Evaluation of the Aboriginal and Torres Strait Islander Mental Health First Aid Program

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Abstract

Objective: This study reports findings from an uncontrolled evaluation of a course designed to educate participants in how to recognise and respond to mental health problems until professional help is received.

Methods: Utilising a mixed methods design, participants in 21 different courses, delivered across two Australian states, were invited to complete pre-, post-, and follow-up surveys and provide qualitative feedback on their training experiences.

Results: Participants reported feeling more confident in their capacity to respond appropriately to a person presenting with a mental health need and believed they would be more likely to provide assistance. Satisfaction was attributed to the skills and sensitivities of instructors who had lived experience of mental health concerns in Aboriginal and Torres Strait Islander communities.

Conclusion: This course holds promise in improving mental health literacy in relation to Aboriginal and Torres Strait Islander mental health.

Implications for public health: Few courses are available that address issues relating to the social and emotional wellbeing of Aboriginal and Torres Strait Islander People. This study illustrates how community engagement with primary health and specialist mental health services might be strengthened.

Key words: mental health, first aid, mental health literacy, Aboriginal, Torres Strait Islander, training, evaluation, community program

Originally developed in Australia, training to deliver Mental Health First Aid (MHFA) training is now available in over 25 different countries, with more than two million people reported to have now participated.[1] The training is best conceptualised as a community-delivered method of promoting mental health literacy, which is based on the principles of community care and lay assistance in times of emergency that underpin medical first aid training.[2,3] This article reports the findings of an evaluation of a cultural adaptation of MHFA,[4,5] designed specifically for delivery in Australia to Aboriginal and Torres Strait Islander adults and those who work with these groups.

While Aboriginal and Torres Strait Islander People constitute only 3.3% of the Australian population,[6] there is evidence that, as a group, they experience a markedly higher burden of disease than the wider community.[7,8] Current indicators suggest, for example, that psychological distress is experienced at a rate that is 2.6 times higher than that found in the general Australian population.[9] Factors identified as directly resulting in poor mental health, high levels of vulnerability, and a high risk of self-harm and suicide in Aboriginal and Torres Strait Islander People include (but are not limited to): historical and intergenerational trauma associated with cultural dislocation and the associated loss of identity and cultural practices,[10,11] direct interpersonal trauma (e.g. physical and/or sexual assault/abuse; within-community violence,[12,13] and past government practices of removal from family (the Stolen Generations).[14] Social and structural factors are also often implicated, including poverty,[15] unemployment, inadequate housing[16] and harmful substance use.[17]

The rationale for developing and delivering specialist training for those working with Aboriginal and Torres Strait Islander People is based on suggestions that these drivers of distress and mental health problems are not always well understood by mainstream healthcare providers, leading to low levels of service utilisation.[18,19] The 2014–2015 National Aboriginal and Torres Strait Islander Social Survey,[20] for example, reveals that more people report problems in accessing services for mental health conditions (23%) than for other long-term health problems (13%) or for general (i.e. non-long-term health) conditions (10%). Furthermore, it has been reported that Aboriginal males are reluctant to access Western treatment, preferring instead to wait until a crisis occurs.[21,22] Other factors that may be relevant to low levels of help-seeking include: exposure to racism and

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discrimination (that can result in a mistrust of mainstream services); cultural and language differences (that make communication ineffective); staff practices being perceived as offensive due to a lack of understanding of Aboriginal and Torres Strait Islander cultures and/or current life circumstances;[21] the stigma associated with experiencing mental health problems;[18,23,24] and long waiting times to access services or the distances required to travel to appropriate services.[21]

The first cultural adaptation of the MHFA training occurred between 2002 and 2007.[25,26,27] A two-year Delphi consultation process was used to modify existing materials and incorporate resources that were considered more culturally appropriate. Hart et al.[25] noted that feedback regarding training content, irrespective of the topic, had two key themes: one was the importance placed on *understanding and assessing mental illness within the cultural context of the person being helped*; the second was *the critical role of family and community* in the promotion and protection of the health and wellbeing of those with mental health problems. Thus, the modified program aimed to ensure a focus on culture and the experience of mental illness by Aboriginal and Torres Strait Islander People while retaining the original practice guidelines for delivery. A new guideline was also developed that focussed on understanding and respecting Aboriginal culture (cultural considerations and communication techniques) when providing mental health first aid.

The only previous evaluation of Aboriginal and Torres Strait Islander MHFA (AMHFA) by Kanowski et al.[27] involved this original adaptation. Data, both qualitative and quantitative, were collected from those who undertook either a five-day instructor training course and, where relevant, delivered the training, or from Aboriginal and Torres Strait Islander community members who attended. The instructor training and 14-hour workshop was described as culturally appropriate and empowering, as well as providing relevant and important information that could assist those with a mental illness. However, suggestions for further program improvement were noted, such as the need to adapt the training materials to suit "those who learn by doing rather than by reading"[27(p8)] and to acknowledge the level of cultural diversity that exists among Aboriginal and Torres Strait Islander People to ensure cultural safety. This led to the development of the most recent AMHFA course, Version 3, which was completed in 2018. Organisational records show that these materials have now been used in more than 135 courses involving over 1,538 participants. It is therefore timely to conduct an evaluation of this new course.

In light of what is now known from a large number of studies examining the impact of MHFA on different participant groups,[28] it can be expected that immediate small-to-moderate improvements in mental health knowledge will be observed following completion of the training, some of which should be maintained at follow-up. The strongest effects have been reported around measures relating to the acquisition of knowledge (i.e. training improves knowledge about mental health problems), which is considered critical as it is this that informs beliefs about appropriate treatment. Similarly, knowledge about different mental health presentations is also thought to improve accuracy in the identification of mental health problems. Given that AMHFA is essentially an adaption of the core MHFA program, it is expected that participant knowledge about mental health will improve upon program completion and will be maintained at post-program follow-up.

Previous evaluations, as described by Morgan et al.,[28] have also reported that participants who complete the MHFA training feel more confident in their ability to appropriately respond to a person presenting with a mental health need, as well as feeling more likely to provide assistance. As such, it is predicted that ratings of confidence and the intention to respond will increase for those completing the AMHFA course. In addition, a third outcome measure routinely used in a number of previous MHFA evaluation studies relates to stigmatising attitudes towards those with mental health problems and, consistent with these, it is expected that endorsement of these attitudes will diminish by the end of the course. To assess both the perceived quality of AMHFA and the extent to which it is regarded as culturally safe, it is also important that participants are afforded the opportunity to rate their experience of the training and to comment on its cultural appropriateness.

Design

A mixed methods approach utilising an embedded design was adopted.[29] Quantitative data was collected first using a one-group pretest-posttest design with three-month follow-up to examine change following participation in the course. Given the importance of differentiating Indigenous research constructs from Western methodologies, a conversational storytelling method that "honours orality as a means of transmitting knowledge"[30(p42)] was used for the qualitative component.[31,32] As this evaluation concerned the adaptation of a mainstream program, this reflects a top-down approach that focusses on the lived experience of participants.

Measures

The study design was discussed with the evaluation team, which included senior Aboriginal and Torres Strait Islander researchers and practitioners and a reference group of experienced Aboriginal MHFA practitioners. After piloting, the evaluation proceeded using data outcome tools consistent with previous research in this area. Participants also rated their level of satisfaction with the provision of training and provided qualitative feedback about their experience.

Knowledge: Two measures assessed knowledge of course content. The 10-item MHFA Knowledge Scale asks about specific mental health issues (e.g. *Anxiety disorders often start while a person is young*). Responses using a true/false format (1=correct; 0=incorrect) are summed, with higher scores indicative of increased knowledge levels. Internal consistency reliability increased from pre- (α=0.58) to post-training assessment (α=0.81). The 8-item AMHFA Knowledge Scale *(e.g. Schizophrenia is the most common mental illness in Aboriginal communities across Australia*) was constructed for the evaluation to reflect course content. An agree/disagree/don't know response format (1=correct; 0=incorrect) was summed with higher scores again indicative of higher levels of post-training knowledge. There was a similar increase in internal consistency reliability from pre- (α=0.50) to post- (α=0.80) measurement.

Confidence and intentions: Participants read two scenarios: one depicting an individual ('Jarrah') experiencing depression and another ('Jedda') experiencing symptoms of schizophrenia. They were then asked to report how confident they felt in their ability to help from 1 (not at all confident) to 5 (extremely confident) and to respond to a 9-item measure assessing the level of intent in the provision of help (e.g. *Wait and see if things get worse before doing anything*) from

1 (very unlikely) to 5 (very likely). Internal consistency reliability was stronger at pre-training (α=0.76 and 0.72 for scenarios 1 and 2, respectively) than at post-training (α=0.54 and 0.64).

Stigmatising attitudes: Four single items (e.g. *People with a problem like Jarrah/Jedda could snap out of it if they wanted to*) assessed stigmatising attitudes towards people with mental health problems. Each item was rated on a 4-point scale from 1 (strongly agree) to 4 (strongly disagree).

Training experience: Participants' experience of the training was examined with six single items assessing their views regarding its organisation, the instructor, program content, cultural appropriateness, recommendation to others and confidence gained. Responses were recorded on a scale from 1 (strongly agree) to 5 (strongly disagree).

Qualitative data: Immediately following training, participants were asked whether they wished to provide further comments or feedback about the course, including whether the training provided a safe place to discuss their culture and views.

Procedure

Research approval was gained from the Aboriginal Health Research Ethics Committee (South Australia) and registered with a university Human Research Ethics Committee. All of those enrolled in a participating AMHFA course were invited to participate at pre- and post-training and again, via email, at three-month follow-up to those who consented and provided a contact address. Two weeks after the follow-up survey was distributed, one reminder email was sent to those who had not responded. For the quantitative component, an evaluation team member was present at the commencement and completion of each course to explain the process, answer questions, and administer surveys. The qualitative element used a conversational storytelling approach.[31,32] Participation was voluntary; no rewards or incentives were offered. At the end of the program, facilitators were also invited to offer their observations about both the group they had just completed and the program more generally. This was an informal process, with contemporaneous notes written by members of the research team to document the main points.

Results

Participants

The sample was comprised of 251 participants (167 females; 80 males; 3 missing) aged 16 to 71 years (M=41.75; SD=13.89). Data were collected at seven sites in two Australian states, Queensland and South Australia. All South Australian data (n=61) was collected from program participants who attended courses in metropolitan Adelaide whereas Queensland data (n=190) was drawn from participants attending courses delivered across five different locations, including metropolitan and regional areas. In terms of demographics, almost equal numbers identified as Aboriginal (n=84; 33.5%) and 'Other' (82; 32.7%), although nearly one-fifth (n=46; 18.3%) did not record their cultural background. (We suspect that these will primarily be non-Indigenous program participants as the question asked if people identified as Aboriginal, Torres Strait Islander, or both; however, we cannot say this for certain). Forty-three (17.1%) participants spoke a language other than English at home. The highest level of education completed for the majority (n=98; 39%) was in a qualification related to a trade or vocational training course. Finally, participants were asked to rate their motivation to attend the training in relation to six non-mutually exclusive categories: To assist people in my workplace; To assist family or friends; To look after my own mental health; I want to learn to help other people; Just interested – no particular reason; Other. The most common responses were "*to assist people in my workplace*" (n=182; 72.5%), "*to learn to help other people*" (n=139; 60.6%) and "*to assist family or friends*" (n=112; 43.8%).

Quantitative analysis

Knowledge

Repeated measures *t*-tests were conducted to determine change in MHFA Knowledge following training. Significant improvement, with a moderate effect size, was noted on mean scores from pre-training (M=5.52, SD=2.05) to post-training (M=6.73, SD=2.64; $t(250)=-6.80$, $p<0.001$, $d=0.43$, 95%CI: -1.5516 - -0.8547). Similarly, a significant increase in knowledge was found on the AMHFA Knowledge Scale from pre-training (M=4.07, SD=1.70) to post-training (M=5.78, SD=2.24), with a moderate to large effect size ($t(250)=-8.63$, $p<0.001$, $d=0.66$, 95%CI: -1.7321 -1.0886). This reflects meaningful improvement in the knowledge and understanding of mental health post-training (the effect sizes suggest 66% of participants were above the pre-training group mean on the MHFA knowledge measure and 75% above the pre-training group on the AMHFA knowledge measure.[33]

Confidence, intentions to provide help, and stigmatising attitudes

Pre-post training changes in self-reported confidence in the provision of help, intention to provide that help, and stigmatising attitudes towards mental health, based on depictions of depression and schizophrenia symptomology, were also assessed using repeated measures *t*-tests. Table 1 shows that, post-training, participants felt significantly more confident in their ability to deal with the circumstances described in both vignettes. Moreover, the large effect size for the depression vignette suggests approximately 84% of participants were above the pre-training group mean, while approximately 82% above the pre-training group mean for the schizophrenia vignette.[33] Participants also responded to nine *intention* items. Given multiple *t*-tests, a Bonferroni adjustment was made and the significance level set at $p<0.01$. The general pattern observed here was for significant improvement in both scenarios across items where change reflected a more positive approach. For example, ratings reflected an increased likelihood of listening to someone experiencing a mental health problem, encouraging the person to access help, providing help-seeking advice, seeking permission prior to contacting mental health services or the individual's doctor, and calling emergency services if concerned. Despite small effect sizes, an examination of response frequencies revealed that for the majority of items the largest shifts occurred with intentions moving from a 'likely' to 'very likely' response.

Finally, to assess change scores on the stigmatising attitudes items, another set of repeated measures *t*-tests were undertaken. This revealed only one significant within-group difference from pre- to post-training on the depression scenario. Participants reported at post-training that they were significantly *less likely* to agree with *not telling* someone if they had similar problems to those described in the scenario, although the effect size was small ($t(223)=-3.91$, $p<0.001$, $d=0.23$, 95%CI: -0.403 - -0.133). A perusal of mean scores on the responses revealed a strong pattern of disagreement with the stigmatising

statements presented, namely, *People with a problem like Jarrah's/Jedda's could snap out of it if they wanted to*, *A problem like Jarrah's/Jedda's is a sign of personal weakness* and *Jarrah's/Jedda's problem is not a real medical illness*.

Follow-up analysis

Approximately 10% of the sample (n=24; 9 male, 15 female) completed the follow-up survey three months after the conclusion of the training. Repeated measures *t*-tests were conducted to determine the extent to which learning was retained over time. A finding of no significant decrease on the MHFA Knowledge Scale ($t(23)=0.86$, $p=0.40$, $d=0.18$, 95%CI: -0.6483 – 1.5649) indicated a retention of mental health knowledge. Although a significant change with a moderate effect size was noted on the AMHFA Knowledge Scale for the same period ($t(23)=2.38$, $p=0.03$, $d=0.50$, 95%CI: 0.0871 - 1.2462), this appears to reflect a regression to the mean. Responses to the two vignettes showed that whereas mean levels of self-reported confidence in providing support had marginally increased over time, this was non-significant. Similarly, mean scores on the intention to provide help and stigmatising attitudes from post-testing to follow-up remained constant.

Table 1: Within-Group Differences on Confidence and Intentions.

	Pre-Training M (SD)	Post-Training M (SD)	t	d	95% CI
Scenario 1					
Confidence (n = 216)	3.20 (0.95)	4.07 (0.81)	-13.62**	0.99	-1.00 – -0.748
*Wait and see if things get worse before doing anything (n = 223)	1.86 (0.99)	1.71 (1.05)	2.23	0.15	0.018 – 0.287
Spend time listening to Jarrah discuss his feelings (n = 225)	4.52 (0.73)	4.70 (0.48)	-3.62**	0.24	-0.281 – -0.083
*Take charge of the situation for Jarrah (n = 219)	2.92 (1.06)	2.94 (1.26)	-0.17	0.02	-0.174 – 0.146
Ask Jarrah how he would like to be supported (n = 224)	4.43 (0.70)	4.68 (0.51)	-4.94**	0.34	-0.339 – -0.146
Ask Jarrah whether there is someone he would trust to help support him	4.51 (0.63)	4.71 (.47)	-4.54**	0.26	-0.288 – -0.144
Encourage Jarrah to get professional help as soon as possible (n = 223)	4.41(0.73)	4.64 (0.58)	-4.03**	0.27	-0.341 – -0.117
Provide Jarrah with information about where he can seek help (n = 223)	4.50 (0.68)	4.74 (0.48)	-5.23**	0.39	-0.327 – -0.148
Seek Jarrah's permission to contact his regular doctor or mental health professional about his thoughts of suicide (n = 223)	3.82 (0.89)	4.24 (0.06)	-6.69**	0.49	-0.644 – -0.351
Call emergency or mental health services if you are concerned and you feel out of your depth (n =224)	4.24 (0.81)	4.60 (0.65)	-6.36**	0.43	-0.468 – -0.247
Scenario 2					
Confidence	3.02 (1.07)	4.03 (0.86)	-13.59**	0.92	-1.16 – -0.867
*Wait and see if things get worse before doing anything (n = 222)	1.98 (1.07)	1.71 (1.06)	3.26	0.17	0.104 – 0.422
Spend time listening to Jedda discuss her feelings (n = 224)	4.30 (0.72)	4.64 (0.57)	-6.41**	0.43	-0.448 – -0.237
*Take charge of the situation for Jedda (n = 222)	3.04 (1.01)	3.11 (1.32)	0.77	0.05	-0.241 – 0.105
Ask Jedda how she would like to be supported (n = 220)	4.30 (0.70)	4.67 (0.61)	-7.54**	0.51	-0.467 – -0.273
Ask Jedda whether there is someone she would trust to help support her (n =219)	4.41 (0.64)	4.70 (0.50)	-6.44**	0.44	-0.369 – -0.196
Encourage Jedda to get professional help as soon as possible (n = 223)	4.37 (0.76)	4.64 (0.60)	-4.68**	0.31	-0.382 – -0.156
Provide Jedda with information about where she can seek help possible (n = 223)	4.40 (0.72)	4.70 (0.55)	-6.18**	0.41	-0.396 – -0.205
Seek Jedda's permission to contact her regular doctor or mental health professional about her thoughts of suicide possible (n = 223)	3.97 (1.00)	4.37 (0.90)	-5.90**	0.40	-0.539 – -0.263
Call emergency or mental health services if you are concerned and you feel out of your depth possible (n = 223)	4.28 (0.76)	4.61 (0.68)	-6.16**	0.41	-0.444 – -0.229

Note:

** negatively keyed items*

*** = p < .001.*

Overall, these data offer some support for the suggestion that changes observed upon completion of training are maintained over time.

Training feedback

At post-training, participants were asked to respond to six statements related to course delivery. Of the 229 who provided feedback, 69.0% strongly agreed the training was *well organised*, 70.9% strongly agreed the instructors were *well-prepared*, 70.3% strongly agreed that they had *learned a lot about mental health*, 68.6% strongly agreed that the AMHFA training was *culturally relevant* to them and their communities, 79.5% strongly agreed that they would *recommend the training* to others in their community, and 62.9% strongly agreed that they *felt confident in helping someone* with a mental health problem. Asked at the post-training stage whether training was a *safe place* for participants to discuss their culture and views, an overwhelming 98.6% agreed that it was.

Qualitative analysis

At the end of each course, participants and instructors were invited to share their observations about the training. Data collection was relational in nature, connected to and reflective of Aboriginal and Torres Strait Islander knowledge, collaborative, dialogic, and flexible.[31,32] Both participants and instructors were provided with an opportunity to engage in the process. Exact numbers were not recorded (many had to leave as soon as the course finished) but are estimated to represent around 10% of total participants. What follows are some reflections from these meetings.

The men in one group commented that they knew people went "womba" ('crazy' in Murri colloquial language) and acknowledged judgmental attitudes from those who tended to laugh at them. But, for them, the training had helped them to see what could be going on – to see the broader perspective as "there were lots hidden in people's lives" – and they felt that they could be more supportive of the people they worked with as a result. When asked how they were feeling after the training, the most typical responses made reference to terms like "tired" and "drained", although these feelings were mixed with positive emotion: "feel good and confident", "I'm feeling proud of myself", "empowered", "happy I come". Specific comments about learning included: "feel more knowledgeable",

"good understanding and knowledge of mental health", "I feel more educated about mental health issues and know how I can help", and "a lot of information to take on board, but I enjoyed it". Many commented on how the training had improved confidence: "knowing that I have had the training in mental health and also have the resources and education", "informed and educated and grateful for this experience", "great – I feel I have learnt heaps that I can take back and use", "confident re the content, angry that racism is still so big in this country", and "better prepared". Other comments included: "I felt it was my story being told – all about me", "it motivates me to get out of the dark", and "changes us from thinking don't go near her, she's womba".

When reflecting on the aspects of the training that worked well, there was a strong and consistent view that much of the value came from the personal experience of the instructors: "hearing real-life stories – the community and bond to keep the family together", "I think having a trainer with real-life experience was the best part, and worked well", "being able to listen to life experiences and learning how to be able to manage difficult situations", "hearing the 'real' stories of people/trainer", "[instructor] being able to tell her own stories to tell real-life examples", "favourite part was learning from an elder with life experience, not just any old trainer", and "it was REAL education not just acting and making things up". Others liked the way in which the course was delivered: "openness to be able to discuss in non-judgemental environment", "presenter was fantastic", "films were good" and "real people were used", and all topics were viewed positively. A key message here was that much of the program quality depended on the instructor being raised up in culture: "lived experience is a good platform to teach out of", and "training should always be delivered by 'black fellas'".

Interviews with instructors revealed they valued the opportunities for group discussion and yarning ("we all learn by storytelling"), although this could be difficult to manage given the requirement to cover all course content, particularly with large groups. Nonetheless, some discussion topics were considered too important to interrupt. Specific comments were made about the importance of attending to the wellbeing of participants, often by talking informally to participants during breaks. One instructor noted that all participants were personally contacted one week after the training to see if they were distressed.

When asked about aspects of the training course that should be changed, there was a mixture of responses: "information overload – but enjoyable – would like to see the training extended over three days instead of two", "it was too short ... needs to go over three days"; others felt that it was "too long". There was a view, particularly expressed in the Queensland courses, that more Torres Strait Islander content was needed: "could be more information of Torres Strait Islander culture included, but need to work with the Torres Strait Islander people to develop content". Some inconsistencies in language were noted throughout the manuals, power points and handbooks, highlighting a need for greater consistency (and to write for both Aboriginal *and* Torres Strait Islander people). Torres Strait Islander participants also suggested that more information about Islander culture and perspectives should be included, but nonetheless found the material meaningful and were able to apply it: "I was able to apply our similar concepts about family's separation, cultural adoption and how finding out you're adopted years later is similar to forced removals and trauma etc". A broader topic that arose regularly in the post-course discussions was the perceived lack of appropriate mental health services in many communities. While it was well understood that AMHFA is not a mental health intervention, one participant argued that it was sometimes viewed as such in her (discrete and remote) community, as other services are simply not available or accessible.

All the Aboriginal and Torres Strait Islander participants said that the training could be culturally appropriate and relevant – as long as it is delivered by Indigenous instructors. Nearly everyone who took part in the post-course discussions agreed with that course content was *culturally relevant to you and your community*': "YES. Cultural connection. Understanding from Aboriginal perspective", "yes definitely, because its focus is on everything holistically", "Yes, as it includes cultural perspectives/info on thoughts, practices and feelings", "Yes, the training covers cultural values, history, stolen gen community and how mental health affects the community", "Yes it's broad and inclusive of different community styles / customs" and "Yes, we have a lot of these issues in the community cause it culturally based". Cultural aspects of mental health were also noted; when participants were asked what they "didn't know before they attended" some of the comments included the following: "Depression, anxiety and how it affects the Aboriginal community. Drugs and alcohol depressants. The lore", "LORE. Sorry cuts. How to deal with a mental health crisis and be culturally aware while doing so", "the difference between law and lore and what happens when people accept lore as punishment" and "sorry business; how close culture is inbred at a young age and it doesn't stop".

Discussion

This study documents findings from an uncontrolled evaluation of the latest iteration of the MHFA course. Given the ethical and practical challenges associated with conducting a randomised trial of this type of training, the evaluation adopted the simple pre-post survey design that has been employed in a number of previous MHFA evaluations. In total, 251 people attending 21 different AMHFA courses volunteered to answer questions about their knowledge of mental health issues, their level of confidence in responding to mental health problems and their intentions to help. Their responses provide evidence that knowledge about mental health problems improved over time and that those who completed the course left feeling more confident in their capacity to respond appropriately to a person presenting with a mental health need and felt more likely to provide assistance. There was a suggestion that these changes were maintained at three-month follow up, although only a small proportion of those who attended the group completed the survey at this point. Although we consider it likely that the feedback provided in the follow-up surveys was reasonably representative of all of those who had completed the training, this is a small proportion of all participants and the possibility of systematic bias remains (e.g. only those who particularly enjoyed – or did not enjoy – the training chose to respond).

These findings are broadly consistent with those reported in evaluations of other MHFA programs[28] and, collectively, can be taken as evidence that the program is achieving its intended goals. Perhaps most encouraging, however, were responses to questions about the quality of the program and the cultural safety of the training; there was a consistent view that the course was well-organised

and delivered to a very high standard, with a number of participants describing the training as the best they had ever attended. Of particular interest here were the comments that attributed the success of the course to the personal skills and sensitivities of the instructors, and the importance of having instructors with lived experience of mental health concerns in Aboriginal and Torres Strait Islander communities. This resonates strongly with the conclusions from a recent evaluation of an adaptation of MHFA for use in Indigenous communities in Canada by Auger et al.[34] where participants also reported that cultural safety was enhanced by the integration of facilitator personal experience into course delivery together with the presence of Elders who facilitated and participated in the program and, when necessary, provided emotional or cultural support.

Participants in this evaluation also made it clear that the AMHFA course was not a simple language translation of existing materials (as appears to have been the case in other adaptations for use with minority groups), but a carefully positioned cultural adaptation of content around how mental health and wellbeing issues are understood and responded to, in and by, Aboriginal and Torres Strait Islander communities. This is a key consideration when assessing the adaptation or importation of program materials into cultural contexts.[35] Indeed, a key feature of the recent Canadian adaptation of MHFA for use in Indigenous communities by Crooks et al.[36] was the embedding cultural activities and content within Western theories of mental illness and health. It is also important to note here that the recipients of AMHFA included those who identified as from both Indigenous and non-Indigenous cultural backgrounds and came from remote communities as well as regional and metropolitan areas. The positive comments made about the quality of delivery offers strong support for the suggestion that training materials can be delivered in a way that has meaning for a wide range of different settings.

Overall, the results of this evaluation are positive. However, the methodology adopted in this evaluation necessarily limits the strength of any conclusions that might be drawn. The most obvious question that arises is the extent to which participation in AMHFA training results in observable and/or meaningful improvement in the mental health of those communities in which participants live and work. Perhaps the biggest limitation of nearly all of the MHFA evaluation studies conducted to date, including this one, is the lack of data to document the impact of training on potential recipients of first aid; in other words, whether the course actually results in first aid being provided and more people receiving support and treatment that leads to their mental health problems being resolved. In addition, it is beyond the scope of this type of training to address the lack of appropriate mental health services in some communities. These are both areas that, from a public health perspective, require further consideration and research going forward. Accordingly, three recommendations are proposed to assist in translating the findings of this evaluation into practice:

1. that mental health programs of this type continue to recruit, train, and support facilitators who identify as from Aboriginal and/or Torres Strait Islander cultural backgrounds;
2. that follow-up work is undertaken, wherever possible, to embed the learnings from training into everyday practice; and
3. that consideration is given to finding ways to support efforts to strengthen service delivery in those settings where existing mental health services are not easily accessible.

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