Submission to Senate Committee on Commonwealth Funding and Administration of Mental Health Services

The Need for All People Working in Human Services to Receive Mental Health First Aid Training

Persons Making Submission
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Summary of Main Points

- Mental Health First Aid is a training program for members of the public in how to support someone who is developing a mental illness or in a mental health crisis situation. Specialty versions of the course have been developed for how to given mental health first aid to adolescents, Aboriginal and Torres Strait Islander people, CALD people, and people with an intellectual disability.
- 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.
- The program was developed in Australia in 2001 and has spread to many other countries. Currently over 170,000 Australians (1% of the adult population) have done the training. It is feasible to greatly expand this number so that the community as a whole can take a greater role in supporting people with a mental illness.
- A first aid certificate is required for practice in certain occupations. Similarly, a Mental Health First Aid certificate needs to become a prerequisite for practice in occupations which involved increased contact with people having mental health problems, such as nursing, medicine, teaching, social work, welfare studies, youth work, Aboriginal health work, pharmacy, occupational therapy, physiotherapy, speech pathology and prosthetics.
- Making a Mental Health First Aid course part of the basic training of these human service professionals would greatly extend the nation's capacity to support people with mental illnesses.

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

Our submission is relevant to the following terms of reference:

(e) mental health workforce issues, including:
    (iii) workforce shortages;
(f) the adequacy of mental health funding and services for disadvantaged groups, including:
    (i) culturally and linguistically diverse communities,
    (ii) Indigenous communities, and
    (iii) people with disabilities;
    (j) any other related matter.

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 capacity to support 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 several national surveys of Australians showing that many people lack adequate skills in supporting someone they know who has a mental health problem. Because of the need for training in this area, we developed the world's first Mental Health First Aid course in Australia in 2001. This is a 12-hour course that is usually run over 4 weekly 3-hour sessions. At the end of the course, participants receive a Mental Health First Aid Certificate of Completion.

The course can be taken by any adult 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.

Course Content

The course teaches the symptoms, risk factors and evidence-based treatments for the common mental health problems of depression, anxiety, and substance misuse, and also the low prevalence illness of psychosis. It also addresses the possible crisis situations arising from these mental health problems and actions to help. The crisis situations include: a person who is feeling suicidal or is self-injuring; a person having a panic attack; a person who has had a recent traumatic experience; a person who is acutely psychotic, a person who is aggressive; and a person who has severe effects from alcohol or drug use.

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 health problems as they are developing.

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

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. The manual gives information about the major types of mental illnesses, the best types of help available, local resources, and how to apply the actions of Mental Health First Aid to various situations. The manual is based on extensive research which we have carried out to develop international mental health first aid guidelines. The guidelines are available from the Mental Health First Aid website (http://www.mhfa.com.au/) and the NHMRC Clinical Practice Guidelines Portal.

Specialized Versions of the Course
Youth. The most critical time for early intervention is when people are first developing a mental illness. Often this occurs during adolescence. To cover this crucial period of life adequately, we offer a Youth Mental Health First Aid which is aimed at adults who have frequent contact with young people.
Aboriginal and Torres Strait Islander peoples. There is an Aboriginal and Torres Strait Islander Mental Health First Aid course. This course is designed to be delivered and received by Aboriginal and Torres Strait Islander people. The course content is based on an extensive program of research to develop mental health first aid guidelines using the consensus of indigenous mental health workers. The course has been rolled out across Australia and evaluated.
CALD peoples. There is a version of Mental Health First Aid for Vietnamese Australians, which is delivered by Vietnamese-speaking instructors. A version for Chinese Australians is currently being developed.
People with an intellectual disability. The Mental Health First Aid course has been adapted by staff of the NSW Department of Human Services Ageing Disability and Homecare for helping people with an intellectual disability

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. There are currently over 900 instructors in Australia, covering all states and territories, and including Indigenous and CALD instructors. The interest in training as an instructor has been strong 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 Mental Health First Aid Training Works
A factor that really sets Mental Health First Aid apart from other educational approaches is the rigorous evaluation of its effectiveness. Despite being only a decade old, it has a much stronger evidence base than conventional first aid training. There have been 5 controlled trials, 9 uncontrolled trials and several qualitative studies. These include evaluations of the specialty Youth, Aboriginal and Torres Strait Islander and two CALD Mental Health First Aid programs. All these studies are summarized in an editorial for the *Australian and New Zealand Journal of*

Psychiatry (in press) which is reproduced at the end of this submission. These studies show that people who do the course have:

- increased knowledge of how to provide mental health first aid,
- more positive attitudes towards appropriate treatments,
- reduced stigma,
- more confidence in providing support, and
- more supportive behaviours towards others.

These benefits are still evident half a year after completing the training.

Awards for Excellence

The program has been acknowledged for excellence through many awards, including the following:

- Mental Health Services Achievement Award (First Prize) from the Mental Health Services (TheMS) Conference of Australia and New Zealand, 2003
- Victorian Public Health Award for Innovation, 2006
- LIFE Healthy Communities Award from Suicide Prevention Australia, 2007
- Gold Achievement Award from the Mental Health Services (TheMS) Conference of Australia and New Zealand, 2007
- Excellence in Mental Health Education Award, U.S. National Council for Community Behavioral Healthcare, 2008
- Australian Rotary Health Knowledge Dissemination Award, Australasian Society for Psychiatric Research, 2010.

Spread of Mental Health First Aid

Mental Health First Aid training has now been received by over 170,000 Australians, which is 1% of the adult population. It has also spread to the following other countries: Canada, China, England, Finland, Hong Kong, Japan, Nepal, New Zealand, Northern Ireland, Scotland, Singapore, South Africa, Sweden, USA and Wales.

The Need for Greater Spread of Mental Health First Aid Training in the Community

Our view is that the whole community needs skills to assist people affected by mental illnesses. These skills should not be the sole province of mental health professionals. The reasons are:

- *Mental health problems are common*. In Australia, almost one in two adults have experienced a mental illness at some time and, during the past year, approximately one in five will have been affected. Throughout the course of a person's life, it is highly likely that an individual will either develop a mental health problem themselves or have close contact with someone who does.
- *People are not well informed* about how to recognize mental health problems, how to respond to the person, and what effective treatments are available. Lack of knowledge may result in people avoiding or not responding to someone with a mental health problem, or avoiding professional help for themselves. With greater community knowledge about mental health problems, people will be able to recognize problems in others and be better prepared to offer support.
- *Many people with a mental health problem do not seek or delay seeking professional help*. In Australia, only 35% of the people who had a mental illness in the past year received professional help for their problem. Even when people seek treatment, many

wait for years before doing so. The longer people delay getting help and support, the more difficult their recovery can be. People with mental health problems are more likely to seek help if someone close to them suggests it.

- *Professional help is not always available* when a mental health problem first arises. In such circumstances, members of the public can offer immediate first aid and assist the person to get appropriate professional help and supports.
- *There is stigma and discrimination associated with mental health problems*. This stigma leads people not to discuss mental health problems with family and friends, and not to seek professional help. It can lead to people being excluded from employment, housing, social activities and having relationships. Mental Health First Aid training has been found to reduce stigma.

In Australia, 1% of adults have done Mental Health First Aid training, compared to 11% who have done conventional first aid training in the previous 3 years. It is feasible that the spread of Mental Health First Aid training could eventually match that of conventional first aid training.

The Need for Mental Health First Aid Training for Human Service Occupations

While mental health first aid skills need to be widespread throughout the community, these are particularly needed by people who work in human service occupations. People who work in these occupations are not mental health specialists, but have a higher probability of contact with people affected by mental illness. They all need some basic skills in how to be supportive and non-stigmatizing in their interactions. The occupations that need such skills include: nursing, medicine, teaching, social work, welfare studies, youth work, Aboriginal health work, pharmacy, occupational therapy, physiotherapy, speech pathology, and prosthetics.

We believe that these skills are best acquired while human service professionals are receiving their basic tertiary training. This will maximize the benefits across their working life. A secondary advantage of training tertiary students is that they are themselves at a high-risk age. Through Mental Health First Aid training, they are learning how to help themselves and their peers, as well as their future clients.

A number of tertiary institutions have already taken the initiative of providing Mental Health First Aid training as part of certain degree and diploma courses. These are listed in Appendix A below. However, there is considerable scope to extend these initiatives.

Our Recommendations to the Committee

1. We would like to see Australia set national targets for Mental Health First Aid training of the population. Currently, 1% of Australian adults have been trained in around a decade. A feasible target is 3% by 2021.
2. Conventional first aid training is now a requirement for certain occupations (e.g. child care workers). We believe that Mental Health First Aid training should become a requirement for all occupations involving human services.
3. We propose that the government accelerate this process by offering grants to higher education institutions for Mental Health First Aid training of human services students. The grants would have the following elements:
   (a) Set up Mental Health First Aid training for tertiary human service courses that currently do not have it.
   (b) Tertiary courses that already offer training could be funded to train additional instructors or to carry out evaluation activities.

(c) The funding should be time-limited and require a plan for the sustainability of Mental Health First Aid training in the tertiary course.

Appendix A:

MHFA Training Currently Offered to Australian Human Service Students

Nursing

NSW: Newcastle University, University of Notre Dame (Sydney campus), Sydney University,
VIC: GippsTAFE (Warragul campus),
SA: Flinders University

Medicine

NSW: Australian National University
VIC: Monash University

Master of Counselling

WA: Curtin University

Rural Health / Allied Health

NSW: Charles Sturt University (Albury campus)
ACT: University of Canberra, Australian National University

Youth Studies / Disabilities

VIC: Victoria University, Wodonga TAFE

Education

VIC: Victoria University

Aboriginal Health Workers

NSW: Charles Sturt University (Wagga campus)

Pharmacy

NSW: Australian National University, Sydney University
VIC: Monash University (Parkville)

Physiotherapy

ACT: University of Canberra

Occupational Therapy

NSW: Sydney University (on placement), Newcastle University (on placement)

Community Services

South Western Sydney Institute (TAFE) Granville campus

Residential Students & Student leaders

NSW: Charles Sturt University (Bathurst & Wagga campuses)
ACT: Australian National University
VIC: Victoria University, Latrobe University (Bendigo campus), Monash University
SA: Flinders University
QLD: Griffith University

All students

NSW: Newcastle University
VIC: Monash University, across 5 campuses, RMIT, Melbourne
WA: University of Western Australia

Noting a landmark achievement: Mental Health First Aid training reaches 1% of Australian adults

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Editorial in press with *Australian and New Zealand Journal of Psychiatry*.

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Introduction

Mental Health First Aid is a training course for members of the public in how to assist someone developing a mental illness or in a mental health crisis situation (e.g. the person is suicidal or has had a traumatic experience). This first aid is given until the person receives professional help or until the crisis resolves. The course teaches how to give mental health first aid using the Action Plan shown in Table 1.

MHFA began in Australia in 2001 with one part-time volunteer instructor (Kitchener) working in partnership with a researcher (Jorm). From this small beginning, it has expanded rapidly, so that in 2011 there are over 850 instructors in Australia who have trained over 170,000 adults. This is 1% of the adult population. Furthermore, the program has spread internationally starting with Scotland in 2004. Since then, it has spread to Canada, China, England, Finland, Hong Kong, Japan, Nepal, New Zealand, Northern Ireland, Singapore, South Africa, Sweden, USA and Wales.

This rapid expansion far exceeded our expectation as the developers. Here we discuss some of the factors that have contributed to this remarkable growth.

MHFA builds on the familiar first aid model

An important factor in the uptake of MHFA is that it builds on a familiar concept. First aid training dates back to the 19th century in English-speaking countries and is now widely available internationally. In Australia, for example, 11% of adults have done first aid training in the previous 3 years [1]. First aid training is seen not only as required for professional practice in certain fields such as child care, but also as part of a citizen's responsibility to care for other members of their community. By using the first aid model, MHFA links to an existing social concept of early lay assistance and is readily understood and accepted by the public. This model is accepted for medical emergencies, but has not been traditionally associated with mental illnesses.

MHFA fulfils a public need

National surveys have shown that mental illnesses are very common [2-3], so that it is inevitable that members of the public will often have contact with people who are affected. Furthermore, many people with mental illnesses either do not get professional help or they delay getting professional help [4]. In such cases, the person's social network can play a role in facilitating professional help-seeking [5-7].

While contact with people affected by mental illnesses may be common, members of the public often lack mental heath first aid knowledge and do not feel confident in providing assistance. For example, national surveys of mental health literacy in Australian adults and youth have found that many people believe it would be harmful to ask a person about suicidal feelings, and there are substantial minorities who would not encourage professional help [7-9]. Similarly, prior to receiving MHFA training, many people report that they are not confident about assisting someone with a mental health problem [10,11], and this may be a factor motivating their attendance.

Despite the obvious need, traditional first aid courses have ignored mental illness, creating a gap that MHFA has been able to fill.

The course has been tailored to meet different needs

The MHFA Program began with delivering a standard face-to-face MHFA course (currently 12 hours), written to be applicable to a broad range of people [12]. However, it soon became apparent that tailoring became needed for specific cultural, age and special needs groups. Versions of the MHFA course have now been developed for Aboriginal and Torres Strait Islander peoples [13] and Vietnamese Australians [14], and a course for Chinese Australians is near completion. All these courses are taught by MHFA instructors from the relevant cultural group.

Because mental illnesses often have their first onset during adolescence, a Youth MHFA course has been developed for adults to assist adolescents [15]. This 14-hour course focuses on mental illnesses as they present during adolescence and has additional training on adolescent development and communication.

An adaptation has also been produced to provide MHFA to people with an intellectual disability, with additional content on how mental illnesses may appear and how appropriate assistance may be given to people with an intellectual disability [16]. Another adaptation for people with special needs is the captioning of filmclips used in MHFA courses to be suitable for those with hearing impairment.

While maintaining fidelity to the course curriculum, MHFA instructors can also enhance the relevance of the training to various audiences by adapting the activities and examples used during the course. This has been done for specific occupation groups (e.g. teachers, police, court staff) and for particular geographical areas (e.g. farming communities).

Similarly, as the course has been taken up by other countries, the MHFA teaching materials have been adapted to the culture and mental healthcare system of the adopting country. This tailoring to various national needs has contributed to the acceptability of the MHFA Program in diverse countries.

There is a strong partnership with research

Research findings have been very influential in the international spread of MHFA, with many countries first learning of the program through research publications. From the very first courses

taught, evaluation data were collected on the effects of MHFA training. The first evaluation study was published in 2002 and was followed by a succession of others. To date, there have been 5 controlled trials, 9 uncontrolled trials and 3 qualitative studies, as summarized in Table 2. While the initial evaluations were carried out by the originators of the program, there are now many independent evaluations from Australia and other countries. There are a number of consistent findings that have emerged across these studies. Participants show increased knowledge of how to provide mental health first aid, their attitudes towards appropriate treatments become more positive, stigma reduces, they become more confident in providing support, and they report more supportive behaviours towards others. These benefits are still evident half a year after completing the training.

Research has also been important in guiding the contents of the training. Again, conventional first aid training has been a model to follow. International guidelines have been developed about how to give resuscitation and other first aid techniques, based on systematic reviews of the literature and expert consensus [33]. These guidelines provide the content that is taught in first aid courses. Similarly, there is a need for mental health first aid guidelines that provide the content for MHFA training. To fill this need, a series of Delphi expert consensus studies has been carried out using panels of professionals, consumer advocates and carer advocates. Guidelines have been produced covering a range of developing mental illnesses and mental health crisis situations [34-44] and are publicly available from the MHFA website (www.mhfa.com.au) and the National Health and Medical Research Council (NHMRC) Clinical Practice Guidelines Portal (www.clinicalguidelines.gov.au). These guidelines have formed the basis of the second edition MHFA manuals and curriculum content [12,13,15,16].

This commitment to evidence-based content and evaluation of outcomes in controlled trials has enhanced the perception of the training program within the mental health sector and has resulted in numerous Australian and international awards.

There are procedures for quality control

It is important for the reputation of the MHFA program that there are procedures for quality control. A range of procedures have been implemented to protect the quality of the training delivered. These include rigorous selection, training and assessment of candidate instructors; well documented teaching materials; annual requirements for number of courses taught by each instructor to maintain accreditation; standardized feedback questionnaires from course participants; and continuous updating of instructors through newsletters, website and annual instructor conferences. Similar procedures have been adopted by the overseas MHFA organizations.

There is a sustainable funding model

In Australia, MHFA has received a number of start-up grants from governments to launch into new areas, such as Youth MHFA, Aboriginal and Torres Strait Islander MHFA and e-learning MHFA. However, it receives no on-going government funding. Like conventional first aid training, it is primarily funded on a fee-for-service basis, either from training instructors or running courses. A UK report has cited MHFA as an example of 'radical efficiency' in provision of public services, because it delivers services in an innovative way at a lower cost and with better outcomes than a government controlled service could [45].

In other countries, there have been a variety of models, with MHFA either run through non-government organizations or through government agencies. However, all rely on income from

running courses. In this regard, the conventional first aid model of funding, which is known to be sustainable, has been very influential.

The future

While growing from 0 to 1% of the adult Australian population over a decade is a notable milestone, it is likely to be only the beginning. In 2006, the Australian Senate's Select Committee on Mental Health recommended that MHFA programs aim for 6% of the population to be trained and accredited, "targeting those with the greatest probability of coming in contact with mental health issues – teachers, police, welfare workers and family carers" [46]. Even this goal might be modest. If 11% of Australian adults have done conventional first aid training in the previous 3 years [1], it is feasible to equal this with MHFA training. To do so would require that, like conventional first aid, MHFA certification becomes a requirement of certain occupations and roles, and that periodic refresher courses are required to stay current.
In this way, it will be possible to spread the skills to assist people affected by mental illness beyond health professionals to the whole community, encouraging earlier recognition and treatment, reduced stigma and enhanced social support.

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Table 1. The mental health first aid action plan

1. Approach the person, assess and assist with any crisis
2. Listen non-judgmentally
3. Give support and information
4. Encourage the person to get appropriate professional help
5. Encourage other supports

Table 2. Summary of studies that have evaluated MHFA training

Authors and reference	**Version of MHFA**	**Study design**	**Country**	**Sample**	**Main findings**
Kitchener & Jorm. [17]	Standard	RCT with wait-list control	Australia	Public servants (n=301)	• Beliefs about treatment became more like professionals' • Decreased social distance • Increased confidence in providing help • Increased advice to others to seek professional help • Improved personal mental health
Jorm et al. [18]	Standard	Cluster RCT with wait-list control	Australia	Public in a rural area (n=753)	• Improved recognition of disorders • Beliefs about treatment became more like professionals' • Decreased social distance • Increased confidence in providing help • Increased help provided to others
Jorm et al. [19]	Modified Youth	Cluster RCT with wait-list control	Australia	High school teachers (n=327) in 14 schools	• Improved mental health first aid knowledge • Beliefs about treatment became more like professionals' • Increased confidence in providing help • Reduction in some aspects of stigma • Provided more mental health information to students • No change in teachers' individual support for students
Jorm et al. [20]	e-learning	RCT with printed manual and wait-list controls	Australia	Public (n=262)	• Improved recognition of schizophrenia • Beliefs about depression treatment became more like professionals' • Increased confidence in providing help • Reduction in stigma • Increased help provided to others

O'Reilly et al. [21]	Standard	Controlled trial with untrained controls	Australia	Pharmacy students (n=223)	• Improved recognition of disorders • Beliefs about treatment became more like professionals' • Decreased social distance • Increased confidence in providing services to consumers with a mental illness
Kitchener & Jorm [10]	Standard	Uncontrolled trial with pre, post and follow-up measures	Australia	Public (n=210)	• Improved recognition of disorders • Beliefs about treatment became more like professionals' • Decreased social distance • Increased confidence in providing help • Increased help provided to others
Kelly et al [11]	Youth	Uncontrolled trial with pre, post and follow-up measures	Australia	Public (n=246)	• Improved recognition of schizophrenia • Improved mental health first aid knowledge • Increased confidence in providing help • Reduction in stigma • Increased help provided to young people
Lam et al. [22]	Standard	Uncontrolled trial with pre and post measures	Australia	Chinese-speaking public (n=108)	• Improved recognition of disorders • Beliefs about treatment became more like professionals' • Decreased social distance
Minas et al. [23	Standard	Uncontrolled trial with pre and post measures	Australia	Vietnamese-speaking public (n=114)	• Improved recognition of disorders • Improved mental health first aid knowledge • Reduction in some aspects of stigma
Pierce et al. [24]	Standard	Uncontrolled trial with pre and post measures supplemented with qualitative	Australia	Rural football club leaders trained in MHFA (n=36) and club players not trained	• Improved recognition of disorders • Increased confidence in providing help • Project perceived as valuable by stakeholders • Little indirect benefit to club players who were not trained

		focus groups		(n=275)	
Hossain et al [25,26]	Standard	Uncontrolled trial with pre and follow-up measures and supplementary qualitative data	Australia	Rural advisory and extension agents (n=32)	• Improved recognition of disorders • Increased confidence in providing help • More positive beliefs about treatment • Decreased social distance • Course seen by stakeholders as beneficial
Sartore et al [27]	Standard	Uncontrolled trial with pre and post measures	Australia	Rural support workers and community volunteers (n=99)	• Improved ability to identify high-prevalence disorders • Increased endorsement of evidence-based interventions • Increased confidence in providing help
Stevenson and Elvy [28]	Standard Scottish	Uncontrolled trial with pre, post and follow-up measures and supplementary qualitative data	Scotland	Public (n=306 at post-test and n=223 at follow-up)	• Improved recognition of schizophrenia • Improved mental health first aid knowledge • Increased confidence in providing help • Reduction in some aspects of stigma • Increased optimism about recovery • Increased help provided to others
Brandling & McKenna [29]	Standard English	Uncontrolled trial with pre and post measures	England	Managers working in the public sector (n=55)	• Improved mental health first aid knowledge • Increased confidence in providing help • More positive attitudes to helping people with mental health problems • Participants were very positive about the training
Jorm et al [30]	Standard	Qualitative analysis of participant stories about applying first aid	Australia	Public in a rural area (n=94)	• Most participants used what they had learned to help someone • Empathy, confidence and ability to handle crises increased • The course met the needs of a wide range of people • Participants did not over-reach themselves through over-confidence

					• Participants found the course useful and wanted to see it repeated and extended
Kanowski et al [31]	Aboriginal	Qualitative study using focus groups and quantitative data on course uptake	Australia	Aboriginal instructors (n=34) and course participants (n=22)	• Course is seen as culturally appropriate and empowering • Course is seen as providing information that is relevant and important • Course is being taken by many Aboriginal people
Terry et al [32]	Standard Welsh	Qualitative study using semi-structured interviews	Wales	Instructors (n=14)	• Instructors believed there needs to be clear infrastructure to train, support and monitor those delivering courses

Note: RCT = randomized controlled trial