The role of Mental Health First Aid training in nursing education: A response to Happell, Wilson & McNamara (2015)

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Word count: 1973

Abstract

This article responds to concerns Happell, Wilson and McNamara (2015) have raised about the role of Mental Health First Aid (MHFA) training in undergraduate mental health nursing education in Australia. MHFA training was developed in Australia to improve the capacity of members of the public to provide initial help to a person with a mental health problem or in a crisis. In 2012, the Australian government provided funding for MHFA training of frontline workers, including nursing students. From mid 2012-mid 2016, over 15,728 nursing students received the training. An evaluation study found positive effects on intentions to provide MHFA and confidence in helping a peer, improvements in MHFA knowledge and a reduction in stigma. Contrary to Happell, Wilson and McNamara's concerns that MHFA training will become part of the core nursing curriculum at the expense of mental health nursing content, MHFA training is primarily aimed at peer support. The program has been standardized to preserve fidelity and quality, and the curriculum content follows an evidence-based rather than medical model. We agree with Happell and colleagues that MHFA training would be a valuable prerequisite to nursing education, but that it is not sufficient for professional training.

In a recent article in *Collegian*, Happell, Wilson and McNamara (2015) raised some issues about the role of MHFA training in undergraduate mental health nursing education. We agree with some of their points, but disagree with others. However, before responding to these, it is necessary to understand what MHFA training is and what it is not.

The aims of MHFA training

Mental health first aid 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” (Kitchener, Jorm, & Kelly, 2015, p. 12). In order to improve the mental health first aid skills of the public, we developed and began delivering the world’s first MHFA training course in Australia in 2001 (Kitchener & Jorm, 2002). This training was based on the model of physical first aid training, which is widely accepted across the world, but has not included how to assist a person with mental health problems.

The initial Standard MHFA course ,was developed to give adults the skills to assist other adults (Kitchener & Jorm, 2006). Since then, other MHFA courses have been developed in Australia, including Youth MHFA, for adults to help adolescents) (Kelly at al., 2011), Aboriginal and Torres Strait Islander MHFA for adults to help Indigenous Australian adults (Kanowski, Jorm, & Hart, 2009) and teen MHFA for adolescents to help their peers (Hart, Mason, Kelly, Cvetkovski, & Jorm, 2016).

The aim of all these courses is to spread basic skills, as widely as possible in the community of how to help a person with a mental health problem. It is important to note that MHFA training is designed for the public and, like conventional physical first aid training, it does not teach clinical skills.

Dissemination of MHFA training

MHFA training has been extensively rolled out in Australia since 2001 and internationally since 2004 (Pham, 2015). As of 2015, over 375,000 people have done a MHFA course, which

corresponds to over 2% of the adult population. MHFA training has also spread from Australia to over 20 other countries. As of 2015, over 1 million people had done a MHFA course worldwide.

Research underpinning MHFA

One of the factors behind the rapid spread of MHFA training is the extensive research underpinning the program. The first aid strategies taught in MHFA courses are based around expert consensus guidelines developed using the Delphi method. This method is a systematic way of gaining practice-based evidence from a range of experts (Jorm, 2015). These guidelines cover the best mental health first aid strategies for helping a person developing a mental health problem such as depression (Langlands, Jorm, Kelly, & Kitchener, 2008), alcohol problems (Kingston et al., 2009), psychosis (Langlands, Jorm, Kelly, & Kitchener, 2007) or in a mental health crisis situation such as having suicidal thoughts (Ross, Kelly, & Jorm, 2014a) or engaging in non-suicidal self-injury (Ross, Kelly, & Jorm, 2014b). These strategies have been endorsed at a high consensus level by international panels of clinician experts, consumer advocates and, where appropriate, carer advocates.

MHFA training has also been extensively evaluated in trials and in qualitative studies. A meta-analysis carried out by a Swedish team of researchers of 15 MHFA trials found reliable changes in knowledge (Glass's $\Delta = 0.56$; 95% CI = 0.38 - 0.74; $p < 0.001$), attitudes ($\Delta = 0.28$; 95% CI = 0.22 - 0.35; $p < 0.001$), and helping behaviours ($\Delta = 0.25$; 95% CI = 0.12 - 0.38; $p < 0.001$) (Hadlaczky, Hökby, Mkrtchian, Carli, & Wasserman, 2014). They concluded that: "The MHFA programme appears recommendable for public health action" (p. 267). In view of the evidence base, the US Substance Abuse and Mental Health Services Administration (2012) has listed MHFA on its National Registry of Evidence-based Programs and Practices

MHFA training of nursing students

In 2012, MHFA Australia successfully applied for funding from the Australian Government Department of Health and Ageing for training of 'frontline workers'. This application covered the training of (1) workers in financial counselling and (2) students training in nursing and

medicine. The funding covered tailoring of the Standard MHFA course for these groups, development of eLearning versions of the tailored training, the roll-out of the training , and an evaluation of the training. The roll-out of the training included the teaching of courses by existing MHFA instructors and the training of some new instructors

The tailored MHFA course materials for nursing and medical students clearly stated the course was for the benefit of the students' own mental health and those of their peers. It was not intended to be professional mental health training. Advertising of the course stated that: "The focus of the courses is how to help their fellow students, though course participants will learn mental health first aid skills that can be applied to help any adult." The *Mental Health First Aid Supplementary Booklet for Nursing Students* gives a number of reasons why nursing students need to learn MHFA skills including their higher risk of mental health problems, the effects of these problems on completion of studies, reluctance to seek help and stigma attached to being a nurse with a mental health problem, and the opportunities that nursing students have to support their peers peers with mental health problems . (Bovopoulos, Kelly, Bond, & Kitchener, 2013, p. 5).

Under this funding, the tailored MHFA courses have been widely disseminated in Australia. An analysis of data from the MHFA Web Instructor Management System, which holds details of all MHFA courses taught within Australia, show that as of May 2016, training had been delivered to 22,509 frontline workers, including 15,728 nursing students, 5,525 medical students and 1,256 financial counsellors.

An uncontrolled pre-test post-test study was carried out to assess whether the training produced any changes in the students, with data collected on 292 nursing students and 142 medical students (Bond, Jorm, Kitchener, & Reavley, 2015). For the nursing students, both face-to-face and online training was found to have positive effects, with significant increases in intentions to provide mental health first aid, confidence in helping a peer and mental health first aid knowledge, and reductions in various components of stigma, including desire for social

distance, belief that a person affected is weak rather than sick, and belief that they are dangerous and unpredictable. Effects were similar for the medical students. Another evaluation of the tailored nursing student MHFA course was carried out in Queensland and asked the students to give ratings, strengths and weaknesses and comments about their experience of the course (Kelly, & Birks, 2016). Findings showed that the vast majority of students (86%) regarded the course as appropriate for nursing and midwifery students and 89% stated they would recommend the course to other university students. Responses to the open ended questions suggest widespread support for the routine offering of this course for beginning nursing and midwifery students nationwide.

Points of agreement with Happell and colleagues

Happell and colleagues' (2015) major concern is that MHFA will become part of the core nursing curriculum and this may occur at the expense of other content. They state that "the professional level mental health skills expected at this level exceed the mental health awareness outcomes of MHFA, in a similar way that the more physical health focused areas of nursing exceed the content of the traditional first aid programme. Nursing requires a broader range of interventions to be provided over a longer time period than that associated with a first aid response" (p.435). We agree completely. MHFA training is not a substitute for professional training, nor has it ever been claimed to be. As explained above, the aim of MHFA training of nursing students is self and peer support.

Happell et al. (2015, p. 436) propose that: "MHFA could be considered a prerequisite from which pre-registration nursing students come to the commencement of their programme of study. This is consistent with the requirement of many universities that students complete the St John's Ambulance First Aid Course before undertaking clinical placements. Students would then be equipped with a general knowledge about how to render first assistance to a person

with a mental health problem or crisis.” We agree that this would be valuable for all nursing students and would give parity between mental and physical first aid in their training.

Points of disagreement with Happell and colleagues

Happell et al. (2015, p. 436) claim that “MHFA takes a predominantly medical-model approach with a focus on signs and symptoms of mental illness.” We believe that MHFA involves an evidence-based model and supports all approaches that have a good evidence base, whether they be medical, psychological, social or self-help. The bulk of MHFA training is not about signs and symptoms and treatments, but rather what practical actions a member of the public can take to support a person with a mental health problem or in a crisis. (Kitchener, Jorm, & Kelly, 2013). The advice on what is helpful is based on expert consensus, including the consensus of people whose expertise comes from lived experience. Every action statement in MHFA has been rigorously researched and has been supported as important or essential by at least 80% of a panel of consumer advocates (Jorm & Kitchener, 2011)

Happell et al. (2015, p. 434) express concern with statements they have heard that “registered nurses and nursing students learned more from MHFA than from their undergraduate mental health nursing component”. We do not see this as a weakness of MHFA training. Rather, it is a cause for concern about the practical value of the undergraduate training that nurses are receiving in mental health and suggests that this needs strengthening in terms of its quality of content, instructional methods and usefulness.

Happell et al. (2015, p. 434) claim that: “Mental Health First Aid (MHFA) were successful in gaining funding from the Australian Department of Health and Aging grant with the aim of training at least one nursing academic from every Australian University... to become a Mental Health First Aid trainer. Upon successful completion of the programme nurse academics are then able and expected to provide this training to undergraduate nursing students.” This claim is incorrect. The funded project did not aim to train nursing academics from every Australian University. Rather, funding was available for existing instructors to train students, as well as for

the training of some additional instructors. Nursing academics may have already been MHFA instructors or chosen to train under this funding initiative.

Happell et al. (2015, p. 434) claim that: “The rationale for requiring academic nurses to attend MHFA training is to ensure their compliance with instructor materials because the programme is trademark and copyright protected.” This is incorrect. Firstly, as explained above, academic nurses were not required to attend MHFA training. Secondly, as originators of the MHFA program, we can state that it has nothing to do with copyright and trademarking, but rather with fidelity to the evidence base. Amongst other criteria, trainee MHFA Instructors are selected for their mental health knowledge and training expertise (“How to Apply to Become an MHFA Instructor”, 2012). The MHFA curriculum is evidence-based, with the content concordant with expert consensus guidelines (Jorm & Kitchener, 2011) and a substantial evidence base from trials for its efficacy (Hadlaczky, 2014). MHFA Australia requires the instructors to adhere to this standardised approach, consistent with what has been shown to work in the evaluation trials (“5-day Standard Instructor Training Course”, 2012).

Conclusion

In conclusion, we agree with Happell et al. (2015) that MHFA could play a useful role in the training of all nursing students. Indeed, the evidence available supports the benefits of this training to student’s knowledge, attitudes and helping skills. However, it is not sufficient for professional training of nurses in mental health.

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