


Mental health first aid: strengthening its impact for aid recipients

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ABSTRACT

Mental Health First Aid (MHFA) is a potentially valuable first response in mental healthcare. MHFA is formulated as an extension of Psychological First Aid, the latter being a more focal response to crises and disasters. MHFA is a broader strategy which aims to improve the general public's immediate response to mental ill health and mental health crisis. While its effect on those trained in MHFA has been promising, recent meta-analyses have failed to detect any significant benefit to individuals who receive support from an MHFA trainee. Such outcomes highlight the need to revisit the content and implementation of MHFA to optimise and realise the full potential of the concept. Possible solutions are discussed, including developing new MHFA content using methodologies that foster innovation and creativity, in addition to improving the quality and effectiveness of MHFA training.

Considerable progress has been achieved in improving public awareness of mental illness and reducing its stigma.¹ However, this has not driven substantial changes in access to and quality of mental healthcare.² Even in countries that have made considerable gains in raising the public's ability to recognise and respond to mental illness, challenges remain in translating this into better outcomes for those experiencing mental illness. Mental Health First Aid (MHFA) is a related strategy, which moves beyond awareness raising to a first response to people with mental ill health which has obvious face validity. However, despite its wide dissemination and positive effect on MHFA trainees (ie, individuals who have completed MHFA training), so far it has been difficult to demonstrate benefits for the real targets of the programme, the end users or recipients of MHFA (ie, those people who have received support from a MHFA trainee). This has prompted a closer examination of the MHFA programme to identify strategies for improvement.

MHFA is an attractive low-intensity first step in supporting people who are developing or experiencing mental health crises, offering a more practical approach which goes beyond merely raising awareness. The concept of providing mental health-related aid originated in the mid-20th century through the introduction of Psychological First Aid following disasters.³ Drawing on parallels with medical first aid, MHFA has usefully expanded the concept to encompass a broader range of mental disorders and crises. Using a 'train-the-trainer' model it has spread rapidly across many parts of the world.

MHFA results in at least short-term benefits for individuals trained in MHFA. A recent meta-analysis identified improvements in knowledge about mental health problems, beliefs about treatment, identification of mental health problems, intention to provide MHFA, amount of help provided, and confidence in helping a person with a mental health problem, as well as reductions in stigmatising attitudes.⁴ While these effects were overall small-to-moderate up to 6 months post-training, they were unclear at 12-month follow-up.⁴ No improvement was found in the mental health of MHFA trainees. There was also no effect on the quality of MHFA provided at less than 6-month follow-up, although a non-significant improvement was found post-training and at 12 months in one study.⁴

The impact of MHFA, including both its youth and adult programmes, on the recipients or end-users of MHFA is less convincing. The same meta-analysis found that the impact of MHFA on the mental health of recipients of MHFA was small and non-significant by 6-month follow-up, with a non-significant negative effect at 12 months.⁴ Similarly, a further meta-analysis revealed that there were no apparent effects on MHFA recipients across the outcomes of knowledge, attitude, professional and/or MHFA help received or treatment sought, and psychological distress.⁵ There are two potential interpretations: (1) few trials have involved MHFA recipients and there is insufficient power to detect an effect or (2) the current evidence does not support the use of MHFA for individuals who are developing or experiencing mental health crises.

While the effects of MHFA on the recipients of MHFA may be clarified through further research, these initial results cast some doubt on the programme's current ability to directly benefit people experiencing mental illness. How can the MHFA programme be strengthened so that its benefits spread to MHFA recipients?

First, the strategies that have formed the basis for MHFA could be enhanced. The Delphi methodology that has informed the MHFA's curriculum and guidelines is not designed to drive innovation or creativity, since it merely pools existing knowledge and mindsets. This could be strengthened with a new wave of inquiry with quite new panels of participants and a focus on innovation. In some Delphi surveys conducted, the professional panel has comprised only MHFA instructors.^{6,7} In addition to including a new, carefully targeted range of mental health experts who are not affiliated with MHFA, valuable input could also be gained from a broader range of people with lived experience and other professional groups (eg, police and ambulance



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first responders) who may assist an individual in a mental health crisis but are not trained mental health clinicians. There could also be much greater inclusion of family and carers.⁸

In terms of the Delphi survey items, the first round of items have been developed based on a literature search, although some have also been based on focus groups, with items that achieve consensus informing the development of the MHFA content. The quality and strength of this evidence has not been reported. While participants can suggest new items, the Delphi approach used is unlikely to foster innovation or new ideas. Consensus methods are useful when there is insufficient or low quality evidence, however, given that the current MHFA content does not appear to be significantly benefiting the recipients of MHFA, a revised methodology may be indicated. This could involve new creative processes that elicit the expert perspectives of clinicians, people with a lived experience of crisis, mental ill health or mental illness and their families in order to derive new MHFA content. This could take the form of codesign workshops, focus groups or an innovation hub where a select group of individuals are brought together to develop creative solutions. This is distinct from the more passive survey process. In addition, innovation could be fostered through other methodologies to develop ‘minimal viable products’ (that is, the first, basic version of a product that is released and undergoes user feedback to determine if the product requires enhancement),⁹ and new components for further development. This could potentially strengthen the MHFA content and its relevance to MHFA recipients.

Second, it may be that the quality and effectiveness of the training itself could be improved. MHFA uses the train-the-trainer model, which might lead to a progressive dilution of the quality as it diffuses peripherally. While it is a potent method for scaling up, the train-the-trainer model could therefore fail to deliver sufficient competence in MHFA training, as it spreads from ‘mission control’. Providing MHFA instructors with stronger credentials, including more frequent and comprehensive refresher courses than currently provided, could possibly deliver a more standardised training programme, leading to improved outcomes for both MHFA recipients and trainees.

MHFA is a conceptual advance and a potentially valuable step in the pathway to care for mental ill health. The review and proposed suggestions are intended to offer constructive solutions that could potentially enhance the programme’s impact, particularly on MHFA recipients. Changing public attitudes,

knowledge and response to mental illness is clearly important. Yet, as evident from the data from the MHFA programme so far, the benefits gained in targeting these areas do not appear to flow sufficiently strongly to those who need assistance to support their mental health. There is great potential to strengthen the development and implementation of the MHFA programme to maximise its public health impact. Another way to achieve this would be to create stronger linkages between MHFA and clinical services, adopting pathways that exist in medical first aid to ensure that recipients of MHFA indeed receive appropriate services when they need them. In the context of the universal impact of the COVID-19 global pandemic on the mental health of the world’s population, a reinvented MHFA, drawing on the tradition of Psychological First Aid as deployed in disaster situations,³ could play a vital role in mitigating the damage.

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REFERENCES

- 1 Evans-Lacko S, Corker E, Williams P, *et al*. Effect of the time to change anti-stigma campaign on trends in mental-illness-related public stigma among the English population in 2003-13: an analysis of survey data. *Lancet Psychiatry* 2014;1:121–8.
- 2 Patel V, Saxena S, Lund C, *et al*. The Lancet Commission on global mental health and sustainable development. *Lancet* 2018;392:1553–98.
- 3 Drayer CS, Cameron DC, Woodward WD, *et al*. Psychological first aid in community disaster. *J Am Med Assoc* 1954;156:36–41.
- 4 Morgan AJ, Ross A, Reavley NJ. Systematic review and meta-analysis of mental health first aid training: effects on knowledge, stigma, and helping behaviour. *PLoS One* 2018;13:e0197102.
- 5 Maslowski AK, LaCaille RA, LaCaille LJ, *et al*. Effectiveness of mental health first aid: a meta-analysis. *MHRJ* 2019;24:245–61.
- 6 Fischer JA, Kelly CM, Kitchener BA, *et al*. Development of guidelines for adults on how to communicate with adolescents about mental health problems and other sensitive topics. *Sage Open* 2013;3:215824401351676.
- 7 Ross AM, Hart LM, Jorm AF, *et al*. Development of key messages for adolescents on providing basic mental health first aid to Peers: a Delphi consensus study. *Early Interv Psychiatry* 2012;6:229–38.
- 8 Jorm AF, Ross AM. Guidelines for the public on how to provide mental health first aid: narrative review. *BJPsych Open* 2018;4:427–40.
- 9 Ries E. *The lean startup*. New York: Crown Business, 2011.