit too many participants, participants could be informed that they may not be needed. This could be put in the participant information letter explaining the reasons why.
14. The research would attain a higher uptake in the recruitment of participants by telephoning them first and explaining that they would be sent an invitation letter, rather than only sending them the letter.

Appendix C: Consent Form



Centre Number:
Study Number:
Patient Identification Number for this trial:

CONSENT FORM

Title of Research: A phenomenological study of health professional experience before and after attending Mental Health First Aid training.

Name of Researcher: Graeme Potter

Please initial box

1. I confirm that I have read and understand the Participant Information Sheet dated 11th December 2009 (Version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these questions answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

3. I understand that relevant sections of my data collected during the study, may be looked at by individuals from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to this data.

4. I understand that this research includes audio recordings and anonymous quotations may be published in the research write up.

5. I agree to take part in the above study.

Name of Participant

Date

Signature

Name of Person
taking consent

Date

Signature

When completed, 1 for participant; 1 for researcher site file

Appendix D: Participant Information Sheet



Participant Information Sheet

How does “Mental Health First Aid” (MHFA) training affect treatment and care given by those attending?

Invitation Paragraph

We would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish and please ask us if you would like more information.

What is the purpose of the study?

We would like to gain an understanding of how MHFA training affects the treatment and care given by those attending the course. To help us to do this, interviews will be conducted with MHFA training participants, before and after they attend the training. The first interview will take place in the two months prior to the training, and the second interview will occur three months following, allowing time for the knowledge gained on the training to be applied in a real life setting. All those participating in this research will be front line health professionals, with no prior training in mental health. For the purpose of this study, front line health professionals will include health and wellbeing staff within the community (such as Health Trainers, Fitness Instructors, Children and Family Centre staff) or front line health care staff (such as Health Visitors, Physios and Community Nurses). This research is being undertaken as part of an educational qualification.

Why have I been invited?

We have invited you to take part in this study in order to develop the evidence base around the practical application of MHFA. We are hoping to conduct interviews with 16 people. This research will also enable future, larger studies into MHFA, and help us to realise the potential that the methods used in this research can have in helping England to understand the affect of this training.

Do I have to take part?

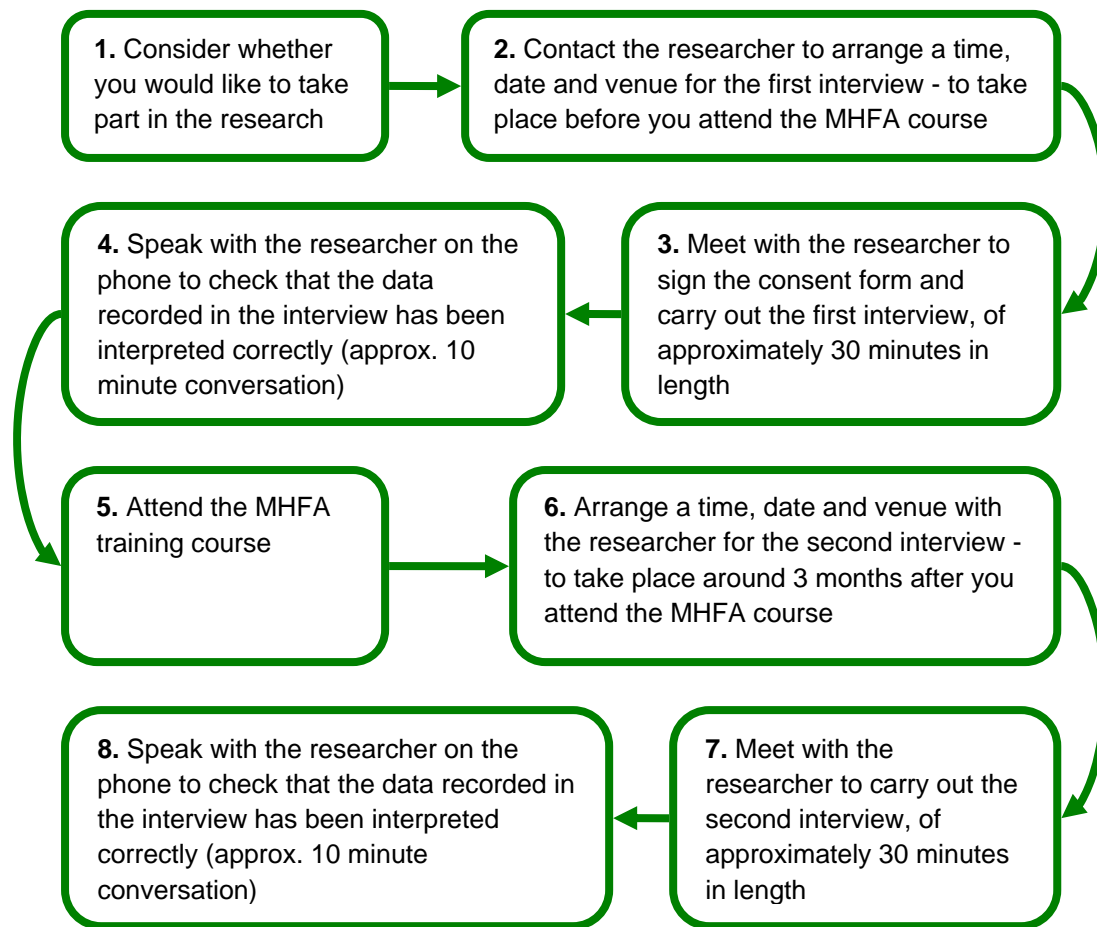
It is up to you to decide. We will describe the study to you and answer any questions that you may have. Should you wish to be involved in the research, we will then ask you to sign a consent form to show you have agreed to take part. You are free to withdraw at any time, without giving a reason. This would not affect your enrolment on the MHFA course to which you are registered.

What will happen to me if I take part?

We would like to speak with you before and after you attend the MHFA training. This would consist of one informal interview of about 30 minutes in length before you attend the training, and one interview after. The interviews will be semi structured – they will involve a structure to guide the discussions, but will still allow flexibility to explore individual experiences and thoughts. The person carrying out the research will ask questions around your experience of discussing mental health with patients or members of public that you see or talk to in a professional capacity. The interviews will be tape recorded and later transcribed in order to make a comparison between the information given in the interviews. To aid this comparison, themes and categories will be drawn from your interview responses in order to understand any changes that might result from attending the MHFA training. To check that these themes and categories are interpreted correctly (i.e. they correctly reflect what you said in the interview), the person carrying out the research will call you in the two weeks following each interview. This phone call will take about 10 minutes.

Information timeframe for taking part in the research:

The diagram below helps to understand the order of events.



Expenses and payments

Interviews will take place in a setting and at a time of your choice, assuming the acoustics are suitable for sound recording equipment. Whilst your participation in the research will be greatly appreciated, we are unable to offer you expenses and payment in this instance.

What are the possible benefits of taking part?

We cannot promise the study will help you but the information we get from this study will help to develop the evidence base around MHFA England. It is important to develop a better understanding of the practical application of MHFA by health professionals and the contribution that MFHA can make to mental health strategies and policies in England, and indeed to the mental wellbeing of patients, members of the public and the workforce.

What are the possible disadvantages of taking part?

The interviews will ask about your professional experience of discussing mental health with patients or members of the public. Discussing mental health can be an emotive subject and when this topic is discussed in the interview, it may raise your own awareness of the impact these discussions have on you. Such discussions are not outside the boundaries of the interview. However, the interview will not provide a structured opportunity for you to debrief as the focus of the interviews will be on your experiences with patients or members of the public. Opportunities to debrief are important, and should be provided through your work place setting. If you feel it is appropriate, the researcher will explore with you what opportunities might be available for you to access support through your work or

locally elsewhere. The researcher conducting the interview will be trained in exploring these opportunities.

What if relevant new information becomes available?

Should we get new information about the MHFA course, such as a change in course times or cancellation of the course, we will discuss with you whether you should continue in the study. If you are able to continue, we may ask you to sign an updated consent form. Should the research recruit more than 16 people, it may be that participants are not needed. We have decided to limit participation in the study to 16 people because transcribing and analyzing the data will be time consuming, and there is not capacity within the study to exceed this number of participants.

What will happen if I don't want to carry on with the study?

You are free to withdraw at any time, without giving a reason. This would not affect your enrolment in the MHFA course on which you are registered. Depending on the stage of the research, it may or may not be possible to extract the data you provide from the research. For example, if the data has been analysed after the first interview to develop themes and categories to inform the questions in the second set of interviews, it may not be possible to extract all information from the study. However, there will be no identifiable data presented in any of the research.

What if there is a problem?

Any complaint about the way you have been dealt with during the study will be addressed. If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions.

Will my taking part in this study be kept confidential?

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. It will not be possible to identify those taking part or any information about patients / members of the public in the research write up, and all data will be coded based on themes and categories in the analysis, and not related to individuals. The data will be stored on a NHS (National Health Service) West Sussex desktop, or laptop computer, which will be encrypted, and stored in a secure setting and behind a key coded entrance.

Some parts of the data collected for the study may be looked at by authorised persons from NHS West Sussex, the University of Brighton or representatives of regulatory authorities to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we guarantee confidentiality throughout this study.

What will happen to the results of the research study?

You will be written to at the end of the study to thank you for your involvement. The results of the study will be sent to you either by post or electronically depending on your preference. You will be informed of internet links to where the research is posted and information about plans for publication.

Who is organising and funding the research?

NHS West Sussex are sponsoring the research and the University of Brighton are providing academic guidance and supervision.

Who has reviewed the study?

All research in the National Health Service (NHS) is looked at by an independent group of people, called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given ethical support by Brighton West Research Ethics Committee.

Further information and contact details

If you would like further information, advice or are considering taking part in the study, please contact:

Graeme Potter

Public Health Directorate, North East Area Office, NHS West Sussex
3rd Floor Crawley Hospital, West Green Drive, Crawley, West Sussex, RH11 7DH
(01293 600300 ext. 3952)

Graeme.potter@westsussexpct.nhs.uk

Appendix E: Analytical prompts

Words or phrases	Words or phrases that seemed significant or that were repeated
Experiences	How an experience might differ if the variable discussed by a participant were to be experienced at the other end of the dimension (i.e. if they said it was too expensive, what if it wasn't?)
Key phrases	Key phrases, such as 'it was impossible', 'forever', 'everybody does this', as such phrases were good indicators that something shouldn't happen in that way, and so were helpful for generating memos and themes
Specific narrative	Specific narrative behind a response or an action taken, as this can emphasise an important theme for further consideration

Appendix F: Elements of the axial coding model (Strauss and Corbin 1998)

Model Element	Explanation
Causal conditions	What influences the central phenomenon, events, incidences, happenings
Phenomenon	The central idea, event, happening, incident about which a set of actions or interactions are directed at managing or handling or to which the set of actions is related
Strategies	For addressing the phenomenon, purposeful, goal-oriented
Context	Locations of events
Intervening conditions	Conditions that shape, facilitate or constrain the strategies that take place within a specific context
Action / interaction	Strategies devised to manage, handle, carry out, respond to a phenomenon under a set of perceived conditions
Consequences	Outcomes or results of action or interaction that result from the strategy

Appendix G: Example of coding

The following provides a snap shot of the coding under the 'Referrals to mental health services' theme. 'P1', 'P2' and 'P3' refers to participant number, 'Pre' refers to data collected from the pre-MHFA attendance interview, and 'L' refers to the line from which the code relates. So (P2, Pre, L53) means that this refers to Participant Number 2, is taken from the pre-MHFA attendance interview and it relates to Line 53 in the original transcript.

- Not felt the need to make one yet (P2, Pre, L53)
- Feels it is likely to be necessary, possibly in more deprived communities (P2, Pre, L54)
- No referrals so far (P2, Pre, L61)
- Wouldn't know where to signpost to, if issues such as self-harming and suicide arose (P2, Pre, L86-86)
- Would discuss with a senior health trainer (P2, Pre, L86-86)

- Client hasn't asked for referrals (P1, Pre, L55)
- Suggested family intervention centre in relation to possible loneliness (P1, Pre, L87)
- Suggested self-help book (P1,Pre, L46)
- Aware of local primary mental health care service – met one of the staff which was useful (P1,Pre, L133)
- Knows that there are charitable organisations such as Mind – would like to know more (P1,Pre, L135-137)

- Has felt the need to link with other mental health services (P3, Pre, L57)
- No referrals made at present (P3,Pre,L70)
- Feels there has been one occasion where a client would benefit from accessing a mental health professional (P3,Pre,L61-62)
- Role to try and engage with local primary mental health care services, IAPT (P3,Pre,L63-64)
- Feels quite knowledgeable about what's there, but understanding the context of what they do is a different matter – "it's a bit out there for me" (P3,Pre,L81)

Appendix H: The role of health trainers

Health trainers help people to develop healthier behaviour and lifestyles in their own local communities. They offer people practical support to change their behaviour to achieve their own choices and goals. The exact role will depend upon the needs of the community in which they work, but typically would involve encouraging people to:

- Stop smoking
- Participate in increased physical activity
- Eat more healthily
- Drink sensibly
- Practice safe sex

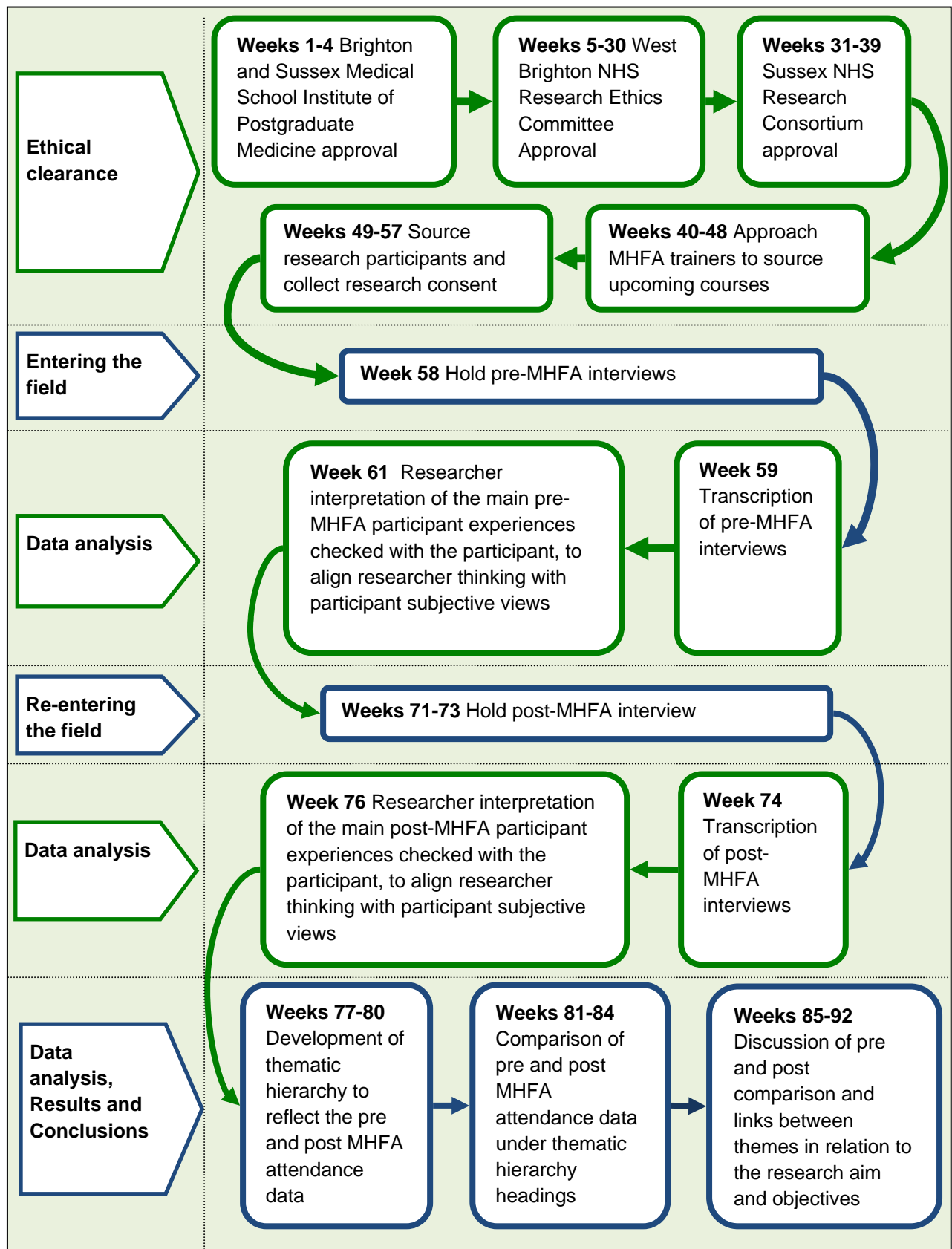
The ability to motivate people is therefore a key part of the work of a health trainer.

Health trainers need to be able to work with existing community groups and to be involved in supporting new groups. This might involve networking with other agencies and organisations.

Explaining how a healthy lifestyle can benefit an individual or group is an important part of this type of work. This might be done verbally or through providing information in a written format, or it might mean referring individuals to other agencies or organisations for further support or resources.

Source: NHS Careers Website (December 2010)

Appendix I: Research timeline



Appendix J: Interview Matrix

Name of study: Mental Health First Aid

Participant ID Number:

Date:

Time:

Location:

Interviewer:



Description of the interview:

- “To talk about your professional experience of discussing mental health and mental health problems with patients or members of the public.”
- Provide a definition of mental health and mental health problems to participant, as these terms will be used in the questions.
- Outline that the interview will last about 30 minutes, is confidential and will not affect MHFA enrolment.
- Ask participant to try to answer the questions as naturally and freely as possible.
- Confirm that the interview will be recorded on a Dictaphone, but occasionally I may note a few things down – this is just so that I can further explore the answers given.
- Make sure participant is comfortable to ask to clarify any questions they are unsure on.

Interview Matrix:

Questions	Elements to explore						
	Practical example	Action taken	How were the discussions	Referral made	Conversations had	Advice given	Frequency
Please could you tell me a little bit about your profession and what it entails?	Could you say something on the types of settings in which your patients are most frequently seen?						
How frequently would you say that mental health is discussed with your patients / members of the public that you see?	Opening question to ease in to others – explore answer appropriately – use as a lead in to the other questions below.						On a daily / weekly / monthly basis?
Are you able to give an example of a time when you referred, recommended or suggested a patient / member of the public speak with another health professional about their mental health?	Explore two examples if possible.	Who was the patient / member of public referred to?	Did they find the discussions difficult? Was it a difficult subject to raise? How did they find the patient's reaction?	What was suggested? Was an actual referral made?	Can you remember how the conversation went?		On a daily / weekly / monthly basis?
What are some of the things that you do to help to promote mental wellbeing in your patients and people that you see?	What resources were used to support this promotion?		Did they find the discussions difficult? Was it a difficult subject to raise? How did they find the patient's reaction?		Can you remember how the conversation went?		
Are there any other areas of your role that you feel have a part to play in helping people's mental health?	Explore as appropriate. How do they see the impact of their "physical" care on mental health?						
Can you give an example of when it became apparent that a patient / member of the public was	Go into depth on how participant identified mental health problem – in patient notes,		Did they find the discussions difficult? Was it a difficult subject to raise? How did they find	If there were specific discussions with regards to mental health, did discussions explore		If patient was not in contact with mental health	

suffering with a mental health problem and how did this impact on your appointment?	discussed in appointment?		the patient's reaction? Could you say more about what makes the discussions easy or difficult?	contact with mental health services?		services, was any advice / support given to this effect?	
What would you say are the most common types of mental health problems that your patients / members of the public that you see experience?	Ask for examples.						
Do you feel you are given the opportunity to debrief?	Ask for examples.		If opportunity to debrief is available, how to you find these discussions? Do you find it important?				Enough opportunities?
Are you aware of local support mechanisms available to you to support and promote your own mental health?	Ask for examples.						
Is there anything that we haven't discussed that you would like to raise?	Keep within scope.						

Closing the interview:

- Thank participant for their time.
- Say that the interview has now ended.
- Stop the tape recording.
- Ask the participant how they feel following the interview and spend time debriefing – make clear this is not part of the research.
- Ask participant if they would like to find out about local support mechanisms.
- Confirm that I will follow up with a phone call over the next few weeks to check that the themes that have come through in the discussions today correctly reflect their responses to the questions.
- Check the time and date that would be appropriate for this phone call.
- Check contact details are correct on both parts – encourage participant to call with any questions / concerns.