Stone in a pond — the ripple effect of mental health first aid education, on fire- and drought-affected rural communities

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The intention of this paper is to report early findings regarding the impact of Mental Health First Aid (MHFA) education, (1) to fire and drought effected rural communities in North East Victoria. Previous research has indicated improvement in knowledge, attitudes, helping behaviour, in urban participants. (2) There have also been indicators of improved self-health in urban participants' post MHFA education. (3) The proposed research will explore beyond this earlier research. It will investigate rural participants perceptions of how MHFA education has impacted on their roles, relationships and identity as individuals and with in their families and broader community context. Positive findings from this research will have implications for future health policy in rural/remote Australian communities.

A key issue for mental health clinical practice in remote/rural Australia is the limited availability of specialist mental health practitioners, (4, 5, 6) and if, as predicted by the World Health Organization (WHO) the burden of disease from mental health disorders increases(6,7,8) this problem will be exacerbated. It's noted in literature reviewed, that people living in remote/rural areas are at high risk for mental illness, and are characterised by non-help seeking behaviours. (6,7) It is postulated that community members knowledgeable about mental health problems, appropriate interventions and pathways to care may be a valuable resource to mental health clinicians, assisting in earlier intervention and potentially resulting in diminished illness acuity for individuals.

Since introduction of MHFA in this region, community demand for this course has been continuous, and shows no sign of abating. Anecdotally various themes are emerging. Participants identify utilisation of new knowledge and skills appropriately for improvements in self, family and community mental health. Participants are confident talking about mental illness, and providing information regarding appropriate pathways to care. Further exploration of this anecdotal evidence is required, and we are currently awaiting ethics approval for qualitative phenomenological research into participants' experiences.

Meanwhile, indicators are that MHFA is an economically viable method of promoting community mental health in rural communities. The value of knowledgeable community members identifying and providing initial assistance to individuals with mental health problems has the potential to positively influence the mental health of rural Australians. Future policy may consider the dispensing of MHFA similarly to the well-established medical first aid, and implementing it Australia wide, to improve the public's management of mental health disorders and their personal mental health.

THE RURAL CONTEXT

Classifications of remote/rural are imperfect, and certainly one has no sense of what rural is, classification do not explicate the social, economic, demographics, infrastructures, or political contexts of rural. The locale needs to be considered along with cultural, social, and economic aspects of the environment, as the context in which people live being significant. It may be

simpler to define rural in broad terms, to incorporate, everything that excludes capital cities, and major metropolitan centres of Australia — that is approximately 30% of the Australian population.(9,10,11) However as identified earlier, rural is not only geographical, there are relevant terms such as patterns of connectedness, that link an individual living in that environment to other individuals, and to a group, and community settings.(12) There are socioeconomic and cultural constraints and opportunities associated with environments. Rural Australia is characterised by long distance travel, at times in inhospitable circumstance, with minimal public transport, limited services, and difficult access. (8, 13) These are aspects of rural that are relevant to our activities in the communities we work, live and play, and to this paper. Communities presented with MHFA education ranged in population from 200–2000.

WHAT IS DROUGHT?

Drought exists in specific regions when there is less rainfall than normal, over a period of time compared to the same time in other years (14,15,16,17) National Drought Policy changes, and identification of what is a drought-effected area, or what are exceptional circumstances, becomes problematic in the sense of economic assistance to farmers.(18,19) Suffice to say, when communities are experiencing a drought, the literature clearly identifies their are major emotional, economic, and social impacts on families, and entire communities, whether areas reach official classification or not.(20, 21, 22) It is clearly documented that this was/is a one in a hundred year drought,(23) with unprecedented water shortages, subsequently exacerbated by bushfires.

Relevance of the bushfires

Extensive bushfires in January and February 2003 had a major impact on communities of north-east Victoria. Three fires merged to form one long front covering the Victorian Alps, with adjacent fires surrounding two smaller townships. Winds and continuous weather changes meant the emphasis of the fire fluctuated from mountain ranges, to towns and valleys. Communities were engulfed in smoke for weeks with visibility limited and high levels of smoke pollution. The unpredictability of fire, ensured, that already drought stressed community members would experience high anxiety. Resulting from these fires were massive community losses, through lost infrastructure, tourist income, capital assets, stock, and pasture. These problems exacerbated the downturn in the rural economy, resulting from the drought, and a decade of economic rationalism, meaning the communities were particularly vulnerable to stress and subsequent mental health issues. (24)

MHFA

MHFA is a twelve-hour course which was developed in 2000, at the Australian National University Canberra. (1) MHFA was developed in an attempt to redress poor mental health literacy of the general community, (25, 1) and the stigma associated for those people experiencing mental health disorders.(1) A National survey, of mental health literacy, carried out by the University's Centre for Mental Health Research in 1995, discovered there was a wide disparity of knowledge, and understanding, by mental health professionals and members of the general public, regarding, the recognition, causes, and treatment options of mental health disorders. (25) It is also considered that stigma and discrimination towards people with a mental health disorder is rife in the Australian community, and an absence of knowledge, and incorrect beliefs may contribute to this. (26,2) A general population survey of Australia's mental health discovered that one in five members of the population will experience a mental health disorder in any one-year, and 64% of that population, had not sought help.(7) Subsequently it was postulated the knowledge gap, and stigma associated with mental health

disorders, may be contributing to members of the public not seeking appropriate professional assistance, and/or adhering to evidence based treatments recommended.(25) General First Aid courses are a well-established method, of improving the public's management of medical emergencies. It is suggested that training in mental disorders may replicate the effectiveness of general first aid.

The MHFA course is designed to provide skills, knowledge and understanding to participants, to enable them to provide the initial assistance to a person experiencing a mental health problem. Similar to other first aid courses it does not train people to diagnose, or treat health problems. The course provides information regarding helping people in crisis situations, and/or early interventions in mental health disorders such as, depression, anxiety, psychosis, and substance use disorders. Participants learn to recognise symptoms, possible causes or risk factors, evidence-based treatments available and how to give initial support to a person suffering one of these disorders. It also provides knowledge on appropriate actions if a crisis situation arises, involving suicidal behaviour, panic attack, stress reactions to trauma, or threatening psychotic behaviour. (1)

A quantitative research project pertaining to stigma, literacy levels, and help provided to others, was carried out and indicated improvements post MHFA training.(2) This research was conducted following public courses at the Australian National University, Canberra, with participants from urban areas. (2) A more recent randomised controlled trial of employees of Government Departments in Canberra has validated earlier evidence and discovered some indicators of improvement in self-health, which needs further exploration.(3) Literature reviews currently reveal no qualitative research into the subjective experiences of rural/remote participants, post MHFA training.

MENTAL HEALTH IN RURAL REGIONS

It is well documented that living in a rural/remote location, is associated with higher risks of suicide especially for young males. (10, 11). Across Victoria the health status of residents differs considerably between urban and rural populations, males and females, rich and poor. Rural people are twice as likely to die or suffer injuries as a result of road trauma, suicide and drowning than city people.(27)) Judd, identifies that farmers and farming families are a high-risk group for mental illness, problems such as isolation, the negative impact of economic restructuring and environmental hazards such as drought and fire. Contributing significantly is the lack of appropriate services and service providers, and the distance from those services. (24) Recent rural suicide rates amongst farmers and farming families are a significant percentage of rural suicides in this region.

The rural culture of self-reliance creates in individuals a reluctance to seek help from mental health specialists. (7) Instead they utilise family, friends and doctors. It is perceived that this assistance is accessible, acceptable, and offered in a manner that is congruent with the local values. (29) There are several rationales regarding non help-seeking behaviour in rural communities. The primary reasons seem to be associated with stigma, absence of mental illness knowledge, and rural stoicism. (6, 29, 30) Another contributing factor to non-help seeking behaviours may be related to the limited availability of specialist mental health services in rural/remote regions. Due to their limited numbers and extensive geographical regions crisis workers may be unavailable, or when available too far away to assist during crisis. Communities are aware of who is likely to be available when required, and this may well influence who individuals consult when they or a family member has a mental health problem. It is noted that referrals to mental health services tend to focus on acuity, or severe mental health problems, so many people with high prevalence disorders, such as anxiety, depression and early psychosis, are not seen by mental health specialists until crisis occurs. (29)

BACKGROUND TO OUR INTERVENTIONS

As evidenced in the National Mental Health and well-being survey, there is a high level of unmet need, for the one in five people experiencing mental illness. Indeed less than half of these people sought professional help.(7) WHO, predicts that mental health problems will dominate the burden of disease in the next decade(5) and the high prevalence of mental health problems makes it unlikely that individual care will ever be available to all those needing help. Given we currently have a dearth of skilled mental health professionals, in rural regions, it seems logical to focus on the local population to assist in reducing mental health problems. (6) It is postulated that one way to focus on populations is to increase community skills and knowledge in high prevalence mental health disorders, appropriate interventions, and direct pathways to care, MHFA appears to be a suitable vehicle, to implement this strategy.

At the time of providing MHFA, the North East Victoria region was still in the grips of an unprecedented drought, and recovering from the aftermath of widespread bushfires. Communities needed assistance to cope with the financial, social and emotional stresses they had experienced. It was essential that local and contextual knowledge, and recognition of the "dynamic interactive and multi-layered nature of individuals' social worlds" (24) was considered in order to implement effective assistance to these communities. It was imperative that the informal networks and links that existed outside the formal mental health-sector were utilised to guide and assist us. (16) In order to ensure the success of this mental health promotion project, we had to build on community strengths from the beginning.

Upper Hume Primary Care Partnerships (UHPCP) health promotion members were seeking avenues to support their communities' recover from the disasters. (31) Primarily, the intention was to up-skill workers regarding early recognition of mental health disorders. (4) To achieve this they implemented MHFA for their work force. Coinciding with this, a colleague presented a paper on men's mental health in the rural context. During a subsequent interview with rural ABC radio, he discussed the idea of accidental social workers, more specifically men in their work environments. The idea was that farmers while fencing, selling farming supplies or livestock sales, looking after their mates noting changes in the mental health status and acting constructively when they became aware of change. A logical sequence was to then discuss the MHFA course.

No further mention of MHFA within communities has been required, except for information regarding how and when courses could be conducted in particular regions. Community members have driven the demand for knowledge, with the UHPCP recognising community need and assisting by financing initial courses. UHPCP's intention is to establish innovative method of broad intervention to reduce illness acuity, and strengthen the capacity of communities (32, 33) by increasing their knowledge of mental illness and promoting healthy behaviours. MHFA has been recognised as a valuable resource. A secondary gain from a local level may be a valuable build up of social networks. Due to continued community demand, regional councils directed some fire and drought relief funding towards implementation of MHFA and we have been busy ever since.

Since implementation twelve months ago, approximately thirty courses have been conducted, with four hundred participants completing the course. Participants have been rural community members, with courses being conducted in work places, local shire halls, adult education centres, wherever sites are available. There is no sign of demand for the course abating. Maximum numbers of fifteen are accepted for each course, with female participants in the majority.

Reasons participants give for attending are:

- to increase knowledge of mental illness, and reduce stigma

- increase awareness of family, significantly affecting their spouses and families, where farming life has a greater sense of being a commercially driven business, These changes have upset the status quo of farming being a lifestyle, and participants have a sense of emotional dysregulation

- uncertain financial future, increasingly dictated to by external forces, (fire, drought, economy, are cited) is contributing to changes in how individuals see themselves, and to high levels of stress in the farming sector.

In the process of delivering the course participants reflected on their social worlds, and indicated a variety of current concerns:

- a sense of loneliness, overburden of work both on, and off the farm, to ensure a living wage, and concern regarding the mental health of their spouses, families and community

- concerns regarding the volatility of weather and markets, and the pressure of new types of technological knowledge required, as in computer usage. Concern was also expressed regarding the demands of farming, fire and drought induced stock and crop losses. , participants inherited viable farms, but are currently asset rich, cash poor, seeing no future in farming for their children, and having a sense of guilt regarding non-viability and potential loss of the family farm

- participants report being caught in a state of confusion regarding the future. They recognise an aging generation of farmers who continue to toil with minimal assistance apart from their equally aging spouse, and hold out despite doubting their futures.

Initially following completion of the MHFA course we attended meetings with each group. We had encouraged a buddy system for emotional support within the groups, and wished to ensure this was effective. Various themes have been elicited during these post MHFA meetings.

- Free mental health education is needed by the community, and should be available in schools. "I feel comfortable now I understand and know more, you should be in the schools"

- Decrease in stigma "I can now say to this group I have well controlled Bipolar, I feel guilty not saying so before, your all so good "

- Personal introspection "it is confronting, but good to understand my own experiences and normalise them, I'm not depressed I'm grieving"

- Family Interventions "I talked to my granddaughter about concerns she had regarding her partners' behaviours and she acted with that knowledge."

- Community interventions "One of my parishioners has a significant depressive illness. I've been concerned about him for a couple of weeks, I was able to sit and talk, listen and encourage him to go to the Doctor, and get counselling and I felt good."

The comments made us reflect on the initial intent of the course developers (1); it seemed to be having a broader impact than initially considered. Anecdotally earlier research was validated, with self-reports of decreased stigma, and increased knowledge. (2,3) Additionally there

appeared to be minimal interventions with community members, major reflection on self and family and implementations of self-help strategies, or utilisation of appropriate pathways to care. Further understanding of the experiences of participants post MHFA education appeared an important research priority. How has MHFA impacted on participants' roles, relationships and identity, individually, within the family and the broader community?

Currently there is an ethics application lodged at Melbourne University which is seeking permission to research the lived experience of MHFA participants. The method of the proposed research will be a qualitative study informed by phenomenological research, with thematic analysis of individual, taped interviews. The interviews will be guided by semi-structured questions. The intention is to gain a narrative style response, with the individual participants disseminating their experiences post MHFA education, with minimal input from the interviewer. The researcher will be the sole interviewer, and anticipates one session of approximately an hour. The participant will determine the location and time of interview. A copy of the interview transcript will be forwarded to the participant who is then encouraged to add or subtract any information they consider appropriate. Interviews will be audio taped, and notes regarding other researcher observations, will be made immediately post interview. The aim will be for a minimum sample size of 20 participants, from diverse geographical areas, and backgrounds randomly selected from several groups, who enrolled in and completed the MHFA course. These participants all reside in rural/ remote areas that experienced the recent effects of drought and bushfires. The one limitation to participation in the course is it is not recommended for people currently experiencing disabling mental health problems. This limitation relies on self-exclusion and no screening regarding individuals' status occurred.

MHFA delivery varied in that:

- it was delivered over a weekend with live in facilities/ two consecutive days/ two days a week apart/ one evening per week for four weeks. This was consumer driven and according to local needs

- one facilitator was constant, with various colleagues assisting; two people delivered each course, both being mental health clinicians with extensive experience

- content remained constant, as described by developers of the course at Australian National University; (1) the variables were presentation by power point rather than overheads. Participants were encouraged to interact and different groups focused on different areas of the course for extended discussion.

Interviews will be transcribed and de-identified immediately. Emerging themes will be coded, and computer software, "invivo", will be utilised as an adjunct to data analysis. Sequential analysis will allow the researcher to check and interpret data collected and develop tentative conclusions based on data already collected. This will allow for refinement of the questions and enable pursuit of emerging avenues in depth, and a look at deviations or negative cases. (34, 35)

MHFA is an evidenced based course (1) that has been provided to North East Victorian rural fire and drought effected self-selecting community members. Initial anecdotal evidence supports the value of implementing MHFA more widely. There are indicators of significant benefits to individual participants, their families and their communities. Increased knowledge and awareness of mental health problems, symptoms, causes, and risk factors appears to be resulting in improved broad spectrum mental health care. Potentially, this effect will reduce illness prevalence and acuity, benefiting both the population and mental health professionals. It is important that the proposed research is conducted to establish the subjective experiences of participants, in order to better understand the impact of MHFA. Currently there are minimal

participant reports of interventions that ensure appropriate pathways to care for someone with a mental illness. Conceivably the health promotion rather than the illness intervention will be the primary benefit of MHFA. High demand for MHFA courses, within these rural communities indicates high need. Increased rural self-awareness and care, and increased ability to identify and to provide initial assistance to individuals with mental health problems, has the potential to positively influence the mental health of rural Australians. Future policy may consider the promotion of MHFA similarly to the well-established medical first aid. With the aim of improving community management of mental health problems, and the improved awareness of management of their own mental health.

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PRESENTERS

Gilian Malone is a psychiatric nurse, with a Degree in Nursing and Graduate Diploma in Advanced Psychiatric Nursing. Gil has 20 years' experience in a variety of settings, including general and psychiatric in-patient units, followed by community in both. Gil has a special interest is men's health and was involved in the introduction of 'Pit Stop' (program from Gasgoyne Junction), and 'Pub Watch,' into a rural community, both of which were extremely successful. More recently he has worked with an Integrated Primary Mental Health Service (a new initiative in Victoria) as a community development officer, the primary aim being to offer support and education to community health agency's and primary health workers. An added component of this work is mental health promotion, and currently Mental Health First Aid (MHFA) is being provided to community members as well as the health care providers. Gil is studying her Masters in Rural Health with research into the impact of MHFA on the individual, family friends and community.