



**Mental Health
Commission
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**Commission de
la santé mentale
du Canada**

Mental Health First Aid: An Evidence Review

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August 2012

Literature Search:

A keyword search on “mental health first aid” was performed in the MEDLINE, PsycINFO and EMBASE databases on July 6, 2012. Mental Health First Aid web sites from various countries were also examined for relevant grey literature. A total of 45 articles and evaluation studies were reviewed for evidence regarding the effectiveness of mental health first aid (MHFA).

Background on MHFA Canada

MHFA was brought to Canada from Australia in 2006 by the Alberta Mental Health Board. At that time, the course was reviewed by experts in the mental health field and adapted for the Canadian population, incorporating Canadian statistics and ensuring the material was culturally relevant for Canadians. In 2010, the program was transferred to the Mental Health Commission of Canada. Australia and Canada share many cultural and demographic similarities, and the core action plan and the teaching structure used in both countries courses remain the same. This leads to strong fidelity of the Canadian program, with content and structure following closely to the Australian version. Because of this, results of evaluations about the Australian course are able to be generalized to the Canadian population well.

General Evidence Regarding the Effectiveness of MHFA

Most of the strongest evidence for the effectiveness of MHFA comes from Australia, where the program was pioneered. Several randomized controlled trials have been conducted there. A randomized controlled trial of a “typical” MHFA implementation in a rural area of Australia found that the group that received MHFA training had “significantly greater recognition of the disorders, increased agreement with health professionals about which interventions are likely to be helpful, decreased social distance, increased confidence in providing help to others, and an increase in help actually provided”(1). However, the course did not lead to an increase in the number of people with mental health problems that trainees has contact with, or to an increase in the percentage advising someone to seek professional help.

A review of MHFA evaluation studies in Australia found that “most mental health first-aiders tend to be middle-aged women whose work involves people contact”(2). The review also found that all three studies identify the following statistically significant benefits 5-6 months post-training: improved agreement with health professionals about treatment; improved helping behaviour; more confidence in providing help; and decreased social distance from people with mental disorders. It may not always be feasible or cost-effective to offer MHFA training in person, and e-learning options may be considered. One trial of an e-learning intervention concluded that it was more effective than a print resource alone(3).

Evidence Around Workforce and Occupational Groups

The very first randomized controlled trial of MHFA was carried out in a workplace setting, in two government departments in Canberra, Australia. Benefits identified by the trial included “greater confidence in providing help to others, greater likelihood of advising people to seek professional help, improved concordance with health professionals about treatments, and decreased stigmatizing attitudes. An additional unexpected but exciting finding was an improvement in the mental health of the participants themselves”(4).

Since then, MHFA has been evaluated with other occupational groups. In England, Brandling and McKenna undertook an evaluation of MHFA for front-line managers in the public sector. They studied 55 front-line managers, and used both quantitative and qualitative methods. On all quantitative measures, the investigators found significant positive results. Participants demonstrated increased knowledge and confidence and an improvement in their perceptions of mental health issues. The semi-structured interviews with participants generated overwhelmingly enthusiastic feedback about the course content(5).

Evidence for the Effectiveness of MHFA in Rural Settings

In Australia, a MHFA training was offered to a group of 32 Advisory and Extension Agents (AEAs) from various government departments; these agents have extensive front-line contact with rural workers. Skills pre-training and six months post-training were compared. Post-training, AEAs showed enhanced mental health knowledge, a greater willingness to work with people who have mental health problems, and an improved ability to refer people appropriately for help.

Evidence around the Effectiveness of MHFA for Youth Populations and Those Who Work with Them

In 2007, the Youth Mental Health First Aid program was launched in Australia. It was a modification of the original MHFA program for adults who work with or care for adolescents. The program focuses on helping adults to recognize the signs of mental illness or mental health crisis, and to assist adolescents in getting help as soon as possible. An uncontrolled trial of this program found improvements in knowledge of adolescent mental health issues; recognition of schizophrenia; confidence in offering help; stigmatizing attitudes; confidence in offering help; and application of the Mental Health First Aid action plan(6). Most of these results were maintained at the six-month follow-up.

A randomized controlled trial of MHFA for high-school teachers in Australia found that the intervention increased teachers’ knowledge about mental health problems and their treatment, reduced some aspects of stigma, and gave teachers more confidence about helping students or fellow teachers. Indirect effects on students in these teachers’ schools were also measured, and the students reported receiving more mental health information from school staff(7).

In 2007, MHFA training in Canada was undertaken with 92 justice staff at the Manitoba Youth Centre (a youth correctional facility). Of the 92 staff who received Mental Health First Aid training, 74 responded to a feedback survey, and indicated that they felt such training was needed and beneficial to their work with youth in crisis(8). Clark’s evaluation found that post-training, staff were better able to recognize mental health problems in their clients, and more familiar with treatments. Participants indicated that the training had given them a better understanding of stigma and felt more confident of their own ability to help someone experiencing a mental health problem.

Evidence around the Effectiveness of Adaptations of MHFA for Specific Cultural Groups

A question of particular importance is whether mental health first aid is effective for all cultural groups, as different groups may have different beliefs about mental health, and different historical experiences that affect the mental health of the community.

Aboriginal populations have been a particular focus of study, both in Canada and Australia. In Canada, the Alberta Mental Health Board piloted the delivery of MHFA to 25 First Nations groups in 2008 and 2009, and evaluated the program using both quantitative and qualitative instruments(9). They found that, similar to other groups studied, First Nations participants demonstrated improved knowledge of mental health, and increased confidence about helping others. They were slightly less likely than other groups to view the ALGEE action plan (Assess, Listen, Give reassurance and information, Encourage appropriate professional help, Encourage self-help) as a strength. First Nations graduates show lower levels of stigmatizing attitudes than has been found in other groups. While the program was shown to be effective for First Nations, it was recommended that research be undertaken on how to adapt MHFA more specifically to a First Nations audience. This adaptation is currently being undertaken, with a change of ALGEE to EAGLE, which is showing a much more positive response from pilot participants.

In Australia, consensus methods have been used to develop guidelines for Aboriginal and Torres Strait Islander populations. Delphi consensus development methods were used with a panel of Aboriginal people who were also mental health experts(10). While consensus-based methods are not a gold standard for evidence, they are an accepted method of guideline development in the absence of a strong evidence base. This method helped the panelists to develop culturally appropriate MHFA guidelines around depression, psychosis, suicidal thoughts and behaviours, deliberate self-injury, trauma and loss, and cultural considerations. The process was used again to develop culturally appropriate MHFA guidelines for Aboriginal populations around substance use issues(11).

The Aboriginal adaptation of the program was evaluated in terms of quantitative uptake of the course (whether those given MHFA instructor training went on to offer the course in their communities) and qualitative interviews about strengths, weaknesses, and recommendations for the future of the course(12). The evaluation found that the majority of the instructors who received MHFA training subsequently ran the course in their communities, and that post-course contact with trainer-instructors improved the likelihood of this happening. Qualitative interviews found that participants perceived the course to be culturally appropriate, empowering, and to contain relevant information.

Immigrant groups are another population that may benefit from MHFA training. In Bristol, England, an MHFA program for black and minority ethnic individuals was evaluated(13). Participants identified several ways in which the curriculum did not necessarily reflect their life circumstances or cultural norms, but overall feedback from participants was positive.

In Australia, the delivery of the program to the Chinese and Vietnamese communities has been evaluated. The studies found improvements in recognition of mental disorders, better understanding of treatment, improved knowledge of appropriate forms of assistance, and a reduction in stigma(14),(15).

Other Evidence from Canada

Canadian studies of MHFA programming are in the preliminary stages. However, a few evaluations have been done of the program's implementation in Canada and there are plans to increase the number of evaluations completed about the MHFA Canada program.

The Alberta Mental Health Board conducted an evaluation of MHFA Canada during the period of November 2006-June 2007(16). While the study is limited in that it relies solely on subjective participant impressions and not on assessment of skills or evaluation of whether participants used the information they learned in the course later on, it generally reinforces the evidence gathered from other countries. Over 95% of participants indicated that course content was easy to understand, well presented, and relevant to participant needs.

Queens University conducted an independent evaluation of MHFA Canada in 2010, evaluating the effectiveness of the program among school staff(17). The methodology of the evaluation used pre and post training surveys and interviews, drawing from both quantitative and qualitative techniques. The conclusions of the evaluation are in line with other findings of the MHFA course worldwide, including increasing knowledge, enhancing sensitivity, and increasing confidence of helping behaviours. Recommendations from the report such as expanding the range of participants and exporting the model to other universities have been followed up on and are continuing to occur.

Canadian evaluations as well as a link to other countries evaluations are posted on the MHFA Canada website at <http://www.mentalhealthfirstaid.ca/EN/about/Pages/Evaluation.aspx>.

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