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Early Intervention in the Real World

Mental Health First Aid: an international programme for early intervention

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Abtract

Aim: To describe the development of the Mental Health First Aid (MHFA) programme in Australia, its roll-out in other countries and evaluation studies which have been carried out.

Methods: A description of the programme's development and evaluation, its cultural adaptations and its dissemination in seven countries.

Results: The programme was developed in Australia in 2001. By the end of 2007, there were 600 instructors and 55 000 people trained as mental health first aiders. A number of evaluations have been carried out, including two randomized controlled trials that showed changes in knowledge, attitudes and first aid behaviours. Special adaptations of the course have been rolled out for Aboriginal and Torres Strait Islander peoples and some non-English speaking immigrant groups. The course has spread to seven other countries with varying degrees of penetration. In all countries, the programme has been initially supported by government funding. Independent evaluations have been carried out in Scotland and Ireland.

Conclusions: The concept of first aid by the public for physical health crises is familiar in many countries. This has made it relatively easy to extend this approach to early intervention by members of the public for mental disorders and crises. Through MHFA training, the whole of a community can assist formal mental health services in early intervention for mental disorders.

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INTRODUCTION

Early intervention is usually discussed in the domain of formal health providers. However, family, friends and other members of the public can be the givers of the very first early intervention prior to contact with health professionals. Many people with mental disorders delay seeking help,[1] but they are more likely to receive professional help when this is suggested by someone in their social network.[2] However, many members of the public lack the skills to facilitate early intervention. Here we describe the Mental Health First Aid (MHFA) Training and Research Program as a method of achieving this. MHFA is defined as 'the help provided to a person developing a mental health problem or in a mental health crisis. The first aid is given until appropriate professional treatment is received or until the crisis resolves'.[3] The concept of MHFA extends the notion of first aid which is already familiar to members of the public for helping with physical health crises.

The purpose of this article is to describe the development of the MHFA programme in Australia, its roll-out in other countries and evaluation studies which have been carried out.

PROGRAMME DESCRIPTION

Development of MHFA Training and Research Program in Australia

The MHFA Training and Research Program began in response to the findings from Australian surveys of mental health literacy showing that members of the public had poor recognition of mental disorders and

BOX 1. The MHFA action plan: ALGEE

1. **A**ssess Risk of Suicide or Harm
2. **L**isten Non-judgmentally
3. **G**ive Reassurance and Information
4. **E**ncourage Person to Get Appropriate Professional Help
5. **E**ncourage Self-help Strategies

MHFA, Mental Health First Aid.

BOX 2. MHFA instructor selection criteria

- Good knowledge of mental health problems
- Personal or professional experience with people with mental health problems
- Good background knowledge of mental health and community services
- Favourable attitudes towards people with mental health problems
- Good teaching and communication skills
- Good interpersonal skills
- Good business plan or organizational support

MHFA, Mental Health First Aid.

lacked knowledge about evidenced-based treatments and first aid responses.[4,5] Initially, a 9-h MHFA course was developed, following the model successfully applied to conventional first aid, by training members of the public to give early help to adults developing a mental disorder and to give assistance in mental health crisis situations. A year later, it was extended to 12 h of training, based on participant feedback that more time was needed. This course covers the symptoms and risk factors in depressive, anxiety, psychotic and substance use disorders and associated mental health crises situations: suicidal thoughts and behaviours, panic attack, experiencing a traumatic event, behaviour which is perceived as threatening and drug overdose. As in conventional first aid, an action plan is taught – see Box 1. Appropriate skills of these five actions are practised for each mental disorder and crisis covered. Participants are provided with a course manual, which is also available as a downloadable PDF from the MHFA website (http://www.mhfa.com.au). Participants who complete the full 12-h course receive an MHFA Certificate.

The MHFA programme began in mid-2001 in Canberra with only one part-time volunteer course developer and instructor (BAK) working in partnership with a researcher (AFJ). A subsequent state government grant allowed five more MHFA instructors to be trained in 2002. By 2005, every state and territory of Australia had MHFA instructors. MHFA instructors need to meet the selection criteria set out in Box 2. By the end of 2007, there were 600 instructors and seven trainers of instructors. The initial uptake has been stronger in rural areas. We speculate that this has been because there are fewer mental health services available in rural regions and there is perhaps a greater feeling of community responsibility for the welfare of others.

The MHFA Training and Research Program at ORYGEN Research Centre provides ongoing support to MHFA instructors through the following services: an annual 2-day instructor conference; provision of expert help by phone and email if instructors need more information to handle difficult questions from participants; and a regular newsletter, including an update on any relevant new research knowledge and changes in course curriculum. The MHFA website has been important in disseminating information about the programme. Instructors can advertise their courses and members of the public

TABLE 1. Decentralized model of MHFA training dissemination in Australia

Training level	Employing organization	Role	No. of people involved
Level 1 Trainers of instructors	ORYGEN Research Centre, University of Melbourne	To train MHFA instructors in 5-day MHFA Instructor Training course	4 full-time; 3 part-time
Level 2 Instructors	Area health services, non-government organizations, social welfare agencies, places of employment, private practitioners	To deliver the 12-h MHFA course to members of the public or to workplaces	600
Level 3 First aiders	Some are trained in their work role. Others train in a private capacity as a citizen's duty or as a carer	To assist people developing mental disorders or in a crisis	Approx. 55 000

MHFA, Mental Health First Aid.

can locate an MHFA instructor in their area. By December 2007, the MHFA website was receiving over 87 000 visits annually.

In 2006, the first National Youth Mental Health Literacy Survey confirmed that adolescents have poor knowledge about mental disorders and how to get professional help and are particularly likely to need first aid from adults.[6,7] Furthermore, the survey revealed inadequacies in adults' beliefs about appropriate first aid for young people with mental disorders.[8] Given these findings and the fact that mental health problems frequently first arise in adolescence, a Youth MHFA manual[9] and course was developed in early 2007 to train adults in how to better assist adolescents. This 14-h course covers the same mental health problems as the general MHFA course, but with a youth focus, and has additional modules on deliberate self-harm and eating disorders. In April 2007, the inaugural Youth MHFA instructor training course accredited 20 Youth MHFA instructors.

Model of dissemination

An important factor in the spread of the programme in Australia has been the decentralized model for dissemination. The MHFA Training Program trains instructors who then deliver MHFA courses under the auspices of local organizations and arrange their own funding (see Table 1). Some MHFA instructors conduct the MHFA courses as private practitioners.

Although the course is widely available in Australia, there are some people who are unable to attend the course (e.g. people in remote areas, shift workers). To accommodate this need, an e-learning version of the course has recently been developed. This version involves acquiring the course information from a CD. To obtain the MHFA Certificate, attendance is required at a 3.5-h course with a focus on skills training.

Cultural variations in Australia

Because the first aiders' role may vary according to the culture in which they are working, there have been modifications to the MHFA course to suit culturally and linguistically diverse groups living in Australia. The course has been modified for Australian Vietnamese, Croatian and Italian communities and MHFA instructors have been trained from the relevant communities.[10–12] There is also a 14-h Aboriginal and Torres Strait Islander MHFA Program which trains indigenous instructors to deliver a culturally sensitive MHFA course to their local communities.[13] All the cultural adaptations have been made in consultation with expert reference groups involving the relevant local communities.

The MHFA programme in other countries

The MHFA programme has been adopted in other countries with appropriate cultural and content modification. To date, it has been adapted in Canada, England, Finland, Hong Kong, Ireland, Scotland and Singapore; and a number of countries are in the early stages of adapting the programme (Japan, New Zealand, USA and Wales). Table 2 summarizes the developments in a number of these countries.

EVALUATION

An important factor in the spread of the MHFA programme has been formal evaluation and publication in peer-reviewed journals. This solid research has given credibility to the programme and funding agencies have been willing to support a programme with a strong evidence base. A review article has been published of the evaluation studies of the MHFA programme.[14] The initial evaluation involved

TABLE 2. Overview of MHFA in various countries

Country (year MHFA started)	National hosting organization	Source of funding	Modifications to original MHFA Australia course	Evaluation (completed or in progress)	Number of trainers, instructors and first aiders	Website, contact person
Australia (2000)	ORYGEN Research Centre, University of Melbourne	1. Competitive Government grants for new initiatives. 2. Fees paid by instructors to train. 3. Fees paid by course participants to instructors	Adapted courses for: 1. Indigenous Australians; 2. Vietnamese, Croatian and Italian speaking Australians; 3. Adults assisting youth; 4. E-learning version on a CD	1. Uncontrolled trial[13] 2. Two randomized controlled trials,[14,15] 3. Qualitative study of participants' stories[16]	As of 1 December 2007: Trainers: 4 full-time, 2 sessional Instructors: 600 First aiders: Approx. 55 000	http://www.mhfa.com.au; Betty Kitchener: bettyk@unimelb.edu.au
Canada (2004)	Alberta Mental Health Board	1. Moving towards operating on a cost recovery basis through fees paid by instructors to train and through materials sold to instructors. 2. Government grants for one-time initiatives (e.g. MHFA in schools) 3. Alberta Mental Health Board provided one-time infrastructure development funding	Adapted the course: 1. To reflect Canadian mental health system and data 2. For adults assisting youth (under development)	1. Quantitative study of participant ratings of programme effectiveness. 2. Qualitative study of participant ratings of programme effectiveness	As of 1 December 2007: Trainers: 2 Instructors: 102 First aiders: Approx. 1503	http://www.mentalhealthfirstaid.ca Ruby Brown: ruby.brown@amhb.ab.ca
England (2007)	National Institute for Mental Health in England		Using Scottish adaptation	None	As of 1 December 2007: Trainers: 15 part-time sessional workers Instructors: 20 First aiders: 124	John Pattinson: John.Pattinson@nlpct.nhs.uk
Finland (2006)	Ostrobothnia-Project and Suomen Mielenterveysseura (The Finnish Association for Mental Health)	1. Government grants for new initiatives 2. Ostrobothnia Project allowances for MHFA programme	Adapted courses for: 1. Indigenous Finnish; 2. Indigenous Swedish speaking Finnish	1. Uncontrolled trial 2. Qualitative study of participants'stories	As of 1 December: Trainers: 9 Instructors: 52 First aiders: 1000	http:// www.mielenterveydenensiapu.fi Mikko Häikiö mikko.haikio@lshp.fi Minna Laitila (minna.laitila@seamk.fi)
Hong Kong (2003)	1. The Mental Health Association of Hong Kong (Adult MHFA) 2. Private MHFA Instructors	1. Initial start-up covered by corporate funding. 2. Fees paid by participants 1. Fees paid by participants	1. Chinese and localized content. 2. Chinese version of the course manual 1. Using MHFA Australia materials	Post course satisfaction questionnaire (on-going)	As of 8 August 2007: Trainers: 3 Instructors: 19 First aiders: Approx 2000 First aiders: Approx 300	http://www.mhahk.org.hk Kimmy Ho: hokimmy@mhahk.org.hk

Ireland (2007)	Co-operation and Working Together (CAWT), The Health Promotion Agency (HPA) for Northern Ireland and Aware Defeat Depression	1. CAWT funding through EU Programme for Peace and Reconciliation 2. Department of Health, Social Services and Public Safety in Northern Ireland under Promoting Mental Health Strategy and Action Plan	MHFA was piloted in Ireland using Scotland's Mental Health First Aid training and resources which have already been adapted for use in Scotland. Some supporting information was provided to reflect local context and epidemiology	Evaluation with instructors focussed on process. This included: 1. Qualitative work with instructors 2. Instructor diary proforma following delivery of courses during pilot phase. 3. Participant evaluation used, pre and post questionnaires looking at changes in knowledge awareness attitude and behaviour	As of October 2007: Trainers: 0 Instructors: 15 First aiders: 234	http://www.healthpromotionagency.org.uk Deirdre McNamee (HPA) d.mcnamee@hpani.org.uk Sharon Sinclair (AWARE) Sharon@aware-ni.org John Meehan (CAWT) Johnf.meehan@mailb.hse.ie
Scotland (2003)	NHS Health Scotland, Edinburgh	1. Scottish government funding as part of the implementation of National Mental Health Policy 2. Fees paid by instructors to train 3. Fees paid by course participants	1. Adapted course for the Scottish context. Additions to Australian materials to cover self-harm, recovery, key learning points, delivery methods to reflect multiple intelligences and learning styles. Developed DVD with personal testimonies on mental illnesses 3. Development of Instructor competencies	Independent evaluation has been carried out involving process, outcome and formative evaluation components[17] 2. All material translated into British Sign Language, brail and daisy disk format	As of 1 December 2007: Trainers: 4 Instructors: 209 First aiders: 8246	http://www.smhfa.com Kirsty Robertson kirsty.robertson@health.scot.nhs.uk
Singapore (2006)	Changi General Hospital – Department of Psychological Medicine	1. Administrative support from Changi Hospital. 2. Fees from trainee Instructors and first aiders or their employer. 3. DVD of 5 film clips and printing of manual funded by a pharmaceutical company	Manual and course content have been adapted to reflect Singapore services and data. Manual published November 2007 Five film clips on stigma, attitudes and applying MHFA actions	Formal evaluation planned to start in 2008	As of October 2007 Trainers: 7 Instructors: 18 First aiders: 470	http://www.traumarecovery.com.sg/mhfa.html Dr Angelina Chan Angelina_Chan@cgh.com.sg

MHFA, Mental Health First Aid; NHS, National Health Service.

an uncontrolled trial showing improved recognition of mental disorders, changed beliefs about treatment to be more like those of health professionals, decreased social distance from people with mental disorders, increased confidence in providing help and an increase in the amount of help provided to others. These improvements were maintained over a 6-month period.[15] This study was followed by two randomized controlled trials, the first involving employees in two government departments and the second with members of a large rural community.[16,18] The following statistically significant benefits were found 5–6 months post-training: improved concordance with health professionals about treatments, improved helping behaviour, greater confidence in providing help to others and decreased social distance from people with mental disorders. Only one trial evaluated the mental health benefits to participants and this found positive effects.[16]

One of the difficulties in evaluating a first aid programme is in obtaining information about the recipient of the first aid, as distinct from the first aider. We have attempted to do this with a qualitative study collecting stories of what actions the first aiders took and the reported effects on recipients. This study found that 78% of the respondents reported providing some first aid and in most cases they were able to act in a way that led to a better outcome than might otherwise have been the case. There were positive effects in terms of confidence to respond, increased empathy and better handling of crises. There was no evidence of the first aiders overreaching themselves because of overconfidence.[19]

More recently, we have been developing guidelines for MHFA using Delphi consensus studies with clinicians, consumers and carers from a range of developed English-speaking countries. Guidelines for depression and psychosis first aid have been published[20,21] and we are currently developing guidelines for first aid with eating disorders and alcohol misuse and for the crisis situations of suicidal thoughts and behaviours, deliberate self-injury, exposure to a traumatic event and having a panic attack. Work is also underway to develop guidelines for Aboriginal and Torres Strait Islander peoples, using indigenous mental health professionals as the Delphi panellists, and we have developed psychosis first aid guidelines for Asian countries using Asian clinicians as the expert panellists. Copies of all guidelines can be found at http://www.mhfa.com.au/guidelines.shtml

Table 2 lists work on the evaluation of MHFA in other countries.

DISCUSSION

The MHFA programme has spread rapidly within Australia and across a number of other countries. We can identify a number of reasons for this success. First, members of the public readily relate to and accept the first aid concept, which is familiar to them from conventional first aid training. It helps to emphasize that mental health problems should be responded to in the same way as physical health problems and that members of the public can play a useful initial role. Second, the demand for MHFA training has also been driven by the high prevalence of mental disorders, which means that contact with people developing a mental disorder or in a mental health crisis is almost universal. In fact, members of the public are far more likely to have contact with someone in a mental health crisis, such as being suicidal, than in a physical health crisis, such as a major coronary event.[22,23] Given the high chances of such contacts, people want to know how to respond with initial help. Third, there is a considerable unmet need for mental health services, even in developed countries. MHFA training is seen as extending basic mental healthcare skills to people working in other sectors, such as educational institutions, employment and welfare agencies, human resources departments within places of employment, disability services, police, prison officers and court staff. In this way, the responsibility for mental health care is extended beyond specialist mental health services and even beyond health services in general. Finally, the MHFA Training Program has been closely linked with the MHFA Research Program. This has ensured that the content is as evidenced-based as possible and the effects of the training have been rigorously evaluated. Publication of the evaluation studies has been particularly important in the spread of the programme to other countries.

We can anticipate a number of developments of the MHFA programme in the future. A likely development is that MHFA training will be a prerequisite for work in certain occupations, such as teaching, police and welfare work. This may require specific adaptation of the training to suit the needs of particular occupations. In Australia, this has already begun for two professional groups: middle school teachers and staff of the Family Court (who handle cases of marital breakdown).

Another area where work is needed is extending MHFA to developing countries. In these countries, the approach will need to be different, because the first aider may not have an adequate range of health services that they can refer the person to. MHFA

training could be used to develop basic primary healthcare skills in non-professional healthcare workers. However, this would require the development of MHFA guidelines that are appropriate for the cultures and health systems of developing countries.

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