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# Summary of the evidence on the effectiveness of Mental Health First Aid (MHFA) training in the workplace

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**The Mental Health First Aid (MHFA) training programme was first developed to train the public in providing help to adults with mental ill-health problems. Recently there has been an increase in undertaking MHFA training in workplace settings.**

**As the regulator for workplace health and safety, the Health and Safety Executive (HSE) wishes to understand the strength of the available evidence on the effectiveness of MHFA in the workplace. A rapid scoping evidence review was undertaken that considered three research questions on the impact, influence and application of MHFA training in workplaces.**

**A number of knowledge gaps have been identified in this evidence review that mean it is not possible to state whether MHFA training is effective in a workplace setting. There is a lack of published occupationally-based studies, with limited evidence that the content of MHFA training has been considered for workplace settings. There is consistent evidence that MHFA training raises employees' awareness of mental ill-health conditions. There is no evidence that the introduction of MHFA training in workplaces has resulted in sustained actions in those trained, or that it has improved the wider management of mental ill-health.**

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# Summary of the evidence on the effectiveness of Mental Health First Aid (MHFA) training in the workplace

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## KEY MESSAGES

A Mental Health First Aid (MHFA) training programme was first developed in Australia to train the public in providing help to adults with mental ill-health problems. Subsequently MHFA training has been taken up by other countries including Great Britain. Recently there has been an increase in undertaking MHFA training in workplace settings. In order to understand the strength of the available evidence on the effectiveness of MHFA in the workplace to improve the organisational management of mental-ill health, a rapid scoping evidence review was undertaken. This review considered three research questions on the impact, influence and application of MHFA training in workplaces. The review found that:

- There are only a small number of published occupational studies that have addressed mental health first aid (MHFA) and these had design and quality limitations.
- There is limited evidence that the content of MHFA training has been adapted for workplace circumstances.
- There is consistent evidence that MHFA training raises employees' awareness of mental ill-health conditions, including signs and symptoms.
- There is limited evidence that MHFA training leads to sustained improvement in the ability of those trained to help colleagues experiencing mental ill-health.
- There is no evidence that the introduction of MHFA training has improved the organisational management of mental health in workplaces.

# EXECUTIVE SUMMARY

**Background**: The Mental Health First Aid (MHFA) training programme originated in Australia in 2001 in response to survey findings showing poor mental health literacy amongst the public. Initially a short MHFA training course was developed, comparable to conventional first aid training. This was offered to members of the public to improve their understanding of and change attitudes towards mental ill-health, as well as enable them to identify individuals at risk of mental-ill health, or experiencing a mental ill-health crisis.

An evaluation of this training led to the course content and duration being extended. Subsequently, MHFA training has been taken up by other countries including in Great Britain (GB). In recent years there has been an interest in applying MHFA training in workplaces to provide early interventions to employees experiencing mental ill-health problems in work, or as a consequence of their work.

Improving the management of mental health in the workplace is an important topic for GB government. Understanding the quality of the current evidence base on the effectiveness of MHFA training in workplaces will inform HSE in the development of its policy position on work-related mental ill health.

**Methodology:** A rapid scoping evidence review was undertaken to provide informed conclusions about the volume and quality of the evidence base in relation to three specific research questions that would help inform HSE's policy development. A structured approach was used to assess the relevance and robustness of international peer-reviewed research on the application of MHFA specifically in the workplace setting.

A search of published primary research, grey literature and reviews was undertaken. These studies were examined and exclusion and inclusion criteria applied to identify studies about MHFA training in workplaces. Conclusions and results from the relevant studies were then extracted using data extraction tables containing a consistent set of questions and check lists to capture information about the research aims, study design, methodology, analysis of the results etc. In addition to searching published research, an internet search was conducted to look for United Kingdom (UK) organisations providing MHFA training to ascertain whether they had adapted their services to specific occupational groups or professions. In the context of this review the term 'mental health' is used synonymously with the World Health Organisation's definition[1]. With regard to employees experiencing mental ill-health, this term is used in the broadest sense reflecting a spectrum of conditions from e.g., anxiety to mental-illness.

[1] http://www.who.int/mental_health/en/

The research questions addressed in this evidence review were:

1. Has there been an increase in awareness of mental health amongst employees (i.e. all staff employed by an organisation, including leaders/managers) receiving MHFA training?
2. Is there evidence of improved management of mental health in the workplace as a consequence of the introduction of MHFA training?
3. Is there evidence that the content of the MHFA training has been considered for workplace settings?

**Conclusions:** Based on the published research, it is not possible to state whether MHFA training is effective in a workplace setting to improve the organisational management of mental-ill health. There is a lack of published occupationally-based studies, and the studies that have been conducted are limited in quality. Based on the evidence reviewed, the following summary statements can be made:

- There is consistent evidence that MHFA training raises employees' awareness of mental ill-health conditions, including signs and symptoms. Those trained have a better understanding of where to find information and professional support, and are more confident in helping individuals experiencing mental ill-health or a crisis.
- There is no evidence from the published evaluation studies that the introduction of MHFA training in workplaces has resulted in sustained actions by those receiving the training or that it has improved the management of mental health in the workplace.
- There is limited evidence that the content of MHFA training has been considered for workplace settings.

**Gaps in the evidence base** were attributable to a lack of well-designed cross-industry evaluations of the impact of MHFA training. Other knowledge gaps included:

- Does MHFA training lead to sustained improvement in trainees' ability to help colleagues experiencing mental ill-health.
- What is the impact of MHFA training on the management of mental health in the workplace?
- Are the resource requirements and costs of undertaking MHFA training commensurate with the potential beneficial outcomes for the individual with metal ill-health, and for their organisation.
- What are the most achieve effective ways to undertake MHFA training in different workplaces to improve personal metal health as well as the organisational management of mental-ill.

# CONTENTS

# 1.0 INTRODUCTION

Improving the management of mental health in the workplace is an important topic for GB government. Understanding the quality of the current evidence base on the effectiveness of mental health first aid (MHFA) training in workplaces is important to the Health and Safety Executive (HSE) to inform its policy position on work-related mental ill health.

The MHFA programme was developed in Australia by Betty Kitchener and Anthony Jorm (Jorm *et al*., 1997; cited in Kitchener and Jorm, 2008). It began in 2001 in response to the findings from Australian surveys showing poor mental health literacy among the public, i.e. poor recognition of mental health disorders and lack of knowledge about appropriate responses and treatments (Jorm *et al*., 1997; Jorm *et al.,* 2005, both cited in Kitchener and Jorm, 2008). Initially, a nine-hour course was developed, following a model successfully used for conventional first aid training. The purpose of the course is to equip members of the public to help others suffering with mental ill-health, or those experiencing a mental ill-health crisis. A year later, based on participant feedback the course was extended to 12 hours (Kitchener and Jorm, 2002, cited in Kitchener and Jorm, 2008).

According to MHFA England[2] this course

*'has evolved into a global movement with licensed programmes so far in 24 countries and counting. Over two million people have been trained in MHFA skills worldwide. MHFA came to England in 2007 and was launched under the Department of Health… as part of a national approach to improving public mental health'* (see the MHFA England website[3]).

The MHFA training provided in GB follows closely the process developed in Australia. The Department of Health has subsequently encouraged all employers in England to provide MHFA training as one of three steps in its 2012 'No Health Without Mental Health: Implementation Framework'[4].

MHFA is 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 treatment is received or until the crisis resolves"*

(Kitchener and Jorm, 2002, cited in Kitchener and Jorm, 2008).

The concept of MHFA extends the notion of conventional first aid which is already familiar to members of the public as a means of helping with physical health crises (Kitchener and Jorm, 2008).

[2] MHFA England is a community interest company that delivers MHFA training, courses and consultancy.
[3] https://mhfaengland.org/mhfa-centre/about/" [Accessed 19.07.2017]
[4] https://www.gov.uk/government/publications/mental-health-implementation-framework [Accessed 19.07.2017]

On their website, MHFA England (a community interest company which delivers MHFA courses, training and consultancy) state that their training courses teach people to spot in others symptoms of mental health, and to initiate help for these persons.

"*We don't teach people to be therapists – but just like physical first aid, we teach people to listen, reassure and respond, even in a crisis*." (See Mental Health First Aid England[5])

As described by Kitchener and Jorm (2008), the MHFA course in England includes the recognition of symptoms and risk factors in depressive, anxiety, psychotic and substance use disorders and associated mental ill-health and crisis situations; as well as suicidal thoughts and behaviours, panic attacks, experiencing a traumatic event, behaviour which is perceived as threatening, and issues surrounding drug overdosing. As in conventional first aid, an action plan is taught following ALGEE ('*Assess risk of suicide or harm'; 'Listen non-judgementally'; 'Give reassurance and information'; 'Encourage the person to get appropriate professional help*'; and '*Encourage self-help strategies'*). Appropriate skills for these five actions are practised for each mental health disorder and crisis covered. In addition, employees undergoing the training are helped to recognise and to support colleagues experiencing mental ill-health or experiencing a crisis situation; including where to access further help, information, and additional professional support.

## PURPOSE OF THE EVIDENCE SUMMARY

This document summarises the existing literature on the MHFA training in the workplace context since the methodology was introduced in 2001. To address HSE policy needs, the summary focusses on three research questions:

1. Has there been an increase in awareness of mental health amongst employees (i.e. all staff employed by an organisation, including leaders/managers) receiving MHFA training?
2. Is there evidence of improved management of mental health in the workplace as a consequence of the introduction of MHFA training?
3. Is there evidence that the content of the MHFA training has been considered for workplace settings?

For the first research question, HSE policymakers wished to know if there is evidence of increased awareness of mental health in members of a workforce who have received MHFA training (i.e. individual-level training outcomes). The research question considered awareness raising in its broadest sense to include: increased awareness of mental ill-health issues affecting staff/colleagues; improved attitudes towards mental health (i.e. reduced stigma); being able to recognise when

[5] https://mhfaengland.org/organisations/workplace/ [Accessed 20.07.2017]

colleagues may be experiencing mental ill-health or experiencing a crisis situation; understanding appropriate ways to provide initial help and identify appropriate information sources and professional support; and increased confidence to provide help.

For the second research question, HSE policymakers wanted to know if there is evidence that MHFA training is supported by improved management of mental health. Consistent with the MHFA guidelines for organisations implementing workplace prevention of mental ill-health[6] this requires:

- evidence of 'improved management' including a full understanding of the legal responsibilities; and the development of a comprehensive health and wellbeing policy to prevent mental ill-health[7];
- an assessment of current mental health and wellbeing needs;
- development of a positive workplace culture through making leaders/managers accountable for maintaining a mentally healthy workplace;
- being good role-models and taking action to support employee mental health;
- senior management provision of appropriate resources to implement the strategy, to educate and upskill staff, to provide a range of support systems (e.g. occupational health services or employee assistance programmes), and to support treatment interventions.

For the third research question, HSE policymakers wished to know if there is evidence showing how MHFA training has evolved to be used in workplaces. In particular, evidence that the training has been tailored to meet the needs of different organisations. This included consideration of:

- the sector
- the size of the organisation
- current needs/culture (all of which influence an organisation's level of receptiveness and ability to implement the learning from the training).

In the context of this review the term 'mental health' is used synonymously with the World Health Organisation's definition[8]. With regard to employees experiencing mental ill-health, this term is used in the broadest sense reflecting a spectrum of conditions from e.g., anxiety to mental-illness.

[6] https://mhfa.com.au/sites/default/files/GUIDELINES-for-workplace-prevention-of-mental-health-problems.pdf
[7] This should consider the impact of work factors on mental health or aggravation of mental health issues.
[8] http://www.who.int/mental_health/en/

# 2.0 METHODOLOGY

The approach adopted for this evidence summary is consistent with a rapid scoping review to provide informed conclusions about the volume and characteristics of the evidence base and a synthesis of what that evidence indicates in relation to the research questions posed (Collins *et al.,* 2014). A structured approach was adopted to assess the level of relevance and robustness of international peer-reviewed research relevant to the application of MHFA in the workplace. This was used to produce evidence-based statements addressing each research question and to identify gaps in the evidence.

A team of HSE researchers undertook the following:

- Searches for published research and reviews of such research (between January 2000 and July 2017) in peer review journals using on line academic databases and using specific search terms (Tables 1, 2 and 3 in the Appendix);
- Screening the search results to sift out relevant articles based on their titles (first phase screening) and abstracts (second phase screening) and employing inclusion/exclusion criteria

  (Tables 4 and 5 in the Appendix);
- Extracting data from selected articles using a data extraction form (Table 6 in the Appendix) to assess the quality of each article (using the criteria in Tables 7, 8, 9 and 10 in the Appendix). Researchers jointly assessed the first article to promote consistency in extraction techniques;
- A meeting to evaluate the robustness of the evidence (Table 11 in the Appendix), to prepare the evidence statements, and to identify limitations and knowledge gaps.

In addition to searching published research, an internet search was conducted to look for United Kingdom (UK) organisations providing MHFA training to ascertain whether they adapted these services to specific occupations (relevant to research question 3).

The details of the methodology used including search terms, inclusion and exclusion criteria and quality rating of the source studies are summarised in the Appendix (Section 6.0).

The research questions were used to identify search terms and to set exclusion and inclusion criteria. These questions also informed additional questions and criteria used in the data extraction tables.

# 3.0 RESULTS

## 3.1 OVERVIEW OF THE EVIDENCE

As shown in Figure 1, there were very few studies (n=22) that were relevant to the research questions. Overall, the majority of these were single studies and only three of these met the criteria for the highest quality score; that is studies sufficiently well-designed and executed to reduce uncertainty due to bias.

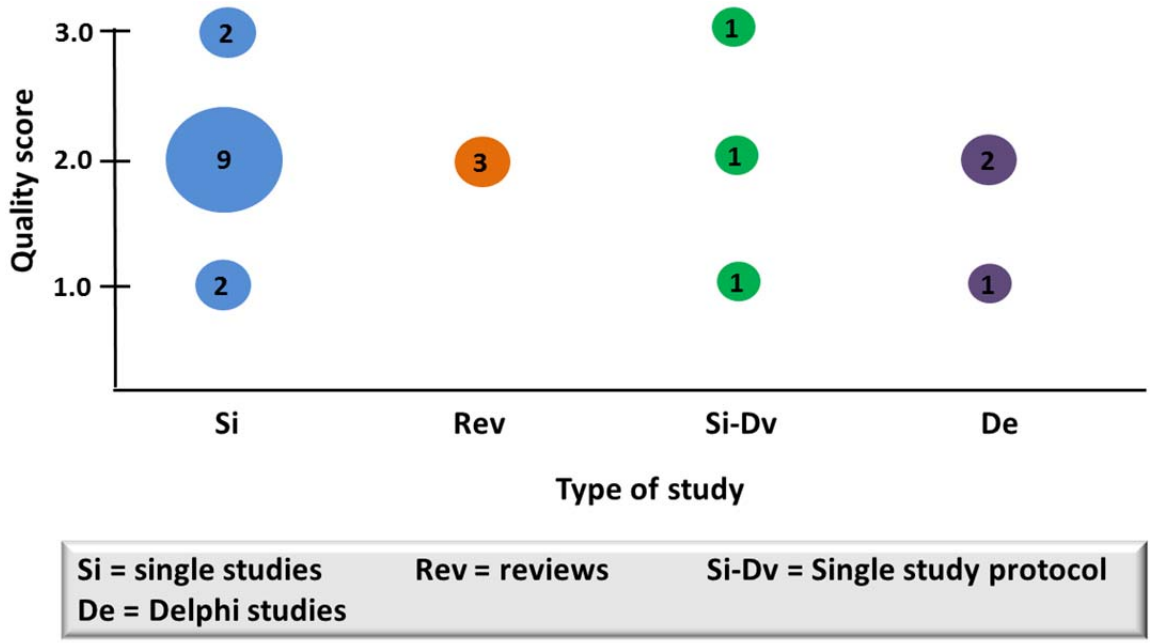


**Figure 1**: Summary of the distribution of quality scores against each category of evidence used, and number of papers in each category for papers published between January 2000 and July 2017. The quality score is described in detail in table 9 in the Appendix: score 3 is for the highest quality evidence with low risk of bias, score 2 is for evidence with risk of bias, and score 1 is for evidence with high risk of bias.

## 3.2 EVIDENCE-BASED STATEMENTS

This section presents the evidence statements for the three research questions. These summaries focus on studies considered of high, or at least, reasonable quality (i.e., 18 studies shown in Figure 1 with quality score 3 or 2.) These mostly included single studies and narrative reviews. The searches did not find any systematic reviews of studies that considered MHFA training in workplaces.

**Research question 1:** Has there been an increase in awareness of mental health amongst employees (i.e. all staff employed by an organisation, including leaders/managers) receiving MHFA training?

**Evidence Statement 1**

There is consistent evidence that MHFA training raises employees' awareness of mental ill-health conditions, including signs and symptoms. Trainees have a better understanding of where to find information and professional support, and are more confident in helping individuals experiencing mental ill-health or a crisis.

This statement is based on 14 sources of evidence (Table 12). The evidence sources ranged in quality with the majority having a quality score of 2 (Table 9 in the Appendix for the scoring criteria). Only two papers showed low risk of bias, with a quality rating of 3 (Jorm *et al.,* 2010; Jenson *et al.,* 2016).

Studies by Jorm *et al*. (2010) in Australia and Jenson *et al*. (2016) in Denmark reported that training improved trainee knowledge and their confidence in helping other people with mental ill-health conditions. The study by Jorm *et al.* (2010) considered teachers that received MHFA training to support students. Both studies found that positive changes were sustained six months after the training. Whilst both studies found improved positive attitudes (i.e. decreased stigmatizing attitudes) towards people suffering from mental ill-health, these attitudinal changes were limited. For example, no beneficial effects were found on teachers' individual support towards students with mental health problems or on student mental health. Furthermore, these studies did not find an increase in 'helping behaviours' six months after the training. Jorm *et al*. (2010) found that the students receiving MHFA did not perceive an improvement in help they received; including those students who had the worst mental health outcome score at the start of the intervention. An indirect benefit of the intervention was that students reported receiving more information about mental health from these teachers. These conclusions were supported by lower quality single studies, which also indicated that trainees showed an improvement in knowledge about mental health, and in their attitude to and confidence in providing help[9] to others. For example:

- In a study of Swedish public sector workers by Svensson and Hansson (2014), they showed improved awareness of mental ill-health and preparedness to help those experiencing a mental

[9] **Please note:** Not all of the studies assessed every planned outcome, i.e., whether the training improved knowledge about mental ill health, or the help provided to those in need; whether trainee confidence in offering help was supported as well improving attitudes to those with mental ill health.

ill-health crisis sustained over two-years (Svensson and Hansson, 2015). However, the results two years after the training showed that many trainees struggled to deal with addressing suicidal ideation, but all found it easier to listen non-judgmentally.

- In a pilot study of UK teachers, Kidger *et al.* (2016) reported that both the adult and youth MHFA courses were effective at improving the knowledge, attitudes, confidence and skills in supporting both staff and students.
- An earlier study by Kitchener and Jorm (2004) of Australian government workers demonstrated improved mental health literacy (concordance with health professionals in beliefs about treatment), increased confidence in providing help to others, decreased social distance from people suffering from depression, and greater likelihood of advising people to seek professional help. The training also benefited the mental health of the trainees; however, the cause of the improvement was not clear.

The three reviews (Booth *et al*., 2017; Hadlaczky *et al*., 2014; Kitchener and Jorm, 2016) all reported a positive improvement amongst public sector workers' immediately following the training and up to six months after. These improvements included their knowledge, preparedness and confidence to intervene to help others.

Kitchener and Jorm (2016) included three of their studies in a review of evidence, whereas Booth *et al.* review included three randomised control trials of MHFA training (i.e. Jorm *et al*., 2010; Svensson *et al*., 2014; Lipson *et al*., 2014) in their review. These reviews provided limited evidence about the impact of MHFA on the trainee's awareness of mental ill-health or longer term changes resulting in helping behaviour. The Kitchener and Jorm review (2016) mentioned an example of improved behaviour towards those with mental ill-health, and Booth *et al* (2017) summarised an example where trained staff provided additional information to students experiencing mental ill-health.

**Key Knowledge Gap 1**

- It is not known (even in studies by the MHFA course providers) whether the MHFA training leads to sustained improvement in trainees' ability to help colleagues experiencing mental ill-health.
- There is an assumption in many of the published studies that individuals undertaking MHFA training benefit themselves from this process.
- There is a lack of well-designed impact evaluation studies in the various industries that have investigated the impact of training non-professionals to assist those with mental ill-health.

**Research question 2:** Is there evidence of improved management of mental health in the workplace as a consequence of the introduction of MHFA training?

**Evidence Statement 2**

There is no evidence from the published evaluation studies that the introduction of MHFA training in workplaces has resulted in sustained actions in those trained or improved the management of mental health in workplace settings.

This statement is based on three sources of evidence (Table 12). The studies ranged in quality and only one was designed sufficiently well to reduce bias (Jorm *et al.,* 2010).

Two of the three studies explored a specific organisational intervention (i.e. changes to mental health policies/procedures and a peer-support intervention), central to management of mental health in the workplace:

- The study by Jorm *et al.* (2010) provided evidence that MHFA training affected school policies and procedures for addressing mental health. Teachers at schools who had received the training were more likely to report six months after the training that there was a written school policy on student mental health and that this policy had been implemented. For example, the teachers who had received the training said that they had personally followed the school policy in the past month. However, it was not made clear whether this led to new policies being introduced and training introduced as well as raising awareness of these policies. The study also did not explore if the existing policies were adequate.
- The Kidger *et al*. (2016) pilot study of English secondary schools reported on the implementation of a peer-support system that included staff of different seniority in various roles. Those staff nominated to be peer-supporters received the MHFA training. The authors concluded that the peer-support intervention may have equipped those already providing help to do this more effectively. They also concluded that the group's confidence in helping colleagues with mental ill-health rose substantially at follow up, without increasing the workload of the peer-supporters.
- The third study by Bovopoulos *et al*. (2016) provided limited findings about the impact of MHFA training on organisational outcomes, these included a reduction in employee stress related legal claims, increased referral to counselling services and a reduction in worker compensation injury claims as well as the cost of the insurance. However, these findings were based only on 120 accredited/recently-lapsed MHFA instructors' self-reporting up to 12 months after receiving the training.

Whilst there is currently a lack of relevant studies about the application of MHFA in workplaces, current research is studying organisational-level changes following the implementation of MHFA training. Kidger *et al*., (2016) published a protocol for a larger intervention trial and this was based on the results of a pilot study that examined the impact of MHFA training in English secondary schools. Their protocol proposed a study to consider the following outcomes; the impact of the training on the senior management in these schools; changes to peer support for teachers and students; changes in self-reporting of concerns about mental ill-health; and the application and overall value of the training. Researchers at the University of Nottingham have recently launched a new study to evaluate MHFA training in workplaces, to identify those most in need of help, and to provide support before long-term sickness absence or 'presenteeism' occurs. These studies are likely to report in 2018.

**Key Knowledge Gap 2**

- Evidence is required whether introducing MHFA training improves the management of mental health in workplaces.
- Evidence is required about resource requirements and costs of MHFA training versus beneficial outcomes for organisations.

**Research question 3:** Is there evidence that the content of the MHFA training has been considered for workplace settings?

**Evidence Statement 3**

There is limited evidence that the content of the MHFA training has been considered for workplace settings.

This statement is based on nine studies (Table 12) but the quality of these studies was generally low and only one study (Jenson *et al*., 2016) was undertaken in a way that reduced bias.

MHFA training has been introduced into the public, educational, healthcare and agriculture sectors, and feedback from participants has been used to adapt the course to the target occupational group (e.g. Kitchener & Jorm, 2004; Moffitt, *et al.,* 2014). However, details were not provided about how the course content was modified for each occupation. For example:

- The highest quality study by Jenson *et al*. (2016) reported that the course was *"translated and modified to suit the Danish context"*, but no explanation was provided about what this modification entailed.
- The three studies included in the Booth *et al.* (2017) review also provided little insight into how the MHFA course was tailored for specific occupational groups. At one of the sites departmental policies on mental health had been considered as well as issues likely to impact trainees such as common mental health disorders in adolescents.

Some of the studies provided limited insight into the design and delivery of MHFA training in workplaces for example:

- In considering how to adapt MHFA training (Bovopoulos *et al.,* 2016) some groups had considered workplace factors influencing anxiety, depression, suicidal thoughts and behaviours. However, dealing with other issues such as non-suicidal self-injury, acute intoxication, and psychotic illness, were subjects of ongoing debate.
- Providing short duration courses for busy employees whilst providing sufficient depth and scope for practicing skills. Kidger *et al.* (2016) suggested focussing only on skills and strategies relevant to teachers in schools given the many demands on their time.
- Bovopoulos *et al*. (2016) considered whether MHFA courses should be tailored to the grade of staff e.g. teachers or teaching assistants. They concluded that a standard course was unlikely to be effective and that the training should be adapted to the needs of each profession and industry.
- Tailored workplace training should address specific workplace barriers such as concerns about confidentiality; being judged at work for discussing mental ill-health; being concerned that a person reporting problems might become a burden to others in high pressure environments (Kidger *et al*., 2016).
- MHFA courses have generally been delivered by mental health professionals with a good background understanding about mental health (e.g. Jenson *et al.*, 2016; Moffitt, *et al*., 2014). Terry's (2011) study involving MHFA instructors from the public and private sectors, considered that MHFA instructors needed prior general experience of mental ill-health and a good support network with access to clinical support and supervision. Furthermore, delivery of MHFA courses by two trainers enabled them to give 'one-to-one' support should trainees experience distress.

- Guidelines for MHFA training[10] were modified to support organisations considering MHFA training based on a Delphi exercise reported by Bovopoulos, *et al.* (2016). These guidelines outlined key ways to recognise signs and symptoms in those experiencing mental ill-health at work. This included understanding how work contributes to mental ill-health problems; developing skills for initiating conversations with colleagues in a non-judgmental way; and strategies for managing crisis situations such as acute distress and intoxication.

  They also recognised the need for specific guidance for line managers. For example, what reasonable adjustments are required in managing the performance of an individual experiencing mental ill-health? Bovopoulos, *et al.* (2016) did not state whether these guidelines had been tested to ensure they are 'fit-for-purpose'. MHFA training bodies were likely to consider this guidance most applicable to large organisations.

To assess the current provision in GB, an internet search was conducted for providers of MHFA training to organisations and businesses. Of 28 businesses and organisations providing this training, only a few specifically mentioned tailoring the MHFA training for workplaces. Some of these organisations described their training course as accredited. However, it should be noted that it is only the MHFA instructor course which is accredited by Royal Society of Public Health[11].

**Key Knowledge Gap 3**

- The published research mentioned the importance of tailoring MHFA training to different organisations, but robust evidence for how achieve this for different sectors and specific workplaces has not been presented in the current published research.

[10] See https://mhfa.com.au/sites/default/files/GUIDELINES-for-workplace-prevention-of-mental-health-problems.pdf"
[11] MHFA website: https://mhfaengland.org/

### 3.3 LIMITATIONS IN THE EVIDENCE

The following limitations in the design of the studies of MHFA training were recognised:

- In most of the published studies the training was evaluated by the individuals who developed MHFA, and by the wider consultancy group that developed this methodology with affiliated research organisations. The evaluations were mostly restricted to large organisations with employees working in public sector professions (public servants, healthcare workers and teachers).
- The studies typically involved self-selected workers in public sector professions who were likely to have some understanding of mental ill-health and relevant helping skills before they received the training.
- The studies did not consider professions, such as construction workers, who have no experience of a health care culture (Hadlaczky, *et al*., 2014).
- The studies mostly involved female workers and therefore, may not be representative of the outcomes for men receiving MHFA training.
- In most studies MHFA trainees were asked to self-report improvements in their knowledge, attitudes, and confidence after completing MHFA courses. The questionnaires used for this purpose were widely adopted but the studies did not assess whether sustained mental health and well-being benefits had been the experience in those helped by MHFA trainees.
- Only a few studies had investigated whether MHFA trainees' helping behaviour was sustained and what impact this had on the colleagues they helped, with MHFA trainees mostly self-reporting that they had used their newly acquired skills (e.g. Jorm *et al.,* 2005; Kitchener and Jorm, 2008; Svensson and Hansson, 2014).
- A few studies provided evidence that organisational change may be required to support MHFA training, including revised organisational policies/procedures, and broader cultural changes.
- Insights from research on Psychological First Aid[12] has shown that people are less likely to be comfortable discussing sensitive issues with co-workers when their organisation does not support employee well-being (Chandra *et al*., 2014).
- There was only anecdotal evidence that MHFA training improved organisational outcomes resulting in fewer employee claims for stress related illness.

[12] Psychological First Aid is based on a model applicable to public health disaster management.

# 4.0 CONCLUSIONS

It is not possible at the time of writing this evidence summary to state whether MHFA training is effective in a workplace setting. This is due to the small number of occupationally based studies on MHFA training and their limited quality which raises questions about uncertainty and bias affecting the outcomes reported.

Based on the evidence reviewed in relation to the three research questions, there is consistent evidence that MHFA training raises employees' awareness of mental ill-health conditions. MHFA trainees have a better understanding of where to find information and professional support, and are more confident in helping individuals experiencing mental ill-health or a crisis. However, there is no evidence from the published studies that the introduction of MHFA training in workplaces has resulted in sustained actions in those trained. There is no evidence that the introduction of MHFA training improved the management of mental health in workplace settings; and limited evidence that the content of MHFA training has been adapted to workplace settings.

More robust research evidence is required on the use of MHFA training in workplaces.

Does MHFA training lead to sustained improvement in the ability of those trained to help colleagues experiencing mental ill-health?

What is the impact of MHFA training on the management of mental health in the workplace?

What are the beneficial outcomes for organisations implementing MHFA, and what investment in resources and funding is required?

Good quality studies are being undertaken which are likely to report in 2018 (see page 6) which should help to address some of these questions and knowledge gaps.

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Burns S, Crawford G, Hallett J, Hunt K, Chih H-J, Tilley PJM (2017): What's wrong with John? A randomised controlled trial of mental health first aid (MHFA) training with nursing students. *BioMed Central BMC Psychiatry*; **17**: 1-12

Chandra A, Jee K, Pieters HC, Tang, McCreary J, Schreiber M, Wells K (2014): Implementing psychological first-aid training for medical reserve corps volunteers. *Disaster Medicine and Public Health Preparedness*; **8** (1) 95-100

Cleary M, Horsfall J, Escott, P (2015): The value of Mental Health First Aid Training. *Issues in Mental Health Nursing;* **36** (11) 924- 926

Collins A, Miller J, Coughlin D and Kirk S (2014): The production of quick scoping reviews and rapid evidence assessments: a How to guide – Joint Water Evidence Group April 2014, Beta Version 2 (https://connect.innovateuk.org/)

Crawford G, Burns SK, Chih HJ, Hunt K, Tilley, PJM, Hallett J, Coleman K, Smith S (2015): Mental health first aid training for nursing students: a protocol for a pragmatic randomised controlled trial in a large university. *BioMed Central BMC Psychiatry*; **15**: 1-8

Dieltjens T, Moonens I, Van Praet, K, De Buck E, Vandekerckhove P (2014). A systematic literature search on psychological first aid: lack of evidence to develop guidelines: *Plos One*; **9** (12) **article 114714**

Dimoff JK, Kelloway EK, Burnstein MD (2016): Mental Health Awareness Training (MHAT): the development and evaluation of an intervention for workplace leaders. *International Journal of Stress Management*; **23** (2) 167-189

Hadlaczky G, Hokby S, Mkrtchian A, Carli, V, Wasserman D (2014): Mental health first aid is an effective public health intervention for improving knowledge, attitudes, and behaviour: a meta-analysis. *International Review of Psychiatry*; **26** (4) 467-475

Hossain D, Gorman D, Eley R (2009: Farm advisors' reflections on mental health first aid training: *Australian e-Journal for the Advancement of Mental Health*; **8** (1) 105-111

Hossain D, Gorman D, Eley R, Coutts J (2010): Value of mental health first aid training of advisory and extension agents in supporting farmers in rural Queensland. *Rural and Remote Health*; **10** (4) 1-9

Jensen KB, Morthorst BR, Vendsborg PB, Hjorthoj C, Nordentoft M (2016): Effectiveness of mental health first aid training in Denmark: a randomized trial in waitlist design. *Social Psychiatry and Psychiatric Epidemiology*; **51** (4) 597-606

Jorm AF, Kitchener BA, Fischer JA, Cvetkovski S (2010): Mental health first aid training for high school teachers: a cluster randomized trial. BioMed Central BMC Psychiatry; **10**: 1-12

Jorm AF, Kitchener BA, Mugford, SK (2005): Experiences in applying skills learned in a mental health first aid training course: a qualitative study of participants' stories. *BioMed Central BMC Psychiatry*; **5**: 1-10

Kidger J, Stone T, Tilling K et al (2016): A pilot cluster randomised controlled trial of a support and training intervention to improve the mental health of secondary school teachers and students – the WISE (Wellbeing in Secondary Education) study. *BioMed Central BMC Public Health*; **16**: 1-14

Kidger J, Evans R, Tilling K, Hollingworth W (2016): Protocol for a cluster randomised controlled trial of an intervention to improve the mental health support and training available to secondary school teachers – the WISE (Wellbeing in Secondary Education) study. *BioMed Central (BMC) Public Health* **16**: 1-13

Kitchener B A and Jorm A F (2008) Mental health first aid: an international programme for early intervention. *Early Intervention in Psychiatry*; 2 (1) 55-61

Kitchener BA and Jorm AF (2006) Mental health first aid training: review of evaluation studies. *Australian and New Zealand Journal of Psychiatry;* **40** (1) 6- 8

Kitchener BA and Jorm AF (2004) Mental health first aid training in a workplace setting: A randomized controlled trial ISRCTN13249129. *BioMed Central (BMC) Psychiatry*; **4**: 1-8

Langlands RL, Jorm AF, Kelly CM, Kitchener BA (2008): First aid for depression: A Delphi consensus study with consumers, carers and clinicians. Journal of Affective Disorders; 105:(1-3) 157-165

Langlands RL, Jorm AF, Kelly, CM, Kitchener BA (2008): First aid recommendations for psychosis: Using the Delphi method to gain consensus between mental health consumers, carers, and clinicians: *Schizophrenia Bulletin*; **34** (3) 435-443

Lewis V, Varker T, Phelps A, Gavel E, Forbes D (2014): Organizational implementation of psychological first aid (PFA): training for managers and peers. *Psychological Trauma-Theory Research Practice and Policy*; **6** (6) 619-623

Moffitt J, Bostock J, and Cave A (2014): Promoting well-being and reducing stigma about mental health in the fire service. *Journal of Public Mental Health*; **13** (2) 103-113

Svensson B, Hansson L (2014): Effectiveness of mental health first aid training in Sweden. A randomized controlled trial with a six-month and two-year follow-up: *Plos One*; **9** (6) 1-8

Svensson B, Hansson L, Stjernsward S (2015): Experiences of a mental health first aid training program in Sweden: a descriptive qualitative study. *Community Mental Health Journal*; **51** (4) 497-50

Terry J (2011): Delivering a basic mental health training programme: views and experiences of mental health first aid instructors in Wales. *Journal of Psychiatric Mental Health Nursing*; **18**: 677-686

# 6.0 APPENDIX

## 6.1 EVIDENCE SUMMARY METHODS

**6.1.1 Sources of Evidence:** The following databases were used to search for published studies, reviews and commentaries about MHFA training.

**Table 1** Source databases for literature searches

| Source | URL |
|---|---|
| BL Inside Conferences | http://www.bl.uk/services/bsds/dsc/conference.html |
| British Nursing Index | http://www.library.dmu.ac.uk/Resources/Databases/ |
| DH Data | http://www.dhdata.org/ |
| Embase | https://www.embase.com/login |
| Google and Google Scholar | https://www.google.co.uk/https://scholar.google.co.uk/ |
| Kings Fund | https://www.kingsfund.org.uk/ |
| MEDLINE | https://www.medline.com/ |
| PubMed | https://www.ncbi.nlm.nih.gov/pubmed/ |
| Social Science Search | https://www.ssrn.com/en/ |
| Web of Science | https://apps.webofknowledge.com |

**6.1.2 Search boundaries and search period:** The following factors in Table 2 were used to define the scope and publication window for the searches undertaken.

**Table 2** Search focus and boundaries

| Topic | Comments |
|---|---|
| From 2000 to July 2017 | The first description of the methodology for the MHFA training was in 2001. |
| English language articles only | This constraint was necessary because of the time constraints for preparing the summary. The majority of the research about MHFA has been undertaken in English- speaking countries. |
| Focus on existing reviews | Reviews of MHFA studies and their application in occupational circumstances were sought, prioritising systematic reviews and meta analyses and then expert narrative reviews. Delphi exercises were also considered appropriate. |
| Occupational populations | Searches for MHFA studies designed to assess its application in occupational circumstances. |
| Assessment or evaluation of MHFA training outcomes | The focus was studies that examined the impact of MHFA on the trainees and the beneficiaries of their training. The outcomes considered included knowledge; understanding about mental health; actions taken to address mental health issues; improved awareness and attention to their mental health; and the mental health of others. |
| Describes workplace application of MHFA training | Studies that provided contextual information when MHFA was used in occupational circumstances. |
| Include both peer reviewed sources and grey literature. | The primary evidence source was peer- reviewed studies but other sources including expert technical reports and commentaries were considered. |
| Non-occupational populations | All studies of MHFA training including those in the wider community were included in the searches. In the sift, non-occupational studies were mostly excluded except, for example, a review if this provided strong evidence about the impact and longevity of MHFA training based on large cohort studies. |

**6.1.3 Search terms:** Relevant search terms were organised as a hierarchy to identify the broadest terms to use in combinations with appropriate Boolean operators to increase the likelihood for identifying relevant studies (*represents a wildcard truncated term).

**Table 3** Search terms

| Main Terms | Synonyms | Specialised Terms |
|---|---|---|
| 'Mental health' | 'Psychological health'<br>'Psychological well-being' | Adjustment, alcoholism, anorexia, anxiety, 'bipolar disorder', bulimia, burnout, 'compulsive disorder', depression, 'eating disorder', 'emotional disorder', fatigue, 'mental disorder', 'mental disease', mood, 'nervous breakdown', 'nervous disorder', obsessive, panic, 'personality disorder', phobia, psycho*, schizo*, self-harm, stress, 'substance abuse', suicide |
| 'First aid*' | Emergency care<br>Emergency assistance<br>Emergency treatment<br>Medical assistance<br>Medical treatment | |
| Occupation* | Work*<br>Employ*<br>Profession*<br>Job* | |

**6.1.4 Inclusion/exclusion criteria:** Publication abstracts containing the relevant content were sifted based on specific inclusion and exclusion criteria listed in Table 4. The criteria were informed by the research questions and based on a consensus view of the team preparing the evidence summary.

**Table 4** Inclusion / exclusion criteria for initial sift

| Inclusion criteria | Exclusion criteria |
|---|---|
| • English language only;<br>• Primarily UK research or occupational circumstances comparable to the UK (i.e. New Zealand, Australia, America, the EU);<br>• Occupational applicability of the MHFA training;<br>• Systematic reviews, meta-analysis and quantitative peer-reviewed studies;<br>• Expert narrative peer review of quantitative or qualitative studies;<br>• Single studies (e.g. intervention studies) in an occupational context;<br>• Methodological rigour (have the authors described the methods used, e.g. how selected participants, how minimised bias);<br>• Grey literature informative about the type and content of the MHFA training in workplace settings. | o Non-occupational settings or participant groups;<br>o Inappropriate grey literature sources, including: lecture notes, presentations, opinion pieces, newsletters, unpublished manuscripts and patents;<br>o Insufficient data to assess methodological rigour. |

**6.1.5 Criteria for prioritisation of papers:** The order in which the sifted papers were reviewed was based on prioritisation criteria (Table 5).

**Table 5** Prioritisation criteria

| Order | Basis of Prioritisation |
|---|---|
| **1** | Study addresses RQ 1, 2, 3 or a combination of RQ 1 to 3 |
| **2** | English language articles from UK, EU, Australia, New Zealand, Canada, US |
| **3** | Occupational populations > non-occupational populations |
| **4** | Examined outcomes from interventions based on MHRA |
| **5** | Systematic review / meta-analysis of relevant studies |
| **6** | Relevant expert narrative review |
| **7** | Relevant and well-designed single studies (quantitative or qualitative measurement of outcomes[#]) |
| **8** | Large cohort (>60) over small cohort studies (<60) |
| **9** | Peer reviewed technical report > report from non-verifiable source |
| **10** | Commentary/ editorial |

[#]***Relevant outcomes included*:**

Increased engagement of staff receiving MHFA training in terms of awareness of:

- Mental health issues affecting fellow staff;
- Working with others to prevent deterioration of an at risk individual until they have received professional help;
- Engaging with fellow staff to raise awareness of mental health and its impact in the workplace.

**6.1.6 Data extraction:** The content of the sifted papers was summarised using a data extraction table which contained common and specific questions (Table 6) related to the type of study (Table 7).

**Table 6** Data extraction check list

| **General descriptors** |
|---|
| What is the country of origin? |
| Is the content and results of the study relevant to address RQ1? |
| Is the content and results of the study relevant to address RQ2? |
| Is the content and results of the study relevant to address RQ3? |
| Is the content and results of the study relevant to address a combination of RQ 1, RQ2 & RQ3? |
| What is the country of origin for the study? |
| **Specific questions depending of type of study** |
| Did the article appear in a peer- review publication or publication site? |
| Were the authors technical experts in this subject? |
| Is there evidence of a range of experts being included? |
| Is the aim and scope of the review clearly stated? |
| Is the methodology clear and relevant? |
| Have criteria for exclusion / inclusion of studies been stated clearly? |

| |
|---|
| How many occupational studies were included in the meta-analysis / review? |
| What occupational groups was MHFA applied to? |
| What was the size of the study population(s)? |
| What were the characteristics of the study population? |
| Did the study involve a pre and post intervention assessment of MHFA? |
| Did these studies consider the same type of MHFA interventions? |
| What did the study conclude was the outcome(s) of the intervention? |
| Are the results of the analysis clearly stated and consistent with the aims and objectives? |
| What were the main results relevant to the RQ's? |
| For RQ1 and RQ2, what were the main outcomes measured? |
| For RQ3, do the studies describe topics covered in the MHFA training? |
| If positive outcome(s), what beneficial outcomes were described? |
| If negative, what outcomes were described? |
| If 'no change', what reasons were provided? |
| What was the strength of the reported findings? |
| What were the limitations of the reported findings? |
| Were caveats in studies identified? |
| Were knowledge gaps identified? |
| Were sources of funding and vested interests declared? |

**Table 7** Categories of studies ranked in descending order

| Categories of studies | Study Design Type |
|---|---|
| **1** | Systematic review with meta-analysis of data |
| **2** | Systematic review |
| **3** | Narrative review |
| **4** | Individual studies |
| **5** | Other, i.e.: Government/public sector report; industry technical report; or expert commentary/editorial/Delphi |

**6.1.7 Quality and relevance rating of the study:** Following the data extraction specific criteria were applied to assess the quality of each study (Table 8). Quality (Table 9) and relevance scores (Table 10) were then applied to each paper. The team met to discuss a consensus view on these scores and a consistency check on the ratings was then undertaken by a member of the team.

**Table 8** Criteria applied to rate the quality of the study

| Criteria used to assess the quality of the study |
|---|
| • Relevance of the research to the key research questions |
| • The methodology used was clearly and transparently presented |
| • The degree to which the study design and methodology reduced bias |
| • The methodology was appropriate to the aim and objectives |
| • The methods used for measurements and analytical techniques were reliable |

- Assumptions made were outlined
- Methodology used was independently validated
- Links between descriptions of existing research, data analysis and conclusions were clear and logical
- Conclusions were backed up by well- presented data and findings
- Study limitations and quality were discussed
- Sources of funding and vested interests were declared

**Table 9** Criteria applied to rate the quality of the study

| Score | Definition |
|---|---|
| **3** | All or most of the methodological criteria appropriate for the study type have been fulfilled (*low risk of bias*) |
| **2** | Some of the methodological criteria appropriate for the study type have been fulfilled and those criteria that have not been fulfilled or not adequately described are thought unlikely to alter the conclusions (*risk of bias*) |
| **1** | Few or no methodological criteria have been fulfilled. The conclusions of the study are thought likely or very likely to alter (*high risk of bias*). |

**Table 10** Criteria applied to rate the relevance of the study

| Score | Criteria used to assess the relevance of the study |
|---|---|
| **3** | The results of the study were very relevant to RQ 1, 2, 3 or a combination of these |
| **2** | The results of the study were relevant to at least one of RQ 1, 2, and 3 |
| **1** | The results of the study were of limited relevance to RQ 1, 2, and 3 |

**6.1.8 Certainty of evidence:** Due to the small number of relevant sifted studies it was not possible to consider for each of the RQ1, 2 or 3 the overall consistency of the results as set out in Table 11.

**Table 11** Scores relevant to evidence statements

| Categorisation of certainty | Description |
|---|---|
| High | Consistent evidence from several studies scored as 3 for quality and relevance. |
| Medium | Common areas of evidence from several studies scored as 3 or 2 for quality and relevance. |
| Low | Evidence from a small number of studies classed as 1 or 2 for quality and relevance. |
| Contested | Inconsistent evidence between studies of poor quality (score 1) |

## 6.2 TABLE 12 SUMMARY OF KEY STUDIES, THEIR QUALITY AND RELEVANCE RATING

| SINGLE STUDIES: MHFA INTERVENTIONS IN OCCUPATIONAL SETTINGS | Relevance to RQ1-3 | Quality score | Relevance score |
|---|---|---|---|
| **Nursing staff** | | | |
| Bond K S *et al.* (2015) Mental health first aid training for Australian medical and nursing students: an evaluation study. *BMC Psychology*; **3**(1): article 11 | **RQ1 & RQ3** | **1** | **2** |
| Burns S *et al*. (2017) What's wrong with John? A randomised controlled trial of Mental Health First Aid (MHFA) training with nursing students. *BMC Psychiatry*; **17: article** 111 | **RQ1** | **2** | **2** |
| **Farmers** | | | |
| Hossain D *et al.* (2009) Farm advisors' reflections on mental health first aid training. *Australian e-Journal for the Advancement of Mental* Health; **8:** (1) 105-111 | **RQ1** | **2** | **2** |
| Hossain D *et al.* (2010) Value of Mental Health First Aid training of Advisory and Extension Agents in supporting farmers in rural Queensland. *Rural and Remote Health*; **10:** (4) 1-9 | **RQ1** | **1** | **1** |
| **Public, private and non-governmental organizations employees** | | | |
| Jensen KB *et al.* (2016) Effectiveness of mental health first aid training in Denmark: a randomized trial in waitlist design. *Social Psychiatry and Psychiatric Epidemiology;* **51:** (4) 597-606 | **RQ1 & RQ3** | **3** | **3** |
| **Teachers** | | | |
| Jorm AF *et al.* (2010) Mental health first aid training for high school teachers: a cluster randomized trial. *BMCPsychiatry* **; 10:** article 51 | **RQ1 & RQ2** | **3** | **3** |
| Kidger J *et al* (2016) A pilot cluster randomised controlled trial of a support and training intervention to improve the mental health of secondary school teachers and students – the WISE (Wellbeing in Secondary Education) study. *BMC Public Health*; **16**: article 1060 | **RQ1, RQ2 & RQ3** | **2** | **3** |
| **Public servants** | | | |
| Kitchener BA and Jorm AF (2004) Mental health first aid training in a workplace setting: A randomized controlled trial ISRCTN13249129. *BMC* Psychiatr;y **4: article** 23 | **RQ1 & RQ3** | **2** | **2** |
| Svensson B and Hansson L (2014) Effectiveness of mental health first aidtTraining in Sweden. A randomized controlled trial with a six-month and two-year follow-up. *Plos One*; **9** (6): article 100911 | **RQ1** | **2** | **2** |
| Svensson B *et al.* (2015) Experiences of a mental health first aid training program in Sweden: a descriptive qualitative study. *Community Mental Health Journal*; **51:**(4) 497-503 | **RQ1** | **2** | **2** |
| **Firefighters** | | | |
| Moffitt J, Bostock J, and Cave A ( 2014) Promoting well-being and reducing stigma about mental health in the fire service. *Journal of Public Mental Health*. **13** (2)103-113 | **RQ1 & RQ3** | **2** | **3** |
| **REVIEWS** | | | |
| Booth A *et al.* (2017) Mental health training programmes for non-mental health trained professionals coming into contact with people with mental ill health: a systematic review of effectiveness. *BMC Psychiatry*; **17:** (1) article 196 | **RQ1 & RQ3** | **2** | **1** |
| Dieltjens T *et al*. (2014). A systematic literature search on psychological first aid: lack of evidence to develop guidelines. *Plos One*; **9** (12) article 114714 | **Low** | **2** | **1** |

| REVIEWS (continued) | Relevance to RQ1-3 | Quality score | Relevance score |
|---|---|---|---|
| Hadlaczky G. *et al.* (2014) Mental health first aid is an effective public health intervention for improving knowledge, attitudes, and behaviour: a meta-analysis. *International Reviews in Psychiatry*; **26:** (4) 467-475**.** | **RQ1** | **2** | **2** |
| Kitchener BA and Jorm AF (2006). Mental health first aid training: review of evaluation studies.*Australian and New Zealand Journal of Psychiatry*; **40** (1): 6-8. | **RQ1** | **2** | **2** |
| **SINGLE STUDIES: ABOUT THE DEVELOPMENT OF MHFA TRAINING COURSES OR RESEARCH STUDY PROTOCOLS** | | | |
| Kidger J *et al*. (2016) Protocol for a cluster randomised controlled trial of an intervention to improve the mental health support and training available to secondary school teachers - the WISE (Wellbeing in Secondary Education) study. *BMC Public Health*;**16**:article 1089. | **High** | **3** | **3** |
| Crawford G *et al.* (2015) Mental health first aid training for nursing students: a protocol for a pragmatic randomised controlled trial in a large university. *BMC Psychiatry;* **15: article** 26 | **Low** | **2** | **1** |
| Bovopoulos N. *et al.* (2016) Delivering mental health first aid training in Australian workplaces: exploring instructors' experiences. *International Journal of Mental Health Promotion*; **18:** (2) 65- **82** | **RQ2 & RQ3** | **1** | **2** |
| **DELPHI STUDIES** | | | |
| Bovopoulos N. *et al.* (2016) Providing mental health first aid in the workplace: a Delphi consensus stud.: *BMC Psychology*; **4: (**1) article 41 | **RQ3** | **1** | **1** |
| Langlands RL *et al. (*2008) First aid for depression: A Delphi consensus study with consumers, carers and clinicians. *Journal of Affective Disorders*; **105:** (1-3) 157-165 | **Low** | **2** | **1** |
| Langlands RL *et al.* (2008) First aid recommendations for psychosis: Using the Delphi method to gain consensus between mental health consumers, carers, and clinicians. *Schizophrenia Bulletin*; **34:** (3) 435-443 | **Low** | **2** | **1** |

| COMMENTARIES | Relevance to RQ1-3 | Quality score | Relevance score |
|---|---|---|---|
| Cleary M *et al.* (2015) The value of mental health first aid training. *Issues in Mental Health Nursing*; **36:** (11) 924-926 | **Low** | **1** | **1** |
| Terry J (2011) Delivering a basic mental health training programme: views and experiences of mental health first aid instructors in Wales. *Journal of Psychiatric Mental Health Nursing*; **18:** 677-686 | **Low (RQ3)** | **1** | **1** |
| **INTERVENTIONS BASED ON OTHER METHODS APPLIED TO MENTAL HEALTH** | | | |
| **Military & Medical Reserves** | | | |
| Chandra A *et al*. (2014) Implementing psychological first-aid training for Medical Reserve Corps Volunteers. *Disaster Medicine and Public Health Preparedness;* **8:** (1) 95-100 | **Low** | **2** | **1** |
| **Managers** | | | |
| Lewis V *et al. (*2014) Organizational implementation of sychological First Aid (PFA): training for managers and peer.: *Psychological Trauma-Theory Research Practice and Policy;***6:** (6) 619-623 | **Low** | **1** | **1** |
| Dimoff JK *et al.* (2016) Mental Health Awareness Training (MHAT): the development and evaluation of an intervention for workplace leaders. *International Journal of Stress Management*; **23** 2) 167-189 | **Low** | **2** | **1** |

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# Summary of the evidence on the effectiveness of Mental Health First Aid (MHFA) training in the workplace

**The Mental Health First Aid (MHFA) training programme was first developed to train the public in providing help to adults with mental ill-health problems. Recently there has been an increase in undertaking MHFA training in workplace settings.**

**As the regulator for workplace health and safety, the Health and Safety Executive (HSE) wishes to understand the strength of the available evidence on the effectiveness of MHFA in the workplace. A rapid scoping evidence review was undertaken that considered three research questions on the impact, influence and application of MHFA training in workplaces.**

**A number of knowledge gaps have been identified in this evidence review that mean it is not possible to state whether MHFA training is effective in a workplace setting. There is a lack of published occupationally-based studies, with limited evidence that the content of MHFA training has been considered for workplace settings. There is consistent evidence that MHFA training raises employees' awareness of mental ill-health conditions. There is no evidence that the introduction of MHFA training in workplaces has resulted in sustained actions in those trained, or that it has improved the wider management of mental ill-health.**

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