indicates that the physical location of recovery colleges differs considerably[2,6]. Some are in the community (e.g., Calgary Recovery College, Canada), while others are within hospitals and mental health services (e.g., Butabika Recovery College, Uganda). New models are also emerging, such as online recovery colleges (e.g., https://lms.recoverycollegeonline.co.uk/). Given this variation, research comparing different funding and service delivery models is needed.

Current evidence indicates that recovery colleges are popular with students, and that college experience can be beneficial to recovery[6,7]. Furthermore, colleges can engage people who find existing services unappealing, and are associated with self-reported improvements in several domains, including self-esteem, self-understanding and self-confidence. Futhermore, students have reported a positive impact on occupational, social and service use outcomes.

Indeed, recovery colleges have the potential to equip students with new skills that can help their entry into the workforce[5,6], but there is little quantitative research examining specific impact on employment outcomes. Interestingly, a recent empirical study indicates that colleges may have beneficial impacts beyond the student, by positively affecting the attitudes of mental health staff, reducing stigma within health and social service systems, and increasing inclusiveness in wider society[9].

Research and evaluation examining recovery colleges is expanding, with ongoing studies in Canada, England and elsewhere. That said, most existing research has uncontrolled, single-case or retrospective designs. There is a lack of rigorous quantitative research and there has not been any randomized trial. Nonetheless, this situation is rapidly changing. A recent rigorous study used a controlled before-and-after design to analyze mental health service use in a large sample of recovery college students, finding that students had lower rates of service utilization after attending a college[8].

Similarly, a 39-college UK study developed and psychometrically validated recovery college implementation checklists and a fidelity scale (available at researchintorecovery.com/recollect) to assess modifiable and non-modifiable components[5]. This study confirmed that an educational approach and the use of co-production are foundational to recovery colleges. Importantly, most research has occurred in high-income anglophone countries such as the UK, US, Canada and Australia, indicating a need for further research elsewhere.

In summary, recovery colleges are a tangible manifestation of the international push to make the mental health system more recovery-oriented[1]. They are a pioneering intervention that enact much of the theory and evidence surrounding recovery. First, they can help students address functional and educational deficits that contribute to high rates of social exclusion. Second, they can equip students with self-care techniques, encouraging them to successfully manage their illness and take control of their life[2]. Third, they are based on an effective partnership between experts by experience (peers) and experts by training (clinicians)[3]. Hence, recovery colleges have the potential to foster individual student recovery, as well as catalyze wider service change and reduce societal stigma[6,9].

In conclusion, recovery colleges offer something very different from current pharmacological and psychological interventions. They have enthusiastic proponents, but rigorous evidence about their impact on outcomes is missing. In particular, randomized controlled trials are needed which evaluate their impact on social and functional outcomes, as much as clinical and service use outcomes.

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1. Slade M, Amering M, Farkas M et al. World Psychiatry 2014;13:12-20.
2. Perkins R, Meddings S, Williams S et al. Recovery colleges 10 years on. Nottingham: ImROC, 2018.
3. McGregor J, Repper J, Brown H. J Ment Health Training Educ Pract 2014; 9:3-15.
4. Gill K. Health Issues 2014;113:10-4.
5. Toney R, Knight J, Hamill K et al. Can J Psychiatry (in press).
6. Toney R, Elton D, Munday E et al. Psychiatr Serv 2018;69:1222-9.
7. Meddings S, McGregor J, Roeg W et al. Ment Health Soc Incl 2015;19:212-21.
8. Bourne P, Meddings S, Whittington A. J Ment Health 2018;27:359-66.
9. Crowther A, Taylor A, Toney R et al. Epidemiol Psychiatr Sci (in press).

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Mental Health First Aid training: lessons learned from the global spread of a community education program

Many health education interventions achieve limited dissemination, even when there is supporting evidence for their efficacy[1]. We think there are lessons to be learned for those aiming to disseminate such interventions from those rare examples where the dissemination has been successful. Here we describe the factors that appear to underlie the success of one such program: Mental Health First Aid (MHFA) training.

The MHFA training program conducts courses which teach members of the public how to provide mental health first aid, which has been defined as "the help offered to a person developing a mental health problem, experiencing a worsening of an existing mental health problem or in a mental health crisis; the first aid is given until appropriate professional help is received or until the crisis resolves"[2]. Participants are trained to: approach, assess and assist with any crisis; listen and communicate non-judgmentally; give support and information; encourage appropriate professional help; encourage other supports.

MHFA training began in Australia in 2000 as a collaboration between one volunteer with lived experience of mental illness (BAK) and a researcher (AFJ)[3]. From this small beginning, it spread rapidly in Australia and to other countries. By mid 2018, over 700,000 Australians had been trained and the program had spread to 25 other countries, with over 2.7 million people trained globally[4].

We believe that six factors underlie this successful dissemination.

The first is that MHFA training builds on the familiar First Aid model. Members of the public are familiar with the idea that they can help in a physical health emergency if professional help is not available, and many people have done a First Aid course. It is a natural extension to expand this concept to include mental health problems.

The second factor is that MHFA training fulfills a public need. Because the prevalence of mental disorders is so high, members of the public will frequently have contact with people who are affected[5]. Many people lack knowledge and confidence in how to help, which may motivate them to seek training.

The third factor is that the course has been tailored to meet different needs. In addition to the standard MHFA course for adults to assist other adults, courses in Australia have been tailored for specific age groups (e.g., adults helping youth, adults helping older people, teenagers helping their peers), professional roles (e.g., medical and nursing students, legal professionals) and cultural groups (e.g., indigenous people, people from non-English speaking background)[6]. When MHFA training is disseminated in other (mainly high-income) countries, there is tailoring to local languages, health systems and cultures, including for minority groups.

The fourth factor is that there is a strong partnership with research. The content of MHFA training has been based on expert consensus guidelines developed using Delphi studies[7]. The experts in these studies have been mental health professionals and people with lived experience. The guidelines have covered how to assist with a wide range of developing mental health problems and crises. The Delphi method has also been used to draw on cultural expertise in assisting people from special groups (e.g., indigenous Australians; refugees and immigrants; lesbian, gay, bisexual and transgender people).

The other area in which research has been important is evaluation of outcomes. From the very first MHFA courses taught, evaluation data were gathered and published[8]. These data have now expanded considerably, with 18 controlled trials in a range of countries. A systematic review and meta-analysis of these trials showed improvements in mental health first aid knowledge, recognition of mental disorders, beliefs about treatments, confidence in helping, intentions to help and amount of help actually provided[9]. MHFA training also leads to a reduction in stigma[9].

The fifth factor is that dissemination is devolved rather than centralized. In Australia, MHFA training is run by Mental Health First Aid International. This organization trains instructors but does not employ them. Rather, the instructors are employed by non-governmental organizations (NGOs), government agencies or private businesses. This devolution has allowed well-targeted local marketing by instructors. When MHFA training is disseminated in other countries, there is a partnership with a local organization, generally a mental health NGO or a government agency. Again, the decentralized dissemination facilitates roll-out by drawing on local knowledge in a way that a centralized model would not.

The sixth factor is that there is a sustainable funding model. In Australia, government and philanthropic grants have been used for development, initial dissemination and evaluation of new training products, but such grants are time limited and not a sustainable basis for ongoing funding. However, like First Aid, MHFA training is potentially sustainable by offering courses on a fee-for-service basis. A longer-term aim is for MHFA training to become accepted as a necessary qualification for certain human services roles, as is the case for physical First Aid training, which will facilitate sustainability.

In recent years, MHFA International has received many enquiries about local training from low- and middle-income countries. However, major health system and cultural differences between these countries and Australia, where the program originated, mean that the appropriateness of course content and implementation models in these settings is unknown. In general, evidence in low- and middle-income countries on how best to translate, adapt and scale-up population mental health interventions that have shown benefit in high-income countries is limited.

In 2017, in collaboration with investigators from China and Sri Lanka, we were awarded a Global Alliance for Chronic Diseases grant to develop and trial MHFA training for these countries. This project represents the first effort to formally adapt MHFA training to lower-resource countries. We have recently started a similar program of work in collaboration with researchers in Brazil, Chile and Argentina. These projects offer opportunities to identify and evaluate the most appropriate models for cultural adaptation and implementation of community-based education programs that aim to improve population health.

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1. Peters DH, Adam T, Alonge O et al. BMJ 2013;347:f6753.
2. Kitchener BA, Jorm AF, Kelly CM. Mental Health First Aid International manual. Melbourne: Mental Health First Aid International, 2015.
3. Jorm AF, Kitchener BA. Aust N Z J Psychiatry 2011;45:808-13.
4. Mental Health First Aid International. https://mhfa.com.au/.
5. Reavley NJ, Jorm AF. Aust N Z J Psychiatry 2015;49:906-13.
6. Mental Health First Aid International. https://mhfa.com.au/courses.
7. Jorm AF, Ross AM. BJPsych Open 2018;4:427-40.
8. Kitchener BA, Jorm AF. BMC Psychiatry 2002;2:10.
9. Morgan AJ, Ross A, Reavley NJ. PLoS One 2018;13:e0197102.

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