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# Predictors of adults' helping intentions and behaviours towards a person with a mental illness: A six-month follow-up study

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ABSTRACT

Little is known about the relationship between adults' intentions to assist a hypothetical person experiencing a mental illness and their subsequent first aid actions in reality. This study examines whether the quality of respondents' stated first aid intentions predicts the quality of their helping behaviour towards a person they know in real life. A convenience sample of 820 Australian adults completed two surveys six months apart which asked questions about a hypothetical person experiencing depression with suicidal thoughts, and how they had assisted someone with a similar problem in their lives. The quality of helping intentions at baseline predicted the quality of mental health first aid behaviours at follow-up, as did the quality of past behaviours. In particular, people who intended to assess and assist with the crisis situation in the vignette were five times more likely to perform the same action when helping someone they knew. The quality of past intentions and behaviour, and confidence in helping, were the most significant predictors of behaviour at follow-up. These findings suggest that adults' mental health first aid intentions can be used to predict their subsequent behaviours, therefore, educating communities about effective first aid responses may increase future rates of appropriate help.

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## 1. Introduction

Mental health literacy is defined as "knowledge and beliefs about mental disorders which aid their recognition, management and prevention" (Jorm et al., 1997). Individual mental health literacy encompasses competency in several different areas (Jorm, 2012), including the provision of help, support and care towards someone with an emerging or established mental illness. This assistance is termed "mental health first aid" and can involve recognising the symptoms of mental illness, assisting with mental health crises, offering support and information, and encouraging and facilitating professional help seeking (Kitchener et al., 2013).

Mental health first aid skills are important for several reasons. Although mental illnesses are common, research suggests that a significant proportion of adults who meet the criteria for a mental illness do not seek treatment or utilise available mental health services (Kohn et al., 2004), and delaying treatment seeking adversely affects future recovery prospects (Thompson et al., 2008). People may not recognise or acknowledge that they are experiencing symptoms of a mental illness, for example, because they are concerned about how their illness will be perceived by others (Gulliver et al., 2010). However, mental health literacy surveys conducted in several countries find that respondents consistently endorse informal sources of help, particularly family and friends, as helpful when addressing mental health concerns (Jorm et al., 1997, 2005c; Riedel-Heller et al., 2005; Wright et al., 2005; Reavley and Jorm, 2011a). Lastly, people with a mental illness often cite encouragement from members of their social networks as a motivator for seeking professional assistance for their problems (Cusack et al., 2004; Downs and Eisenberg, 2012). This suggests that family and friends are ideally placed to recognise a developing mental illness, provide timely assistance and offer ongoing support during treatment and recovery. Mental health first aid skills are also increasingly sought after by carers of people with mental illnesses, who desire practical advice on symptoms, resources, management of the ill person and ways of coping with their own stress levels (Treasure et al., 2007; Sepulveda et al., 2008; Sommerlad et al., 2014).

However, evidence suggests that the public lack extensive, good quality knowledge of how to approach and assist someone with a mental illness. Although Australian mental health literacy surveys find that adolescents and adults are highly likely to listen, encourage professional help and offer support and information to a hypothetical person experiencing a mental illness, they are reluctant to assist someone in crisis (Jorm et al., 2005a, 2008; Yap and Jorm, 2012; Rossetto et al., 2014; Mason et al., 2015). However,

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these studies are limited in two important ways. Firstly, they primarily focus on the public's responses to a hypothetical person, which may not accurately reflect the reality of approaching and assisting someone with a mental illness, particularly if, for example, the person displays a mixture of characteristic and uncharacteristic behaviours, or is reluctant to discuss their mental health (Owens et al., 2011; Sweeney et al., 2015). Secondly, they rarely establish how people's responses towards a hypothetical person (their intention to assist) relate to the actions they would take to help someone in reality. Studies that ask about participants' intentions and behaviours towards people with mental illnesses are usually cross-sectional and vignette-based, precluding a prospective analysis of how well their knowledge about mental health first aid translates into action. Researching the relationship between intention and behaviour in mental health first aid contexts would provide important information about the validity of using this type of measure to predict behaviour (Yap and Jorm, 2012) and generate evidence for the effectiveness of skills-based mental health first aid programmes (e.g., Kitchener and Jorm, 2002; Jorm et al., 2005b; Gould et al., 2013).

The present study aims to examine whether the quality of respondents' stated first aid intentions predicts the quality of their helping behaviour towards a person they know in real life in a sample of Australian adults. It also assesses how including intention at baseline among other factors associated with helping behaviour contributes to the prediction of helping behaviour quality at follow-up.

## 2. Method

### 2.1. Participants and procedures

Two online questionnaires were administered to participants six months apart between April 2013 and April 2014. A convenience sample of participants, who were required to be aged over 18 and living in Australia, were recruited through Facebook advertisements; noticeboards at the University of Melbourne; community mental health organisation noticeboards; free of charge newspaper advertisements, radio interviews where the project was mentioned on air; online community noticeboards; and emails sent to participants who had previously completed mental health literacy research. Participants clicked the link provided in the email or advertisement, which took them to an information and consent form containing the aims of the research, how to participate, information about privacy and data storage and a question confirming their consent to participate. Informed consent was implied by submitting the completed questionnaire. The first survey took approximately 15 min to complete. At the end of the survey, participants were asked to enter their email address so they could be sent the follow-up questionnaire six months later. The six month time frame was used due to time constraints associated with the project. Participants were emailed the link to the follow-up survey at six months, and sent a reminder email one month later. The follow-up questionnaire was identical to the initial survey. Participants were also offered the opportunity to enter a prize draw to win one of two Kindle e-readers if they completed both surveys. Ethics approval for this study was received from the University of Melbourne's Human Research Ethics Committee.

Of the 1605 people who completed the initial survey, 1353 people (84.3%) entered their email address to receive the follow-up survey, and 1018 people (75.2%) completed the follow-up survey. However, due to problems with record linking (e.g., people who had not provided their email address at follow-up), 155 surveys (15.2%) could not be matched with their baseline data. After duplicate responses were removed ($n=43$, 4.2%), 820 surveys remained, resulting in an overall retention rate of 51.1%.

### 2.2. Surveys

Both questionnaires were administered electronically using an online survey software system (www.surveymonkey.com). Both contained the same questions and were based an earlier mental health literacy survey (see Reavley and Jorm (2011a, 2011b) for further information). The respondent was first asked for basic demographic information. A vignette detailing a male (John) exhibiting symptoms of depression with suicidal thoughts was then presented (see Rossetto et al., 2014 for the vignette). Respondents were asked what, if anything, was wrong with John, an open-ended question about how they would help him if he was someone they knew and cared about (that is, their intention to assist John), how confident they would feel in helping John, and their perceptions of John's likely recovery prospects if he were to receive, or not receive, professional help. The question relating to confidence in helping John was taken from another, earlier study (Kitchener and Jorm, 2002). Participants completed a social distance scale and personal stigma scales (covering beliefs that the person is weak-not-sick and dangerous or unpredictable) in relation to the person in the vignette (Yap et al., 2014). Five items assessing people's willingness to interact socially with John were rated by participants on a five point scale ranging from "*very willing*" to "*very unwilling*" (Link et al., 1999). The ratings on these items were summed to create the social distance scale. Based on the work of Yap and colleagues (Yap et al., 2014), two stigma scales were created from several stigma measurement items in the survey. Participants responded on a five point scale from "*strongly agree*" to "*strongly disagree*". The weak-not-sick scale comprised five items and represented the belief that people with a mental illness are weak in character, rather than sick. The dangerous-unpredictable scale, representing the belief that people with mental illnesses are dangerous to others and unpredictable, consisted of three items.

The second section of the survey asked if participants had known anyone with a problem like John's in the past six months. If participants answered "*No*," they were taken to the third section of the survey, described below. If participants answered "*Yes*" or "*Don't know*," they were asked whether they knew more than one person with the problem and, if so, answered subsequent questions about the person that they knew best. These questions included the person's age, gender and relationship to the respondent. Participants were then asked what they believed the person's problem to be, whether they had the opportunity to provide help to the person and whether they did anything to help. If participants answered "*Yes*" or "*Don't know*" to the latter question, they were asked to describe what they did to help (that is, their behaviour towards the person). If they answered "*No*," they were asked to outline why they did not provide help to the person. Respondents then rated their confidence in helping the person they knew in real life, using the same scale that assessed their confidence in helping John.

The last section of the surveys asked participants to provide information about whether they had ever had problems like John's, whether they had ever had a job providing treatment or services to someone with a problem like John's, whether they had ever heard of any organisations related to mental health and to complete the K6 scale of psychological distress (Kessler et al., 2002). The K6 asks participants to select, on a scale ranging from 1 ("*not at all*") to 5 ("*all of the time*") how often they felt nervous, hopeless, restless, so depressed that nothing could cheer them up, that everything was an effort and worthless over the past 30 days. Ratings are summed to provide a total score ranging between 6 and 30. The scale is designed to measure non-specific levels of distress in both clinical and community samples, and was included to assess whether participants' own mental state affected their helping behaviours. The K6 was used as a continuous variable in this research, with no ranges or cut offs imposed.

### 2.3. Coding of responses to intention and behaviour questions

The two open-ended questions asking how the participant would help the person in the vignette (intention to assist) and what the participant did to help the person they knew with a similar problem to John (behaviours taken to assist) were scored using a system based on the ALGEE action plan taught in the Mental Health First Aid course (Kitchener et al., 2013). The action plan was developed from various expert consensus studies of how to help someone experiencing a mental illness or mental health crisis. ALGEE represents the core elements of all mental health first aid responses and stands for *Approach the person, Assess and Assist with any crisis, Listen non-judgementally, Give support and information, Encourage appropriate professional help* and *Encourage other supports* (Kitchener et al., 2013). Responses were scored according to their quality and the level of detail provided for each of the six components of the action plan, where quality is defined as the description of appropriate, effective and specific actions. Responses with inadequate or no coverage received 0 points, superficial responses (e.g. "Talk to the person") received 1 point and clear, descriptive responses that reflect expert consensus views (e.g. "Listen empathically") received 2 points. The points per category were summed to give a total score representing the quality of the response that ranges from 0 to 12.

A rater was trained in the use of the scoring system (detailed in Yap and Jorm, 2012; Rossetto et al., 2014) and then scored all the help giving responses for the intention and behaviour questions in both surveys. The scoring of ambiguous or unusual responses was checked with the scoring system developers.

### 2.4. Statistical analyses

Analyses were performed using SPSS 22.0. Data were analysed using percent frequencies, within-subjects *t*-tests and linear and logistic regressions. Three main sets of regressions were undertaken. ALGEE scores were dichotomised and a set of binary logistic regressions were performed for each component of the ALGEE action plan to establish whether respondents' intention scores for a particular action at baseline predicted their performance of the same action at follow-up towards a person they knew in real life. Results are reported as odds ratios and measures of the strength of associations between variables are presented using Nagelkerke $R^2$. Next, the ALGEE scores of participants who had not helped someone they knew,

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