Submission to Senate Select Committee on Mental Health: The Need for Community-Wide Mental Health First Aid Training

Persons Making Submission
Professor Anthony Jorm (Professional Fellow) and Ms Betty Kitchener (Program Director, Mental Health First Aid)
ORYGEN Research Centre, University of Melbourne, Locked Bag 10, Parkville, Victoria 3052, Phone 0401449672.

Summary of Main Points

- Mental Health First Aid is a training program for members of the public in how to support someone in a mental health crisis situation or who is developing a mental disorder.
- The program has solid evidence for its effectiveness from randomized controlled trials and qualitative studies. It increases knowledge, reduces stigma and, most importantly, increases supportive actions. It even improves the mental health of first-aiders.
- Mental Health First Aid training can assist in early intervention and in the on-going community support of people with mental illnesses. It is useful for people employed in areas which involve increased contact with mental health issues and for carers of people with mental illnesses.
- The Mental Health First Aid approach is sustainable without long-term government funding, just like conventional first aid. It simply needs a kick-start from government.
- Australia needs a sizable cohort of instructors who can train a large number of people in Mental Health First Aid. Priority groups for training are people who are outside the mental health sector, but have an increased probability of contact with mental health issues. These groups include teachers, nurses, welfare workers and family carers.
- Mental Health First Aid training needs to become a prerequisite for practice in certain occupations which involved increased contact with people having mental health problems, such as teachers and police.

Relevance of the Submission to the Committee's Terms of Reference

Our submission is relevant to the following terms of reference:
b. the adequacy of various modes of care for people with a mental illness, in particular, prevention, early intervention, acute care, community care, after hours crisis services and respite care;
g. the role and adequacy of training and support for primary carers in treatment, recovery and support of people with a mental illness;
l. the adequacy of education in de-stigmatising mental illness and disorders and in providing support service information to people affected by mental illness and their families and carers;
m. the proficiency and accountability of agencies, such as housing, employment, law enforcement and general health services, in dealing appropriately with people affected by mental illness.

Overview of Mental Health First Aid Training

We wish to let the Committee know about Mental Health First Aid training and the role it can play in improving the community's response to people with mental health problems.

First aid training is widespread throughout the world to give members of the public skills to help an injured person before medical help arrives. However, first aid courses typically teach little or nothing about helping people with mental health issues. This is curious given how common these problems are. Most first-aiders would never get a chance to use their CPR skills, but they would have a good chance of having close contact with someone in a mental health crisis.

We have data from a national survey of Australian adults showing that many people lack adequate skills in supporting someone they know who has a mental health problem (Jorm et al., 2005). Because of the need for training in this area, we developed the world's first Mental Health First Aid course in Australia in 2000 (Kitchener & Jorm, 2002a). This is a 12-hour course that is usually run over 4 weekly sessions. At the end of the course, participants receive a Mental Health First Aid certificate.

The course can be taken by any member of the public. Most participants choose to do the course for one of three reasons: their work involves people contact, they have someone close who is affected by a mental health problem, or they see it as their duty as a citizen to learn first aid skills. We emphasize that the course is not therapy and that it is not a substitute for getting professional help. However, it is useful for people who may have experienced a mental health problem but are currently functioning reasonably well. We also emphasize to participants that the course does not qualify them to be a counsellor, just as a conventional first aid course does not qualify someone to be a doctor or a nurse. Its role is to promote first aid—the initial help that is given before professional help is sought.

Course Content

The course teaches the symptoms, causes and evidenced- based treatments for the common mental health problems of depression, anxiety disorders, psychosis and substance use disorder. It also addresses the possible crisis situations arising from these mental health problems and steps to help. The crisis situations include a person who is feeling suicidal; a person having a panic attack; a person who has had a recent traumatic experience; a person who is acutely psychotic and perceived to be threatening violence; and a person who has overdosed.

Although crises are dramatic consequences of mental health problems, it is better to intervene early before such crises develop. We therefore emphasize in the course the need for early intervention for mental disorders as they are developing.

Just as conventional first aid courses teach a series of steps under the acronym DRABC, we teach mental health first-aiders to use 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

For example, for a person who may be depressed, the first-aider will initially assess if the person is suicidal. Of course, this will not be an issue in all cases, but it is important that the first-aider knows how to enquire about suicidal thoughts and how to respond. If the person is not suicidal, the first-aider needs to listen actively and non-judgmentally before giving appropriate reassurance and information. Such reassurance may help the person to feel hope and optimism by realizing that: they have a real medical condition; depression is a common illness; depression is not a weakness or character defect; effective treatments are available for depression; appropriate and effective help is available from a GP and / or counsellor; depression is not laziness, rather it makes people motivationally challenged; depression takes a while to develop and sometimes takes a while to resolve, but will get better faster with the right help. The fourth step is to encourage the person to get appropriate professional help such as seeing a GP or a clinical psychologist and the final step is to encourage the person to use some evidenced-based self-help treatments such as exercise, light therapy and St John's Wort.

Mental Health First Aid Materials

To give participants information that they can take away from the course, we have developed a Mental Health First Aid manual (Kitchener & Jorm, 2002b). The manual gives information about the major types of mental disorders, the best types of help available, local resources, and how to apply the steps of Mental Health First Aid to various situations.

There is also a Mental Health First Aid web site (http://www.mhfa.com.au/) which is very easy to navigate. Basic mental health first aid information is available, along with information about the 12-hr Mental Health First Aid course and the 5-day Mental Health First Aid Instructor Training Course. Instructors are able to advertise the courses they are conducting. The Mental Health First Aid Manual is available to be downloaded freely as a PDF file.

Instructor Training

Because the Instructor Training Course is only 5 days long, successful applicants need to meet the following criteria: substantial knowledge about mental health problems and treatments, good teaching skills and "fire in the belly" to improve the mental health literacy of the community and to reduce the stigma surrounding mental illness. We have now trained over 200 instructors in Australia, covering all states and territories. The interest in training as an instructor has been strongest in rural areas, both because of the shortage of mental health services in these areas and the greater concern to support others in the local community. Instructors usually work through an NGO (e.g. Lifeline, Red Cross, Anglicare), a state area health service, a large employer (e.g. a university, government department), or work as fee-for-service private practitioners.

Evidence That it Works

A factor that really sets Mental Health First Aid apart from other educational approaches is the rigorous evaluation of its effectiveness. This began with an uncontrolled trial with 210 participants who were given questionnaires at the beginning of the course, at the end, and 6 months later. The course was found to produce a number of benefits, such as improved knowledge of mental health problems, a decrease in stigmatizing attitudes, increased confidence in providing help to others, and an increase in the amount of help actually provided (Kitchener & Jorm, 2002a).

A problem with this evaluation was, of course, that there was no control group. So we next did a randomized controlled trial with a wait-list control group (Kitchener & Jorm, 2004). This was done in a workplace setting with 301 public servants. The results were similar to the earlier uncontrolled trial, but one surprising additional finding is that the course had a mental health benefit to participants. This effect was unexpected because the course does not provide therapy and promises no personal benefits. Also, participants are not recruited because of their own mental health problems; however, we found that the people in the trial tended to have somewhat worse mental health than the general population. We think the course may have improved mental health by providing participants with good quality information which allows them to make better choices about their own mental health care.

While this randomized control trial provided stronger evidence that the course is effective, the teaching was all done by Betty Kitchener who is the originator of the course. Perhaps she was an exceptional teacher who could inspire participants. We next wanted to find out if other instructors could achieve similar changes. We therefore conducted a second randomized controlled trial in a large rural area of Australia, using staff from the local health services as the instructors (Jorm et al., 2004). The results of this study were similar to the earlier trial, confirming that the benefits of the course were present with other instructors.

As another approach to evaluation, we have also collected systematically stories from people who have used the skills learnt from a mental health first aid course. We have found that most participants actually use their skills to help someone and that there are usually positive effects. Importantly, we have found no evidence of negative effects, for example through the first-aider being over-confident and taking on more than they should.

Mental Health First Aid in Other Countries

Mental Health First Aid has been adopted by the Scottish government as a national approach to suicide prevention. In September 2004, six Trainers of Instructors were established and plans are presently underway to begin training about 150 instructors, with a national launch in April 2005. The Scottish government aims to have 6% of the adult population trained in Mental Health First Aid by 2010.

Mental Health First Aid has also taken root in a number of other countries. In early 2004, an Instructor Training Course was conducted in Hong Kong and also in the state of New York in the USA. These international Mental Health First Aid Instructors are presently modifying the course to be sensitive to their local society and culture. Some instructors from Scotland have already conducted the 12-hr course in Ireland where there is now interest in the Instructor Training Course. In Finland, the Finnish Association of Mental Health is currently translating the manual.

Mental Health First Aid for Culturally and Linguistically Diverse Australians

The Mental Health First Aid program has core elements that translate across various cultural groups. However, there is always a need for some cultural modification. In Australia, we have developed the course to suit the mainstream of society, but we recognize this is not suitable for cultural minority groups. Versions of the course are currently being developed for Aboriginal Australians and have recently been developed for a number of groups with non-English speaking backgrounds, including Vietnamese, Croatian and Italian. Instructors have been trained from each of these communities.

Mental Health First Aid for Supporters of Youth

The most critical time for early intervention is when people are first developing a mental disorder. Often this occurs during adolescence and early adulthood. To cover this crucial period of life adequately, we are planning to develop a Youth Mental Health First Aid which is aimed at teachers and other adults who have frequent contact with young people. It will emphasize the mental disorders and the crisis situations that are most common in this age group.

The Need for National Standards for Mental Health First Aid

Another direction is to develop standards for Mental Health First Aid. Just as there are national standards for conventional first aid, we need to develop standards for how best to help someone in a mental health crisis situation or who is developing a mental disorder. We plan to develop these standards using international panels of clinicians, service users and carers who have expertise in the relevant area. When the standards are developed, this will facilitate getting national accreditation of courses. Our ultimate aim is that a Mental Health First Aid certificate a prerequisite for certain professions such as teachers, police and nurses.

Our Recommendations to the Committee

1. Scotland has set a target of 6% of the adult population to be trained in Mental Health First Aid. We think Australia, which originated the program, could boost its activity in this area. What it needs is government support to train a national cohort of instructors. Once these are trained, the program can be self-supporting just like conventional first aid courses. For example, to train 100 additional instructors and to provide seeding support for them would cost around $400,000. These instructors would then train people who are outside the mental health sector, but have an increased probability of contact with mental health issues. These groups include teachers, nurses, welfare workers and family carers.
2. Conventional first aid certificates are required for certain professions, such as child care workers. We believe the same approach needs to be taken with professions that involve increased contact with people with mental health problems, such as teachers and police. Mental Health First Aid training should be seen as a prerequisite for practice in these professions.

References

Jorm, A.F., Blewitt, K.A., Griffiths, K.M., Kitchener, B.A. and Parslow, R.A. (2005). Mental health first aid responses of the public: Results from an Australian national survey. *BMC Psychiatry*, 5: 9.

Jorm AF, Kitchener BA, O'Kearney R and Dear KBG (2004) Mental health first aid training of the public in a rural area: a cluster randomized trial [ISRCTN53887541]. *BMC Psychiatry*, 4: 33.

Kitchener BA and Jorm AF (2002a) Mental health first aid training for the public: evaluation of effects on knowledge, attitudes and helping behavior. *BMC Psychiatry*, 2: 10.

Kitchener BA and Jorm AF (2002b) *Mental Health First Aid Manual*. Canberra: Centre for Mental Health Research.

Kitchener BA and Jorm AF (2004) Mental health first aid training in a workplace setting: A randomized controlled trial [ISRCTN13249129]. *BMC Psychiatry*, 4: 23