



Mental health first aid training for members of the public

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ABSTRACT. The prevalence of mental disorders is so high that members of the public will frequently have contact with someone experiencing a disorder. How they respond to that person may affect help-seeking and outcome of the disorder. However, community surveys show that many members of the public lack knowledge and skills in this area. To overcome this lack, a mental health first aid training course has been developed in Australia and widely disseminated. It has also been adapted for different national and cultural groups. A number of trials have been carried out to evaluate the course, showing improvements in recognition of mental disorders, concordance with professionals about treatments, confidence in providing first aid, actual help provided to others, and reduction in stigmatizing attitudes. The course is continually being extended and improved. Work is currently underway to develop a version for supporters of adolescents, and to develop best practice standards for first aid, both for developing disorders and in crisis situations.

KEYWORDS. First aid. Mental health literacy. Health education. Mental disorders. Theoretical study.

RESUMEN. La prevalencia de los trastornos mentales es tan alta que los habitantes frecuentemente tendrán contacto con alguien que esté padeciendo uno de ellos. La forma en que responden a esa persona puede influir tanto en el proceso de búsqueda de ayuda como en el resultado del trastorno. Sin embargo, las encuestas poblacionales

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muestran que muchos habitantes carecen de conocimiento y habilidades en este área. Para superar esta carencia, un curso de entrenamiento en primeros auxilios en salud mental ha sido desarrollado en Australia y ampliamente divulgado. También ha sido adaptado para diferentes grupos nacionales y culturales. Se han efectuado diversos ensayos para evaluar el curso, encontrándose mejoras en el reconocimiento de los trastornos mentales, en la concordancia con profesionales acerca de los tratamientos, en la confianza sobre los primeros auxilios, en la ayuda real proporcionada a otros, y en la reducción de actitudes de estigmatización. El curso sigue extendiéndose y mejorando. Actualmente, el trabajo se encamina a elaborar una versión para los que procuran apoyo a los adolescentes, y a conseguir mayor estandarización en la práctica de primeros auxilios, cubriendo en ambos casos los trastornos tanto en sus comienzos como en situaciones de crisis.

PALABRAS CLAVE. Primeros auxilios. Instrucción en salud mental. Educación en salud. Trastornos mentales. Estudio teórico.

RESUMO. A prevalência de perturbações mentais é tão alta que os habitantes frequentemente terão contacto com alguém que está sofrendo de uma delas. A forma como respondem a essa pessoa pode influenciar tanto o processo de procura de ajuda como o resultado da perturbação. No entanto, os inquéritos populacionais mostram que muitos habitantes carecem de conhecimento e competências nesta área. Para superar esta carência, um programa de treino em cuidados primários em saúde mental tem sido desenvolvido na Austrália e amplamente divulgado. Também tem sido adaptado para diferentes grupos nacionais e culturais. Efectuaram-se diversos ensaios para avaliar o programa de treino, encontrando-se melhorias no reconhecimento das perturbações mentais, na concordância entre profissionais acerca das perturbações, na confiança sobre os cuidados primários, na ajuda real proporcionada a outros, e na redução de atitudes de estigmatização. O programa continua a desenvolver-se e a ser melhorado. Actualmente o trabalho encaminha-se para a elaboração de uma versão para os que procuram apoiar adolescentes, e a conseguir maior estandardização na prática dos cuidados primários, cobrindo em ambos os casos as perturbações tanto no seu início como em situações de crise.

PALAVRAS CHAVE. Cuidados primários. Instrução em saúde mental. Educação em saúde. Perturbações mentais. Estudo teórico.

Introduction

Across the world, the prevalence of mental disorders is high (Demyttenaere *et al.*, 2004). In the European Union, for example, it has been estimated that 27% of the adult population aged 18-65 has been affected by a mental disorder in the past 12 months (Wittchen and Jacobi, 2005). An implication of this high prevalence is that members of the public have a high probability of having contact with someone who has a mental disorder.

Given the high chances of contact, it can be argued that the public need knowledge and skills to provide support to people with mental disorders. However, community

surveys of mental health literacy in a range of countries have found that many members of the public lack knowledge about mental disorders: they do not correctly recognize specific disorders, have beliefs about treatments which are at variance with those of professionals, have simplistic beliefs about causes, and frequently hold stigmatizing attitudes (Angermeyer, Breier, Dietrich, Kenzine, and Matschinger, 2005; Croghan *et al.*, 2003; Jorm, Angermeyer, and Katschig, 2000; Jorm, Nakane *et al.*, 2005; Lauber, Nordt, Falcató, and Rössler, 2003; Magliano, Fiorillo, De Rosa, Malangone, and Maj, 2004; Martínez-González and Trujillo-Mendoza, 2005; Priest, Vize, Roberts, Roberts, and Tylee, 1996). Furthermore, when community surveys directly assess knowledge of how to support others with mental disorders, some deficiencies are revealed. A Swiss survey found that the public have difficulty in dealing with people who have mental disorders, saying they do not know how to behave, are afraid of making mistakes and do not have sufficient knowledge (Brändli, 1999). An Australian survey presented members of the public with case vignettes and asked how they would respond if this was someone they knew and cared about (Jorm, Blewitt, Griffiths, Kitchener, and Parslow, 2005). The most common responses were to encourage professional help-seeking and to listen to and support the person. However, a significant minority did not give these as their responses. Fewer people mentioned other supportive actions, such as assessing the problem or the risk of harm, giving or seeking information, encouraging self-help, supporting the person's family, contacting a professional on the person's behalf or accompanying them to a professional. A survey of Australian adolescents similarly found deficiencies in how they said they would respond to a friend (Kelly, Jorm, and Rodgers, 2006). Around half said they would provide social support, but only a minority said they would engage the help of an adult such as a parent, teacher or school counselor.

This lack of mental health literacy and support skills could have an effect on the help-seeking and outcome of people with mental disorders. Family and friends are seen by the public as one of the most important sources of help for a person with a mental disorder (Jorm, Nakane *et al.*, 2005; Wright *et al.*, 2005). Good social support is known to be a predictor of better outcome (Goldberg and Huxley, 1992) and may reduce risk of self-harm (Skegg, 2005). Furthermore, it has been found that professional help for depression is more likely to occur when another person recommends that help be sought (Dew, Bromet, Schulberg, Parkinson, and Curtis, 1991) and a reason that the public give for not seeking professional help for depression is a belief that others would have a negative reaction (Barney, Griffiths, Jorm, and Christensen, 2006). Once professional help is sought, relatives and friends can influence attitudes and adherence to treatment (Fischer, Goerg, Zbinden, and Guimon, 1999).

In view of the potentially important role that members of the public can play in supporting someone with a mental disorder, and the deficiencies in mental health literacy revealed in community surveys, a Mental Health First Aid (MHFA) training course has been developed in Australia. This course takes the notion of first aid training, which is well accepted in many countries for dealing with physical disorders and injuries, and applies it to mental disorders. The purpose of this theoretical study (Montero and León, 2005) is to describe the course, review studies evaluating its effectiveness, and outline future directions for this approach.

Mental health first aid training for members of the public

Course content

The course extends over 12 hours and is divided into four sessions of three hours duration each. A variety of teaching methods are used including slides, videos, discussions, role plays and group activities. The course begins with an overview of mental health problems in Australia, including the high prevalence rates and the disability of mental disorders. A focus is then given to the three most common mental health problems of anxiety, substance use and depressive disorders, and the less common but often most disabling mental illness of psychosis. Course participants learn how to recognise signs and symptoms of these disorders, gain an understanding of the range of possible risk factors and learn which medical and psychological treatments and self-help strategies currently are best supported by the evidence as helpful. An action plan of the five steps of MHFA, as shown in Table 1, is taught to give guidance in how to help someone either developing a mental disorder or experiencing a mental health crisis, such as feeling suicidal, having a panic attack, experiencing a traumatic event, being psychotic and perceived to be threatening, and having overdosed. A manual accompanies the course (Kitchener and Jorm, 2002a) and it is available for sale or can be downloaded free from the MHFA website: <http://www.mhfa.com.au>.

TABLE 1. Steps of Mental Health First Aid.

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1. Assess risk of suicide or harm
 2. Listen non-judgmentally
 3. Give reassurance and information
 4. Encourage person to get appropriate personal help
 5. Encourage self-help strategies
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Dissemination of the course

A wide variety of people attend the course. The three main reasons given for attendance are: to help one's role in the workplace, to better understand and help a family member with a mental disorder and as a civic duty. Although the course was initially envisaged as a community education program, workplaces have increasingly requested the course for their employees. Such workforces have included the police force, university staff, school teachers, community nurses, members of the justice system, welfare, rehabilitation, employment and social housing agencies, and youth workers.

The course is conducted by accredited MHFA instructors, who have successfully applied for and completed a one week training course. Selection criteria need to be met and successful completion of two assessments attained during the training. More information about the requirements is available at: <http://www.mhfa.com.au/training.htm>. Ongoing support from MHFA Australia is given to instructors, including email and phone support, a quarterly newsletter and an annual instructor refresher weekend. At the beginning of 2006, there were over 400 MHFA instructors delivering the 12 hour course across every state and territory of Australia.

MHFA Australia does not employ the instructors. Once accredited, much autonomy is given to instructors to arrange, conduct and financially manage their courses. A small fee is paid by each instructor to the MHFA program for a manual and a certificate for each course participant. There are different models under which instructors can conduct their courses. One of the more common models is for regional health services to pay for some of their own staff to train as instructors to provide the course for other health staff or for the public. Another model is where a non-government organisation involved in providing human services employs instructors to deliver the course to members of the public, *e.g.*, the Australian Red Cross. A third model is for private practitioners to conduct their own business providing the MHFA course on a fee-for-service basis.

Governments and peak mental health organisations in some other countries have shown much interest in the MHFA program and already it has been adopted by Scotland (the Scottish Executive <http://www.healthscotland.com/smhfa/>), Hong Kong, (the Mental Health Association of Hong Kong <http://www.mhahk.org.hk/>), Singapore (National University of Singapore) and Canada (Alberta Mental Health Board <http://www.amhb.ab.ca/>). A different approach has been taken in New York, USA, where MHFA has been disseminated by a private business. A Memorandum of Understanding is signed by these countries with MHFA Australia to facilitate the sharing of any new MHFA materials developed.

Cultural adaptations

In Australia, the MHFA course has been developed to suit the mainstream of society and it has been recognised that this standard course may not be suitable for all cultural groups. Therefore, adapted versions of the course are being developed for a number of groups from non-English speaking backgrounds, with courses for Vietnamese, Croatian and Italian communities already completed. The course is currently being adapted for Aboriginal and Torres Strait Islander communities.

The process we used when working with other cultural groups involved close partnerships between MHFA staff and members of the respective communities. This assisted in the development and delivery of course content and in finding the appropriate explanatory models for mental disorder for the respective communities. There are trained instructors from each of these language groups who conduct MHFA courses in their respective communities.

There has been good uptake of the culturally adapted courses, especially in the Australian Vietnamese communities in two major Australian cities. The approach taken by the Vietnamese MHFA Instructors involved targeting religious leaders to improve their knowledge of mental disorders. It is anticipated that the religious leaders will use the knowledge gained during the course to refer people with mental disorders to appropriate professionals and services.

While there has been limited evaluation of the dissemination of the culturally and linguistically diverse versions of the MHFA course, initial reports from participants indicated increased knowledge levels and enhanced understanding of the signs and symptoms of the mental disorders taught in the course. Participants also reported an enhanced understanding of where and how to refer people with mental disorders, especially during periods of crisis.

Evaluation studies

A series of studies has been carried out to evaluate the effects of MHFA training, beginning with an uncontrolled trial and proceeding to randomized controlled trials under two very different sets of conditions.

Uncontrolled trial

An initial study was carried out with the first 210 members of the Australian public who elected to do the course in response to publicity (Kitchener and Jorm, 2002b). These participants were mainly well-educated women. The main reasons they gave for doing the course were relating to the workplace (42%), relating to family or close friends (21%), own mental health status (7%), duty as a citizen (5%) or “just interested” (24%). Evaluation questionnaires were given out at the beginning of the course, at the end, and at 6 months follow-up. A comparison of the questionnaire responses showed a number of benefits of the training. Participants were better able to recognize a mental disorder in a vignette, their beliefs about treatment became more like those of professionals, social distance from people with mental disorders was reduced, there was increased confidence in providing help to someone with a mental health problem and an increase in the amount of help actually provided to others. There was no evidence that the training led participants to over-labelling of people as having a mental disorder. The main limitation of the study was the lack of a control group. This was rectified in subsequent controlled trials.

Efficacy study in a workplace

The first randomized controlled trial was carried out in a workplace setting with 301 employees of two government departments randomly assigned to either do the course immediately or placed on a waiting list for five months (Kitchener and Jorm, 2004). This trial was an efficacy rather than an effectiveness trial, because it was carried out under fairly ideal conditions. The participants were well-educated public servants doing the course in their work time and the sole instructor was the developer of the MHFA course. To evaluate the training, questionnaires were given before the course and after five months. Questionnaires were not given immediately post-training, because the interest was in longer-term sustainable changes. Benefits were found in terms of greater confidence in providing help to others, greater likelihood of advising someone to seek professional help, improved concordance with professionals in beliefs about treatments, and decreased social distance. This study also included a measure of the mental health of the participants. Surprisingly, a significant change was found relative to controls, even though the course is not designed to benefit the participant's own mental health and only a small minority said they did the course for reasons relating to their own health. However, at pre-test the participants were found to score one standard deviation lower than population norms on the mental health questionnaire. What led to the improvement is unknown, but it is possible that the training gave information which allowed participants to take better action if they were themselves experiencing mental health problems.

Effectiveness study in a rural area

The workplace trial was carried out under fairly ideal conditions. The next trial evaluated the training under more realistic circumstances (Jorm, Kitchener, O’Kearney, and Dear, 2004). This trial was carried out with members of the public in a large rural area of Australia who did the training in their own time. The instructors were employees of the regional mental health service. There were 753 participants who came from 16 local government areas. These areas were grouped into 8 pairs and randomized to either receive training immediately or be placed on a waiting list. Questionnaires to evaluate the effects were given before the course started and four months after it ended. Training was found to produce significant improvements in recognition of disorders, concordance with professionals about treatment, confidence in providing help, actual help provided, and decreased social distance. Unfortunately, a measure of mental health of the participants was not included in this trial.

Qualitative analysis of stories about providing first aid

A weakness of all the above trials is that they assessed the knowledge gained by course participants and the help they reported giving, but not whether this help was beneficial to the recipients of the first aid. The reason for this omission is that it is impractical in most circumstances to actually contact the recipients of the first aid and to measure any mental health benefits. To get at least some information about the effects on recipients, a further study was carried out with participants in the rural effectiveness trial. This study systematically gathered stories about experiences of providing first aid, 19-21 months post-training (Jorm, Kitchener, and Mugford, 2005). The aim was to find out what type of first aid was provided and whether there were any good or bad effects on the recipient. The analysis of the stories was carried out by a social researcher who was independent of the MHFA course and was instructed to look for any ill effects as well as benefits. It was 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 over-reaching themselves because of over-confidence.

While this study indicates that there may be benefits to first aid recipients, further research is needed to measure these more directly. This research would need to be carried out in settings like families or schools where the recipients of any first aid are more readily identifiable. There is also a need for evaluation of the course in various cultural communities.

Future directions

The MHFA program and associated research work continue to evolve. Below we briefly outline two on-going developments: one involving the development of the training to cover first aid to a younger age group, and the other to establish best practice standards for the provision of first aid by members of the public.

Mental health first aid to help adolescents

Due to an increasing demand for more information about first aid for adolescents with mental health problems, a MHFA for adolescents version is being developed. The existing curriculum will be adapted to reflect what is known about the common and serious mental disorders in adolescents, with the addition of new sections on eating disorders and self harm. This course will be delivered to adults working with adolescents such as school teachers, youth workers and workers in the drug and alcohol field.

Development of first aid standards

The first aid strategies described in the MHFA course were developed by creating practical advice from existing evidence, asking experts for their advice, and sometimes simply using common sense. A major project currently underway will improve the first aid strategies by establishing expert consensus on the best ways to respond to a person in a mental health crisis or in the early stages of developing a disorder. This consensus will be presented in the form of MHFA standards. Consensus methods are an excellent way to develop best standards of practice when it is not possible to conduct randomized controlled trials, as is the case for first aid strategies.

The consensus method the MHFA team is using to develop these standards is called the Delphi method. Claims for effective first aid strategies are sought from various sources, including the medical and psychological literature, carers' manuals, websites and elsewhere. Panels of experts, who never meet, respond to a survey, rating their agreement as to whether the claims listed should form part of the MHFA standards. While panels of experts in most Delphi studies are made up of published or renowned professionals in their field, our panels will also include mental health consumers and carers of people with mental illness. The focus for the standards will be on Western English speaking countries (Australia, New Zealand, the United Kingdom, Ireland, Canada and the United States), with sub studies conducted in the developing world, special cultural groups (such as Australian Aboriginal people) and in special settings (such as jails).

Currently, the Delphi method is being used to develop standards for six crisis situations and three developing disorders. The crisis first aid standards are first aid for suicidal behaviours, first aid for self harm without suicidal intent, first aid for someone who doesn't want help, first aid for a person who is psychotic and becoming violent, first aid for panic attacks and first aid after a traumatic event. The three MHFA standards being developed for first-onset disorders are first aid for depression, first aid for psychosis and first aid for eating disorders. Some standards will be developmentally sensitive as, for example, depression developing in a child or adolescent may require different first aid strategies than first aid for an older adult developing depression.

In the longer term, we intend to develop standards for first aid for substance misuse (alcohol, cannabis and recreational drugs), first aid for anxiety disorders and first aid for onset of children's mental illnesses.

Conclusions

MHFA has rapidly spread within Australia and to a number of other countries. There are several reasons for this success. The first is that it takes the concept of first aid training, which is already widely accepted for medical emergencies, and applies this to a new area which has previously been neglected. In other words, there is an existing cultural niche into which this type of training readily fits. Coupled to this is the high prevalence of mental disorders and the clear need for greater public skills in the area. Another factor is the close link between the research program and the training program. Every effort has been made to make the course content evidence-based and there have been rigorous trials to evaluate its impact. There has also been a realization that an identical course cannot fit all countries, cultural groups and social roles, so that local adaptation has been encouraged. It is hoped that in the future, MHFA training will become as common as regular first aid across the world, that national or international bodies will set standards that are widely adopted and used as the basis for certification, and that a MHFA certificate will become a requirement for many professions that provide human services.

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