BJPsych open
BJPsych Open (2018)
4, 427–440. doi: 10.1192/bjo.2018.58

Review

Guidelines for the public on how to provide mental health first aid: narrative review

Anthony F. Jorm and Anna M. Ross

Background

Expert-consensus guidelines have been developed for how members of the public should assist a person with a mental health problem or in a mental health crisis.

Aims

This review aimed to examine the range of guidelines that have been developed and how these have been implemented in practice.

Method

A narrative review was carried out based on a systematic search for literature on the development or implementation of the guidelines.

Results

The Delphi method has been used to develop a wide range of guidelines for English-speaking countries, Asian countries and a number of other cultural groups. The primary implementation has been through informing the content of training courses.

Conclusion

Further work is needed on guidelines for low- and middle-income countries.

Declaration of interest

A.F.J. is an unpaid member of the Board of Mental Health First Aid International (trading as Mental Health First Aid Australia), which is a not-for-profit organisation.

Keywords

Alcohol disorders; anxiety disorders; self-harm; depressive disorders; drugs of dependence disorders.

Copyright and usage

© The Royal College of Psychiatrists 2018. This is an Open Access article, distributed under the terms of the Creative Commons Attribution-NonCommercial-NoDerivatives licence (http://creativecommons.org/licenses/by-nc-nd/4.0/), which permits non-commercial re-use, distribution, and reproduction in any medium, provided the original work is unaltered and is properly cited. The written permission of Cambridge University Press must be obtained for commercial re-use or in order to create a derivative work.

'Mental health first aid' has been defined as 'the help provided to a person developing a 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'.[1] More recently, the definition has been broadened to also include the help offered to a person 'experiencing the worsening of a mental health problem'.[2] This concept distinguishes the initial assistance given by a layperson from ongoing carer roles and from professional help.

There is evidence to support the importance of this type of initial assistance. When a person develops a mental health problem, they will frequently turn to others in their social network for help.[3] Indeed, seeking help from family and friends is often one of the first actions taken to deal with mental health problems, and this frequently occurs before seeking help from a health professional.[4] However, although many people with mental health problems receive positive support from their social network,[5] avoidance and discrimination are also common, particularly for people with more severe mental disorders.[6–8]

The reactions from a person's social network can affect the outcome of their mental health problem. A person is more likely to seek professional help for a mental health problem if someone else suggests that they do this,[9,10] and faster treatment is associated with a better outcome.[11,12] It is also known that good social support from family can aid recovery,[13] whereas negative interactions can impede it.[14] Positive social support also helps to reduce the impact of traumatic life events.[15]

Mental health first aid training

Given the potential importance of the public providing mental health first aid, there is a need to improve public knowledge and skills in this area. For this reason, a Mental Health First Aid (MHFA) training course for the public was developed in Australia in 2000 and has been disseminated to many other countries.[16] This course is an adaptation of the first aid training model used for physical health emergencies and it covers developing mental health problems (e.g. depression, psychosis, substance use problems) and mental health crises (e.g. suicidal, self-injuring, exposed to a traumatic event). MHFA training was initially developed to train adults to assist other adults,[17] but has since been extended to adults to assist youth,[18] to adolescents to assist their peers[19] and to adults to assist older persons.[20] There have also been a number of adaptations of the training to cover cultural subgroups.[21,22]

Early in the development of MHFA training in Australia, it became apparent that there was limited evidence available on how a member of the public should give mental health first aid. The techniques taught in conventional, physical first aid courses are based on international guidelines that have been developed using systematic reviews of the literature and expert consensus.[23] There is thus a need to develop similar international guidelines for the provision of mental health first aid. The purpose of this review was to examine the range of guidelines that have been developed, their implementation in practice and to identify any gaps that remain to be filled.

Method

To find relevant research, we carried out a systematic search of databases and guidelines listed on the MHFA Australia website (www.mhfa.com.au), which includes grey literature. The inclusion criteria were: (a) reports on mental health first aid guidelines, with 'mental health first aid' defined as by Kitchener *et al*;[2] (b) the primary purpose of guidelines is provision of mental health first aid; and

(c) articles that detail the development of guidelines, uses/implementations of guidelines and evaluations of guidelines. Exclusion criteria were: (a) guidelines developed for health professionals (psychiatrists, psychologists, counsellors, physicians, etc.), including clinical practice guidelines; (b) guidelines aimed at carers (involving longer-term caring roles); and (c) guidelines for the provision of medical first aid. Items published in a language other than English were to be translated into English. Records were excluded if reasonable efforts to obtain full-text copies were unsuccessful.

Searches were carried out in PubMed, PsycINFO, Scopus and Web of Science on 4 April 2018. The search terms were 'mental health first aid' across all four databases, limiting the results from year 2000 to the present day.

Figure 1 shows the PRISMA flow diagram. A total of 55 records met eligibility criteria and were included in the review. Both authors read through records, extracting main points of information into a summary table of MHFA guidelines. Included records were classified as involving guideline development, guideline evaluation and guideline implementation.

Results

The 56 studies covered guidelines for assisting people with specific mental health problems in English-speaking countries (13 studies), guidelines for assisting people with mental health problems from high-risk groups and settings in English-speaking countries (six studies), guidelines for assisting Australian Aboriginal and Torres Strait Islander people (six studies), guidelines for assisting people from Asian countries (five studies), cross-cultural generalisability of guidelines (one study) and implementation of the guidelines in practice (25 studies).

Methods used for developing guidelines

Mental health first aid guidelines have been developed based on expert consensus using the Delphi method.[24–26] The Delphi method is supported by research on 'wisdom of crowds' which shows that aggregated judgements of groups of people with imperfect expertise can lead to better decisions than individual experts.[26] This method involves recruiting a group of individuals with expertise on a topic, compiling a questionnaire with a list of statements that the experts rate for agreement, providing anonymous feedback to individuals on how their responses compare with the rest of the group, giving members the opportunity to revise their responses based on the feedback over a number of survey rounds and using a statistical criterion to define consensus.[24–26] There are many ways in which Delphi methodology can be implemented. The application of this method for the development of mental health first aid guidelines has involved the steps described below.

Framing of research questions

The Delphi studies have been guided by a question that defines the scope of the project. The questions covered the type of person who is providing the help (e.g. adult,[1] adolescent,[27] workplace colleague[28]), the type of person who is being helped (e.g. Aboriginal or Torres Strait Islander person,[29] adolescent,[30] LGBTIQ+ person[31]) and the type of mental health issue the person has (e.g. suicidal thoughts and behaviours,[32] psychosis,[1] panic attack[33]).

Selection of expert panels

The chosen panel members have relevant expertise; this expertise may have been gained through professional experience or from lived experience as a consumer or carer. In all the projects on guidelines, a panel of mental health professionals has been used. Wherever possible, there have also been panels of consumers and carers who have taken on advocacy roles, either through membership of advocacy organisations or by creating peer support resources. The requirement for consumers and carers to also have an advocacy role was to ensure that their expertise was broader than their own individual experience. However, in some areas it was difficult to find lived-experience experts because relevant mental health advocacy organisations are rare or do not exist, for example in Asian countries and for cultural minorities such as Aboriginal Australians and refugees.

Determining expert panel size

Panels consisting of 20 or more members tend to produce stable results.[26] Because there are generally dropouts across rounds of a Delphi study, the aim was to have a minimum of 30 experts on a panel at the start of the study. However, experts on some topics are so scarce that this number has not been possible (e.g. mental health professionals with experience working with Iraqi refugees in Australia[34]), so smaller panels have been used.

Construction of Delphi questionnaires

The Delphi questionnaires have listed potential actions that a first aider can take to assist a person with a mental health problem as well as potential knowledge they may need to guide their actions. The questionnaires were constructed in such a way as to give a comprehensive list of possibilities to the panel members to consider. For most studies on guidelines, this has been achieved by a systematic search for possible actions in websites, books and journal articles. The text from these sources was qualitatively analysed to arrive at a set of items that clearly express a single action, while trying to remain as faithful as possible to the original wording in the source. One member of the research team carried out a draft content analysis which was presented to the other researchers in the team, who then agree on the final wording of questionnaire items. Additional items have been created from gaps identified by the research team and by panel members when they were responding to the initial questionnaire. Items that have been included in the questionnaire have sometimes been contradictory because of differing opinions in the literature about appropriate first aid actions (for example, 'the first aider should say whatever they feel they need to help the suicidal person decide against suicide, including the use of guilt and threats, e.g. telling them they will go to hell or they will ruin the lives of others if they die by suicide' versus 'the first aider should not use guilt or threats to prevent suicide, e.g. do not tell the person they will go to hell or ruin other people's lives if they die by suicide').[32]

For some guidelines, a systematic search has been a poor source of questionnaire items because of the limited literature on the topic. This was the case for guidelines on how an adult should communicate with an adolescent about a mental health problem or other sensitive topic.[27] In this case, focus groups of consumers and clinicians were used to generate additional items for the questionnaire.

Administration of Delphi questionnaires

Questionnaires were administered by web survey which made it possible to have panel members from around the world. Panellists were asked to rate items according to whether they should be included in the guidelines using the following scale: 'essential', 'important', 'don't know/depends', 'unimportant' or 'should not be included'. Panellists were provided with comment boxes to provide reasons for their responses, suggest additional items or suggest modifications to wording of items.

Analysis of Delphi rounds and providing feedback to the panel

In most of the Delphi studies, items that were endorsed as essential or important by 80% or more of each panel were accepted, whereas

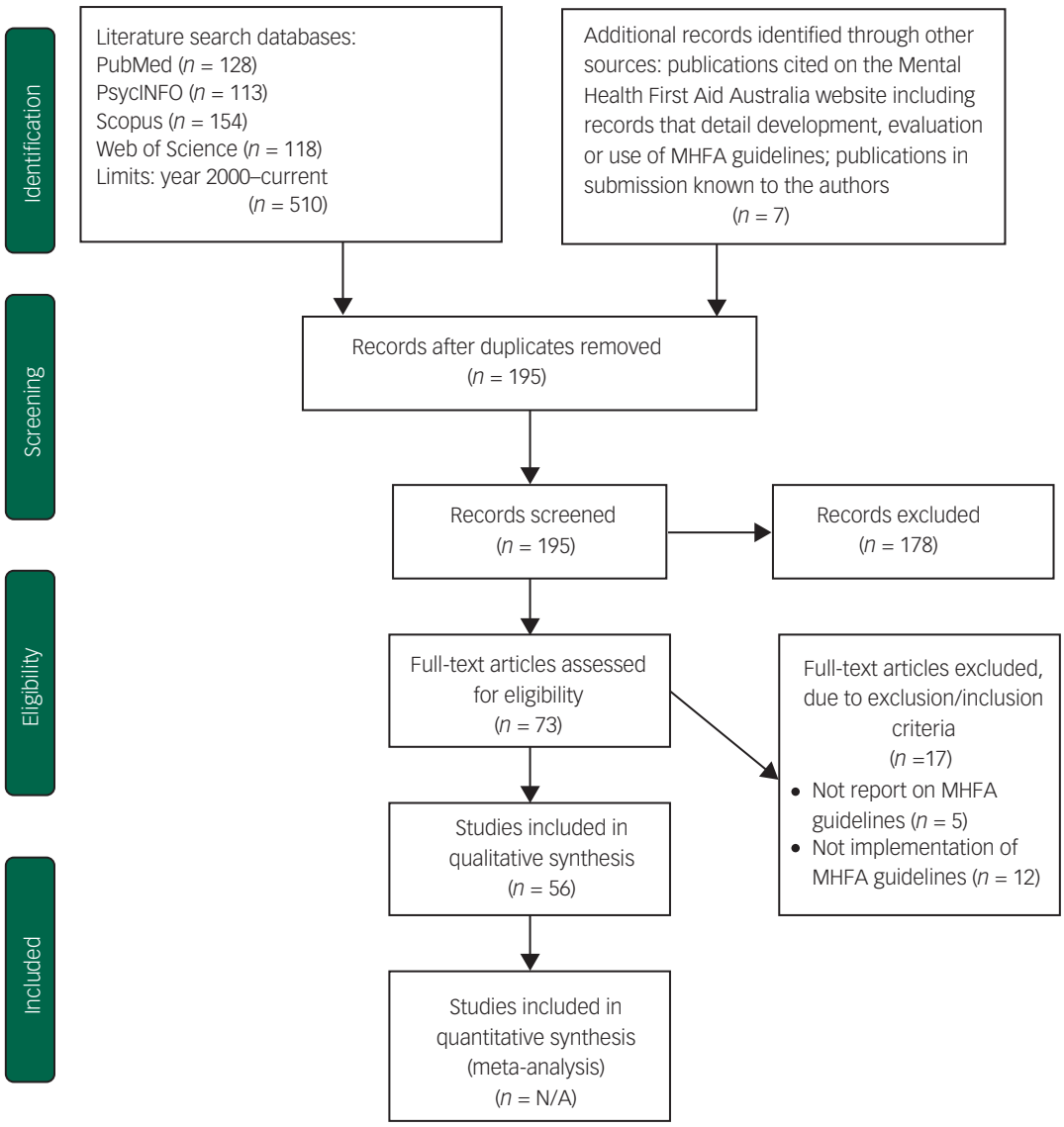

Fig. 1 PRISMA flow diagram.

items that were endorsed by 70–79% were put back to the panels to be rerated in the subsequent survey round. Items endorsed by less than 70% of the panel were rejected. For a small number of Delphi studies, the required endorsement rate was increased to 90% or decreased to 70% to reflect differences in overall endorsement rates. For example, Australian Indigenous panels tended to have high endorsement rates across items, so the cut-off for inclusion was raised to 90%.[29] By contrast, Japanese experts were less likely to rate items highly and more often used the don't know/depends option, so the cut-off was lowered to 70%.[35]

When items were rerated, feedback was given to panel members about the ratings of all the panels on each item, as well as their own ratings. They were then given an opportunity to rerate the items in the subsequent survey round. Items that received low ratings (typically under 70%) were not rerated as experience has shown that rerating does not result in such major changes that the endorsement threshold (typically 80%) is reached.

Reliability of Delphi results

Data on the reliability of expert panel judgements could be obtained from Delphi studies that were performed on the same topic at two time points. This was done for suicide first aid by comparing common items from two Delphi studies on how to support a suicidal person.[32,36] The correlation across item frequencies was 0.84 between 22 professionals in the earlier study and 41 professionals in the later one. Similarly, there was a correlation of 0.77 between endorsement frequencies for a panel of 16 consumers and carers in the earlier study and 35 consumers from the later study. Given the passage of 6 years between the studies and the small size of some of the panels, this shows a high degree of reliability.

Five of the Delphi studies also looked at agreement between professional, consumer and carer panels within the same Delphi study (summarised in Table 1). Despite considerable variation in source of expertise, the level of agreement across expert panels is very high.

Construction of guidelines from endorsed items

Guideline documents were constructed from the endorsed items by connecting them together under headings to make a coherent text. The guidelines were sent back to the expert panellists for comment and final approval before publication.

Table 1 Correlations across items in endorsement frequencies for different types of expert panels

Delphi topic	Expert groups compared	Correlations across items
Suicidal ideation and behaviour[32]	Professionals and consumers	0.92 (round 1) 0.80 (round 2)
Non-suicidal self-injury[79]	Professionals and consumers	0.91 (round 1) 0.75 (round 2)
Gambling problems[80]	Professionals and lived-experience experts	0.82
Cognitive impairment or dementia[81]	Professionals and carers	0.81
Workplace mental health[28]	Consumers and managers	0.88
	Consumers and workplace mental health professionals	0.86
	Managers and workplace mental health professionals	0.92

Guidelines for English-speaking countries

Guidelines have been developed for assisting with a range of mental health problems, as summarised in Table 2. All have involved the use of both professional and lived-experience expert panels, with 80% or greater endorsement required from all panels for inclusion in the guidelines. Given the need to keep guidelines up to date, two of the guidelines – on suicidal thoughts and behaviours and non-suicidal self-injury (NSSI) – have been revised in new studies. Other guidelines have been developed to assist people in high-risk groups or settings (see Table 3).

Although there is broad agreement across various types of experts on appropriate first aid actions, the various Delphi studies have noted differences as well, which are summarised in Table 4. The areas of difference are diverse and influenced by the type of first aid situation (e.g. the urgency of action) and the type of person in the role of first aider (e.g. adolescent versus adult). Nevertheless, there are some common themes across a number of these studies. Professionals place a greater emphasis on privacy, confidentiality and on first aiders not straying into professional roles. Consumers place greater emphasis on autonomy in decision making and talking about feelings, whereas carers place greater emphasis on taking action to protect the person.

Guidelines for Asian countries

As summarised in Table 5, guidelines have been developed for assisting a suicidal person in various Asian countries, where professionals from individual countries were used as expert panellists. However, other guidelines for assisting a person with psychosis have been developed using professional experts from a range of Asian countries. All of these Delphi studies required 80% or more endorsement for inclusion in the guidelines, except for the study on first aid for a suicidal person in Japan,[35] which used a criterion of 70% or more, due to the greater tendency of Japanese experts to give responses of don't know/depends.

None of these guidelines have had expert panels of consumers or carers because of the rarity of consumer and carer advocacy organisations in these countries. Another limiting factor was that the Delphi studies were carried out in English due to resource limitations. This has also limited the participation of consumer and carer experts as they were less likely to have the high level of English comprehension required. This may have resulted in bias towards the expertise of clinicians who have had Western training.

Guidelines for Australian Aboriginal and Torres Strait Islander people

A range of guidelines were developed for Aboriginal and Torres Strait Islander people, as summarised in Table 6. All but one of these guidelines used Aboriginal or Torres Strait Islander clinicians as experts; in the case of problem gambling, it was not possible to recruit an all-Aboriginal panel. As with Asian countries, it proved impossible to find sufficient Aboriginal consumer and carer advocates to tap into lived-experience expertise. Nevertheless, it was found in the studies of suicidal thoughts and behaviours and NSSI that most of the Aboriginal professionals had personal experience as well as professional experience, so they could draw on these different sources of expertise.[37,38] All of these Delphi studies required 90% or greater endorsement for inclusion, with the high criterion set because of the high rates of item endorsement by these experts.

Cross-cultural generalisability

Because Delphi studies to develop suicide first aid guidelines have been carried out for a range of Asian countries and high-income English-speaking countries, it has been possible to compare the results to see whether they are similar across countries and cultures.[39] Comparing results for English-speaking countries, Sri Lanka, Japan, India, the Philippines and for refugees and immigrants, correlations across items in endorsement rates were all 0.60 or above, but were higher for countries that are socioeconomically similar. These results indicate that suicide first aid actions are generalisable across countries and cultures to some degree. These actions include assessing the risk of suicide, listening to the person, showing care and respect and ensuring the person's safety. However, there is also some cultural specificity, indicating a need for local tailoring of the guidelines. For example, differences were found regarding how appropriate it was thought to be for a first aider to dissuade a person from suicide and to try to solve their problems, and there was variation related to availability of services.

Similarly, it was possible to compare the ratings of Aboriginal and Torres Strait Islander professionals with those of experts from English-speaking countries. For ratings of NSSI items, the Aboriginal and Torres Strait Islander panel had a correlation of 0.73 with the English-speaking consumer panel and 0.71 with the English-speaking professional panel.[37] Similarly, the correlations for items on suicidal thoughts and behaviours were 0.79 and 0.77, respectively.[38] Again, these results indicate a high degree of cross-cultural generalisability. However, there were also differences, e.g. in communication issues and evaluation of urgency in taking action.

Implementation of the guidelines

The aim of mental health first aid guidelines is to improve the supportive behaviours of the public towards people with mental health problems. However, it has been noted both in the literature on clinical practice guidelines and on Delphi studies that these are not sufficient to produce changes in behaviour and that specific implementation strategies are necessary.[26,40] Below is a review of strategies that have aimed to implement the guidelines in practice.

Guiding the content of training courses

The guidelines were primarily developed to inform the content of MHFA training courses. In developing the first edition of the Australian MHFA course,[41] it was recognised that there was little evidence on which to base mental health first aid strategies for the public. As the guidelines in Tables 2 and 3 have been developed over time, they have been used to inform the content of subsequent editions of the Australian Standard MHFA course (for adults helping adults),[42–44] the Youth MHFA training course (for adults

Table 2 Guidelines for assisting people with specific mental health problems in English-speaking countries

Authors, year	Topic	Types of experts (*N*)[a]	Number of items endorsed/ number rated	Main themes in guidelines
Kelly *et al*, 2008[36]	Suicidal thoughts and behaviour	Professionals (*N* = 15–22), people who had been suicidal in the past (*N* = 7–10) and carers of people who had been suicidal in the past (*N* = 0–6)	30/114	Identification of suicide risk; assessing seriousness of the suicide risk; initial assistance; talking with a suicidal person; no-suicide contracts; ensuring safety; confidentiality
Ross *et al*, 2014[32]	Suicidal thoughts and behaviour (revised)	Suicide prevention professionals who were either clinicians or researchers (*N* = 27–41) and consumer advocates who have past lived experience of suicidal ideation (*N* = 21–35)	164/436	How to tell if someone is feeling suicidal; preparing yourself to approach the person; making the approach; asking about thoughts of suicide; talking with someone who is suicidal; determining how urgent the situation is; keeping the person safe; encouraging the person to get professional help; confidentiality and its limits; if the person has acted on suicidal thoughts; if the person has injured themselves but is not suicidal; self-care
Kelly *et al*, 2008[82]	NSSI	Professionals working on NSSI (*N* = 16–21), people who had engaged in NSSI in the past (*N* = 9–13) and carers of people who had engaged in NSSI in the past (*N* = 0–2)	18/79	What the first aider should do if they have interrupted someone who is in the process of injuring themselves; what to do if the first aider suspects someone has been injuring themselves; avoiding self-injury; harm minimisation; professional help
Ross *et al*, 2014[79]	NSSI (revised)	Professionals who were either clinicians or researchers in the NSSI field (*N* = 19–28) and consumer advocates who have past lived experience of NSSI (*N* = 25–33)	98/220	What NSSI is; what to do if you suspect someone is self-injuring; what to do if you find someone self-injuring; talking with the person; helping the person (seeking professional help, seeking emergency medical attention and encouraging alternatives to self-injury)
Langlands *et al*, 2008[1]	Psychosis	Clinical experts who are international authorities on psychosis, as well as mental health clinicians working within clinical settings (*N* = 32–52), consumers who had experienced psychosis (*N* = 31–45) and carers who had looked after someone with a psychotic illness (*N* = 37–60)	89/146	How to know if someone is experiencing psychosis; how to approach someone who may be experiencing psychosis; how to be supportive; how to deal with delusions and hallucinations; how to deal with communication difficulties; whether to encourage the person to seek professional help; what to do if the person does not want help; what to do in a crisis situation when the person has become acutely unwell; what to do if the person becomes aggressive
Langlands *et al*, 2008[83]	Depression	Clinicians who are international authorities in depression, as well as mental health clinicians (*N* = 44–64), consumers who had experienced depression (*N* = 52–70) and carers who had looked after someone with depression (*N* = 27–33)	64/99	Recognising and acknowledging that someone may have depression; how the first aider should approach someone who may be experiencing depression; how the first aider can be supportive; what is not helpful for a person who may have depression; whether the first aider should encourage the person to seek professional help; whether the first aider should encourage the person to use self-help strategies; what the first aider should do if the person does not want help.
Kelly *et al*, 2009[33]	Panic attacks	Professionals with publications in the areas of panic disorder or agoraphobia or experience in treating these patients (*N* = 35–50) and people who had experience of panic attacks and were active in mental health advocacy (*N* = 3–6)	27/144	General intervention principles; things a first aider should say during a panic attack; professional help in an emergency; seeking professional help; self-help strategies
Kingston *et al*, 2009[84]	Problem drinking	Clinicians (*N* = 45–65) and carers/consumers (*N* = 23–34) with experience or expertise in problem drinking	184/285	What alcohol use problems are; approaching someone about their drinking; encouraging the person to change their drinking; reducing the risks associated with drinking; encouraging other supports; managing social pressure to drink; if the person is unwilling to change their drinking; seeking professional help; first aid for alcohol intoxication, poisoning or withdrawal; what to do if the person is aggressive; what to do in a medical emergency

(*Continued*)

Table 2 *(Continued)*

Authors, year	Topic	Types of experts (*N*)[a]	Number of items endorsed/ number rated	Main themes in guidelines
Hart *et al*, 2009[60]	Eating disorders	Clinicians (*N* = 27–36), caregivers (*N* = 24–27) and consumers (*N* = 14–22)	200/456	What eating disorders are; approaching someone who may have an eating disorder; getting professional help; how to continue to be supportive; eating disorders in children and young people
Kelly *et al*, 2010[85]	Adult affected by a traumatic event	Professionals working in trauma (*N* = 23–39) and consumers and carers who had been affected by a traumatic event (*N* = 12–17)	65/180	What the first priorities for helping someone after a traumatic event are; what the priorities are if I am helping after a mass traumatic event; how to talk to someone who has just experienced a traumatic event; whether we should we talk about what happened and how to support someone in doing so; how to help the person to cope over the next few weeks or months; when the person should seek professional help
Kelly *et al*, 2010[85]	Child affected by a traumatic event	Professionals working in trauma (*N* = 17–22) and consumers and carers who had been affected by a traumatic event (*N* = 10–12)	71/155	What the first priorities are for helping a child after a traumatic event; what the priorities are if I am helping after a mass traumatic event; how to talk to a child who has experienced a traumatic event; what should be done if a child has told me they are being abused; how should I behave at home if I am a parent/guardian and the child I am helping lives with me; dealing with temper tantrums and avoidance behaviours; whether the child should receive professional help
Kingston *et al*, 2011[86]	Problem drug use	Clinicians (*N* = 20–27), consumers (people with a past history of drug use) (*N* = 25–29) and carers (people with a past history of caring for someone with problem drug use) (*N* = 25–31)	140/228	Approaching the person about drug use problems; what to do if the person is unwilling to change their drug use; professional and other help; drug-affected states
Bond *et al*, 2016[81]	Cognitive impairment or dementia in an older person	Health professionals specialising in research or treatment of dementia (*N* = 43–56) and carers of people with dementia who are in an advocacy role (*N* = 22–24)	389/656	What to do if you are concerned that a person may be developing dementia; supporting the person with dementia; communicating with the confused person; discussing sensitive issues; behaviours that you may find challenging; assisting the confused person who is wandering; delirium
Bond *et al*, 2016[80]	Gambling problems	Professionals experienced in research or treatment of problem gambling (*N* = 32–41) and people with lived experience of a gambling problem or of assisting a family member or friend with a gambling problem and have experience in an advocacy or peer-support role (*N* = 34–40)	234/412	Motivations for gambling; how to tell if someone has gambling problems; approaching someone about their gambling; encouraging professional help; encouraging the person to change; if the person does not want to change; supporting the person to change; what to do if you are concerned for the safety of the person or others

NSSI, non-suicidal self-injury.
a. *N* varies depending on Delphi round.

helping youth),[45–47] MHFA for medical and nursing students to support their peers[48,49] and for developing a new Older Person MHFA course (for adults helping older people)[20]. The mental health first aid guidelines for Aboriginal and Torres Strait Islander people (see Table 5) have been used to inform the content of an Aboriginal and Torres Strait Islander MHFA course which is taught by instructors from those communities.[50] The key elements of the various guidelines have been summarised in the form of an action plan, which is taught in the course. The most recent version of the MHFA Action Plan is:

(a) approach the person, assess and assist with any crisis
(b) listen and communicate non-judgementally
(c) give support and information
(d) encourage the person to get appropriate professional help
(e) encourage other supports.[43]

There have been 18 controlled trials of the Standard and Youth MHFA courses, of which 10 trials of the second and subsequent editions of the courses were informed by the mental health first aid guidelines listed in Tables 2 and 3. A recent systematic review and meta-analysis of MHFA trials showed improvements up to 6 months following training in mental health first aid knowledge, recognition of mental health problems, beliefs about effective treatments, stigma, confidence and intentions to help, and in the amount of mental health first aid provided.[51]

The Standard and Youth MHFA courses have been widely implemented in Australia, with over 0.5 million people trained by 2017, which is over 2% of the population. MHFA training has spread from Australia to more than 20 other countries, with over two million people trained globally.[52]

A teen MHFA course has also been developed for adolescents aged 15–18 years to learn how to assist their peers,[53] with the

Table 3 Guidelines for assisting people with mental health problems from high-risk groups and settings in English-speaking countries

Authors, year	Target group or setting	Types of experts (*N*)[a]	Number of items endorsed/number rated	Main themes in guidelines
Ross *et al*, 2012[30]	Adolescents to help their peers	Youth Mental Health First Aid instructors (*N* = 77–97) and youth mental health consumer advocates (*N* = 25–36)	For junior adolescents: 78/98 For senior adolescents: 81/98	Do not stigmatise; recognise warning signs; approach; how to communicate: know and share information; involve an adult; confidentiality and its limits; responding in a crisis; be a good friend; do not be the fixer; look after yourself
Fischer *et al*, 2013[27]	Adults to communicate with adolescents about mental health problems and other sensitive topics	Youth Mental Health First Aid instructors (*N* = 36–56) and young consumer advocates (*N* = 15–24)	80/175	Planning your approach; engaging with the adolescent; what to say and how to say it; body language; discussing options; handling difficulties in the conversation
Bovopoulos *et al*, 2016[28]	Workplaces	Consumer advocates (*N* = 23–43), managers (*N* = 26–35) and workplace mental health professionals (*N* = 38–63)	201/246	Making the approach; listening and communicating non-judgementally; giving support and information; helping the distressed worker; helping the intoxicated worker
Bond *et al*, 2017[31]	LGBTIQ+ people	Mental health professionals who were part of the LGBTIQ+ community or who treated people from the LGBTIQ+ community (*N* = 75–106)	164/209	Understanding LGBTIQ+ experiences; mental health problems in LGBTIQ+ people; talking with the LGBTIQ+ person; supporting the LGBTIQ+ person; when the LGBTIQ+ person experiences discrimination and stigma; when the LGBTIQ+ person comes out or discloses; when the person is an adolescent; treatment seeking for mental health problems
Uribe Guajardo *et al*, 2016[34]	Iraqi refugees	Professionals working in refugee mental health who have experience in working with Iraqi refugees (*N* = 16)	38/65	Historical context of war and conflict in Iraq; risk factors for mental health problems in Iraqi refugees; cultural considerations in providing mental health first aid; cross-cultural communication; stigma associated with mental health problems; barriers to seeking professional help.
Colucci *et al*, 2018[87]	Immigrants and refugees	Professionals with expertise in suicide prevention working with people from immigrant or refugee backgrounds and lived-experience advocates from an immigrant or refugee background (*N* = 29–44)	345/553	How to tell if someone is feeling suicidal; getting ready to approach the person; making the approach; asking about thoughts of suicide; how to talk with someone who is suicidal; how to tell how urgent the situation is; how to keep the person safe; considering professional and other help; what to do if the suicidal person has a weapon; what to do if the person wants me to promise not to tell anyone else; what to do if the person has acted on suicidal thoughts; self-injury for reasons other than suicide; take care of yourself

a. *N* varies depending on Delphi round.

content based on a Delphi study.[30] In this course, the expert-consensus messages have been summarised by an action plan:[19]

(a) look for warning signs
(b) ask how they are
(c) listen up
(d) help them connect with an adult
(e) your friendship is important.

A randomised controlled trial comparing teen MHFA with physical first aid showed improvements in mental health first aid intentions and confidence to help a peer, an increase in number of adults rated as likely to be helpful and a reduction in stigmatising attitudes.[54]

The revised suicide first aid guidelines[32] have been used to develop a 4-hour training course for the Australian public in how to assist a suicidal person,[55] but at present no evaluation has been published. In Japan, guidelines have been used to develop a 2-hour course on depression and suicide first aid for medical staff[56] as well as a 2.5-hour suicide gatekeeper training course.[57] Randomised controlled trials of the course for Japanese medical staff have found improvements in suicide first aid competence and confidence,[58,59] as did an uncontrolled trial of the gatekeeper training course.[57]

The guidelines on eating disorders[60] have been used to develop a 4-hour course on mental health first aid for eating disorders.[61] An uncontrolled trial with Australian university students and staff found that knowledge of appropriate mental health first aid strategies increased and was maintained at 6-month follow-up. Some participants reported providing assistance to a person with a suspected eating disorder, with some of those assisted seeking professional help as a result.

Table 4 First aid actions given greater emphasis by different types of experts

Authors, year	Topic	Greater emphasis by professionals	Greater emphasis by consumers	Greater emphasis by carers
Kelly *et al*, 2008[36]	Suicidal thoughts and behaviour	Getting professional help	(a) Discussion of feelings (b) Making their own decisions	Protection of life at any cost
Ross *et al*, 2014[32]	Suicidal thoughts and behaviour (revised)	Gathering information about the suicidal person's situation	Actions that provide a caring and understanding experience for the suicidal person	No panel included
Kelly *et al*, 2008[82]	NSSI	Nothing reported	(a) Respect and the right to make choices (b) Let the person talk about feelings motivating NSSI	Nothing reported
Ross *et al*, 2014[79]	NSSI (revised)	Ensuring safety of person	(a) Adequate first aid supplies should be available (b) First aider should accompany person to professional help (c) Helping process should be consumer driven	No panel included
Langlands *et al*, 2008[1]	Psychosis	Maintaining the person's privacy and confidentiality	Right to decide not to seek help if they are not harming themselves	Seeking professional help on behalf of the person
Kelly *et al*, 2009[33]	Panic attacks	Nothing reported	De-escalating panic attacks through breathing techniques	No panel included
Hart *et al*, 2009[60]	Eating disorders	(a) Right to privacy and confidentiality (b) Taking early action	Right to privacy and confidentiality	(a) Taking early action (b) Enlisting the help of the person's family
Kelly *et al*, 2010[85]	Adults and children affected by a traumatic event	Nothing reported	Talking about what happened, expressing emotions and validating emotions	Talking about what happened, expressing emotions and validating emotions
Bond *et al*, 2016[81]	Cognitive impairment or dementia	(a) Including person in decisions and discussions about diagnosis, care and living arrangements (b) Rejection of actions that are perceived as requiring the first aider to act in the role of professional or that may be appropriate for some helpers but not others	No panel included	(a) Rejection of actions that are seen as falling outside helper's role (b) Rejection of actions that may not be helpful as disease progresses
Bond *et al*, 2016[80,a]	Gambling problems	Rejection of actions that are perceived as requiring the first aider to act in the role of a professional	Signs of gambling problems that may not be evident in professional settings	No panel included
Ross *et al*, 2012[30]	Adolescents to help their peers	Greater mental health knowledge of the first aider	More involvement from the adolescent being helped	No panel included
Fischer *et al*, 2013[27]	Adults to communicate with adolescents about mental health problems and other sensitive topics	Asking person directly about risk of harm	Self-disclosure by first aider	No panel included
Bovopoulos *et al*, 2016[28]	Workplaces	(a) Manager to provide information on sick leave entitlements (b) Not using team meeting to confront person misusing substances	(a) Approaching the person (b) Approaching someone in a more senior role (c) Communicating non-judgementally, non-verbally and verbally (d) Talking to others (e) Giving support and information (f) Confidentiality	No panel included

NSSI, non-suicidal self-injury.
a. This study had a 'lived-experience' panel consisting predominantly of consumers.

Table 5 Guidelines for assisting Australian Aboriginal and Torres Strait Islander people with mental health problems

Authors	Topic	Types of experts (*N*)[a]	Number of items endorsed/number rated	Main themes in guidelines
Hart *et al*, 2009[29]	Cultural considerations; depression; psychosis; suicidal thoughts and behaviours; self-injury; trauma and loss	Professional experts who identify as an Aboriginal or Torres Strait Islander person, those currently working in the field of mental health or have had previous experience in the field and have an excellent knowledge of Aboriginal mental health (*N* = 17–24)	536/1016	(a) Cultural considerations: Learn about the person's culture and their concept of mental illness; know what is normal, and what is not, in the person's culture; know what is culturally appropriate communication; do not shame the person, their family or community; use community and family supports (b) Depression: How to know if someone is experiencing depression; how to approach someone who may be experiencing depression; how to be supportive; whether the person should be encouraged to seek professional help; whether to use self-help strategies; what to do if the person does not want help (c) Psychosis: How to know if someone is experiencing psychosis; culture and symptoms of psychosis; how to approach someone who appears to be experiencing psychotic symptoms; how to discuss the problem with the person; how to be supportive; how to deal with delusions and hallucinations; how to deal with communication problems; whether the person should be encouraged to seek professional help; what to do if the person does not want help; what to do in a crisis situation when the person has become very unwell (d) Suicidal thoughts and behaviours: How to tell if someone is feeling suicidal; how to talk with someone who is feeling suicidal; how to tell if the situation is serious; how to keep the person safe; identification of suicide risk; how to tell how urgent the situation is; how to keep the person safe; what about professional help; what if the person makes me promise not to tell anyone else (e) Deliberate self-injury: What deliberate self-injury is; how to talk with someone who is deliberately injuring themselves; what to do if I witness someone injuring themselves; what about professional help (f) Trauma and loss: Trauma and loss in Aboriginal people; what is meant by trauma; trauma and loss and Aboriginal mental health; immediate assistance after a traumatic event; professional help; what else can be done
Hart *et al*, 2010[88]	Problem drinking; problem drug use	Aboriginal health experts (*N* = 19–21)	429/735	(a) Problem drinking: How to know if someone is experiencing problem drinking; alcohol use, problem drinking and Aboriginal people; understanding the person's problem drinking; how to talk to the person about their problem drinking; encourage the person to seek professional help; helping the person to change; first aid for alcohol intoxication, poisoning or withdrawal (b) Problem drug use: Understanding problem drug use; encouraging the person to seek professional help; information and support for the person who wants to change; first aid for drug-affected states
Chalmers *et al*, 2014[89]	Culturally appropriate first aid to an adolescent	Australian Aboriginal people who are experts in Aboriginal youth mental health (*N* = 37–41)	194/348	Understanding cultural influences; making the approach; tips for good communication; discussing mental illness with the adolescent; discussing options and getting help; handling difficulties in the interaction; exercise self-care
Bond *et al*, 2016[90]	Gambling problems	Professionals who provide treatment to or conduct research with Aboriginal and Torres Strait Islander people with gambling problems (*N* = 22–26)	225/407	What gambling problems are; gambling problems and Aboriginal culture; motivations for gambling; how to tell if someone has gambling problems; gambling behaviours; signs evident while gambling; mental and physical health signs; financial signs; social signs; signs evident at home; signs evident in the workplace; approaching someone about their gambling; how to talk to the person; dealing with negative reactions; encouraging professional help; encouraging the person to change; if the person does not want to change; supporting the person to change; what to do if you are concerned for the safety of the person or others

(*Continued*)

Table 5 *(Continued)*

Authors	Topic	Types of experts (*N*)[a]	Number of items endorsed/number rated	Main themes in guidelines
Armstrong *et al*, 2017[37]	Non-suicidal self-injury	Aboriginal and Torres Strait Islander people who had expertise in self-harm through their professional experience (*N* = 25–26)	115/185	What to do if I find someone injuring themselves; what to do if I suspect someone is self-injuring; how to with someone who is injuring themselves; what should be said; encouraging alternatives to self-injury; seeking professional help; what to do if the person continues to self-injure; additional considerations if the person is an adolescent
Armstrong *et al*, 2018[38]	Suicidal thoughts and behaviours	Aboriginal and Torres Strait Islander people who had expertise in self-harm through their professional experience (*N* = 25–27)	172/301	How to tell if someone is feeling suicidal; identification of suicide risk; how to tell how urgent the situation is; how to keep the person safe; talking with the suicidal person; establishing a safety plan; what to do if the person wants me to promise not to tell anyone; additional considerations when the person you are assisting is an adolescent; looking after yourself

a *N* varies depending on Delphi round.

Various guidelines for English-speaking countries have informed a Japanese training course for professional caregivers of people with alcohol problems, including psychiatric service providers, mental health welfare workers and nursing-care staff.[62] However, no evaluation data have been reported.

Guidelines on Iraqi refugees[34] have been used to inform a 7-hour Australian training course for community workers on how to assist Iraqi refugees with depression and post-traumatic stress disorder. An uncontrolled evaluation (with measures at pre-, post- and 6-months follow-up) found a number of improvements, including in mental health first aid knowledge, confidence to help and stigma.[63] However, no change in helping behaviours was found over the follow-up period.

Providing mental health first aid information on the internet and in print

Documents on mental health first aid guidelines have been provided as free downloads on the internet.[64] An evaluation has been carried out on the usefulness and impact of these guidelines on people who download them. People using these resources were asked to complete a pop-up questionnaire at the time of the download and were then followed up a month later to ask what use they had made of the guidelines. Most people reported that they downloaded the guidelines because their job involved contact with people with mental illness. Although the response rate at follow-up was only 22%, there were people who reported that they had used the guidelines to assist someone and that the person had sought professional help as a result. The same methodology was used in a study of a French-language version of the eating disorders guidelines that was made available on a website aimed at French college students.[65] Results were similar, with a small minority of people reporting that they used the information to assist someone, including encouraging professional help.

Guidelines have also been used to provide print information. Psychosis first aid guidelines have been included in a book for patients and their families, but no evaluation has been carried out on the impact of this book.[66]

Evaluating the quality of mental health first aid information

Suicide first aid guidelines have been used as a standard to evaluate the quality of information presented on suicide-prevention websites.[67] A checklist was developed from the guidelines to score whether 26 suicide-prevention actions were recommended on each website. The quality of information was found to be highly variable, with scores ranging from 1 to 19. In an effort to improve the quality of the information provided, a randomised controlled trial was carried out on a feedback intervention. A report on a website's quality was sent to a random half of the website administrators, while the other half served as controls. However, the feedback reports were not found to have any effect when the quality of the websites was reassessed 6 months later.

Assessing the quality of mental health first aid responses

Mental health first aid guidelines have been used to assess quality of mental health first aid intentions and actions in surveys of the general public, most of whom have had no mental health training. The assessment on intentions involved presenting a respondent with a vignette describing a person with a mental health problem and then asking the respondent what they would do if this person was someone they knew and cared about. The assessment on actions involved asking what the respondent had done to help an actual person with a problem similar to the one portrayed in a vignette. Schemes for scoring the quality of responses was developed based on the MHFA Action Plan taught in MHFA courses. This approach was used to examine the quality of intentions in

Table 6 Guidelines for assisting people from Asian countries with mental health problems

Authors	Topic	Types of experts (*N*)[a]	Number of items endorsed/number rated	Main themes in guidelines
Jorm *et al*, 2008[91]	Psychosis in Asian countries	Asian mental health clinicians (*N* = 21–28)	128/211	How to know if someone is experiencing psychosis; how to approach someone who may be experiencing psychosis; how to be supportive; how to deal with communication difficulties; how to deal with delusions and hallucinations; how to encourage the person to get professional help; what to do if the person does not want help; what should be done if the psychotic symptoms are very severe; what to do if the person becomes aggressive
Colucci *et al*, 2010[92]	Suicidal thoughts and behaviours in Philippines	Filipino mental health clinicians with fluency in written English (*N* = 28–34)	102/186	How to tell if someone is feeling suicidal; how to tell if the situation is serious; how to keep the person safe; what about professional help; how to talk with someone who is suicidal; no-suicide contracts; passing time during the crisis
Colucci *et al*, 2010[93]	Suicidal thoughts and behaviours in India	Indian mental health clinicians currently working in India who were fluent in written English (*N* = 23–30)	71/138	How to tell if someone is feeling suicidal; how to tell if the situation is serious; how to keep the person safe; what about professional help; how to talk with someone who is suicidal; no-suicide contracts; passing time during the crisis
Colucci *et al*, 2011[35]	Suicidal thoughts and behaviours in Japan	Japanese mental health professionals with fluency in written English (*N* = 26–32)	56/176	How to tell if someone is feeling suicidal; how to tell if the situation is serious; how to keep the person safe; what about professional help; how to talk with someone who is suicidal; no-suicide contracts
De Silva *et al*, 2016[94]	Suicidal thoughts and behaviours in Sri Lanka	Mental health and suicide prevention experts in Sri Lanka (*N* = 12–14)	304/531	How to tell if someone is feeling suicidal; getting ready to approach the person; making the approach; asking about thoughts of suicide; how to talk with someone who is suicidal; how to tell how urgent the situation is; how to keep the person safe; what about professional and other help; what to do if the suicidal person is reluctant or refuses to seek help; what to do if the suicidal person has a weapon; what to do if the person wants me to promise not to tell anyone else; what to do if the person has acted on suicidal thoughts; self-injury for reasons other than suicide; take care of yourself

a. *N* varies depending on Delphi round.

Australian adults,[68,69] British university students,[70] Sri Lankan university students,[71] Japanese high school students[72] and Australian youth and high school students.[73–75] The quality of actions was also examined in Australian adults,[68,69,76] Australian youth[77] and Australian high school students.[75] In general, these studies have found that the quality of mental health first aid intentions and actions is low.

Discussion

Limitations

There are a number of limitations of the existing guidelines. The first relates to the breadth of the evidence base. In contrast to physical first aid guidelines which uses evidence from trials, case series or animal evidence,[78] all of the mental health first aid guidelines are based on expert opinion. There is also a lack of evidence on whether actions based on the guidelines lead to better health and well-being outcomes. A second limitation is that some of the guidelines were based only on professional expertise, as it was not possible to recruit experts with lived experience. Thirdly, all of the Delphi studies for Asian countries were carried out in English rather than the local languages, which may have biased the recruitment of experts towards those with Western training and limited the opportunity for participation by experts with lived experience. Finally, the authors of this review were involved in the studies on the guidelines, so this is not an independent review. Most of the guideline implementation has been carried out by those that developed the guidelines, but there is considerable scope for others to use them to inform training and other educational programs.

Future directions

A major gap is the lack of guidelines that are appropriate for low- and middle-income countries. People in these countries may differ from those in high-income countries in their vocabulary to describe mental health problems and crises, in the emphasis on individualistic versus collectivistic values, in social role constraints on taking action and in the availability of formal mental health services. Wherever possible, such guidelines should be developed in local languages and have diverse panels, including experts with lived experience.

There is a need for further exploration of the cross-cultural generalisability of guidelines. Although the ideal might be to develop a full suite of guidelines for each country and cultural group, this would be a mammoth task that is likely to be beyond the available resources. However, a set of universally applicable guidelines is also unlikely to be realistic, so solutions involving a compromise need to be explored.

There is also a need to extend the evidence informing guidelines beyond expert consensus where possible. Although such evidence is difficult to obtain for mental health first aid situations, there may be

opportunities to collect experimental or observational evidence in some crisis circumstances, such as panic attacks and following a traumatic event.

Guidelines need to be regularly updated as evidence accumulates and consensus on best practice evolves. Physical first aid guidelines have been revised on a 5-yearly cycle by the International Liaison Committee on Resuscitation.[78] With mental health first aid guidelines, only two have undergone revision and these were 6 years apart. To keep all existing guidelines up to date, Mental Health First Aid International has begun to revise them on a regular cycle.

Anthony F. Jorm, PhD, DSC, Professorial Fellow, Centre for Mental Health, Melbourne School of Population and Global Health, University of Melbourne, Australia; **Anna M. Ross**, MPsych (Clinical), Research Assistant, Centre for Mental Health, Melbourne School of Population and Global Health, University of Melbourne, Australia

Correspondence: Anthony F. Jorm, Centre for Mental Health, Melbourne School of Population and Global Health, University of Melbourne, 207 Bouverie Street, Carlton 3010, Australia. Email: ajorm@unimelb.edu.au

First received 18 Apr 2018, final revision 18 Jul 2018, accepted 12 Sep 2018

Funding

A.F.J. is supported by a National Health and Medical Research Council Senior Principal Research Fellowship.

Acknowledgement

Betty Kitchener provided comments to improve the manuscript.

References

1 Langlands RL, Jorm AF, Kelly CM, Kitchener BA. First aid recommendations for psychosis: using the Delphi method to gain consensus between mental health consumers, carers, and clinicians. *Schizophr Bull* 2008; **34**: 435–43.

2 Kitchener BA, Jorm AF, Kelly CM. *Mental Health First Aid International Manual*. Mental Health First Aid International, 2015.

3 Jorm AF, Medway J, Christensen H, Korten AE, Jacomb PA, Rodgers B. Public beliefs about the helpfulness of interventions for depression: effects on actions taken when experiencing anxiety and depression symptoms. *Aust N Z J Psychiatry* 2000; **34**: 619–26.

4 Jorm AF, Griffiths KM, Christensen H, Parslow RA, Rogers B. Actions taken to cope with depression at different levels of severity: a community survey. *Psychol Med* 2004; **34**: 293–9.

5 Reavley NJ, Jorm AF. Experiences of discrimination and positive treatment in people with mental health problems: findings from an Australian national survey. *Aust N Z J Psychiatry* 2015; **49**: 906–13.

6 Reavley NJ, Morgan AJ, Jorm AF. Predictors of experiences of discrimination and positive treatment in people with mental health problems: findings from an Australian national survey. *Soc Psychiatry Psychiatr Epidemiol* 2017; **52**: 269–77.

7 Lasalvia A, Zoppei S, Van Bortel T, Bonetto C, Cristofalo D, Wahlbeck K, et al. Global pattern of experienced and anticipated discrimination reported by people with major depressive disorder: a cross-sectional survey. *Lancet* 2013; **381**: 55–62.

8 Thornicroft G, Brohan E, Rose D, Sartorius N, Leese M. Global pattern of experienced and anticipated discrimination against people with schizophrenia: a cross-sectional survey. *Lancet* 2009; **373**: 408–15.

9 Cusack J, Deane FP, Wilson CJ, Ciarrochi J. Who influence men to go to therapy? Reports from men attending psychological services. *Int J Adv Couns* 2004; **26**: 271–83.

10 Vogel DL, Wade NG, Wester SR, Larson L, Hackler AH. Seeking help from a mental health professional: the influence of one's social network. *J Clin Psychol* 2007; **63**: 233–45.

11 Ghio L, Gotelli S, Marcenaro M, Amore M, Natta W. Duration of untreated illness and outcomes in unipolar depression: a systematic review and meta-analysis. *J Affect Disord* 2014; **152–4**: 45–51.

12 Penttila M, Jaaskelainen E, Hirvonen N, Isohanni M, Miettunen J. Duration of untreated psychosis as predictor of long-term outcome in schizophrenia: systematic review and meta-analysis. *Br J Psychiatry* 2014; **205**: 88–94.

13 Keitner GI, Ryan CE, Miller IW, Kohn R, Bishop DS, Epstein NB. Role of the family in recovery and major depression. *Am J Psychiatry* 1995; **152**: 1002–8.

14 Hooley JM. Expressed emotion and relapse of psychopathology. *Annu Rev Clin Psychol* 2007; **3**: 329–52.

15 Charuvastra A, Cloitre M. Social bonds and posttraumatic stress disorder. *Annu Rev Psychol* 2008; **59**: 301–28.

16 Jorm AF, Kitchener BA. Noting a landmark achievement: Mental Health First Aid training reaches 1% of Australian adults. *Aust N Z J Psychiatry* 2011; **45**: 808–13.

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

18 Kelly CM, Mithen JM, Fischer JA, Kitchener BA, Jorm AF, Lowe A, et al. Youth mental health first aid: a description of the program and an initial evaluation. *Int J Ment Health Syst* 2011; **5**: 4.

19 Hart LM, Mason RJ, Kelly CM, Cvetkovski S, Jorm AF. 'teen Mental Health First Aid': a description of the program and an initial evaluation. *Int J Ment Health Syst* 2016; **10**: 3.

20 Kitchener BA, Jorm AF, Kelly CM. *Older Person Mental Health First Aid: A Manual for Assisting People Aged 65+*. Mental Health First Aid Australia, 2017.

21 Kanowski LG, Jorm AF, Hart LM. A mental health first aid training program for Australian Aboriginal and Torres Strait Islander peoples: description and initial evaluation. *Int J Ment Health Syst* 2009; **3**: 10.

22 Minas H, Colucci E, Jorm AF. Evaluation of Mental Health First Aid training with members of the Vietnamese community in Melbourne, Australia. *Int J Ment Health Syst* 2009; **3**: 19.

23 Zideman DA, Singletary EM, De Buck ED, Chang WT, Jensen JL, Swain JM, et al. Part 9: first aid: 2015 international consensus on first aid science with treatment recommendations. *Resuscitation* 2015; **95**: e225–61.

24 Hasson F, Keeney S, McKenna H. Research guidelines for the Delphi survey technique. *J Adv Nurs* 2000; **32**: 1008–15.

25 Jones J, Hunter D. Consensus methods for medical and health services research. *BMJ* 1995; **311**: 376–80.

26 Jorm AF. Using the Delphi expert consensus method in mental health research. *Aust N Z J Psychiatry* 2015; **49**: 887–97.

27 Fischer JA, Kelly CM, Kitchener BA, Jorm AF. Development of guidelines for adults on how to communicate with adolescents about mental health problems and other sensitive topics: a Delphi study. *SAGE Open* 2013; **3**; DOI 10.1177/2158244013516769.

28 Bovopoulos N, Jorm AF, Bond KS, LaMontagne AD, Reavley NJ, Kelly CM, et al. Providing mental health first aid in the workplace: a Delphi consensus study. *BMC Psychol* 2016; **4**: 41.

29 Hart LM, Jorm AF, Kanowski LG, Kelly CM, Langlands RL. Mental health first aid for Indigenous Australians: using Delphi consensus studies to develop guidelines for culturally appropriate responses to mental health problems. *BMC Psychiatry* 2009; **9**: 47.

30 Ross AM, Hart LM, Jorm AF, Kelly CM, Kitchener BA. Development of key messages for adolescents on providing basic mental health first aid to peers: a Delphi consensus study. *Early Interv Psychiatry* 2012; **6**: 229–38.

31 Bond K, Jorm A, Kelly C, Kitchener B, Morris S, Mason R. Considerations when providing mental health first aid to an LGBTIQ person: a Delphi study. *Adv Ment Health* 2017; **15**: 183–97.

32 Ross AM, Kelly CM, Jorm AF. Re-development of mental health first aid guidelines for suicidal ideation and behaviour: a delphi study. *BMC Psychiatry* 2014; **14**: 241.

33 Kelly CM, Jorm AF, Kitchener BA. Development of mental health first aid guidelines for panic attacks: a Delphi study. *BMC Psychiatry* 2009; **9**: 49.

34 Uribe Guajardo MG, Slewa-Younan S, Santalucia Y, Jorm AF. Important considerations when providing mental health first aid to Iraqi refugees in Australia: a Delphi study. *Int J Ment Health Syst* 2016; **10**: 54.

35 Colucci E, Kelly CM, Minas H, Jorm AF, Suzuki Y. Mental Health First Aid guidelines for helping a suicidal person: a Delphi consensus study in Japan. *Int J Ment Health Syst* 2011; **5**: 12.

36 Kelly CM, Jorm AF, Kitchener BA, Langlands RL. Development of mental health first aid guidelines for suicidal ideation and behaviour: a Delphi study. *BMC Psychiatry* 2008; **8**: 17.

37 Armstrong G, Ironfield N, Kelly CM, Dart K, Arabena K, Bond K, et al. Re-development of mental health first aid guidelines for supporting Aboriginal and Torres Strait Islanders who are engaging in non-suicidal self-injury. *BMC Psychiatry* 2017; **17**: 300.

38 Armstrong G, Ironfield N, Kelly CM, Dart K, Arabena K, Bond K, et al. Re-development of mental health first aid guidelines for supporting Aboriginal and

Torres Strait Islanders who are experiencing suicidal thoughts and behaviour. *BMC Psychiatry* 2018; **18**: 228.

39 Jorm AF, Ross AM, Colucci E. Cross-cultural generalizability of suicide first aid actions: an analysis of agreement across expert consensus studies from a range of countries and cultures. *BMC Psychiatry* 2018; **18**: 58.

40 Grimshaw JM, Thomas RE, MacLennan G, Fraser C, Ramsay CR, Vale L, et al. Effectiveness and efficiency of guideline dissemination and implementation strategies. *Health Techno Assess* 2004; **8**: iii–iv, 1–72.

41 Kitchener BA, Jorm AF. *Mental Health First Aid Manual*. Centre for Mental Health Research, 2002.

42 Kitchener BA, Jorm AF, Kelly CM. *Mental Health First Aid Manual* (2nd edn). Orygen Youth Health Research Centre, 2010.

43 Kitchener BA, Jorm AF, Kelly CM. *Mental Health First Aid Manual* (4th edn). Mental Health First Aid Australia, 2017.

44 Kitchener BA, Jorm AF, Kelly CM. *Mental Health First Aid Manual* (3rd edn). Mental Health First Aid Australia, 2013.

45 Kelly CM, Kitchener BA, Jorm AF. *Youth Mental Health First Aid: A Manual for Adults Assisting Young People* (2nd edn). Orygen Youth Health Research Centre, 2010.

46 Kelly CM, Kitchener BA, Jorm AF. *Youth Mental Health First Aid: A Manual for Adults Assisting Young People* (3rd edn). Mental Health First Aid Australia, 2013.

47 Kelly CM, Kitchener BA, Jorm AF. *Youth Mental Health First Aid: A Manual for Adults Assisting Young People* (4th edn). Mental Health First Aid Australia, 2017.

48 Bond KS, Jorm AF, Kitchener BA, Reavley NJ. Mental health first aid training for Australian medical and nursing students: an evaluation study. *BMC Psychol* 2015; **3**: 11.

49 Davies EB, Beever E, Glazebrook C. A pilot randomised controlled study of the mental health first aid eLearning course with UK medical students. *BMC Med Educ* 2018; **18**: 45.

50 Hart LM, Kitchener BA, Jorm AF, Kanowski LG. *Aboriginal and Torres Strait Islander Mental Health First Aid Manual* (2nd edn). Mental Health First Aid Australia, 2010.

51 Morgan AJ, Ross A, Reavley NJ. Systematic review and meta-analysis of Mental Health First Aid training: effects on knowledge, stigma, and helping behaviour. *PLoS One* 2018; **13**: e0197102.

52 Jorm AF, Kitchener BA. The truth About Mental Health First Aid training. *Psychiatr Serv* 2018; **69**: 492.

53 Hart LM, Kelly CM, Kitchener BA, Jorm AF. *teen Mental Health First Aid: A Manual for Young People Helping Their Friends*. Mental Health First Aid Australia, 2012.

54 Hart LM, Morgan AJ, Rossetto A, Kelly CM, Mackinnon A, Jorm AF. Helping adolescents to better support their peers with a mental health problem: a cluster-randomised crossover trial of teen Mental Health First Aid. *Aust N Z J Psychiatry* 2018; **52**: 638–51.

55 Kelly CM, Blee FC, Claesson GH. *Mental Health First Aid for the Suicidal Person: Course Handbook*. Mental Health First Aid Australia, 2016.

56 Kato TA, Suzuki Y, Sato R, Fujisawa D, Uehara K, Hashimoto N, et al. Development of 2-hour suicide intervention program among medical residents: first pilot trial. *Psychiatry Clin Neurosci* 2010; **64**: 531–40.

57 Hashimoto N, Suzuki Y, Kato TA, Fujisawa D, Sato R, Aoyama-Uehara K, et al. Effectiveness of suicide prevention gatekeeper-training for university administrative staff in Japan. *Psychiatry Clin Neurosci* 2016; **70**: 62–70.

58 Nakagami Y, Kubo H, Katsuki R, Sakai T, Sugihara G, Naito C, et al. Development of a 2-h suicide prevention program for medical staff including nurses and medical residents: a two-center pilot trial. *J Affect Disord* 2018; **225**: 569–76.

59 Suzuki Y, Kato TA, Sato R, Fujisawa D, Aoyama-Uehara K, Hashimoto N, et al. Effectiveness of brief suicide management training programme for medical residents in Japan: a cluster randomized controlled trial. *Epidemiol Psychiatr Sci* 2014; **23**: 167–76.

60 Hart LM, Jorm AF, Paxton SJ, Kelly CM, Kitchener BA. First aid for eating disorders. *Eat Disord* 2009; **17**: 357–84.

61 Hart LM, Jorm AF, Paxton SJ. Mental health first aid for eating disorders: pilot evaluation of a training program for the public. *BMC Psychiatry* 2012; **12**: 98.

62 Aoyama-Uehara K. [Supporting caregivers for people with alcohol-related problems ways to listen, support, and link with care]. *Seishin Shinkeigaku Zasshi* 2012; **114**: 1284–90.

63 Uribe Guajardo MG, Slewa-Younan S, Kitchener BA, Mannan H, Mohammad Y, Jorm AF. Improving the capacity of community-based workers in Australia to provide initial assistance to Iraqi refugees with mental health problems: an uncontrolled evaluation of a Mental Health Literacy Course. *Int J Ment Health Syst* 2018; **12**: 2.

64 Hart LM, Jorm AF, Paxton SJ, Cvetkovski S. Mental health first aid guidelines: an evaluation of impact following download from the World Wide Web. *Early Interv Psychiatry* 2012; **6**: 399–406.

65 Melioli T, Rispal M, Hart LM, Chabrol H, Rodgers RF. French mental health first aid guidelines for eating disorders: an exploration of user characteristics and usefulness among college students. *Early Interv Psychiatry* 2018; **12**: 229–33.

66 Compton MT, Broussard B. *The First Episode of Psychosis: A Guide for Patients and Their Families*. Oxford University Press, 2009.

67 Jorm AF, Fischer JA, Oh E. Effect of feedback on the quality of suicide prevention websites: randomised controlled trial. *Br J Psychiatry* 2010; **197**: 73–4.

68 Rossetto A, Jorm AF, Reavley NJ. Quality of helping behaviours of members of the public towards a person with a mental illness: a descriptive analysis of data from an Australian national survey. *Ann Gen Psychiatry* 2014; **13**: 2.

69 Rossetto A, Jorm AF, Reavley NJ. Predictors of adults' helping intentions and behaviours towards a person with a mental illness: a six-month follow-up study. *Psychiatry Res* 2016; **240**: 170–6.

70 Davies EB, Wardlaw J, Morriss R, Glazebrook C. An experimental study exploring the impact of vignette gender on the quality of university students' mental health first aid for peers with symptoms of depression. *BMC Public Health* 2016; **16**: 187.

71 Amarasuriya SD, Reavley NJ, Rossetto A, Jorm AF. Helping intentions of undergraduates towards their depressed peers: a cross-sectional study in Sri Lanka. *BMC Psychiatry* 2017; **17**: 40.

72 Yoshioka K, Reavley NJ, Rossetto A, Jorm AF. Beliefs about first aid for mental disorders: results from a mental health literacy survey of Japanese high school students. *Int J Cult Ment Health* 2015; **8**: 223–30.

73 Yap MBH, Reavley NJ, Jorm AF. Intentions and helpfulness beliefs about first aid responses for young people with mental disorders: findings from two Australian national surveys of youth. *J Affect Disord* 2012; **136**: 430–42.

74 Yap MBH, Reavley NJ, Jorm AF. Is the use of accurate psychiatric labels associated with intentions and beliefs about responses to mental illness in a friend? Findings from two national surveys of Australian youth. *Epidemiol Psychiatr Sci* 2015; **24**: 54–68.

75 Mason RJ, Hart LM, Rossetto A, Jorm AF. Quality and predictors of adolescents' first aid intentions and actions towards a peer with a mental health problem. *Psychiatry Res* 2015; **228**: 31–8.

76 Rossetto A, Jorm AF, Reavley NJ. Examining predictors of help giving toward people with a mental illness: results from a national survey of Australian adults. *SAGE Open* 2014; **4**; DOI:10.1177/2158244014537502.

77 Yap MBH, Jorm AF. Young people's mental health first aid intentions and beliefs prospectively predict their actions: findings from an Australian National Survey of Youth. *Psychiatry Res* 2012; **196**: 315–9.

78 Singletary EM, Zideman DA, De Buck ED, Chang WT, Jensen JL, Swain JM, et al. Part 9: first aid: 2015 international consensus on first aid science with treatment recommendations. *Circulation* 2015; **132**: S269–311.

79 Ross AM, Kelly CM, Jorm AF. Re-development of mental health first aid guidelines for non-suicidal self-injury: a Delphi study. *BMC Psychiatry* 2014; **14**: 236.

80 Bond KS, Jorm AF, Miller HE, Rodda SN, Reavley NJ, Kelly CM, et al. How a concerned family member, friend or member of the public can help someone with gambling problems: a Delphi consensus study. *BMC Psychol* 2016; **4**: 6.

81 Bond KS, Jorm AF, Kitchener BA, Kelly CM, Chalmers KJ. Development of guidelines for family and non-professional helpers on assisting an older person who is developing cognitive impairment or has dementia: a Delphi expert consensus study. *BMC Geriatr* 2016; **16**: 129.

82 Kelly CM, Jorm AF, Kitchener BA, Langlands RL. Development of mental health first aid guidelines for deliberate non-suicidal self-injury: a Delphi study. *BMC Psychiatry* 2008; **8**: 62.

83 Langlands RL, Jorm AF, Kelly CM, Kitchener BA. First aid for depression: a Delphi consensus study with consumers, carers and clinicians. *J Affect Disord* 2008; **105**: 157–65.

84 Kingston AH, Jorm AF, Kitchener BA, Hides L, Kelly CM, Morgan AJ, et al. Helping someone with problem drinking: mental health first aid guidelines - a Delphi expert consensus study. *BMC Psychiatry* 2009; **9**: 79.

85 Kelly CM, Jorm AF, Kitchener BA. Development of mental health first aid guidelines on how a member of the public can support a person affected by a traumatic event: a Delphi study. *BMC Psychiatry* 2010; **10**: 49.

86 Kingston AH, Morgan AJ, Jorm AF, Hall K, Hart LM, Kelly CM, et al. Helping someone with problem drug use: a Delphi consensus study of consumers, carers, and clinicians. *BMC Psychiatry* 2011; **11**: 3.

87 Colucci E, Jorm AF, Kelly CM, Minas H. Suicide first aid guidelines for individuals from immigrant or refugee background: a Delphi consensus study. *Adv Ment Health* 2018; **16**: 105–16.

88 Hart LM, Bourchier SJ, Jorm AF, Kanowski LG, Kingston AH, Stanley D, et al. Development of mental health first aid guidelines for Aboriginal and Torres

Strait Islander people experiencing problems with substance use: a Delphi study. *BMC Psychiatry* 2010; **10**: 78.

89 Chalmers KJ, Bond KS, Jorm AF, Kelly CM, Kitchener BA, Williams-Tchen A. Providing culturally appropriate mental health first aid to an Aboriginal or Torres Strait Islander adolescent: development of expert consensus guidelines. *Int J Ment Health Syst* 2014; **8**: 6.

90 Bond KS, Dart KM, Jorm AF, Kelly CM, Kitchener BA, Reavley NJ. Assisting an Australian Aboriginal and Torres Strait Islander person with gambling problems: a Delphi study. *BMC Psychol* 2017; **5**: 27.

91 Jorm AF, Minas H, Langlands RL, Kelly CM. First aid guidelines for psychosis in Asian countries: a Delphi consensus study. *Int J Ment Health Syst* 2008; **2**: 2.

92 Colucci E, Kelly CM, Minas H, Jorm AF, Nadera D. Mental Health First Aid guidelines for helping a suicidal person: a Delphi consensus study in the Philippines. *Int J Ment Health Syst* 2010; **4**: 32.

93 Colucci E, Kelly CM, Minas H, Jorm AF, Chatterjee S. Mental Health First Aid guidelines for helping a suicidal person: a Delphi consensus study in India. *Int J Ment Health Syst* 2010; **4**: 4.

94 De Silva SA, Colucci E, Mendis J, Kelly CM, Jorm AF, Minas H. Suicide first aid guidelines for Sri Lanka: a Delphi consensus study. *Int J Ment Health Syst* 2016; **10**: 53.

OPEN ACCESS

BY NC ND

University Library

MINERVA ACCESS

A gateway to Melbourne's research publications

Minerva Access is the Institutional Repository of The University of Melbourne

Author/s:
Jorm, AF;Ross, AM

Title:
Guidelines for the public on how to provide mental health first aid: narrative review

Date:
2018-11

Citation:
Jorm, A. F. & Ross, A. M. (2018). Guidelines for the public on how to provide mental health first aid: narrative review. BJPSYCH OPEN, 4 (6), pp.427-440. https://doi.org/10.1192/bjo.2018.58.

Persistent Link:
http://hdl.handle.net/11343/253413

License:
CC BY-NC-ND