

Employing Youth Mental Health First Aid in the Foster Care and Adoption Community

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Abstract

Background and Purpose: Children involved with the child welfare system have a higher incidence of mental health challenges, and it remains their number one unmet need. Foster, kinship, and adoptive (resource) parents are often left to handle these challenges without training. This project aims to implement an evidence-based practice to increase mental health literacy for resource parents.

Materials and Methods: An agency in the southwest region of the United States that supports and trains resource parents provided training in Youth Mental Health First Aid (YMHFA). IRB approval from Arizona State University for an exempt status was secured. Six resource parents consented to participate in this evidence-based project using the Mental Health Literacy Scale (MHLS) via a pre- and post-questionnaire to evaluate the effectiveness of YMHFA training. All participants who completed the course received a certification in YMHFA. Survey Monkey was used to send the pre and post-MHLS questionnaire to those participants who consented to participate.

Results: Descriptive statistics and a two-tailed paired samples t-test using Intellectus Statistics™ were completed. Caucasian female participants 4 (67%) made up the majority of participants. The results were insignificant based on an alpha value of 0.10, $t(5) = 1.97, p = .107$, indicating the null hypothesis cannot be rejected but is moving towards significance.

Discussion and Conclusion: The finding suggests the difference in the pre and post-MHLS was not significant from zero, but the effect outcome variable was high, $d=0.80$, indicating it was moving towards significance. The impact of this study is that training may increase resource parent's ability to recognize signs and symptoms of mental health challenges.

Keywords: Foster care, foster parent, mental health literacy, youth mental health first aid

Employing Youth Mental Health First Aid in the Foster Care and Adoption Community

Children in or adopted out of foster care are often susceptible to higher rates of mental and behavioral health challenges. Foster parents, kinship parents, and adoptive parents (resource parents) are often the first to recognize these challenges in the children they care for. This unique position allows them to act as mental health gatekeepers. However, knowing what to assess for, asking for help, and handling a crisis can be overwhelming. Additional training could potentially help ease this burden.

Problem Statement

In 2020, the United States had 213,964 children enter the foster care system. The total number of children in foster homes across the U.S. was 407,493, and 45% lived in non-relative foster homes (The Annie E. Casey Foundation [Casey], 2022). As of July 2022, 6,641 children in Maricopa County, Arizona, had been placed in out-of-home care by the Department of Child Safety. In total, Arizona had 11,494 children in out-of-home care (Arizona Department of Child Safety [AZDCS], 2022). Research has shown that children in foster care have higher rates of mental and behavioral health problems and learning delays compared to their non-foster peers (Keefe et al., 2020; York & Jones, 2017). This includes post-traumatic stress disorder (PTSD), attention-deficit hyperactivity disorder (ADHD), major depression disorder (MDD), anxiety, oppositional defiant disorder (ODD), cognitive/learning disorders, mood disorders, and more (Keefe et al., 2020; York & Jones, 2017).

Upwards of 80% of children in foster care have mental health issues compared with 18 to 22% of non-foster youth. The American Academy of Pediatrics acknowledges that mental and behavioral health issues are the number one unmet healthcare need of children in foster care (National Conference of State Legislatures [NCSL], 2019). According to the Suicide Prevention Resource Center (SPRC) (2014), children in foster care are 2.5 times more likely to think about

suicide and four times more likely to attempt suicide than non-foster peers. In 2020, youth and young adults between the ages of 10 and 24 across the U.S. accounted for 14% of all suicides, which was the third leading cause of death in this age group. For children aged 10 to 14 years old, suicide is the second leading cause of death (Centers for Disease Control and Prevention [CDC], 2022; National Alliance on Mental Illness [NAMI], 2020).

Purpose and Rationale

Mental health problems often emerge in adolescence but are not diagnosed or treated until later in life. There is, on average, an 11-year delay between the onset of symptoms and treatment (Marsico et al., 2022; NAMI, 2020). Resource parents are crucial in caring for children with mental and behavioral health issues. Resource parents are often the first to realize there is a problem, yet stigma, fear of causing more harm, and not knowing how to ask for help can lead to delays in care (Marsico et al., 2022). The purpose of this paper is to improve mental health literacy in resource parents through the Youth Mental Health First Aid program.

Background and Significance

The stigma around mental illness, lack of resources, and inadequate mental health awareness contribute to the increased incidence of mental illness in foster care. Often, it is believed that individuals with mental or behavioral health issues are dangerous, weak, lazy, rebellious, or lack intelligence (Noltemeyer et al., 2019; SPRC, 2014). Mental health literacy aims to recognize mental health as a medical condition. Mental health literacy can help change negative thoughts and beliefs while increasing confidence to help oneself or others dealing with psychological distress. Mental health stigma is detrimental, and programs like Youth Mental

Health First Aid are working to change this by increasing mental health literacy (Aekre et al., 2016; Noltemeyer et al., 2019).

Population

Children and adolescents who do not receive adequate mental health treatment are at higher risk for long-term negative consequences. When left untreated, problem behaviors increase, leading to multiple home disruptions, decreased chance of reunification with family, and higher chances of incarceration (Conn et al., 2018; Keefe et al., 2020; York & Jones, 2017). More than 30% of children in foster care will move placements at least twice per year, and 70% of incarcerated youth have mental health conditions (Casey, 2020; Conn et al., 2018; NAMI, 2020). When left untreated, mental and behavioral health problems follow children into adulthood, leading to higher unemployment rates, poor relationship skills, drug use, and homelessness.

Resource parents are faced with the daunting task of caring for children who often have more social-emotional issues related to mental and behavioral health problems than their non-foster peers. Resource parents are often not known to the child before being placed in their care, yet are expected to provide affection, encouragement, and safety while also setting limits, redirecting behaviors, and managing mental and behavioral health problems (Conn et al., 2018; Keefe et al., 2020; York & Jones, 2017). Recruiting and retaining resource parents has become more complicated in recent years. Additional supports that help families feel connected, educated, and appreciated could help with this issue.

Intervention(s)

Often, people do not know how to recognize a mental health challenge or help someone struggling. Lack of education leaves people feeling insecure and unsure of how to approach the

situation, let alone access resources or treatment (Morgan et al., 2018). Mental Health First Aid (MHFA) was created to address this problem. MHFA originated in Australia in 2001. Since then, it has been embraced throughout the United States and globally (Rose et al., 2019; York & Jones, 2017). MHFA aims to improve mental health literacy, decrease stigma, and provide the public with the tools to support someone developing a mental health challenge or crisis.

Youth Mental Health First Aid (YMHFA) was explicitly created to train laypeople to interact with adolescents aged 12 to 18 years experiencing a mental health challenge (Noltemeyer et al., 2019; Rose et al., 2019). YMHFA is an eight-hour course that uses the mnemonic ALGEE to train people to handle budding mental health concerns. ALGEE stands for A-Assess for risk of suicide or harm; L-Listen non-judgmentally; G-Give reassurance and information; E-Encourage appropriate professional help; E-Encourage self-help and other support strategies (Aakre et al., 2016; Marsico et al., 2022; Noltemeyer et al., 2019; Rose et al., 2019).

Since 2014, SAMHSA (Substance Abuse and Mental Health Services Administration) has provided over \$15 million to states and educational agencies to provide YMHFA to anyone with contact with youth. As of 2021, the U.S. has trained over 2.5 million people in MHFA (National Counsel for Mental Well-being [NCMW], 2021; Marsico et al., 2022).

YMHFA has been widely embraced throughout the U.S., leading to federal initiatives such as the AWARE program (Advancing Wellness and Resilience in Education). The AWARE program aims to increase mental health awareness in the school setting. AWARE works to train school personnel to recognize mental health issues, prepare for how to respond to crises, and help support families in locating services (Walters, 2021). AWARE's target area is primarily the public school system.

YMHFA targets all populations. Rose et al. (2019) evaluated 79 Masters Level Social Work students at a large mid-Atlantic university. They found that even with foundational and advanced courses that directly relate to mental health and child development, those who completed YMHFA had increased knowledge and self-confidence. Aakre et al. (2016) conducted a similar study on Social Workers who had completed MHFA and had similar results. Morgan et al. (2020) studied 384 parents with children aged 12 and 15 who completed YMHFA and found improved knowledge and confidence in helping their children. The children also reported feeling improved support from their parents. Marsico et al. (2022) looked at parents in a school setting and had similar results.

YMHFA has three main goals. The first goal is to increase knowledge that will allow the trainee to recognize psychological problems quickly while also helping to provide appropriate resources for care. The second goal is to decrease the stigma around mental health so more people will feel comfortable interacting with this population. Third, trainees will be confident to help themselves or others needing mental health intervention (Aakre et al., 2016).

PICOT Question

For foster, kinship, and adoptive parents, how does training in Youth Mental Health First Aid, compared to no training, affect their mental health literacy, confidence in helping skills, and help-seeking attitude towards the children in their care.

Search Strategy

The Arizona State University Library website was used to access database searches. The databases searched included Pubmed, ProQuest, PsychINFO, and Grey literature. The PICOT question was used strategically to guide the search. The grey literature search produced a yield of

262 studies. This search did not produce any final studies that were not duplicated in other database searches.

The search on Pubmed database included the combinations of the words Youth Mental Health First Aid, foster parents, foster care, mental health literacy, and Mental Health First Aid. Each search term was linked with the Boolean term AND. The initial search produced 679 results. Using the same database, different word combinations, including youth mental health first aid, foster carer, mental health first aid, and parent, produced 25 studies. This search produced two final studies that were not duplicated by other searches.

In ProQuest, the search terms foster parents and mental health literacy, linked with the Boolean term AND, produced 148 initial results. Using the same database with different word combinations, including YMHFA and MHFA, using the Boolean term OR produced 467 results. From this, the terms YMHFA and training was used to produce 37 results. Advanced filters were applied to include peer-reviewed research articles within the last five years and English language only. The final number of studies obtained was eight.

The PsychINFO database combined the keywords Mental Health First Aid and parents, producing 238 results. Using the search terms Mental Health First Aid and foster parent, foster care, and foster produced no results. Using the term Youth Mental Health First Aid produced 11 results. The term MHFA and training with the Boolean term AND yielded 46 results. Advanced filters again were applied, resulting in a total of nine studies.

Ten final studies were selected and included in the evaluation table (Appendix A). These studies included two systematic reviews, one randomized control trial, one quasi-experimental non-randomized comparison group design., one mixed methods study, one qualitative study, and four non-randomized pre and post-test studies.

Critical Appraisal and Synthesis of Evidence

Melnyk and Fineout-Overholt's (2019) rapid critical appraisal was used to evaluate the validity, reliability, and applicability of the ten studies selected for this literature review. Out of the ten studies, six looked at the use of YMhFA in the community, one looked at mental health literacy in the community, and two looked at the resource family perspective. The final two were narrative syntheses looking at mental health literacy and resource family perspectives. These studies were published between 2017 and 2022. The level of evidence ranged from II to IV. The largest sample size was 9,019 parents and caregivers (Hurley et al., 2019). The setting was primarily in the community and school setting. YMhFA accounted for six interventions studied, and MHL accounted for another. Resource parent perspective was assessed in the final three. The heterogeneous measurement tools used included Likert scales, questionnaires, self-reported written open-ended responses (SRWOR), mixed methods appraisal tool (MMAT), preferred reporting times for systematic reviews and meta-analysis (PRISMA), manual screening, pre and post-test assessment (PPTA), strengths and difficulties questionnaire (SDQ), and mental health beliefs and literacy scales (MHBLIS). All six studies using YMhFA reported significant increases in mental health literacy and confidence in helping skills. A significant increase was associated with a $p \leq 0.050$. Help-seeking intention increased significantly in four studies, while mental health stigma decreased significantly in four studies.

Conceptual Framework

The Unified Theory of Behavior (UTB) came about in 1991 when the National Institute of Mental Health (NIMH) came together to examine different behavior change theories and how they impact treatment. Although they could not agree on the core elements of behavior change, they did reach a consensus for a general framework that led to the UTB (Lindsey et al., 2012).

UTB provides a framework for understanding determinants, which are the barriers and facilitators of change affecting mental health engagement. UTB focuses on the immediate determinants of behavior and the determinants affecting employment in behavior change, including willingness and intention (Banh, 2018; Lindsey, 2012). Eleven factors contribute to behavior change (Appendix B). These include environmental constraints, knowledge and skills for behavioral performance, intention or decision to perform a behavior, salience of behavior, habit and automatic processes, attitudes toward behavior, expectancies, social norms, self-concept/image, affect and emotions, and self-efficacy (Banh, 2018; Lindsey 2012). YMHFA aims to provide training that addresses these factors by providing the participant with an interactive class that increases mental health literacy, decreases stigma, and increases help-seeking attitudes.

Evidence Based Practice (EBP) Model

The Rosswurm and Larrabee Model for evidence-based practice (Appendix C) was selected to guide the implementation of this project. This model utilizes six steps to implement change. These six steps include assessing the need for change in practice, linking problems, interventions, and outcomes, synthesizing best evidence, designing a practice change, implementing and evaluating the change in practice, and integrating and maintaining the change in practice (Rosswurm & Larrabee, 1999). Resource parents have expressed the need for more education related to mental health literacy. YMHFA is an evidence-based program designed to increase mental health literacy within the community. Increasing resource parents' mental health literacy through YMHFA can potentially improve mental health outcomes for youth in care.

Methods

A non-profit organization in the southwest region of the United States has been created to support resource families caring for youth who have been involved in foster care. With their help, a project was designed to provide resource parents with YMHFA training while crediting them with eight hours of continuing education approved by the Office of Licensing and Regulation (OLR). In addition to this organization, stakeholders in this project included the resource parents themselves, OLR, the YMHFA instructors teaching the course, and a local organization that supplied grant funds to cover the cost of the class.

An exempt IRB approval for this project was obtained in July 2023 from Arizona State University. This project provided resource parents with the benefits of Youth Mental Health First Aid Training, which outweighed the potential risk for emotional harm. Participants were warned about content that may have been sensitive, and an instructor was available at all times during the course to meet with participants if they needed additional support. No additional support was needed or reported during or after the completion of the course.

Resource parents were invited via the organization's website to attend a YMHFA training and were also allowed to participate in this study. The training was offered to resource parents over 18 who could read and write in English, as no translator service was provided for this class. Consent was obtained before class participation. This class was limited to twenty people, so the first twenty resource parents to sign up were given access to this intervention project.

Upon acceptance to the course, a letter of consent and the Mental Health Literacy Scale (MHLS) pre-questionnaire (Appendix D) was sent to participants via Survey Monkey, inviting them to engage in the intervention project. Completing the pre-questionnaire and attending the live portion of the training was used to validate consent for participation in the project.

Participants completed approximately two hours of the asynchronous YMHFA curriculum before attending the class's live session. The class was held from 5 PM to 8 PM via a live Zoom classroom on October 9th and 10th, 2023. After completing the two-day course, the post-class work was sent out to all participants so they could receive their certification from YMHFA. A separate email using Survey Monkey was used to send the post-MHLS questionnaire (Appendix E) to those participants who had completed the MHLS pre-questionnaire.

Data Collection Plan

The MHLS Questionnaire was created by O'Conner and Casey (2015) and is a 35-item, univariate Likert scale used to assess attributes of mental health literacy in individuals and across populations. This scale takes approximately 5 to 10 minutes to complete, and features include recognizing disorders, knowledge of help-seeking information, understanding of risk factors and causes of mental health concerns, how to self-treat, how to get professional help, and attitudes that support help-seeking behaviors. Demographic information collected included age, gender, ethnicity, role as a foster parent, adoptive parent, or kinship placement, and how many years they had been a resource parent. The MHLS and demographics were sent to participants via Survey Monkey, where they select a four-digit number code to enter in the participant ID section. This number was not linked to identifiable information collected during registration, allowing the participant to stay anonymous. Data collected was securely stored in Survey Monkey and on the study author's computer throughout the completion of the project. During data analysis, inferential statistics was used. A paired T-test was run to analyze the data. Cohen's d was used to evaluate the effect of the intervention on the outcome variable. A Two-tailed test was run, and the critical value was set at $p < .10$.

The MHLS was selected because it is a psychometrically methodologically robust tool demonstrating good internal and test-retest reliability and validity (O’Conner & Casey, 2015). The Cronbach’s alpha was ($\alpha = .873$) for reliability, and construct validity was $p < .001$ (O’Conner & Casey, 2015). The MHLS was used by Marsico et al. (2022) to evaluate YMHFA training for parents within the school setting using the pre- and post-questionnaire. The variables assessed were mental health literacy, help-seeking intentions, help-seeking attitudes, decrease in stigma, confidence in helping skills, behavioral intentions to support youth with schizophrenia, and behavioral intentions to support youth with depression. Of the 64 participants who completed all three surveys, there was an increase in all categories and a decrease in stigma with $p < .001$ for all seven variables.

MHLS and the UTB framework complement each other in this project. Both look at and assess change in behavior towards intention and decision. The goal is for resource parents to have increased mental health literacy after attending the intervention, as seen in the MHLS post-test. In turn, this would mean a positive change in the eleven areas of the UTB, indicating improved overall mental health literacy.

Permission was obtained from Matt O’Conner on May 31, 2023, to use the MHLS for instrumentation in Employing Youth Mental Health First Aid in the Foster Care and Adoption Community.

Results

Intellectus Statistics TM was used to store, manage, and analyze this data. There were $n=6$ resource parents involved in this evidence-based study. The age groups were divided as 35-49 and 50-64 and had equal results. Females comprised most subjects, 4 (67%), and males accounted for 2 (33%). In the race section, White/Caucasian was 4 (67%), and Latino/Spanish

represented 2 (33%). In marital status, married was 4 (67%), never married was 1 (17%), and divorced was 1 (17%). The type of resource parent was comprised of foster parents 4 (67%), foster/kinship parent 1 (17%), and foster/adopted parent 1 (17%). In Years of experience, 10+ years was 3 (50%), 6-9 years was 1 (17%), and 0-2 years was 2 (33%). Frequencies and percentages are presented in (Appendix F), Table 1.

The average Mental Health Literacy score before the intervention was 133.50 ($SD = 11.84$), which ranged from 115 to 149 points out of 160. The median score was 135.50. The average Mental Health Literacy score after the intervention was 139.17 ($SD = 10.03$), which ranged from 123 to 150 points out of 160. The median score was 141.50 points. The summary statistics can be found in (Appendix F), Table 2.

The two-tailed paired sample t -test result was insignificant based on an alpha value of .10, $t(5) = -1.97$, $p = .107$, indicating the null hypothesis cannot be rejected but is moving towards significance. This project is like an exploratory pilot study to generate a hypothesis. For this study, due to the importance of detecting small to moderate differences with a small sample size (p values >0.05 but <0.10 are referred to as trend), significance was tested at $p < 0.10$ (Fugate Woods Lentz, Mitchell, Heitkemper & Shaver, 1997). This finding suggests the difference in the mean of Pre-Mental Health Literacy and the mean of Post-Mental Health Literacy was not significantly different from zero. The effect of the outcome variable was high, $d = 0.80$. The results are presented in (Appendix F) Table 3. A bar plot of the means is illustrated in (Appendix F), Figure 1.

Discussion

While data from this project indicated a null hypothesis, there was an indication it was moving towards significance. The small sample size $n=6$ most likely contributed to this null

hypothesis. Going forward, it is recommended that larger sample sizes be included to see if the hypothesis changes. The outcome variable was high, which indicates that the study was moving towards significance but did not have enough data to reach it. The organization in this study plans to continue to offer YMHFA training to resource parents in the future.

Conclusion

Mental health challenges are on the rise, and children affected by foster care have higher rates than their non-foster peers. Working to find programs like YMHFA that can help resource parents learn how to overcome these challenges while caring for these children is paramount. Organizations like the one involved in this study can continue offering programs like YMHFA to provide additional training to resource parents. These additional trainings provide needed information to increase mental health literacy, decrease stigma, and improve attitudes toward help-seeking.

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Appendix A

Evaluation and Synthesis Tables

Table 1
Evaluation Table of Quantitative and Mixed Studies

Citation	Theoretical/ Conceptual Framework	Design/ Method/ Purpose	Sample/Setting	Variables	Measurement/ Instrumentation	Data Analysis	Results/ Findings	Level of Evidence; Application to practice; Generalization
Marsico et al., (2022). Effectiveness of youth mental health first aid training for parents at school. Country: US Funding: Graduate School at University of MD, College Park, Research and Scholarship Award	Unified Theory of Behavior Change.	Design: Mixed methods QUAN+qual design Purpose: To increase parent's helping intentions by increasing self-efficacy, addressing social beliefs and instilling a sense that using YMHFA will positively impact their children's attitudes and behaviors.	N= 63 Mothers = 84.11% Mean age = 44.99 Demographics: White = 48.60% Asian = 36.79% Setting: 5 training sessions at local public schools and one at university in MD and PA. Exclusion: Participants had to be parents. Attrition: 45.32%	IV1: Training & certification in YMHFA DV1: MHL DV2: HSI DV3: HSA DV4: STG DV5: CNF DV6: BID DV7: BIS	Tools: Pre/post training assessments. Self-report written open-ended responses Likert scales.	Statistical Tests Used: SPSS to analyze data MCAR test ANCOVAs Bonferroni's correction Cohen's d Inductive thematic analysis Descriptive statistics	DV1: Increase in MHL, (p < .001; d = 0.79) DV2: Increase in HIS, (p < .001; d=0.37) DV3: Increase in HAS, (p < .001; d = 0.46) DV4: Decrease in STG, (p <	LOE: III Strengths: Mixed methods design Weakness: Small sample size, high attrition rate, unknown validity. Feasibility: Effective in creating mental health awareness. Application: YMHFA has been shown to results in improved MHL

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<p>Bias: No perceived bias in the study.</p>							<p>.001; d = 0.46) DV5: Increase in CNF, (p < .001; d = 1.41) DV6: Increase in BID, (p < .001; d = 0.90) DV7: Increase in BIS, (p < .001; d = 0.83)</p>	<p>knowledge, intention to use and awareness.</p>

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<p>Morgan et al., (2018). Does mental health first aid training improve the mental health of aid recipients? The training for parents of teenagers randomized control trial.</p> <p>Country: Australia</p> <p>Funding: NHMRC</p> <p>Bias: CK, BK & AJ are authors of YMHFA course. MHFA International employs CK.</p>	<p>Inferred: Unified Theory of Behavior Change</p>	<p>Randomized control trial.</p> <p>Purpose: The study was an RCT with participants randomized to YMHFA or PFA training. The goal was to assess adolescent mental health outcomes and parental support towards adolescents at baseline 1-year and 2-year follow up.</p>	<p>N : IG: 170 CG: 152</p> <p>Demographics: 2-parent home (IG 71.8%, CG 75.7%)</p> <p>Single-parent home (IG 6.5%, CG 6.6%)</p> <p>Median Age (IG 45.2, CG 45.1).</p> <p>Female Parent (IG 89.4%, CG 86.8%)</p> <p>Exclusion: People without children between the ages of 12-15.</p> <p>Attrition: 1-year = 35.4% 2-year = 44.7% (Parents)</p>	<p>IV1: YMHFA for parents</p> <p>DV1: Adolescent mental health</p> <p>DV2: Perceptions of parent support by adolescents with a MH problem</p> <p>DV3: Quality of parental support towards adolescents with MH problem</p> <p>DV4: MHL</p> <p>DV5: CNF</p> <p>DV6: HSI</p>	<p>Strengths and difficulties questionnaire</p> <p>Likert scale</p> <p>Verbatim responses were scored for consistency with the ALGEE action plan in YMHFA manual.</p> <p>Verbatim responses scored.</p> <p>Validity/Reliability Cronbach's α was used to assess reliability.</p>	<p>ICC</p> <p>Test-retest</p> <p>Cohen's d</p> <p>MCAR</p>	<p>DV1, DV2 and DV3: No difference in number in IG and CG ($p > 0.5$).</p> <p>DV4, DV5, DV6: Increased parental MHL 1-year ($d=0.43$) ($p < .001$). 2yr ($d=0.26$), ($p < .05$)</p> <p>CNF ($d=0.26$), ($P < .05$)</p> <p>HSI ($d=0.22$) at 1-year follow up. ($p < .001$).</p>	<p>LOE: II</p> <p>Strengths: Had an active control condition and a long period follow up for MH education course.</p> <p>Weakness: Lack of power to detect primary outcome effects. Study did not reach recruitment goal Primary DV1-DV3. DV2, Secondary DV 4-6 did have positive outcomes in MHL, HSI and STG compared to CG.</p> <p>Feasibility: MHFA has potential to raise MH awareness.</p> <p>Application: Parents can increase MHL, CNF and HSI</p>

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<p>Rose et al., (2019). Effectiveness of youth mental health first aid USA for social work students.</p> <p>Country: USA</p> <p>Funding: First 4 authors received financial support from University of Maryland School of Social Work Teaching Scholars Award.</p> <p>Bias: No conflict of interest declared</p>	<p>Unified Theory of Behavior Change.</p>	<p>Design: Quasi-experimental non-randomized comparison group design.</p> <p>Purpose: To identify outcomes that differed between Master of social work (MSW) students trained in YMHFA and those who are not. Students were assessed at baseline, 2wks after course and at 5 month follow up.</p>	<p>IG: 39 CG: 34 Demographics: Female: IG 94.9% CG: 94% Previous MH training: IG 30.8% CG: 52.9% Advanced Academic: IG: 66.7% CG: 47.1% Inclusion: MSW students enrolled in field education, serving youth age 12-18yrs and trained in YMHFA. CG was the same with no MHFA training Attrition: IG: 28% CG: 29%</p>	<p>IV1: YMHFA training.</p> <p>DV1: MHL</p> <p>DV2: STG</p> <p>DV3: CNF</p>	<p>MHBSL</p> <p>Likert Scale</p> <p>Validity/Reliability Bivariate analyses was used to identify significant differences between group.</p> <p>The Cronbach α and Greenhouse-Geisser also used to assess validation reliability.</p>	<p>ANOVA</p> <p>ANCOVA</p> <p>Post hoc analysis</p> <p>Cohen's d</p> <p>MCAR</p>	<p>DVI: $p < .001$ indicating growth in student knowledge in IG vs. CG. $d = 0.48$</p> <p>DV2: ($p = .174$) indicating no real change in stigmatic views. However, importance of implementing YMHFA was $p = .02$. in IG.</p> <p>DV3: Increase in CNF ($P < .001$) $d = 0.98$</p>	<p>LOE: III</p> <p>Strengths: Study showed significant difference between IG an CG in ability to provide MHFA ($p = .03$), confidence ($p = .002$), and knowledge of MHL ($p < .001$) all in favor of IG.</p> <p>Weakness: Small sample size, was not randomized, data was self-reported, the personal stigma scale did not meet reliability criteria in the sample</p> <p>Feasibility: YMHFA is a feasible intervention to implement with those working with youth</p>

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<p>Gryglewicz et al., (2018). An evaluation of youth mental health first aid training in school settings.</p> <p>Country: USA</p> <p>Funding: National Institute of Justice.</p> <p>Bias: No conflict of interest declared or noted.</p>	Theory of Planned Behavior.	<p>Design: Study – nonrandomized non controlled trial: Pre and Post test</p> <p>Purpose: YMHFA was provided to school personnel to assess for increased MHL, STM and CNF and training satisfaction.</p>	<p>N = 356 school personnel N = 286 valid data on all variables.</p> <p>Demographics: 83% Female 77% Caucasian 96% bachelor's degree or higher</p> <p>Setting: Five schools grades K-12 in one school district</p> <p>Inclusion: All school personnel who took mandated YMHFA training.</p> <p>Attrition: 20%</p>	<p>IV1: YMHFA training</p> <p>IV2: Training satisfaction</p> <p>DV1: MHL</p> <p>DV2: STG</p> <p>DV3: CNF</p> <p>DV4: HSI</p>	<p>76-item self-report questionnaire.</p> <p>Likert Scale</p> <p>Cronbach α</p> <p>STG- 11 questions ($\alpha = 0.69$ pre-test) ($\alpha = 0.70$ posttest)</p> <p>CNF- 12 question Perceived Behavioral control (PBC) scale used. ($\alpha = 0.95$)</p> <p>HIS- 11 item Likert scale ($\alpha = 0.79$).</p> <p>Training satisfaction- 7 item Likert scale ($\alpha = 0.73$)</p>	<p>Paired-sample t-test</p> <p>Chi-square tests of differences.</p> <p>ANOVA</p> <p>OLS regression</p> <p>Bonferroni Corrections</p> <p>Multivariate regression analyses</p> <p>Bivariate analyses</p> <p>Descriptive analyses</p> <p>Cronbach α</p>	<p>DV1: 57% improvement across sample ($p < .001$).</p> <p>DV2: 64% reduction ($p < .001$).</p> <p>DV3: 89% increase ($p < .001$).</p> <p>DV4: 76% increase ($p < .001$).</p> <p>IVF2: 76% of first aiders agreed or strongly agreed that they like the YMHFA training.</p>	<p>LOE: IV</p> <p>Strengths: Conducted in the USA with large population size, low risk.</p> <p>Weakness: Variance (R^2) was relatively low (ranged 0.5 to 0.11), lack of a control group, no long term follow up.</p> <p>Feasibility: Effective in increasing MHL, decreasing STG, Increasing CNF and HIS.</p> <p>Application: YMHFA can be used to train school personnel and laypersons.</p> <p>LOE: IV</p>

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<p>Noltemeyer et al., (2020). Youth mental health first aid: Initial outcomes of a statewide rollout in Ohio</p> <p>Country: USA</p> <p>Funding: Substance abuse and mental health services administration, U.S. Department of Health and Human Services.</p> <p>Bias: No conflict of interest declared or noted.</p>	<p>Inferred: Unified Theory of Behavior Change</p>	<p>Design: Uncontrolled pretest and posttest study</p> <p>Purpose: To evaluate the outcomes of YMHFA training throughout the state of Ohio through project AWARE.</p>	<p>N: 1,445 at pretest. N: 599 at 3-month N: 271 at 6-month N: 129 at 9-month N: 59 at 12-month</p> <p>Demographics: Of the 1,224 who provided demographics 842 were white females with average age of 42.</p> <p>Setting/Inclusion: Throughout the state of Ohio open to anyone.</p> <p>Attrition: 58%</p>	<p>IV1: YMHFA training</p> <p>DV1: MHL</p> <p>DV2: STG</p> <p>DV3: CNF</p> <p>DV4: HIS</p> <p>Validity/Reliability: All four scales had a reliability rating higher than Cronbach's α of .83 for both pre and posttest.</p>	Likert scale	<p>Paired t-tests</p> <p>OLS regression</p> <p>Cronbach α</p> <p>Descriptive statistics.</p>	<p>D1: Increase in MHL 3-months post training ($p < .001$).</p> <p>DV2: Decrease in STG 3-months post training ($p < .001$).</p> <p>DV3: Increase in CN, 3-months post training ($p < .001$).</p> <p>DV4: Increase in HIS, 3-months post training ($p < .001$).</p>	<p>Strengths: Follow up after 3 months, completed in USA, available to anyone, Non-invasive</p> <p>Weakness: No control group, low response rate after month 3, high attrition rate.</p> <p>Feasibility: YMHFA training can be offered to wide variety of individuals and have positive outcomes.</p> <p>Application: YMFA can be applied to community members.</p>

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<p>Childs et al., (2020). An assessment of the utility of the youth mental health first aid training: Effectiveness, satisfaction, and universality.</p> <p>Country: USA</p> <p>Funding: None stated.</p> <p>Bias: Author denies any conflict of interest. No perceived bias.</p>	<p>Inferred: Unified Theory of Behavior Change</p>	<p>Design: Uncontrolled pretest and posttest study</p> <p>Purpose: To assess the effectiveness, satisfaction, and universality of YMHFA across child-serving occupations.</p>	<p>N: 1,709 participated in training. Final sample was 893.</p> <p>Demographics: 65% Caucasian 83% Female 77% youth focused or SA training in the past.</p> <p>Setting: 81 YMHFA trainings across 12 counties in Southeastern state at community events.</p> <p>Inclusion: Work in child welfare, justice system, non-profit support services or education.</p> <p>Attrition: 48%</p>	<p>IV1: YMHFA training</p> <p>DVI: CNF</p> <p>DV2: HSI</p> <p>DV3: Preparedness</p> <p>DV4: MHL</p> <p>DV5: Satisfaction across fields</p> <p>Validity/Reliability</p> <p>Cronbach's α</p> <p>Satisfaction: $\alpha = 0.65$</p> <p>CNF: $\alpha = 0.94$</p> <p>HIS: $\alpha = 0.71$</p>	<p>Likert scale</p> <p>Multi-item, self-reported questionnaire</p>	<p>ANOVA</p> <p>ANOVAs</p> <p>Pairwise comparisons using Bonferroni method</p> <p>Chi-square tests</p> <p>Paired sample t-tests</p> <p>OLS regression</p>	<p>DV1: Increase in CNF, ($p < 0.05$)</p> <p>DV2: Increase in HIS, ($p < 0.01$)</p> <p>DV3: Increase in Preparedness, ($p < 0.05$)</p> <p>DV4: Increase in MHL, ($p < 0.05$)</p> <p>DV5: Satisfaction of training across fields, ($p = 0.09$)</p>	<p>LOE: IV</p> <p>Strengths: Training was provided across multiple occupations confirming utility, effectiveness, and satisfaction.</p> <p>Weakness: No follow-up data, to measure sustainability of training. No control group.</p> <p>Feasibility: YMHFA training can be offered to wide variety of individuals and have positive outcomes.</p> <p>Application: Can increase MHL, CNF, and HSI across occupations.</p>

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<p>Hurley et al., (2019). A systematic review of parent and caregiver mental health literacy.</p> <p>Country: Australia, UK</p> <p>Funding: The Movement Foundation; The Australian MH initiative.</p> <p>Bias: No conflict of interest declared or noted.</p>	MHL Framework	<p>Design: Systematic reviews and meta-analyses using the PRISMA-Protocol guidelines for preferred reporting.</p> <p>Purpose: Review MHL in parents and caregivers of children and adolescents.</p>	<p>N: 21 studies with a total of 9,019 parents and caregivers</p> <p>Quantitative: 13</p> <p>Qualitative: 7</p> <p>Mixed methods: 1</p>	<p>IV: MHL</p> <p>DV1: Knowledge and understanding</p> <p>DV2: Attitudes and beliefs</p> <p>DV3: Help-seeking and support</p> <p>DV4: Mental health literacy intervention</p>	Mixed methods appraisal tool (MMAT)	<p>Narrative Synthesis</p> <p>Thematic Summary</p>	<p>DV1: Degree & nature of knowledge, knowledge source, Correlates of knowledge</p> <p>DV2: stigma, role of parent, attitudes to help-seeking, fear and worry</p> <p>DV3: source of support, help-seeking strategies, factors influencing help-seeking</p> <p>DV4: Improved MHL with some intervention</p>	<p>LOE: II</p> <p>Strengths: Used the PRISMA-P guidelines for measurement.</p> <p>Weakness: Narrative synthesis was not able to statistically pool quantitative data or determine the strength of association between the DV's in the study.</p> <p>Application: Providing training in MHL to parents and caregivers can improve knowledge, understanding, attitudes, beliefs, help-seeking, support and MHL literacy.</p>

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Citation	Theoretical/ Conceptual Framework	Design/ Method/ Purpose	Sample/Setting	Variables	Measurement/ Instrumentation	Data Analysis	Results/ Findings	Level of Evidence; Application to practice; Generalization
<p>Kaasbøll et al., (2019). Foster parents' needs, perceptions and satisfaction with foster parent training: A systematic literature review.</p> <p>Country: Norway</p> <p>Funding: Norwegian Directorate for children, youth and family affairs, SINTEF Digital, Department of Health Research and NTNU Social Research.</p>	None indicated	<p>Systematic review based on peer-reviewed academic journals. Methods were followed as outlined by PRISMA-Statement</p> <p>Thematic synthesis</p> <p>Purpose: To explore foster parents' perceptions of and satisfaction with foster parent training and what they need out of training.</p>	<p>N = 13 studies with a total of 2,042 foster parents.</p> <p>Quantitative = 9</p> <p>Mixed methods = 4</p> <p>Exclusion: Focusing on adoption or biological parent training including parents who have children in foster care.</p>	<p>IV1: Foster parent training programs or modules</p> <p>DVI: Satisfaction with training</p> <p>DV2: Need for training in specific themes.</p> <p>DV3: Flexibility, format and approach</p> <p>DV4: Training needs beyond existing preservice/in-service sessions</p>	<p>EndNote X8 for Windows</p> <p>Manuel screening</p>	<p>Systematic literature review</p>	<p>DV1: Showed satisfaction in quan study, but qual suggested need for more specific knowledge.</p> <p>DV2: Showed high levels of satisfaction yet expressed unmet needs for children with special needs and real-life situations.</p> <p>DV3: Online options seem promising</p> <p>DV4: Increased need for</p>	<p>LOE: II</p> <p>Strengths: First compilation of foster parents' perceptions of foster parent training.</p> <p>Weakness: Low sample size and response rate. Findings regarding foster parents' needs and perceptions of training were sparse and difficult to synthesize.</p> <p>Application: This systematic review supports the need for increased training related to children with special needs,</p>

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Citation	Theoretical/ Conceptual Framework	Design/ Method/ Purpose	Sample/Setting	Variables	Measurement/ Instrumentation	Data Analysis	Results/ Findings	Level of Evidence; Application to practice; Generalization
Bias: No conflict of interest declared or noted.							training related to children with special needs, MH, behavior, diversity, and culture	MH, behavior problems, more information on diversity and culture.

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Citation	Theoretical/ Conceptual Framework	Design/ Method/ Purpose	Sample/Setting	Variables	Measurement/ Instrumentation	Data Analysis	Results/ Findings	Level of Evidence; Application to practice; Generalization
<p>Barnett et al., (2017). Foster and adoptive parent perspectives on needs and services: a mixed methods study.</p> <p>Country: USA</p> <p>Funding: US Department of Health and Human Services, Administration for Children and Families, Children's Bureau</p> <p>Bias: No conflict of interest noted.</p>	None indicated.	<p>Design: Mixed methods, focus groups and survey</p> <p>Purpose: To assess foster and adoptive parents perspectives of needs and services.</p>	<p>Focus group: 27</p> <p>Survey: 512 (215 adoptive parents, 168 foster parents, 66 both foster/adoptive parents)</p> <p>Online user satisfaction survey: 7 social workers and 22 foster parents.</p> <p>Demographics: Focus group 70% female. Survey 74% female.</p> <p>Mean age was 47</p>	<p>IV1: Foster/adoptive parents' perspective of needs and services.</p> <p>DV1: Communication & collaboration across providers and families</p> <p>DV2: Child welfare agency culture and context</p> <p>DV3: Preparation to foster and adopt</p> <p>DV4: Need for mental health services for children</p>	<p>91 -item survey</p> <p>Likert scales of quality, usefulness, frequency and satisfaction.</p> <p>Three point scale assessed availability of mental health services and use of available resources.</p> <p>One open-ended question looking at preparedness of foster parents.</p> <p>Validity: The survey engaged a large sample to further test foster and adoptive parent experiences lending</p>	<p>Data was uploaded into Dedoose (Version 7.0.23)</p> <p>Stata (v.13)</p> <p>Descriptive statistics.</p>	<p>DV1: Parents discussed poor communication and inclusion in case planning.</p> <p>DV2: Focus group reported low levels of perceived respect from child welfare agency and courts.</p> <p>DV3: expressed feeling ill-prepared to foster or adopt.</p> <p>DV4: felt MH providers did</p>	<p>LOE: III</p> <p>Strengths: Both a focus group and survey group were used with a large sample size.</p> <p>Weakness: In this study the surveyed parents gave more positive feedback than the focus group which could have been influenced by conformity norms or biases.</p> <p>Application: There is room for improved training and more specific topics that directly affect foster and adoptive parents.</p>

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Citation	Theoretical/ Conceptual Framework	Design/ Method/ Purpose	Sample/Setting	Variables	Measurement/ Instrumentation	Data Analysis	Results/ Findings	Level of Evidence; Application to practice; Generalization
				<p>DV5: Support for foster and adoptive parents</p>	<p>to increased construct validity.</p>		<p>not understand the need of children in care.</p> <p>DV5: felt there was a lack of resources</p>	

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Table A2
Evaluation Table for Qualitative Studies

Citation	Theory/ Conceptual Framework	Design/ Method/ Sampling	Sample/ Setting	Major Themes Studied/ Definitions	Measurement/ Instrumentation	Data Analysis	Findings/ Themes	Level/ Quality of Evidence; Decision for/ Application to practice; Generalization
<p>Patterson et al., (2019). Maximizing the success of resource parents who care for adolescents: training recommendations from caregivers and child welfare professionals.</p> <p>Country: USA</p> <p>Funding: U.S. Children's Bureau</p> <p>Bias: No conflict of interest declared or noted.</p>	<p>Adult Learning Theory</p> <p>21st Century Learning Theories</p>	<p>Design: Mixed methods</p> <p>Qual+quan</p> <p>Method: Qualitative semi-structured interviews with foster/adoptive families.</p> <p>Online survey for child welfare workers.</p> <p>Purpose: To explore the perspectives and recommendations of foster/adoptive parents and child welfare professionals on training</p>	<p>Sample: (n= 44)</p> <p>Demographics: 18 foster/adoptive parents.</p> <p>26 child welfare workers.</p> <p>88% of participants were women.</p> <p>61% Caucasian</p> <p>Setting: Both by phone and in person for interviews. Survey was done through Survey Monkey.</p> <p>Attrition: 0</p>	<p>• RQ1 How can training be delivered to prepare resource parents to care for adolescents adequately?</p> <p>Definitions: Resource parents = foster and adoptive parents</p>	<p>Data Collection: Two teams collaborated to collect data. The first team recruited participants, collected data for study and provided de-identified data to the other team. The evaluation team then completed the data analysis. Both teams co-developed the interview and survey protocols.</p>	<p>Data was examined word by word to develop code list. The data was coded by a team of seven analysts with at least two analysts coding each interview or survey (95% agreement). Analysts then reviewed coded patterns and relationships creating categorical formation</p>	<p>(1) Participants felt training should be more interactive vs. didactic.</p> <p>(2) Training should be taught by a foster or adoptive parent and include youth input to gain a more realistic training experience with people who have lived it.</p>	<p>Level of Evidence: III</p> <p>Strengths: Study includes the perspectives of both foster/adoptive parents and child welfare workers.</p> <p>Weakness: Less foster/adoptive parents than child welfare workers. Majority of participants were female and Caucasian.</p> <p>Feasibility: Finding foster/adoptive parents to lead trainings that are more interactive is feasible.</p>

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Table A3
Synthesis Table

Study (Author, year)	Barnett et al., 2017	Childs et al., 2020	Gryglewicz et al., 2018	Hurley et al., 2019	Kaasbøll et al., 2019	Marsico et al., 2022	Morgan et al., 2018	Noltemeyer et al., 2020	Patterson et al., 2019	Rose et al., 2019
Design	III	IV	IV	II	II	III	II	IV	III	II
LOE										
Study Characteristics										
<i>Sample size/studies</i>	27 Focus GP 512 Survey	893	286	21 studies	13 studies	63	322	1,445	44	73
<i>Community Setting</i>	X	X				X	X	X	X	
<i>Measurement Tools</i>	LS, SRW, Questionnaire	LS, Questionnaire	Questionnaire, LS	MMAT	PRISMA-S Manuel screening	PPTA, LS, SRWOR	SDQ, LS, SRWOR	LS	SRWOR, Questionnaire	MHBLS, LS
Intervention										
<i>YMHFA</i>		X	X			X	X	X		X
<i>MHL</i>				NS						
<i>Resource Parent perspective</i>	Q				NS				X	
Outcomes										
<i>MHL</i>		↑*	↑*			↑*	↑*	↑*		↑*
<i>HSI</i>		↑*	↑*	NS		↑*	↑*			
<i>HSA</i>				NS		↑*				
<i>STG</i>			↓*	NS		↓*		↓*		↓*
<i>CNF</i>		↑*	↑*			↑*	↑*	↑*		↑*
<i>BID</i>						↑*				
<i>BIS</i>						↑*				
<i>Preparedness to Foster/adopt</i>	Q									
<i>Training Satisfaction</i>		↑*	↑*		NS					
<i>Flexibility format and approach</i>					NS				Q	

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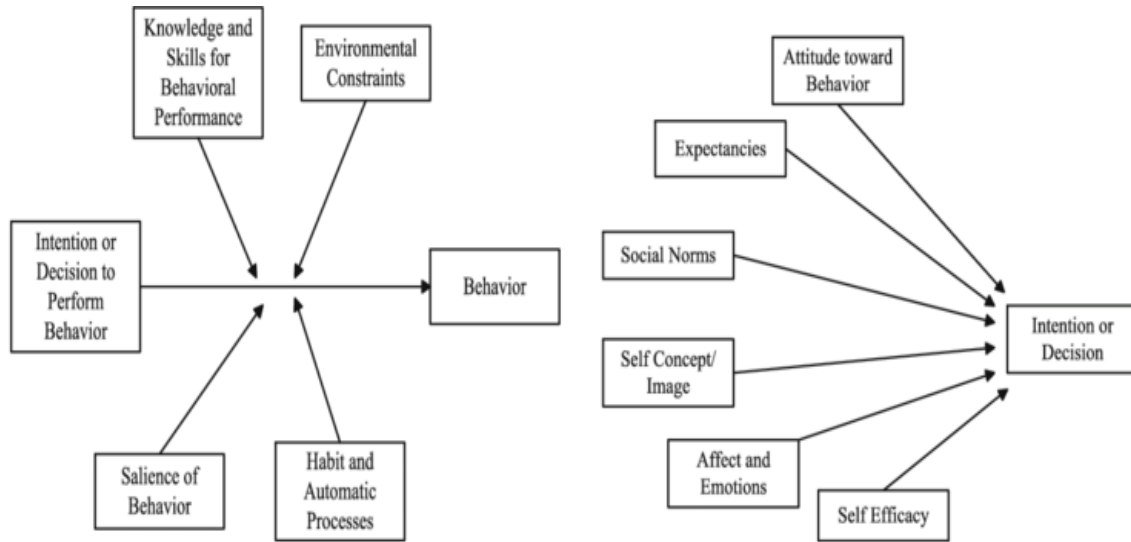
Study (Author, year)	Barnett et al., 2017	Childs et al., 2020	Gryglewicz et al., 2018	Hurley et al., 2019	Kaasbøll et al., 2019	Marsico et al., 2022	Morgan et al., 2018	Noltemeyer et al., 2020	Patterson et al., 2019	Rose et al., 2019
<i>Support for resource family</i>	Q								Q	
<i>Need for MH services</i>	Q									
<i>Communication & Collaboration</i>	Q									
<i>Adolescent MH</i>							Q			
<i>Adolescent perspective of parental support</i>							Q			
<i>Quality of parental support toward MH</i>							Q			

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Appendix B

Conceptual Framework

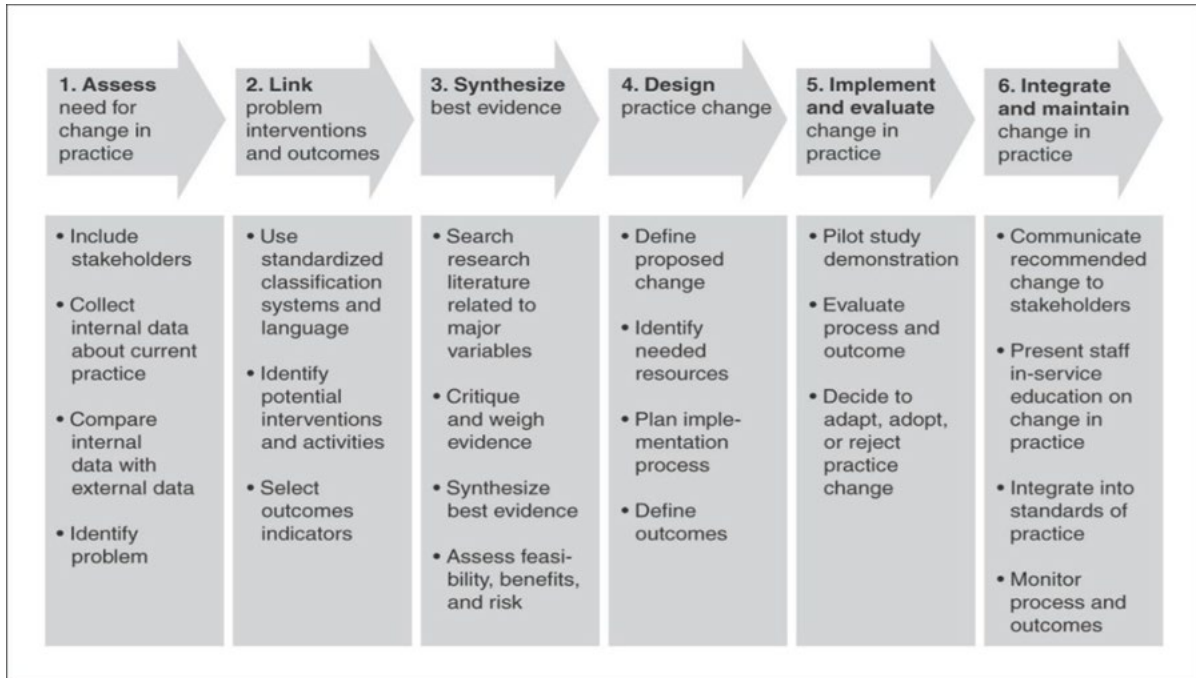
Unified Theory of Behavior



(Lindsey et al. 2012)

Appendix C
Evidence Based Practice (EBP) Model

Rosswurm & Larrabee Model for Evidence-based Practice



(Rosswurm & Larrabee, 1999)

APPENDIX D
MHLS PRE-QUESTIONNAIRE

DEMOGRAPHICS

We want to know a little bit more about you. Please tell us more.

1. Are you Hispanic, Latino, or Spanish origin? (*Mark ONE box.*)

Yes
 No

2. What is your race? (Mark one or more.)

White/Caucasian Asian
 Black/African American American Indian/Alaska Native
 Native Hawaiian or Other Pacific Islander
 Other race: _____ (specify)

3. How old are you?

18-24
 25-34
 35-49
 50-64
 65+

4. What is your gender?

Female
 Male
 Other _____ (specify)

5. What is your marital status?

Never Married
 Married

- Divorced
- Widowed
- Separated (Legally)

6. What type of resource parent are you currently? (*Mark one or more.*)

- Foster Parent
- Kinship
- Adoptive Parent

7. Please tell us how many years you have been a resource parent (foster, kinship, adoptive).

- 0-2yrs
- 3-5yrs
- 6-9yrs
- 10+ yrs

Mental Health Literacy Scale

The purpose of these questions is to gain an understanding of your knowledge of various aspects to do with mental health. When responding, we are interested in your degree of knowledge.

Therefore when choosing your response, consider that:

Very unlikely = I am certain that it is NOT likely

Unlikely = I think it is unlikely but am not certain

Likely = I think it is likely but am not certain

Very Likely = I am certain that it IS very likely

If someone became extremely nervous or anxious in one or more situations with other people (e.g., a party) or performance situations (e.g., presenting at a meeting) in which they were afraid of being evaluated by others and that they would act in a way that was humiliating or feel embarrassed, then to what extent do you think it is likely they have **Social Phobia**

2 Very unlikely Unlikely Likely Very Likely

If someone experienced excessive worry about a number of events or activities where this level of concern was not warranted, had difficulty controlling this worry and had physical symptoms such as having tense muscles and feeling fatigued then to what extent do you think it is likely they have **Generalized Anxiety Disorder**

3 Very unlikely Unlikely Likely Very Likely

If someone experienced a low mood for two or more weeks, had a loss of pleasure or interest in their normal activities and experienced changes in their appetite and sleep then to what extent do you think it is likely they have **Major Depressive Disorder**

4 Very unlikely Unlikely Likely Very Likely

To what extent do you think it is likely that **Personality Disorders** are a category of mental illness

5 Very unlikely Unlikely Likely Very Likely

To what extent do you think it is likely that **Persistent Depressive Disorder** (Dysthemia) is a disorder

6 Very unlikely Unlikely Likely Very Likely

To what extent do you think it is likely that the diagnosis of **Agoraphobia** includes anxiety about situations where escape may be difficult or embarrassing

7 Very unlikely Unlikely Likely Very Likely

To what extent do you think it is likely that the diagnosis of **Bipolar Disorder** includes experiencing periods of elevated (i.e., high) and periods of depressed (i.e., low) mood

8 Very unlikely Unlikely Likely Very Likely

To what extent do you think it is likely that the diagnosis of **Substance Abuse Disorder** includes physical and psychological tolerance of the drug (i.e., require more of the drug to get the same effect)

9 Very unlikely Unlikely Likely Very Likely

To what extent do you think it is likely that in general in the United States, **women are MORE likely to experience a mental illness of any kind compared to men**

Very unlikely Unlikely Likely Very Likely

10
To what extent do you think it is likely that in general, in the United States, **men are MORE likely to experience an anxiety disorder compared to women**

Very unlikely Unlikely Likely Very Likely

When choosing your response, consider that:

- Very Unhelpful = I am certain that it is NOT helpful
- Unhelpful = I think it is unhelpful but am not certain
- Helpful = I think it is helpful but am not certain
- Very Helpful = I am certain that it IS very helpful

11
To what extent do you think it would be helpful for someone to **improve their quality of sleep** if they were having difficulties managing their emotions (e.g., becoming very anxious or depressed)

Very unhelpful Unhelpful Helpful Very helpful

12

To what extent do you think it would be helpful for someone to **avoid all activities or situations that made them feel anxious** if they were having difficulties managing their emotions

Very unhelpful Unhelpful Helpful Very helpful

When choosing your response, consider that:

- Very unlikely = I am certain that it is NOT likely
- Unlikely = I think it is unlikely but am not certain
- Likely = I think it is likely but am not certain
- Very Likely = I am certain that it IS very likely

13

To what extent do you think it is likely that **Cognitive Behavior Therapy (CBT)** is a therapy based on challenging negative thoughts and increasing helpful behaviors

Very unlikely Unlikely Likely Very Likely

14

Mental health professionals are bound by confidentiality; however there are certain conditions under which this does not apply.

To what extent do you think it is likely that the following is a condition that would allow a mental health professional to **break confidentiality**:

If you are at immediate risk of harm to yourself or others

Very unlikely Unlikely Likely Very Likely

15

Mental health professionals are bound by confidentiality; however there are certain conditions under which this does not apply.

To what extent do you think it is likely that the following is a condition that would allow a mental health professional to **break confidentiality**:

if your problem is not life-threatening and they want to assist others to better support you

Very unlikely Unlikely Likely Very Likely

Please indicate to what extent you agree with the following statements:

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
16. I am confident that I know where to seek information about mental illness					
17. I am confident using the computer or telephone to seek information about mental illness					
18. I am confident attending face to face appointments to seek information about mental illness (e.g., seeing the GP)					
19. I am confident I have access to resources (e.g., GP, internet, friends) that I can use to seek information about mental illness					

Please indicate to what extent you agree with the following statements:

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
20. People with a mental illness could snap out if it if they wanted					
21. A mental illness is a sign of personal weakness					
22. A mental illness is not a real medical illness					
23. People with a mental illness are dangerous					
24. It is best to avoid people with a mental illness so that you don't develop this problem					
25. If I had a mental illness I would not tell anyone					
26. Seeing a mental health professional means you are not strong enough to manage your own difficulties					
27. If I had a mental illness, I would not seek help from a mental health professional					
28. I believe treatment for a mental illness, provided by a mental health professional, would not be effective					

Please indicate to what extent you agree with the following statements:

	Definitely unwilling	Probably unwilling	Neither unwilling or willing	Probably willing	Definitely willing
29. How willing would you be to move next door to someone with a mental illness?					
30. How willing would you be to spend an evening socializing with someone with a mental illness?					
31. How willing would you be to make friends with someone with a mental illness?					

	Definitely unwilling	Probably unwilling	Neither unwilling or willing	Probably willing	Definitely willing
32. How willing would you be to have someone with a mental illness start working closely with you on a job?					
33. How willing would you be to have someone with a mental illness marry into your family?					
34. How willing would you be to vote for a politician if you knew they had suffered a mental illness?					
35. How willing would you be to employ someone if you knew they had a mental illness?					

Reference

O'Connor, M., & Casey, L. (2015). The mental health literacy scale (MHLS): A new scale-based measure of mental health literacy, *Psychiatry Research*, <http://dx.doi.org/10.1016/j.psychres.2015.05.064>

APPENDIX E

MHLS POST-QUESTIONNAIRE

(Post-Questionnaire)

The purpose of these questions is to gain an understanding of your knowledge of various aspects to do with mental health. When responding, we are interested in your degree of knowledge. Therefore when choosing your response, consider that:

Very unlikely = I am certain that it is NOT likely

Unlikely = I think it is unlikely but am not certain

Likely = I think it is likely but am not certain

Very Likely = I am certain that it IS very likely

1

If someone became extremely nervous or anxious in one or more situations with other people (e.g., a party) or performance situations (e.g., presenting at a meeting) in which they were afraid of being evaluated by others and that they would act in a way that was humiliating or feel embarrassed, then to what extent do you think it is likely they have **Social Phobia**

Very unlikely

Unlikely

Likely

Very Likely

2

If someone experienced excessive worry about a number of events or activities where this level of concern was not warranted, had difficulty controlling this worry and had physical symptoms such as having tense muscles and feeling fatigued then to what extent do you think it is likely they have **Generalized Anxiety Disorder**

Very unlikely

Unlikely

Likely

Very Likely

3

If someone experienced a low mood for two or more weeks, had a loss of pleasure or interest in their normal activities and experienced changes in their appetite and sleep then to what extent do you think it is likely they have **Major Depressive Disorder**

Very unlikely

Unlikely

Likely

Very Likely

4

To what extent do you think it is likely that **Personality Disorders** are a category of mental illness

Very unlikely

Unlikely

Likely

Very Likely

5

To what extent do you think it is likely that **Persistent Depressive Disorder** (Dysthemia) is a disorder

Very unlikely

Unlikely

Likely

Very Likely

6

To what extent do you think it is likely that the diagnosis of Agoraphobia includes anxiety about situations where escape may be difficult or embarrassing

Very unlikely

Unlikely

Likely

Very Likely

7

To what extent do you think it is likely that the diagnosis of **Bipolar Disorder** includes experiencing periods of elevated (i.e., high) and periods of depressed (i.e., low) mood

Very unlikely Unlikely Likely Very Likely

8

To what extent do you think it is likely that the diagnosis of **Substance Abuse Disorder** includes physical and psychological tolerance of the drug (i.e., require more of the drug to get the same effect)

Very unlikely Unlikely Likely Very Likely

9

To what extent do you think it is likely that in general in the United States, **women are MORE likely to experience a mental illness of any kind compared to men**

Very unlikely Unlikely Likely Very Likely

10

To what extent do you think it is likely that in general, in the United States, **men are MORE likely to experience an anxiety disorder compared to women**

Very unlikely Unlikely Likely Very Likely

When choosing your response, consider that:

- Very Unhelpful = I am certain that it is NOT helpful
- Unhelpful = I think it is unhelpful but am not certain
- Helpful = I think it is helpful but am not certain
- Very Helpful = I am certain that it IS very helpful

11

To what extent do you think it would be helpful for someone to **improve their quality of sleep** if they were having difficulties managing their emotions (e.g., becoming very anxious or depressed)

Very unhelpful Unhelpful Helpful Very helpful

12

To what extent do you think it would be helpful for someone to **avoid all activities or situations that made them feel anxious** if they were having difficulties managing their emotions

Very unhelpful Unhelpful Helpful Very helpful

When choosing your response, consider that:

- Very unlikely = I am certain that it is NOT likely
- Unlikely = I think it is unlikely but am not certain
- Likely = I think it is likely but am not certain
- Very Likely = I am certain that it IS very likely

13

To what extent do you think it is likely that **Cognitive Behavior Therapy (CBT)** is a therapy based on challenging negative thoughts and increasing helpful behaviors

Very unlikely Unlikely Likely Very Likely
14

Mental health professionals are bound by confidentiality; however there are certain conditions under which this does not apply.

To what extent do you think it is likely that the following is a condition that would allow a mental health professional to **break confidentiality**:

If you are at immediate risk of harm to yourself or others

Very unlikely Unlikely Likely Very Likely
15

Mental health professionals are bound by confidentiality; however there are certain conditions under which this does not apply.

To what extent do you think it is likely that the following is a condition that would allow a mental health professional to **break confidentiality**:

if your problem is not life-threatening and they want to assist others to better support you

Very unlikely Unlikely Likely Very Likely

Please indicate to what extent you agree with the following statements:

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
16. I am confident that I know where to seek information about mental illness					
17. I am confident using the computer or telephone to seek information about mental illness					
18. I am confident attending face to face appointments to seek information about mental illness (e.g., seeing the GP)					
19. I am confident I have access to resources (e.g., GP, internet, friends) that I can use to seek information about mental illness					

Please indicate to what extent you agree with the following statements:

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
20. People with a mental illness could snap out if it if they wanted					
21. A mental illness is a sign of personal weakness					
22. A mental illness is not a real medical illness					
23. People with a mental illness are dangerous					
24. It is best to avoid people with a mental illness so that you don't develop this problem					
25. If I had a mental illness I would not tell anyone					
26. Seeing a mental health professional means you are not strong enough to manage your own difficulties					
27. If I had a mental illness, I would not seek help from a mental health professional					
28. I believe treatment for a mental illness, provided by a mental health professional, would not be effective					

Please indicate to what extent you agree with the following statements:

	Definitely unwilling	Probably unwilling	Neither unwilling or willing	Probably willing	Definitely willing
29. How willing would you be to move next door to someone with a mental illness?					
30. How willing would you be to spend an evening socializing with someone with a mental illness?					
31. How willing would you be to make friends with someone with a mental illness?					

	Definitely unwilling	Probably unwilling	Neither unwilling or willing	Probably willing	Definitely willing
32. How willing would you be to have someone with a mental illness start working closely with you on a job?					
33. How willing would you be to have someone with a mental illness marry into your family?					
34. How willing would you be to vote for a politician if you knew they had suffered a mental illness?					
35. How willing would you be to employ someone if you knew they had a mental illness?					

1. What will you do differently now that you’ve attended this course?

2. How likely are you to recommend this course to a friend/colleague?

3. Do you think this course was useful for resource parents? Why or why not?

Thank you for your time and effort filling out this survey. You are appreciated!!!

Reference

O’Connor, M., & Casey, L. (2015). The mental health literacy scale (MHLS): A new scale-based measure of mental health literacy, *Psychiatry Research*, <http://dx.doi.org/10.1016/j.psychres.2015.05.064>

APPENDIX F

Statistical Data

Table 1*Frequency Table for Demographic Variables*

Variable	<i>n</i>	%
Age		
50-64	3	50.00
35-49	3	50.00
Gender		
Male	2	33.33
Female	4	66.67
Race		
White/Caucasian	4	66.67
Latino_Spanish	2	33.33
Marital_Status		
Married	4	66.67
Never Married	1	16.67
Divorced	1	16.67
Resource_Parent		
Foster	4	66.67
Foster/Kinship	1	16.67
Foster/Adopted	1	16.67
Years_of_Experience		
10+ yrs	3	50.00
0-2yrs	2	33.33
6-9yrs	1	16.67

Note. Due to rounding errors, percentages may not equal 100%.

Table 2*Summary Statistics Table for Pre- and Post-Mental Health Literacy Intervention*

Variable	<i>M</i>	<i>SD</i>	<i>n</i>	Min	Max	<i>Mdn</i>
Pre-Mental Health Literacy	133.50	11.84	6	115.00	149.00	135.50
Post-Mental Health Literacy	139.17	10.03	6	123.00	150.00	141.50

Table 3

Two-Tailed Paired Samples t-Test for the Difference Between Pre-Mental Health Literacy and Post-Mental Health Literacy

Pre-Mental Health Literacy		Post-Mental Health Literacy		<i>t</i>	<i>p</i>	<i>d</i>
<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			
133.50	11.84	139.17	10.03	-1.97	.107	0.80

Note. N = 6. Degrees of Freedom for the *t*-statistic = 5. *d* represents Cohen's *d*.

Figure 1

The means of Pre-Mental Health Literacy and Post-Mental Health Literacy with 95.00% CI Error Bars

