

HB

355

<TARGET><BILL>HB 355</BILL><SUBJECT>HB
355</SUBJECT><COMM>HHSS28</COMM></TARGET>

ALASKA STATE LEGISLATURE



REPRESENTATIVE GERAN TARR

H.B. 355

“Youth Mental Health First Aid Training”

Sponsor Statement

Alaska has the highest suicide rate per capita in the country, at almost twice the national rate. There is an average of 136 suicides a year in Alaska and between 2000 and 2009, there was at least one suicide in 176 different Alaskan communities. Alaska Native men between the ages of 15-24 have the highest rate of suicide among all demographics in the United States, and the rate of suicide for all Alaska youth in this age group was nearly twice as high as the rate for adults over 25. Compounding this problem, youth exposed to suicide or suicidal behaviors are more likely to attempt suicide. Notably, 90% of suicide victims have a diagnosable, treatable mental or substance abuse disorder. We must reverse this trend.

In your life, you are more likely to see a person having a panic attack than you are to see someone having a heart attack. Though many of us know how to properly respond to a heart attack, few of us know what to do when confronted with someone having mental or emotional crises. Creating an environment where people know how to properly respond to these situations is a small step towards treating Alaska's problems with suicide, addiction, and abuse. Mental Health First Aid courses teach people how to recognize the signs and symptoms of mental health problems and how to provide initial aid before guiding a person toward appropriate professional help.

MHFA was introduced to the United States in 2008 and since then over 50,000 state and municipal employees, clergy members, police officers, and citizens have been trained in 47 states and the District of Columbia. Participants learn how to detect a number of mental illnesses, including schizophrenia, bipolar disorder, psychosis, substance use disorders, depression, anxiety and eating disorders, and how to respond to people who have them. This ultimately saves municipalities money. People with untreated mental illnesses frequently consume fire and police department time, as well as emergency room costs. By recognizing when mental health treatment is necessary for young Alaskans, a community can begin to take care of itself.

I ask for your consideration and support for Mental Health First Aid training for our youth so that we can have a healthier future and healthier Alaskans.

Fiscal Note

State of Alaska
2014 Legislative Session

Bill Version: HB 355
Fiscal Note Number: _____
() Publish Date: _____

Identifier: HB355-DHSS-CAPI-03-24-14
Title: MENTAL HEALTH FIRST AID TRAINING
Sponsor: TARR
Requester: House Health & Social Services Committee

Department: Department of Health and Social Services
Appropriation: Behavioral Health
Allocation: Community Action Prevention & Intervention Grants
OMB Component Number: 2596

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below.

(Thousands of Dollars)

	FY2015	Included in	Out-Year Cost Estimates				
	Appropriation Requested	Governor's FY2015 Request	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
OPERATING EXPENDITURES	FY 2015	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Personal Services							
Travel							
Services	270.0		85.0	85.0	85.0	85.0	85.0
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	270.0	0.0	85.0	85.0	85.0	85.0	85.0

Fund Source (Operating Only)

1037 GF/MH	270.0		85.0	85.0	85.0	85.0	85.0
Total	270.0	0.0	85.0	85.0	85.0	85.0	85.0

Positions

Full-time							
Part-time							
Temporary							

Change in Revenues							
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Estimated SUPPLEMENTAL (FY2014) cost: 0.0 (separate supplemental appropriation required)
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2015) cost: 0.0 (separate capital appropriation required)
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? No
If yes, by what date are the regulations to be adopted, amended or repealed?

Why this fiscal note differs from previous version:

Not applicable, initial version.

Prepared By:	Barbara Henjum, Acting Director	Phone:	(907)269-3410
Division:	Behavioral Health	Date:	03/21/2014 04:30 PM
Approved By:	Sarah Woods, Deputy Director, Finance & Management Services	Date:	03/24/14
Agency:	Health & Social Services		

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2014 LEGISLATIVE SESSION

BILL NO. HB355

Analysis

HB355 requires the department to provide Mental Health First Aid Training statewide to Alaska residents and mental health related agencies and organizations that serve youth who are under 18 years old. The bill allows for provision of training periodically throughout the state, either in person or by electronic means.

The department, under the section of Prevention and Early Intervention Services, is currently funded with a Substance Abuse and Mental Health Services Administration (SAMHSA) grant that targets youth suicide prevention for 10-24 year olds. The primary strategy employed is the Alaska Gatekeeper Suicide Prevention Training. The training is generally 2-4 hours in length and is specific to suicide risk, whereas Mental Health First Aid is an 8-hour training that covers major mental health conditions to include psychiatric emergencies such as acute psychosis, anxiety, severe depression, mania, substance abuse, eating disorders, and self-harm behaviors, in addition to suicide. The goal of the current SAMHSA grant is to train 2,000 persons per year with over 100 certified trainers from a variety of agencies and organizations. The grant is expected to be funded until FY 2016. Considering Mental Health First Aid is a broader training in scope, it has the potential to train a larger audience who are in a position to apply Mental Health First Aid to a broader spectrum of Alaskans who are experiencing a variety of mental health conditions and substance abuse problems.

The department would apply the same approach to Mental Health First Aid as it is currently approaching the Alaska Gatekeeper training by contracting with appropriate agencies to provide training coordination on behalf of the department. Currently, Alaska Gatekeeper is being coordinated through the University of Alaska Anchorage, Center for Human Development, Trust Training Cooperative.

Fiscal Assumptions

Year 1

At this time, there are no trainers in Alaska who are certified in the MHFA Youth Module.

Training Component #1: \$100,000

2 5-day Training-of-Trainers institutes conducted by the National Council on Behavioral Health Care (NCBHC), for up to 30 participants per event

- \$35,000 in NCBHC trainer fees per event (2 trainers) x 2 trainings = \$70,000
- \$15,000 in travel/supply costs per event x 2 trainings = \$30,000 (avg \$500/participant for 60 participants)

Training Component #2: \$170,000

Train 1,000 participants in the MHFA Youth Module using the 60 trainers who were trained in Training Component #1. Requires 2 trainers per class. Assumes class size of 10 participants, total of 100 classes. Class = one 8-hour day.

- \$75 trainer fee/hour x 8 hours/training x 100 training events x 2 trainers/event = \$120,000
- \$25/training manual x 1,000 participants = \$25,000
- \$250/event for facility costs, beverage service x 100 training events = \$25,000

Year 2 and beyond

On-going training to sustain training incentives to 500 people per year: \$85,000

- \$75 trainer fee/hour x 8 hours/training x 50 training events x 2 trainers/event = \$60,000
- \$25/training manual x 500 people = \$12,500
- \$250/event for facility costs, beverage service x 50 training events = \$12,500

Governments Discover Need for Mental Health First Aid

Mental disorders are more common than heart disease and cancer combined -- one reason states and localities are teaching their employees how to recognize the signs of mental health problems and how to help.

BY: CAROLINE COURNOYER | JUNE 2012



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One in four adults and 10 percent of children in the United States will suffer from a mental health illness this year. Mental disorders are more common than heart disease and cancer combined -- the leading causes of death.

"You're more likely to see someone having a panic attack than you are to see someone having a heart attack," says Linda Rosenberg, CEO of the National Council for Community Behavioral Healthcare (National Council). Yet most people, she says, don't know how to react to the former. That's why in 2008, the National Council, the Maryland Department of Health and Mental Hygiene, and the Missouri Department of Mental Health joined forces to bring the Australian concept of Mental Health First Aid (MHFA) to the U.S.

The idea behind MHFA is no different than that of traditional first aid: to create an environment where people know how to help someone in emergency situations. But instead of learning how to give CPR or how to treat a broken bone, the 12-hour course teaches people how to recognize the signs and symptoms of mental health problems and how to provide initial aid before guiding a person toward appropriate professional help.

Since its introduction in the U.S. four years ago, more than 50,000 people have been trained in 47 states and the District of Columbia. In at least 22 of those states, state or local governments supported the program, usually paying for employees to take the course, says Susan Partain of the National Council. Several states -- including Arizona, Colorado, Georgia, Maryland and Missouri -- already have statewide programs, which require some public workers and citizens to complete training as part of their job. For example, in Rhode Island the course is part of police officer training. Austin, Texas, offers it to every public library employee. Maryland offers it at every community college -- something several other states are looking to do. And Missouri partners with faith-based organizations since the

clergy is often "the first place people go when they feel stressed," says Edwin Benton Goon, the state's program coordinator. Arizona toyed with the idea a few years ago, but really invested in the program after a mentally ill man shot U.S. Rep. Gabrielle Giffords in Tucson in January 2011.

Sometimes it takes a tragic event for governments to take notice of the program, says Rosenberg, but she believes it has the ability to prevent future incidents like the Giffords shooting. Chief Anthony Silva, the executive director of Rhode Island's Municipal Police Training Academy agrees. "The training helps our officers better understand people with mental illnesses so they can respond appropriately without compromising safety," he said in a testimonial.

Not only does the course increase mental health literacy, according to studies of the Australian model, but it's also shown to improve the mental health of those taking the training, making them more confident in dealing with people who have a mental health illness.

Some universities have started offering training to their staff and students. At least seven colleges in Missouri use MHFA, according to Goon, and at some of them, the course is integrated into the required curriculum for certain majors, like nursing.

Many high schools -- faced with the fear of school shootings and everyday issues like bullying -- have expressed interest in bringing the program into their classrooms. But most are waiting for a pilot program that tailors mental health training to young people. Plans are under way to roll out such a program sometime this year.

An MHFA course costs about \$180, which pays for instructor time, materials, classroom location and snacks. State and local agencies find several ways to finance this: Some pay for it using private donations; some use federal or state mental health funds; some partner with nonprofits; and some reduce costs by holding the training in public buildings for free. Maryland and Missouri pay for it out of the proceeds they receive for every MHFA training manual sold. As part of the national founding organization, they each get \$1 for every sale.

The most cost-effective way to train people, according to Goon, is for agencies to have their employees become MHFA certified instructors. Anyone can become an instructor -- regardless of their background or expertise in mental health -- after successful completion of a five-day training program. Once an agency has its own instructors, it no longer has to pay for the instructors' time -- which makes up most of the course's cost. "This is very cheap to do," says Rosenberg. "You're not talking about millions of dollars. You're talking about hundreds."

And though it's difficult to quantify, increasing the public's mental health literacy can save money. In most municipalities, people with untreated mental health illnesses cost the government money because they're either unaware that they have a mental disorder or they lack health care. This segment of the population takes up a lot of police and fire department time by dialing 911 when they usually need a counselor or doctor.

Many public safety agencies are testing ways to stop this. For example, Baltimore tried connecting repeat 911 callers with a nurse and a case manager, and counties in Oregon and Washington began forwarding nonemergency calls to first responders who specialize in social service referral. But if enough people are trained to detect mental health problems, "not everything has to rise to the level of a professional intervention ... [Mental Health First Aid] creates a better-educated community where people can take care of themselves and take care of each other," says Rosenberg.

The course is typically administered over two or three days. The majority of the training is interactive and uses teaching techniques like role play. For example, one exercise simulates what it's like for people who hear voices. According to Goon, participants tend to be quiet when the course starts, but once it gets rolling, they're eager to learn and share their stories. "It's like they've wanted to have these conversations for a long time," he says.

Participants learn how to detect a number of mental illnesses -- including schizophrenia, bipolar disorder, psychosis, substance use disorders, depression, anxiety and eating disorders -- and how to respond to people who have them. Their response is guided by a five-step action plan, termed "ALGEE," which stands for:

1. Assess for risk of suicide or harm.
2. Listen nonjudgmentally.
3. Give reassurance and information.
4. Encourage appropriate professional help.
5. Encourage self-help and other support strategies.

One of the program's main goals is to erase the stigma associated with mental health illnesses. "It wasn't long ago that cancer wasn't openly spoken about," Rosenberg says. "Mental illness is the last illness that people talk about in whispers." But that will change, she says, once Mental Health First Aid becomes as common as CPR training -- something she sees as inevitable.

http://www.governing.com/topics/health-human-services/gov-governments-discover-mental-health-first-aid.html?utm_source=related&utm_medium=direct&utm_campaign=gov-governments-discover-mental-health-first-aid



Alaska Suicide Facts and Statistics

- ⌘ Alaska has the highest rate of suicide per capita in the country.
- ⌘ The rate of suicide in the United States was 11.5 suicides per 100,000 people in 2007. In 2007, Alaska's rate was 21.8 suicides per 100,000 people. The rate of suicide among Alaska Native peoples was 35.1 per 100,000 people in 2007.
- ⌘ Alaska had 1,369 suicides between 2000 and 2009, an average of 136 deaths by suicide per year. The highest number of suicides, 167, occurred in 2008. The lowest number, 123, occurred in 2003. That is an average of about 2.6 suicides in Alaska every week, or more than 10 a month.
- ⌘ At least one suicide occurred in 176 Alaskan communities between 2000 and 2009.
- ⌘ About 78% of suicides in Alaska are committed by men and 22% are committed by women, according to the Suicide Prevention Resource Center.
- ⌘ Alaska Native men between the ages of 15-24 have the highest rate of suicide among any demographic in the country, with an average of 141.6 suicides per 100,000 each year between 2000 and 2009.
- ⌘ Youth who are exposed to suicide or suicidal behaviors are more at-risk for attempting suicide, according to the American Association of Suicidology.
- ⌘ Suicide deaths consistently outnumber homicide deaths by a margin of three to two, according to the American Association of Suicidology.
- ⌘ More than 90% of people who die by suicide have depression or another diagnosable, treatable mental or substance abuse disorder, according to American Association of Suicidology.

Information is from the Alaska Bureau of Vital Statistics unless otherwise specified.

E-NEWSLETTER

Capitol Ideas: The Council on State Governments

Mental Health—The Final Frontier in First Aid

By **Debra Miller**, *CSG's Director of Health Policy*

One in four adults will suffer from a mental health illness in any given year, according to the National Council for Community Behavioral Health Care.

"You're more likely to see someone having a panic attack than you are to see someone having a heart attack," Linda Rosenberg, executive director of the council, said in an interview with *Governing*, "Yet, most people don't know how to react to the former."

Those realities are behind the idea of mental health first aid, a close cousin to Red Cross first aid and CPR training. Mental health first aid is a nationally recognized eight-hour training course where people learn how to help someone developing a mental illness or in a crisis. CSG will host a webinar, "Mental Health First Aid," at 1 p.m. EST Tuesday, March 11. Rebecca Farley and Bryon Gibb from the National Council for Community Behavioral Health Care will explain the program and how states can benefit.

The training is geared toward first responders and members of the public, as well as teachers and others likely to come into contact with youth and others in crisis. Just as CPR classes teach how to assess a crisis and respond, mental health first aid teaches a five-step action plan to assess risk, give information and encourage appropriate professional help.

The idea for mental health first aid was developed in Australia in 2001. The program has been thoroughly researched and is now recognized as an evidence-based practice and program by the U.S. Substance Abuse and Mental Health Services Administration.

President Obama's plan, "Now Is The Time," released just one month after the December 2012 Sandy Hook school shooting in Connecticut, called for mental health first aid training for teachers as part of a new initiative called Project AWARE—Advancing Wellness and Resilience in Education. The omnibus budget bill, passed in January by Congress and funding the remainder of the 2014 fiscal year, contains \$15 million for mental health first aid. The president also included funding for the plan in his 2015 fiscal year federal budget proposal.

But before the the mental health first aid model and training curriculum gained national attention, it was being adopted by some states and localities.

According to the National Council for Community Behavioral Health Care, more than 50,000 people have been trained in 47 states and the District of Columbia. Statewide programs in Arizona, Colorado, Georgia, Maryland and Missouri require some public employers to undergo the training as part of their jobs. In Rhode Island, police officers take mental health first aid. Library employees in Austin, Texas, also are offered the training.

In July 2013, the Illinois legislature adopted House Bill 1538 establishing the Illinois mental health first aid training program. The bill's sponsor, Rep. Esther Golar, said she would like to see mental health first aid training become standard for first responders.

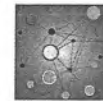
"The bill can also be a model for training schools and educators," she said. "We need to address the high suicide rates in some schools. Teachers may learn to recognize signs they didn't see before."

While the Illinois bill did not contain funding, Golar said, "as we go forward, we are looking to see what agencies may have funding to allocate for the training."

She said the training could end up saving money. "Our prisons are filled with persons who are mentally ill. Some have not committed any crime. Others have committed crimes to be safe off the streets.

"This training brings awareness not just to agencies but to lay people too. In neighborhoods when someone may be acting peculiar, instead of ignoring them, neighbors will respond to them," Golar said.

Rosenberg hopes that mental health first aid will become as commonplace as CPR and will help to erase the perpetuating stigma of mental illness. "Mental health is the last illness that people talk about in whispers," she said.



RESEARCH

Open Access

Youth mental health first aid: a description of the program and an initial evaluation

Claire M Kelly^{1*}, Johanna M Mithen², Julie A Fischer¹, Betty A Kitchener¹, Anthony F Jorm¹, Adrian Lowe², Chris Scanlan¹

Abstract

Background: Adolescence is the peak age of onset for mental illness, with half of all people who will ever have a mental illness experiencing their first episode prior to 18 years of age. Early onset of mental illness is a significant predictor for future episodes. However, adolescents and young adults are less likely than the population as a whole to either seek or receive treatment for a mental illness. The knowledge and attitudes of the adults in an adolescent's life may affect whether or not help is sought, and how quickly. In 2007, the Youth Mental Health First Aid Program was launched in Australia with the aim to teach adults, who work with or care for adolescents, the skills needed to recognise the early signs of mental illness, identify potential mental health-related crises, and assist adolescents to get the help they need as early as possible. This paper provides a description of the program, some initial evaluation and an outline of future directions.

Methods: The program was evaluated in two ways. The first was an uncontrolled trial with 246 adult members of the Australian public, who completed questionnaires immediately before attending the 14 hour course, one month later and six months later. Outcome measures were: recognition of schizophrenia or depression; intention to offer and confidence in offering assistance; stigmatising attitudes; knowledge about adolescent mental health problems and also about the Mental Health First Aid action plan. The second method of evaluation was to track the uptake of the program, including the number of instructors trained across Australia to deliver the course, the number of courses they delivered, and the uptake of the YMHFA Program in other countries.

Results: The uncontrolled trial found improvements in: recognition of schizophrenia; confidence in offering help; stigmatising attitudes; knowledge about adolescent mental health problems and application of the Mental Health First Aid action plan. Most results were maintained at follow-up. Over the first 3 years of this program, a total of 318 instructors were trained to deliver the course and these instructors have delivered courses to 10,686 people across all states and territories in Australia. The program has also spread to Canada, Singapore and England, and will spread to Hong Kong, Sweden and China in the near future.

Conclusions: Initial evaluation suggests that the Youth Mental Health First Aid course improves participants' knowledge, attitudes and helping behaviour. The program has spread successfully both nationally and internationally.

Trial registrationACTRN12609000033246

Background

Mental illness is common, but many people do not seek professional help for such problems [1]. An improvement in mental health literacy of the public may result in more people being encouraged to seek professional help and in increased support by family and friends

when mental health problems are apparent. The Mental Health First Aid (MHFA) Training and Research Program has developed training courses to improve the mental health literacy of members of the public [2-4].

Adolescence is the peak age of onset for mental illness [5]. The Youth Mental Health First Aid (YMHFA) course is a specialty variant on the standard MHFA course and is designed to improve the mental health literacy of adults who assist adolescents.

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The Standard Mental Health First Aid course

The 12-hour standard MHFA course was launched in 2001. The course is designed to teach members of the public how to support someone who might be developing a mental health problem or experiencing a mental health-related crisis, and to assist them to receive professional help and other supports. Each participant receives a course manual and a certificate of attendance [6].

The course provides an overview of mental health problems, the signs and symptoms of individual mental health problems, the risk factors for specific mental illnesses and available evidence-based treatments. The illnesses covered are depressive, anxiety, psychotic and substance use disorders.

The course has a strong focus on skills and provides a Mental Health First Aid Action Plan. The actions are not intended to be taken in a specific order. The Action Plan comprises five actions, forming the acronym 'ALGEE':

- Assess the risk of suicide or harm
- Listen non-judgmentally
- Give reassurance and information
- Encourage the person to get appropriate professional help
- Encourage self-help strategies

Participants are taught how to apply the Action Plan to help people with the mental health problems described above. In addition, a number of crisis situations are covered; suicide, acute psychosis, excessive use of alcohol, drug overdose, perceived aggressive behaviour, panic attacks and traumatic events.

Evaluation trials [2-4,7,8] have shown that participation in the course increases knowledge, reduces stigma, increases confidence in offering appropriate help, and improves actions taken to help people with mental health problems.

The Youth Mental Health First Aid course

The 14-hour YMHFA course, launched in 2007, teaches adults how to support adolescents who might be developing a mental health problem or in a mental health crisis, and to assist them to receive professional help. The course content and manual are modified to provide information which is specific to adolescents [9]. In addition to the mental health problems covered in the standard course, YMHFA covers eating disorders. There is also information provided about how to assist a young person who has been engaging in non-suicidal self-injury. There is a strong theme throughout the whole program about the importance of early intervention to minimise the impact of mental health problems on adolescent development. The course can be delivered

flexibly as either two full days (which do not have to be consecutive) or over four sessions of 3.5 hours each.

Targets for the training include parents, school professionals, adults involved in recreational activities with adolescents (e.g., sport coaches and scout leaders) and other adults who work with or care about adolescents. One small trial conducted externally with sports coaches showed promising results [10]. The Action Plan does not differ from that provided in the standard course, although the application is tailored to the needs of adolescents.

YMHFA Instructor training and program dissemination

Instructors are trained by the YMHFA co-ordinator (CMK) and a consultant trainer, and are supported by an administration team. Instructor training courses are run periodically across Australia, or organisations can arrange for in-house training in order to have a number of instructors available to them.

Instructors in the YMHFA course are not employed by the Program. Rather, successful applicants pay to attend instructor training which equips them to run the course, and the Program provides them with ongoing support. Some are funded by their employers to attend instructor training and to run the courses. Others pay their own fees for instructor training, and may offer training on a fee-for-service basis in the community or by arrangement with other organisations.

Instructors who are already accredited to run the standard MHFA program and meet the additional requirements to become YMHFA instructors attend a three day training program. New instructors attend a five and a half day training program. Applicants must have a strong background in youth mental health, experience in running training programs, positive attitudes towards adolescents with mental health problems and either organisational support or a good business plan. Instructors purchase manuals and certificates for use in their own courses. In order to remain accredited to teach the course, a minimum of three courses must be run each year and registered on a secure website.

There is a MHFA website which lists instructors who can be contacted to run courses, and enables them to advertise courses that are open to the public [11]. The website identifies which of the MHFA courses each instructor runs, and identifies very experienced instructors who have run at least 30 courses as Master Instructors. The website also provides information on MHFA, and members of the public can access information they can use if they are unable to attend a course.

YMHFA Program evaluation

There have been two components to the evaluation of the YMHFA course. The first was an uncontrolled trial with the public, and is described in this paper. The

second involves monitoring the uptake and dissemination of the course in Australia and internationally, and is also reported here. In addition, there has been a cluster randomised controlled trial of an abbreviated and modified version of the course adapted for use in schools, which is published elsewhere [12].

Methods

Uncontrolled trial

Participants

Participants were 246 adults from the general community within two regions of Victoria, Australia who volunteered to attend a 14-hour Youth Mental Health First Aid (YMHFA) course were eligible candidates. Participants were recruited through public advertising and press releases in local newspapers and media outlets and through a local youth mental health service. Seventeen training courses were conducted by one instructor (CS) between October 2007 and May 2008.

Measures

Three questionnaires were administered (pre-test, post-test and 6-month follow-up) and are included as Additional File 1. In only the pre-test questionnaire, participants were asked about sociodemographic characteristics, reasons for doing the course, any previous mental health training and history of personal and family mental health problems.

The questionnaire was based on a mental health literacy survey reported previously [13,14]. Participants were presented with two vignettes of a 15 year old, one portraying major depression (Jenny) and one portraying schizophrenia (John). They were given the open-ended question "What, if anything, do you think is wrong with Jenny/John?" Open-ended responses were classified into categories based on coding rules used in a recent study [15]. Multiple responses were allowed. Scoring was conducted by two researchers who rated responses individually and later arrived at a consensus score for each response. Kappa coefficients for inter-rater reliability were computed for both vignettes.

First aid intentions were measured by open-ended questions asking participants what they would do to help each of the young people portrayed in the vignettes. For scoring purposes, a checklist was developed, based on the Mental Health First Aid Action Plan [4]. It incorporates the 5 basic actions described by the acronym 'ALGEE'. Responses were scored out of a possible total of 10 against the checklist, using a 3 point scale (0 = no mention or inadequate response, 1 = superficial response without details, 2 = specific details/actions). If a response contained the word "ALGEE", but nothing else, 1 point was given per action, i.e. total of 5 points. Extra points were given only where specific detail was given for an action. One person scored all the responses.

However, to ensure inter-rater reliability, a random sample of 60 responses was independently scored by three other researchers, who later arrived at a consensus.

Confidence in providing first aid was measured by asking participants "How confident would you feel in helping Jenny/John?" Confidence was rated on a 5-point Likert scale ranging from 1 ('not at all') to 5 ('extremely') for each of the vignettes [15].

Stigmatising attitudes were measured by a Personal Stigma scale and a Perceived Stigma scale [16]. Scales were modified to suit attitudes towards adolescents rather than towards adults [17]. In Personal Stigma, the respondent was asked about their own attitudes towards the person described in each vignette while in the Perceived Stigma scale respondents were asked what they thought other people's attitudes were towards each person in the vignette.

Knowledge of mental disorders was measured by a 21 item true/false questionnaire specifically designed to cover information in the course. Response options for each item were 'agree', 'disagree' or 'don't know'. Scoring was based on 1 point per correct response, with 'don't know' being counted as incorrect.

Mental health first aid actions taken were assessed by asking how often a participant has talked to a young person about a mental health problem in the past 6 months. If they had talked with someone, the participant was asked to check the actions they took from a list of 9 options as follows: 1) Spent time listening to their problem; 2) Helped to calm them down; 3) Talked to them about suicidal thoughts; 4) Recommended they seek professional help; 5) Recommended self-help strategies; 6) Gave them information about their problem; 7) Gave them information about local services; 8) Made an appointment for them with services; and 9) Referred them to books or websites about their problem. An additional 'other' category was included for participants to provide details of any other actions undertaken, which were not included in the list. Scoring was based on 1 point per action taken.

The post-test and follow-up questionnaires were the same as the pre-test questionnaire except that both omitted the sociodemographic questions and the questions about actions taken were omitted from the post-test questionnaire.

Questionnaires were given out to participants prior to the commencement of training in the first session. On immediate completion of the training course a post-test questionnaire was given out. Six months thereafter, a follow-up questionnaire was sent to participants by post. Participants who did not submit their 6-month follow-up questionnaire within two weeks of it being sent were posted another follow-up questionnaire with a reminder letter. Where no response was received within a further

two week period, a phone call was made to participants, encouraging them to complete the questionnaire and return it at their earliest convenience. A third follow-up questionnaire was posted to participants who had indicated that they had changed address and not received the questionnaire.

Ethics

Ethics approval for the trial was granted on 12 July 2007 by The University of Melbourne Health Sciences Human Ethics Sub-Committee (ID: 0714470). There were no adverse events reported.

Statistical analysis

Participant responses were entered into a Microsoft Access database (version 2003) with values programmed within a set range to reduce data entry error. Data cleaning and statistical analysis was carried out using STATA (version 10).

Differences between pre-test and post-test on continuous outcome measures were tested using a paired t-test where the distribution was approximately normal, and a sign test where the distribution was clearly non-normal. Differences between pre-test and post-test on dichotomous outcome measures were tested with McNemar's chi-square test.

Because there were missing data at the 6-month time point, logistic regression was carried out to investigate predictors of missing data at 6 months. Complete case analysis was then carried out comparing participants with data at pre-test and 6-month follow-up. Changes were analysed using McNemar's chi-square and sign tests. The $P < 0.05$ level of significance was used throughout.

Responses were entered into a Microsoft Access database (version 2003) with values programmed within a set range to reduce data entry error and analysed in STATA (version 10).

Data on program dissemination

Instructor details are recorded on a database contained within the Mental Health First Aid website. Instructors record the courses they run on this database as well. Details recorded include course location and the number of participants who attended. The results of the YMHFA program dissemination were extracted from this database, based on all instructors trained from April 2007, and includes details up to June 20th, 2010.

Results

Uncontrolled trial

Participant characteristics and retention

The participants comprised 58 males and 188 females (mean age of 31 years, range 17 - 68). Fifty percent of participants reported that they had personally experienced a mental health problem, 72% reported that

someone in their family had experienced a mental health problem, and 77% reported that they had spoken to a young person about a mental health problem at least once in the previous six months.

Of the 246 participants at pre-test, 221 completed the post-training questionnaire and 138 completed the 6-month follow-up questionnaire. Regression analysis was used to investigate predictors of missing data. At 6-months follow-up, questionnaire data was less likely to be 'missing' for participants who were female; aged 50-68 years or 30-49 years (compared to 17 - 29 years); or in two of the ten training groups. There was no evidence that knowledge, attitudes or stigma scores for pre-training, post-training and change from pre to post were associated with risk of missing data at 6-months, therefore a complete case analysis comparing pre-test and 6-month follow-up scores is unlikely to be biased.

Results of outcomes assessed

Knowledge of mental illnesses

As a preliminary step, inter-rater reliability was assessed. For the depression vignette, kappa for the correct response 'depression' was 0.94. For the schizophrenia vignette, kappas for the correct responses of 'schizophrenia' and 'psychosis' were 0.96 and 0.92 respectively.

There was strong evidence ($p < 0.001$) of an improvement in participants' knowledge about mental health problems from pre to post training. The mean knowledge score (out of 21) increased from 11.44 (SD = 3.23) pre-training to 15.86 (SD = 2.63) post training (mean difference 4.42, 95% CI 4.0, 4.83). There was a significant improvement in the proportion of participants answering correctly for 19 out of the 21 individual items.

For participants with follow-up data, the difference continued to be significant ($p < 0.001$), with an increase in mean score from 11.96 (SD = 3.16) pre-training to 15.15 (SD = 2.47) at follow-up (mean difference 3.19, 95% CI 2.63, 3.75).

Recognition of mental illnesses

Prior to undertaking YMHFA training, 89.6% of participants correctly recognised the mental illness described in the depression vignette. Post-training, 91.4% of participants correctly identified depression, however, the difference was not significant. For those with 6-month follow-up data, there was a significant improvement from pre-test to follow-up (from 89.1% to 97.1%, $p = 0.019$).

Pre-training, 67.4% of participants correctly recognised the illness in the schizophrenia vignette, and this increased to 91.8% post-training ($p < 0.001$). For those with 6-month follow-up data, there was a significant improvement from pre-test to follow-up (from 68.8% to 83.3%, $p = 0.005$).

Confidence in providing MHFA

For both vignettes, there was strong evidence of improvement in participants' confidence in helping a young person with a mental health problem. Pre-training, 31.8% reported feeling 'quite a bit' or 'extremely' confident in helping the young person described in the depression vignette; this increased to 84.1% post training ($p < 0.001$). Pre-training, 12.4% of participants reported feeling 'quite a bit' or 'extremely' confident in helping the young person described in the schizophrenia vignette; this increased to 60.8% post-training ($p < 0.001$).

For those with 6-month follow-up data, there was a significant improvement from pre-test to follow-up in confidence for both depression (from 30.8% to 72.2%, $p < 0.001$) and schizophrenia (from 11.8% to 40.4%, $p < 0.001$).

First aid intentions: knowledge of mental health first aid action plan

As a preliminary step, agreement was assessed between the person who rated all responses and a consensus rating of a sub-set of responses. The correlation between the consensus score and the overall rater for each action was: A = 0.98, L = 0.89, G = 0.80, E1 = 0.76, E2 = 0.87, Total = 0.96.

There was strong evidence of improvement in participants' knowledge of appropriate mental health first aid actions for both depression ($p < 0.001$) and schizophrenia ($p < 0.001$). For depression, the mean total ALGEE score prior to training was 3.13 (SD = 1.34) and increased to 5.57 (SD = 2.32) post-training. For schizophrenia, the mean total ALGEE score increased from 2.26 (SD = 1.19) at pre-training to 4.76 (SD = 2.11) post-training. A significant increase in the score from pre- to post-training occurred for each of the individual recommended actions for both depression and schizophrenia ($p \leq 0.006$), except for recommending professional help for depression ($p = 0.113$).

For those with 6-month follow-up data, there was a significant improvement from pre-test to follow-up in knowledge of the MHFA Action Plan for both depression (from 3.25(SD = 1.30) to 3.95 (SD = 2.15), $p = 0.043$) and schizophrenia (from 2.27 (SD = 1.21) to 3.39 (SD = 2.02), $p < 0.001$).

Stigmatising attitudes about mental health problems

As shown in Tables 1 and 2, many participants disagreed with stigmatising attitudes towards depression and schizophrenia prior to training, however, there were still improvements after the training was completed.

For the group with 6-month follow-up data, the changes in stigmatising attitudes about depression from pre-test to follow-up showed the same patterns, except that the change in belief in dangerousness was no longer significant (64.2% at pre-test vs 72.3% at follow-up, $p = 0.117$). For the group with 6-month follow-up data, the changes in stigmatising attitudes about schizophrenia from pre-test to follow-up were only significant for disagreement about dangerousness (from 33.1% to 48.5%, $p = 0.008$).

The results for perceived stigma showed that participants believed that 'most other people' agreed with many of the stigmatising attitudes expressed in the statements shown. There was little change in participants' perceived stigma post-training.

Mental Health First Aid actions taken

There was a significant increase in the reported frequency of talking to a young person about their mental health problem compared to before training. Pre-training, 75.2% of participants reported talking to a young person about their mental health problem once or more in the previous six months, compared with 88.4% of participants at 6-month follow-up ($p = 0.003$).

Table 3 shows the strategies used by participants who talked to a young person about their mental health problem in the preceding six months. There was a significant increase in recommending professional help, recommending self-help strategies, giving information about the young person's problem and about local services. There was no significant change in participants' reporting that they had talked to the young person about suicidal thoughts. While a significant improvement in referral to books or websites was detected, the percentage of participants who reported doing this 6-months post-training was quite low.

Table 1 Personal disagreement with stigmatising attitudes about depression pre- and post-training

	n	Percentage 'disagree'/'strongly disagree'		p-value
		Pre-training %	Post-training %	
People with problems like Jenny could snap out of it if they wanted to	218	88.1	94.5	0.007
A problem like Jenny's is a sign of personal weakness.	219	94.1	98.2	0.026
Jenny's problem is not a real medical illness.	219	90.9	95.0	0.108
People with a problem like Jenny's are dangerous.	218	65.1	75.7	0.004
It is best to avoid people with a problem like Jenny's so that you don't develop this problem.	219	99.1	99.5	1.0
People with a problem like Jenny's are unpredictable.	219	35.2	52.1	<0.001
If I had a problem like Jenny's, I would not tell anyone.	218	72.9	78.4	0.119

Table 2 Personal disagreement with stigmatising attitudes about schizophrenia pre- and post-training

	n	Percentage 'disagree'/'strongly disagree'		p-value
		Pre-training %	Post-training %	
People with problems like John could snap out of it if they wanted to	221	94.6	97.3	0.07
A problem like John's is a sign of personal weakness.	220	95.0	98.6	0.022
John's problem is not a real medical illness.	220	93.2	95.9	0.146
People with a problem like John's are dangerous.	221	37.6	49.8	0.005
It is best to avoid people with a problem like John's so that you don't develop this problem.	220	96.4	98.6	0.18
People with a problem like John's are unpredictable.	221	20.4	33.0	<0.001
If I had a problem like John's, I would not tell anyone.	221	58.4	68.8	0.0052

Program dissemination

Instructor training began in April, 2007. Between then and June 2010, 318 Youth Mental Health First Aid instructors were trained, of whom 274 remain accredited. There are instructors in every state and territory of Australia. A total of 872 completed courses have been registered, for a total of 10,686 participants. This result reflects a high level of interest in the program, and indicates that many individuals and organisations see the program as relevant and valuable.

Organisations which have funded their own staff to become YMHFA trainers include state education departments, welfare services (both government and non-government) and government health services. In addition, many individuals have funded themselves to become instructors and deliver courses for interested members of the public and on a consultancy basis to other organisations.

YMHFA was originally rolled out with funding provided by the Australian Government's National Suicide Prevention Strategy. This funding provided a salary for the original program co-ordinator (CS) and a number of scholarships for instructor training. YMHFA now sustains itself by charging fees for instructors to be trained.

In 2008, Mental Health First Aid Canada launched their youth program, with a focus on young people aged 15-25 years old [18]. Mental Health First Aid Singapore launched their youth program early in 2010 [19] and MHFA England is launching a YMHFA program in November 2010 [20]. Youth courses will start in Sweden and Hong Kong [21] and mainland China in 2011.

Discussion

Results of the trials

Two trials have now been run to test the effectiveness of YMHFA; the uncontrolled trial reported here, and a randomised controlled trial in schools of a modified and abbreviated version of the course [12].

In the uncontrolled trial, YMHFA training was associated with increased mental health knowledge, greater disagreement with stigmatising attitudes, increased confidence in helping a young person with a mental health

problem and increased helping behaviour. An uncontrolled trial is a simple, cost-effective design that is useful for generating initial information prior to a larger trial. However, without a control group, changes observed cannot be definitively attributed to an intervention rather than other factors which could have influenced participants. Repeating the questionnaire, might in itself, lead to changed scores. In this study, high loss to follow-up occurred after 6 months, however the analysis undertaken suggests that missing data was unlikely to contribute bias to effects detected. Prior to training, participants reported high levels of personal experience of mental health problems (in self and family); this group may have had greater personal exposure to, or awareness of, mental health problems, and in this respect, might not be representative of the wider Australian adult population. However, the sample might be somewhat representative of other populations of interest, for example, adults with experience in relating to young people and an interest in mental health.

Participants in the school-based randomised controlled trial increased participants' knowledge, changed beliefs about treatment to be more like those of mental health professionals, reduced some aspects of stigma towards people with mental health problems, and increased confidence in offering help to students or colleagues. There was an indirect effect on students, who reported receiving more information about mental health from school staff. Most of the changes were sustained 6 months after training. However, no effects were found on participants' individual support towards students or on student mental health. While the randomised controlled trial was methodologically superior, it was not conducted using the full 14-hour program. The program delivered was an abbreviated course, with only senior school staff and those with welfare responsibilities receiving information about assisting in a crisis, and was also altered to include a component about school policy.

Although it is not possible to directly compare the results of the two trials, the full 14-hour course may produce greater improvements overall.

Table 3 Strategies employed in talking to a young person about their mental health problem in the past 6 months

	Pre-training (n = 99)	6-months (n = 99)	p-value
<i>Strategies employed (frequency ≥ 'Once'):</i>			
Spent time listening to their problem	91.9%	99%	0.016
Helped to calm them down	66.7%	66.7%	.*
Talked to them about suicidal thoughts	46.5%	54.6%	0.169
Recommended they seek professional help	72.7%	87.9%	0.003
Recommended self-help strategies	45.5%	68.7%	<0.001
Gave them information about their problem	19.2%	45.5%	< 0.001
Gave them information about local services	44.4%	63.6%	0.002
Made an appointment for them with services	31.3%	37.4%	0.327
Referred them to books or websites about their problem	20.2%	32.3%	0.043

* could not be estimated.

Ongoing improvements to Youth Mental Health First Aid

The above evaluations were carried out using the first edition of the YMHA course. The course has since been further developed and updated.

Between 2005 and 2008, a number of mental health first aid guidelines projects were carried out [22-30] to give a firmer basis to the content of MHFA training. Guidelines were developed for a number of developing disorders (depression, psychotic illnesses, eating disorders, alcohol use problems and other drug use problems), and a number of crisis situations (suicidal thoughts and behaviours, non-suicidal self-injury, panic attacks, traumatic events, severe psychosis, the acute effects of alcohol and other drug use including medical emergencies, and apparent aggressive behaviour). These projects used the Delphi method, a technique for reaching consensus within and between groups of experts. The panels of experts were professionals (clinicians and researchers), people with experience of mental illness, and care-givers of people with mental illness. Both the youth and standard courses and course manuals have been thoroughly updated using the content of the new guidelines [31,32].

Some text changes have been made to the actions 1, 3 and 5 of the MHFA Action Plan. The acronym is still 'ALGEE', but the actions are now as follows:

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

Other changes to the course content have been made based on ongoing feedback from instructors and participants as recorded on the MHFA website. For example, the original YMHA materials did not discuss the difference between how a parent might apply MHFA and

how another adult might, nor about how another adult might need to involve parents in the process. Other improvements to the curriculum include considerations of how to address communication difficulties and a greater focus on skills than knowledge.

The updated course is being described as Edition 2. In 2010, every accredited instructor has had to attend a one-day update workshop orienting them to the Edition 2 materials. From 2011, only Edition 2 may be taught. Initial feedback from instructors on the new materials has been very positive.

Aims for the future

Future target groups for YMHA training include juvenile justice, police and other emergency services. In addition, we hope to encourage all Australian schools to make training available to all school staff. Another group which is an ideal target for training is parents, because parents are often the first people that an adolescent will turn to when they are concerned about their own mental health [33].

The next evaluation planned, using the Edition 2 materials, is a randomised controlled trial of parents of adolescents. Our intention is to follow up the families for a number of years to see if the course does improve early identification of mental health problems and prompt help-seeking. The advantage of this sort of evaluation is that it enables us to test the outcome for people who receive Mental Health First Aid, a group which has previously been difficult to follow up.

Conclusions

The Youth Mental Health First Aid course provides participants with the knowledge and skills needed to assist a young person who is experiencing a mental health problem. The results of evaluation studies and expert consensus guidelines have been used to further refine and improve the curriculum. The course appears to be valued and relevant to many sectors of the public and

has been adopted across Australia and in a number of other countries.

Additional material

Additional file 1: Questionnaire (PDF). This is the pre-test questionnaire used before the intervention. For the questionnaire used post-test, the sociodemographics (questions 1 to 10) were omitted along with the actions taken in the last six months (question 22). For the 6-month follow-up, the sociodemographics were omitted but the actions taken in the last six months were measured again.

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Authors' contributions

CMK had primary responsibility for writing the manuscript. JMM conducted statistical analysis on the uncontrolled trial and contributed to the writing of the results section of the manuscript. JAF was responsible for the 6-month follow-up in the uncontrolled trial, data entry, data quality and scoring of open-ended data, and contributed to the writing of the manuscript. BAK contributed to the development of the YMHA course and the design of the evaluation. AFJ had primary responsibility for the design of the evaluation, and contributed to both the data analysis and the writing of the manuscript. AL contributed to the statistical analysis of the uncontrolled trial. CS taught all the courses in the uncontrolled trial and gathered the pre-test and post-test data. All authors read and approved the final manuscript.

Competing interests

A number of the authors were involved in the development and roll out of the YMHA course.

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References

- Burgess PM, Pirkis JE, Slade TN, Johnston AK, Meadows GN, Gunn JM: Service use for mental health problems: findings from the 2007 National Survey of Mental Health and Wellbeing. *Aust NZ J Psychiatry* 2009, **43**:615-623.
- Kitchener BA, Jorm AF: Mental Health First Aid: an international programme for early intervention. *Early Interv Psychiatry* 2008, **2**:55-61.
- 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 [<http://www.biomedcentral.com/1471-244X/9/47>].
- 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 [<http://www.ijmhs.com/content/3/1/19>].
- Oakley Browne MA, Wells JE, Scott KM, McGee MA, New Zealand Mental Health Survey Research Team: Twelve-month and lifetime prevalences of mental disorders and treatment contact among Pacific people in Te Rau Hinengaro: the New Zealand Mental Health Survey. *Aust N Z J Psychiatry* 2006, **40**:865-74.
- Kitchener BA, Jorm AF: *Mental Health First Aid Manual* Melbourne: Orygen Research Centre, University of Melbourne; 2009.
- Kitchener BA, Jorm AF: Mental health first aid training: review of evaluation studies. *Aust N Z J Psychiatry* 2006, **40**:6-8.
- Hossein D, Gorman D, Eley R: Enhancing the knowledge and skills of Advisory and Extension Agents in mental health issues of farmers. *Australas Psychiatry* 2009, **17**:S116-20.
- Kitchener BA, Jorm AF: *Youth Mental Health First Aid: A manual for adults assisting youth* Melbourne: Orygen Research Centre, University of Melbourne; 2009.
- Pierce D, Liaw S, Dobell J, Anderson R: Australian rural football club leaders as mental health advocates: an investigation of the impact of the Coach the Coach project. *Int J Ment Health Syst* 2010, **4**:10 [<http://www.ijmhs.com/content/4/1/10>].
- Mental Health First Aid Australia. [<http://www.mhfa.com.au>].
- Jorm AF, Kitchener BA, Sawyer MG, Scales H, Cvetkovski S: Mental health first aid training for high school teachers: a cluster randomized trial. *BMC Psychiatry* 2010, **10**:51 [<http://www.biomedcentral.com/1471-244X/10/51>].
- Jorm AF, Wright A, Morgan AJ: Beliefs about appropriate first aid for young people with mental disorders: Findings from an Australian national survey of youth and parents. *Early Interv Psychiatry* 2007, **1**:73-82.
- Jorm AF, Wright A: Beliefs of young people and their parents about the effectiveness of interventions for mental disorders. *Aust N Z J Psychiatry* 2007, **41**:656-666.
- Wright A, Jorm AF: Labels used by young people to describe mental disorders: factors associated with their development. *Aust N Z J Psychiatry* 2009, **43**:946-955.
- Griffiths K, Christensen H, Jorm AF, Evans K, Groves C: Effect of web-based depression literacy and cognitive-behavioural therapy interventions on stigmatising attitudes to depression: randomised controlled trial. *Br J Psychiatry* 2004, **185**:342-9.
- Jorm AF, Wright A: Influences on young people's stigmatising attitudes towards peers with mental disorders: national survey of young Australians and their parents. *Br J Psychiatry* 2008, **192**:144-149.
- Mental Health First Aid Canada. [<http://www.mentalhealthfirstaid.ca>].
- Mental Health First Aid Singapore. [<http://www.mhfa.sg>].
- Mental Health First Aid England. [<http://www.mhfaengland.org>].
- Mental Health First Aid Hong Kong. [<http://www.mhfa.org.hk>].
- 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 [<http://www.biomedcentral.com/1471-244X/10/49>].
- Kingston AH, Jorm AF, Kitchener BA, Hides L, Kelly CM, Morgan AJ, Hart LM, Lubman DI: Helping someone with problem drinking: mental health first aid guidelines - a Delphi expert consensus study. *BMC Psychiatry* 2009, **9**:79 [<http://www.biomedcentral.com/1471-244X/9/79>].
- Kelly CM, Jorm AF, Kitchener BA: Development of mental health first aid guidelines for panic attacks: a Delphi study. *BMC Psychiatry* 2009, **9**:49 [<http://www.biomedcentral.com/1471-244X/9/49>].
- Hart LM, Jorm AF, Paxton SJ, Kelly CM, Kitchener BA: First Aid for Eating Disorders. *Eat Disord* 2009, **17**:357-384.
- 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 [<http://www.biomedcentral.com/1471-244X/9/47>].
- 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 [<http://www.biomedcentral.com/1471-244X/8/62>].
- 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 [<http://www.biomedcentral.com/1471-244X/8/17>].
- 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.
- 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.
- Kitchener BA, Jorm AF, Kelly CM: *Mental Health First Aid Manual*. 2 edition. Melbourne: Orygen Research Centre, University of Melbourne; 2010.

32. Kelly CM, Kitchener BA, Jorm AF: *Youth Mental Health First Aid Manual: A manual for adults assisting young people*. 2 edition. Melbourne: Orygen Research Centre, University of Melbourne; 2010.
33. Jorm AF, Wright A, Morgan AJ: Where to seek help for a mental disorder? National survey of the beliefs of Australian youth and their parents. *Med J Aust* 2007, **187**:556-560.

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Other States' Mental Health First Aid Initiatives

Mental Health First Aid is a groundbreaking public education program that helps the public identify, understand, and respond to signs of mental illnesses and substance use disorders. Mental Health First Aid USA is managed, operated, and disseminated by three national authorities — the National Council for Community Behavioral Healthcare, the Maryland Department of Health and Mental Hygiene, and the Missouri Department of Mental Health.

Arizona, Colorado, Georgia, Maryland, and Missouri already have statewide programs requiring some people to complete this training as part of their job. In Rhode Island the course is part of police officer training. Austin, Texas, offers it to every public library employee. (Mental Health First Aid, accessed 2/15/13)

Mental Health First Aid Colorado – A National Leader

Mental Health First Aid is a program that teaches first aid skills for mental illness and crises. It is taught in fifteen countries around the world and throughout the US, including Colorado. In fact, our program here in Colorado program has distinguished itself as a national leader with more instructors per capita than anywhere else in the country – currently there are 163 instructors who have trained nearly 5,000 certified Mental Health First Aiders in Colorado!

Mental Health First Aid was developed in Australia in 2001 where it has an impressive track record. Five published studies conducted in Australia show that the program saves lives and increases the awareness and understanding of mental illnesses and treatment options, while improving the mental health of the individual administering care and the one receiving it.

Mental Health First Aid was brought to the US through a collaborative effort between the National Council for Community Behavioral Healthcare, the Maryland State Department of Health and Mental Hygiene, and the Missouri Department of Mental Health. The program was brought to Colorado in 2008 by the Colorado Behavioral Healthcare Council.

Mental Health First Aid Colorado is implemented in an innovative and effective way through a statewide private-public partnership of local mental health centers, the Colorado Department of Public Safety, the Colorado Sheriff's Association, the Colorado Division of Behavioral Health, Mental Health America of Colorado, and the Western Interstate Commission for Higher Education which ensures that the course is taught, supported and recognized in and by communities throughout Colorado.

Mental Health First Aid USA and the National Council for Community Behavioral Healthcare agrees that Colorado's Mental Health First Aid Program is one of the best in the nation. They awarded Mental Health First Aid Colorado the 2012 Mental Health First Aid Best Community Impact in April 2012 in recognition of the way the program has leveraged Mental Health First Aid for maximum community impact.

Mental Health First Aid Colorado is the local chapter of the national program, Mental Health First Aid USA. Introduced in Colorado in 2008, the program has grown to include 136 Instructors reaching a variety of audiences statewide. We are an organization driven by community and state agencies across Colorado with leadership from the Colorado Behavioral Healthcare Council in partnership with the Colorado Division of Behavioral Health.

Colorado has a unique and valuable approach to implementing the program that brings together consumer advocates, providers, state agencies, criminal justice professionals, and statewide provider associations to serve as a formal MHFA Advisory Committee. Organizations include:

- Colorado Behavioral Healthcare Council
- Colorado Division of Behavioral Health
- Colorado Sheriff's Association
- Community mental health and substance abuse providers
- Colorado Providers Association (substance abuse)
- Colorado Department of Public Safety
- Federation of Families for Children's Mental Health – Colorado (Family Advocates)
- Mental Health America of Colorado (Consumer Advocates)
- National Alliance on Mental Illness – Colorado (Consumer Advocates)
- Western Interstate Commission for Higher Education

Mental Health First Aid Colorado is committed to realizing the program's goals to improve participants' knowledge of behavioral health disorders, to reduce stigma, and to increase the amount of help provided to those who may need it. In accomplishing these goals, MHFA helps to prevent the onset and reduce the progression of mental health and substance use disorders while promoting acceptance, dignity and social inclusion of people experiencing behavioral health problems.

To take part in this statewide movement and become a certified Mental Health First Aider or a Mental Health First Aid Instructor, go to our website at www.MHFACO.org or contact director@mhfacolorado.org. (Mental Health First Aid, accessed 2/15/13)

Colorado Mental-Health First-Aid Program Wins National Award

Just as CPR can help someone save the life of a friend or neighbor, so will training in behavioral-health skills help protect people from serious mental-health issues in an increasingly stressed-out world. That's the plan at Mental Health First Aid Colorado, a statewide effort that combines public and private partnerships to train people in detecting emotional crises.

Started in 2008, it is now a national leader, having just won the 2012 Best Community Impact Award from Mental Health First Aid USA, which will be presented in April at the National Council Mental Health and Addictions Conference in Chicago. The news is a boost for the state's behavioral-health community because headlines usually focus on the state's fragmented and underfunded mental-health system. Colorado ranks 32nd in the nation for funding mental-health care.

"Our goal is lofty — to increase mental-health literacy in the state of Colorado," said George DelGrosso, executive director of the Colorado Behavioral Healthcare Council, at a news conference on Tuesday. "We hope that as you see people getting their first-aid classes in how to bandage an arm or take care of a burn, they will also receive training in how to impact someone who has a mental-health or substance abuse disorder."

Colorado has 136 instructors in its program — more per capita than anywhere else in the United States — and they have trained more than 3,000 others across the state, including people in law enforcement, fire departments, prisons and community centers.

Paul Siska, retired undersheriff of Adams County, has taught the classes to law enforcement professionals in Fort Collins, Glenwood Springs and Montrose. "They're tools you can use on a daily basis," he said. Mental Health First Aid is a 12-hour training course that teaches people how to provide initial help to someone developing a mental-health problem or experiencing an emotional crisis. They learn warning signs, how to listen without judgment and a five-step action plan to connect people in crisis to local support systems.

In Colorado, member organizations include the Colorado Department of Public Safety, the Colorado Sheriff's Association, the Colorado Division of Behavioral Health and the Western Interstate Commission for Higher Education.

"The reality is that all of us need help at some time," said state Rep. Ken Summers, R-Lakewood, a supporter, at the new conference. "We live in such a challenging world, where there are stresses of almost historic proportions, and where there are issues of grief and loss that individuals confront on almost a daily basis. "If we're able to elevate the awareness that these issues are just part of the ups-and-downs of life, just like our physical health is, then hopefully we'll be more proactive in seeking help." (Denver Post, 3/29/12)

The Arizona MHFA Program

The Arizona Department of Health Services' Division of Behavioral Health Services (ADHS/DBHS), the National Council for Community Behavioral Healthcare and Arizona's Regional Behavioral Health Authorities (RBHAs), which include Community Partnership of Southern Arizona (CPSA), Magellan of Arizona, Northern Arizona Regional Behavioral Health Authority (NARBHA), and Cenpatico, partnered since 2011 to launch a statewide, extensive training campaign in Mental Health First Aid (MHFA). As part of this initiative, ADHS/DBHS and partners above conducted a total of 3 TOT sessions from which close to 80 new people were certified to become instructors of MHFA. The MHFA TOT (training of trainers) is a 5-day training for community members from around the state to become instructors in Mental Health First Aid. These State-trained instructors have been training thousands of community members ever since. (Arizona Department of Health Services, accessed 2/15/13)

Mentally Ill Focus Of Arizona Bills

Lost in the clamor over gun-control legislation in the wake of the Newtown, Conn., school massacre are several bills designed to prevent people with severe mental illness from committing violent acts against others or themselves.

As with gun bills introduced into the state Legislature, the measures targeting the mentally ill were prompted, in part, by mass shootings in the U.S. perpetrated by young men who struggled with behavioral-health problems.

Lawmakers want the state to spend more money training people to intervene when someone is in crisis, require teachers and health-care workers to call police if they believe someone could be dangerous, and give law-enforcement more power to detain people in hopes of preventing another mass shooting.

Mental-health experts say the bills, together with a new willingness on the part of majority Republicans to talk about additional funding for mental-health services and the prospect of Medicaid expansion, are encouraging signs that the state is willing to do more for people with mental illness, even if some believe the bills themselves may need some work.

House Bill 2570, sponsored by freshman Tucson Reps. Victoria Steele and Ethan Orr, would provide \$500,000 to expand an existing training program at the state Department of Health Services that teaches people how to recognize and intervene when someone is suicidal or could pose harm to others.

Two bills sponsored by Rep. John Kavanagh, R-Fountain Hills, would put a greater burden on counselors, teachers and other education and health professionals to get police involved if they believe someone might harm themselves or others, make it easier for police to detain people whom witnesses said were dangerous and extend to two days from one the length of time someone can be detained without being involuntarily committed.

Steele, a Democrat, and Orr, a Republican, represent the northside Tucson district that includes the Safeway where former U.S. Rep. Gabrielle Giffords and 18 others were shot two years ago, and the home of the shooter, Jared Loughner, who is now serving a life sentence.

"(We) live within a mile from where that shooting occurred. It's real personal to us," said Steele, a mental-health counselor. "We've seen how tremendously our entire community has been impacted."

Arizona launched the Mental Health First Aid program weeks after the Tucson shooting and has since trained more than 2,600 people how to intervene in a mental-health crisis.

HB 2570 would expand the program, which can cost the state up to \$2,000 per person for the 12-hour course, beyond the mental-health field to the broader community and reduce the stigma of mental illness.

Participants are trained on a checklist of responses to potentially volatile situations, including assessing the risk for suicide or harm, listening non-judgmentally and encouraging professional help and self-support strategies.

The idea is to broaden the pool of people educated in the signs and symptoms of a mental-health crisis and are able to respond, potentially heading off a tragedy and getting people the attention and treatment they need.

"We are much better prepared to help someone who's having a heart attack than someone who's having a panic attack," Steele said. "If more people knew how to help, they would." Steele said she's concerned that legislative responses to recent mass shootings could further stigmatize people with mental illness and leave the mistaken impression that they're dangerous or violent, when in fact they're far more likely to be victims themselves than to victimize others.

House Bill 2158 would amend state law to allow police to detain people deemed to be a danger to themselves or others, even if they didn't observe the behavior themselves. That would enable police to take the word of witnesses, such as parents, as they do in criminal cases, to determine whether to take someone into custody. Kavanagh said Arizona is one of few states that doesn't allow police to take witness statements into account. The measure also extends to two days from one the length of time a person can be detained without beginning proceedings to have him or her involuntarily committed for a court-ordered evaluation at psychiatric hospital.

House Bill 2555 would require counselors, teachers, professors and other licensed health-care professionals who have "reasonable cause" to believe a client or student is a danger to themselves or others to notify a law-enforcement agency "as soon as practicable." Kavanagh said he's confident police have sufficient training to judge whether someone needs to be detained. The worst option, he said, is to do nothing.

"We missed Jared Loughner. We've missed all these shooters. The common thread which runs throughout all these mass shootings is mental illness. And it appears to be males in their early 20s," Kavanagh said. "You need to give police the ability to take these people in for evaluation."

Some mental-health advocates say HB 2158 could help diffuse volatile situations and get needed attention for more people in crisis. It passed the House Public Safety, Military and Regulatory Affairs Committee unanimously last week.

"I think this gives an opportunity to truly step in and really, truly calm things down," said Vicki Johnson, former longtime director for Mentally Ill Kids in Distress, a non-profit service and advocacy center. "I realize that some people believe there's a chance that it could be abused," she said. "But right now, I believe the window is too narrow, and I believe sometimes, people are put at risk."

Mary Lou Brncik is the founder of David's Hope and director of the Arizona Mental Health and Criminal Justice Coalition, which works to increase treatment and reduce incarceration for people with behavioral-health issues. She said that she doesn't believe police or teachers are trained well enough to implement Kavanagh's bills and fears that more people would be thrown into the criminal-justice system. "I have a bad feeling about increasing law-enforcement involvement in our mental-health system. We have too much now," she said.

Kavanagh said he's generally supportive of the expanded training in Steele's bill and agrees with mental-health advocates that more early intervention and treatment is needed. He and other key Republican lawmakers have voiced support for additional mental-health funding for fiscal 2014. (Arizona Republic, 2/12/13)

Contact: Rep. Victoria Steele – 602-926-5683

Contact: Emily Jenkins, CEO Arizona Council of Human Services Providers

HB 2570

Introduced by
Representatives Orr, Steele

AN ACT

MAKING AN APPROPRIATION TO THE DEPARTMENT OF HEALTH SERVICES FOR THE MENTAL HEALTH FIRST AID PROGRAM.

AN ACT

AMENDING TITLE 36, CHAPTER 5, ARIZONA REVISED STATUTES, BY ADDING ARTICLE 8; RELATING TO MENTAL HEALTH REPORTING. 1 Be it enacted by the Legislature of the State of Arizona:
Section 1. Appropriation; department of health services; mental health services
The sum of \$500,000 is appropriated from the state general fund in fiscal year 2013-2014 to the department of health services for the expansion of the mental health first aid program.

HB 2555

Introduced by
Representative Kavanagh

Be it enacted by the Legislature of the State of Arizona:

Section 1. Title 36, chapter 5, Arizona Revised Statutes, is amended by adding article 8, to read:

ARTICLE 8. MENTAL HEALTH REPORTING

36-547.01. Potentially violent persons; reporting; immunity; definition

A. NOTWITHSTANDING ANY LAW TO THE CONTRARY, IF A HEALTH PROFESSIONAL WHO IS LICENSED PURSUANT TO TITLE 32, CHAPTER 14, 15, 17, 19.1, 25 OR 33, A TEACHER WHO IS EMPLOYED BY A SCHOOL DISTRICT OR CHARTER SCHOOL, A TEACHER'S AIDE WHO IS EMPLOYED BY A SCHOOL DISTRICT OR CHARTER SCHOOL AND AN INSTRUCTOR IN A POSTSECONDARY EDUCATIONAL INSTITUTION HAS REASONABLE CAUSE TO BELIEVE THAT A CLIENT OR STUDENT IS A DANGER TO SELF OR OTHERS, THE HEALTH PROFESSIONAL, TEACHER, TEACHER'S AIDE OR INSTRUCTOR MUST REPORT THIS INFORMATION TO THE APPROPRIATE LAW ENFORCEMENT AGENCY AS SOON AS PRACTICABLE.

B. A PERSON WHO MAKES A REPORT REQUIRED PURSUANT TO SUBSECTION A OF THIS SECTION IN GOOD FAITH IS NOT SUBJECT TO CRIMINAL OR CIVIL LIABILITY.

C. FOR THE PURPOSES OF THIS SECTION, "REASONABLE CAUSE" MEANS THAT THE PERSON WHO HAS A DUTY TO REPORT PURSUANT TO THIS SECTION EITHER:

1. BELIEVES, THROUGH PERSONAL OBSERVATION, THAT A CLIENT OR STUDENT IS A DANGER TO SELF OR OTHERS.
2. IS AWARE THAT A CLIENT OR STUDENT HAS COMMUNICATED A THREAT OF HARM TO SELF OR OTHERS AND HAS THE INTENT AND ABILITY TO CARRY OUT THAT THREAT.

President's Obama's Plan – Now Is The Time

The following is a quote from the President's plan regarding the goal to "Make sure students and young adults get treatment for mental health issues:"

Three quarters of mental illnesses appear by the age of 24, yet less than half of children with diagnosable mental health problems receive treatment. To increase access to mental health services for young people, we should:

- Provide "Mental Health First Aid" training to help teachers and staff recognize signs of mental illness in young people and refer them to treatment.
- Support young adults ages 16 to 25, who have the highest rates of mental illness but are the least likely to seek help, by giving incentives to help states develop innovative approaches.
- Help break the cycle of violence in schools facing pervasive violence with a new, targeted initiative to provide their students with needed services like counseling.
- Train 5,000 more social workers, counselors, and psychologists, with a focus on those serving students and young adults. (Now Is The Time, (White House, 1/16/2013)

Mental Health First Aid USA is coordinated nationally by the Maryland Department of Health and Mental Hygiene, the Missouri Department of Mental Health and the National Council for Community Behavioral Healthcare in partnership with the Mental Health Association of Maryland. <http://www.mhamd.org/mhfa/>
http://www.mhamd.org/mhfa/Documents/MHFA_JUNE_NEWS.pdf

General Inquiries

Susan Partain, National Council for Community Behavioral Healthcare
202.684.7457 x232

Instructor Technical Assistance & Upcoming Instructor Trainings

Margaret Jaco, National Council for Community Behavioral Healthcare
202.684.7457 x263

Mental Health First Aid Materials (ordering, etc)

Lisa Cinelli, Mental Health Association of Maryland
410.235.1178 x228

Media Inquiries

Meena Davak, National Council for Community Behavioral Healthcare
202.684.7457 x228

Mental Health First Aid in Maryland
www.MHFAMaryland.org
410.235.1178

Mental Health First Aid in Missouri
Brendolyn Bailey-Burch, Missouri Institute of Mental Health

314.877.6458

Virginia MHFA

HB2287, would require school boards to partner with their local Community Service Board to offer mandatory mental health first aid training to teachers. The 12-hour interactive course would provide information on risk factors, symptoms and treatment of various mental health disorders, including depression, anxiety, trauma and substance abuse. (The Roanoke Times, 1/28/13)

HOUSE BILL NO. 2287
AMENDMENT IN THE NATURE OF A SUBSTITUTE
(Proposed by the House Committee on Education on January 28, 2013)
(Patron Prior to Substitute--Delegate Krupicka)

A BILL to amend the Code of Virginia by adding a section numbered 22.1-271.1:1, relating to local school boards; Mental Health First Aid training plan.

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding a section numbered 22.1-271.1:1 as follows:

§ 22.1-271.1:1. Mental Health First Aid training plan. Each local school board, in conjunction with the local community services boards, shall develop a Mental Health First Aid training plan for such teachers and pupil personnel services employees employed in public schools as the local school board may identify. With such funds as may be appropriated to the Department of Behavioral Health and Developmental Services for this purpose, Mental Health First Aid training shall be initially provided by community services board staff members in each health planning region, as defined in § 32.1-102.1, who shall deliver a 12-hour interactive certification course to train such teachers and pupil personnel services employees in the risk factors, warning signs, and communication and referral skills for individuals developing a mental health problem or experiencing a mental health crisis.

2. That each local school board shall seek to complete development of its Mental Health First Aid training plan no later than July 1, 2014.

3. That such training plans and their implementation shall only occur if funds are appropriated for such purposes.

SEARHC offers mental health first aid certification course

Posted: April 10, 2012 - 12:06am

JUNEAU EMPIRE STAFF REPORT

The SouthEast Alaska Regional Health Consortium Behavioral Health Prevention and Community Family Services programs will offer a free, two-day mental health first aid course in May in the communities of Juneau, Sitka, Klawock and Kake.

“Mental health first aid will help anyone in any setting provide the care needed to a person experiencing a mental health problem or mental health crisis until appropriate professional treatment staff is available or until the crisis resolves,” said Behavioral Health Division Director Melody Price-Yonts.

The Juneau class is May 8-9, at the Vocational Training and Resource Center auditorium (3239 Hospital Dr.). The Sitka class is May 10-11, at the SEARHC At Kaník Hít Community Health building first-floor conference room (1212 Seward Ave.). The Klawock class takes place May 24-25, at the Klawock Salvation Army Church (585 Summit). The Kake class is May 28-29, at the Kake Salvation Army Church (on Keku Road).

During the 12-hour certification course, participants will learn:

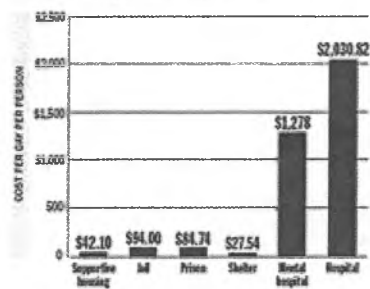
- The potential risk factors and warning signs for a variety of mental health problems, such as depression, anxiety/trauma, psychosis and psychotic disorders, eating disorders, substance use/abuse disorders and self-injury.
- Appropriate professional, peer, social and self-help resources available to help someone with a mental health problem.
- A five-step action plan encompassing the skills, resources and knowledge to assess the situation, to select and implement appropriate interventions, and to help the individual in crisis connect with appropriate professional care.
- An understanding of the prevalence of various mental health disorders in the U.S. and the need for reduced stigma in our communities.

These courses are open to all members of the community, young people, families and the general public. If you work in the following fields we encourage you to take this opportunity to attend this training — health workers, state policymakers, employers, faith communities, school personnel, law enforcement, nursing home staff and mental health support staff. Participants who complete the course will earn a mental health first aid certificate from the National Council for Community Behavioral Healthcare.

To register for the training or for more information, please call Kathryn Mathews in Sitka at 907-966-8744. The registration deadline is April 20. To learn more about the mental health first aid training, go to www.mentalhealthfirstaid.org.

HOMELESS COST ESTIMATES

Daily costs of serving the homeless in San Francisco in 2004



Resources

TOPICS IN HEALTH: LESSONS FROM THE FIELD

The Million Dollar (Homeless)

Patient

Calculating the health care costs of chronic homelessness

Health, Company Location, Social Issues, homelessness, Supportive housing, Housing first, Angelo Solis, Homelessness in the United States, Homelessness in Canada, health insurance, USD, diabetes, California (Show more tags)

By Sarah Arnquist

Angelo Solis is a chronic alcoholic in his late 60s who was homeless for many years in Solano County, California. Solis frequently passed out drunk in public, and police brought him to the hospital emergency room. There, doctors often admitted him to treat his multiple chronic health problems and so he could detoxify safely.

Solis would leave the hospital only to return after police found him passed out, again. This happened, repeatedly, for years. Solis' health never improved; it worsened because he slept outside and couldn't properly care for his diabetes or heart disease.

In three years, Solis racked up nearly \$1 million in medical charges - paid for by taxpayers.

Solis' case represents the immense health care costs associated with homelessness. Nearly every community has at least one chronically homeless person like him. Some have hundreds.

Hospital emergency room staffs call these patients frequent fliers. Many have chronic health problems worsened by living outside, in addition to substance abuse problems and untreated mental illness. Because their cases are so complicated they require expensive treatment and extra time from hospital staff.

But despite receiving repeated rounds of intensive and costly treatment, their health rarely improves when they return to the streets. They return to the hospital for more costly treatment again and again. Taxpayers and people with private insurance pay for this fruitless care, as hospitals shift costs onto them.

That's the reason to convince your editor to write about the health care costs of homelessness in your community.

Here is some advice on where to start, who to talk to, and how to organize your time to report this story. I've also included relevant research, an expert list, and tips I wish someone had given me.

Planning

While conceiving the idea to write about the health care costs of the chronically homeless, two aspects of this problem interested me most. First, what happens when a homeless person is hospitalized and has no place to finish recuperating after being discharged? What does the hospital do? Where do they go?

Second, I wanted to quantify the medical costs for one homeless individual. Malcolm Gladwell's piece called "Million-Dollar Murray" in the New Yorker inspired my story on Solis. Focusing on the immense costs of one individual effectively demonstrated the magnitude of the problem.

The work for a project like this can be divided into two broad categories:

1. Finding the people
2. Getting the numbers

Finding people: Plant seeds early and be patient

Finding homeless people to illustrate these scenarios takes time – lots of it. But it is possible.

Start by getting to know the advocates who work with the homeless daily at shelters, the county programs, food banks, etc. While it's important to have a good relationship with the directors of these programs to guarantee good access, the caseworkers on the frontlines are your key to finding people. They know individuals and stories, and if they're good their clients trust them. If the caseworker trusts you, they can be immensely helpful. They are very busy people, however, so call them once a week to kindly remind them of your project.

Hospital social workers can also be great resources, but tend to be more cautious about helping because of HIPAA, the federal patient privacy law. Meet with them and the hospital public relations officials early to explain your project and get their buy-in.

Be patient. It may take several weeks or months before anyone turns up. Several leads may fail. Let go of them if they aren't right. Another will turn up. In the meantime, get informed. If you're like I was – filing a story nearly every day – set aside a one or two hours each week to find relevant studies and interview experts.

Getting the numbers

In addition to the peer-reviewed studies and abstract quotes from experts, you need solid, local data. Keep this in mind while searching for people to write about. You need them to be entirely transparent.

Calculating one homeless patient's health costs

You'll most likely have to get the patient's medical bills, records and other documents from the hospital or health plan (if they are enrolled in one). Relying on the hospital for billing records is tricky because patients can go to more than one hospital.

I lucked out here. Solis qualified for Social Security Disability Income and Medicaid. In Solano County, all Medicaid patients are enrolled in a managed care health plan. That meant all of Solis' medical claims were in one place. Solis signed a waiver and the health plan produced his medical charges from 2002 to 2006. He had no charges after 2004, which is when he moved into the motel. Most California counties operate similarly so if you find patient enrolled Medi-Cal or even the county indigent program, it will be easier to get reliable numbers. (That is of course if the bureaucracy will help you.)

The following chart shows Solis' medical bills. While it says charges, the numbers indicate what the health plan actually paid. Be sure to differentiate between charges and paid claims or costs. Hospital charges or "sticker prices" do not reflect actual costs or payments.

Angelo Solis' health care charges totaled \$997,550 from 2002 to 2004

Medi-Cal and CMSP public insurance programs paid the bills.

	INPATIENT HOSPITAL DAYS	INPATIENT CHARGES	ER VISITS	ER CHARGES	PHYSICIAN CHARGES	AMBULANCE CHARGES	FILLED PRESCRIPTIONS	PRESCRIPTION CHARGES	TOTAL CHARGES
2002	75	\$463,000	10	\$27,264	\$27,837	\$9,275	44	\$698	\$628,074
2003	5	\$57,107	1	\$4,353	\$5,638	\$1,131	89	\$2,092	\$70,321
2004	55	\$326,765	9	\$45,401	\$19,601	\$6,264	34	\$1,124	\$399,155

Source: Partnership HealthPlan Billing and Accounting Services

Calculating costs of frequent users

Q How did Northbay Medical Center pick out its five most expensive frequent users and determine their total costs were \$1.45 million?

A Sarah Javel, director of business development at Northbay, dug into the hospital's databases. She first searched for patients who visited the emergency room more than four times or racked up more than \$50,000 in charges, and were uninsured or had Medi-Cal. She narrowed that huge list down to the 28 patients with the highest charges — many included all pediatric, obstetric and single-condition patients. The five cases she came up with represented the most expensive frequent users who have long lists of diagnoses and conditions suggestive of mental health or substance abuse problems. The \$1.45 million figure represents actual costs to the hospital, including nursing care, medications and services such as technology and salaries.

COSTS OF FIVE FREQUENT USERS AT NORTHBAY MEDICAL CENTER IN 2004

ER visits	117
Hospital admissions	64
Inpatient days	523
Total hospital costs*	\$1.5 million
Total collections	\$457,000
Hospital's total loss	\$990,000

*Figure is hospital costs including nursing care, drugs and hospital overhead — not charges.
Source: Northbay Medical Center

To demonstrate this was a broader problem, I asked one hospital to calculate the costs of its five most expensive frequent fliers. Admittedly, this was not a very scientific process. We agreed on a process to pick the five patients that satisfied us both. While I sat in the administrator's office, she searched the hospital's databases and looked for patients by how many times they came to the hospital, why they came and how much they cost to treat. She printed out the spreadsheets for me, and I could see that from January to December 2004, five individuals made 117 trips to the emergency room and spent 523 days in the hospital in the course of 64 admissions.

The administrator then worked with the hospital's financial and billing department to estimate the cost of care based on the diagnoses and length of stay to be \$1.45 million. Again, be sure to differentiate between costs and charges. Hospital list prices or charges do not reflect the actual cost of treatment.

Offering solutions

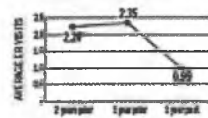
Many homeless advocates and medical experts point to supportive housing as a more cost-effective and humane solution to keeping chronically homeless people out of hospitals. Supportive housing combines affordable housing, case management and access to supportive services. Some programs don't require sobriety, and in response to criticism, they point to studies that show once housed, the addicts' costs to society greatly decrease.

Solis' case was a crude example of supportive housing. Solis lived in a dingy motel and a case manager checked on him regularly. While he didn't stop drinking entirely, he drank much less and didn't return to the hospital for two years after moving into the apartment.

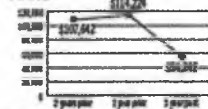
EMERGENCY ROOM USE DROPS WITH SUPPORTIVE HOUSING

San Francisco's emergency room use and costs fell by more than 50 percent for 204 formerly chronically homeless people who spent one year in supportive housing.

AVERAGE ANNUAL VISITS TO EMERGENCY ROOM



HOSPITAL EMERGENCY ROOM COSTS



Source: Corporation for Supportive Housing & Goldman School of Public Policy at UC Berkeley

Example of housing first

The San Francisco Public Health Department dedicates \$30 million of its \$1-billion budget to housing 1,000 chronically homeless frequent fliers. A study by the program by the University of California Berkeley's Goldman School of Public Policy found that San Francisco's investment in supportive housing decreased hospital use of 235 formerly chronically homeless people by more than 50 percent.

Example of interim care

Another large problem is the high, unnecessary costs associated with homeless people who have no place to recuperate after a hospitalization. They either stay in the hospital longer at the price of at least \$1,000 a day, or they return to the streets, where they fail to heal and often return to the hospital with the same problem, sometimes within days.

The Sacramento Salvation Army's Interim Care Program is an example of a program that provides a place for homeless people to stay in the short-term while they recuperate from a hospitalization. Local hospitals helped fund the interim shelter because they realized it would save them money by reducing the extra days homeless people spent in the hospital because they had no other place to go.

Things I wish I had known from the start

- Homeless people are hard to keep tabs on. Once you find someone willing to share his or her story, get information right away about their friends, where they live and hang out.
- A homeless person may agree to work with you, but may soon ask you for things in return. Be clear about expectations and demands up-front.
- Get a photographer involved early in the process, ideally from the first meeting.
- Think multimedia from the beginning! Bring your audio recorder to every interview. Practice using the video camera or request a photographer comfortable with video so you can include that Web element. Brainstorm ways to involve the readers in the story through online comments, listing ways people can help and including maps and user-friendly graphics.
- Without nagging, keep in close touch with the caseworkers and hospital social workers helping you find patients. Otherwise, they will forget about you.
- Don't give yourself or your editors a deadline. You can't determine the timeline for this type of project. It took me seven months to complete.

Research

A landmark study led by Dennis Culhane at the University of Pennsylvania greatly shifted the federal government's philosophy on homelessness. There has been an increasing push to focus on the small number of people who consume the majority of resources. Culhane's study estimated that in 1999, chronically homeless people with several mental illnesses in New York City used about \$40,000 per person in public services, such as emergency shelters, police, jail, mental health crisis centers and hospitals.

Health costs of the chronically homeless

Dr. James Dunford led a study in San Diego that followed 529 homeless, chronic alcoholics from 2000 to 2003. The results showed those people were transported by ambulance 2,335 times, amassed 3,318 emergency room visits, and required 652 hospital admissions, resulting in 3,361 inpatient days. Their health care charges totaled \$17.7 million.

Academic studies

- Dunford, James. et al. "Impact of the San Diego Serial Inebriate Program on Use of Emergency Medical Resources." *Annals of Emergency Medicine*, April, 2006.
- Greene, Jan. "Serial inebriate programs: what to do about homeless alcoholics in the emergency department." Editorial. *Annals of Emergency Medicine*. June 2007.
- Thornquist, Lisa, et al. "Health care utilization of chronic inebriates." *Academic Emergency Medicine*. June 2002. (Minnesota)
- Salit, Sharon, et al. "Hospitalization costs association with homelessness in New York City. *New England Journal of Medicine*. June 11, 1998.

Health status of the homeless:

The U.S. Department of Health and Human Services' Homeless Programs Branch has research on the health problems common to many homeless people. A 1999 survey found that two in three homeless people had substance abuse and mental health problems; 3 percent had HIV or AIDS; one in four had acute medical problems including tuberculosis and pneumonia; and nearly half had chronic health conditions such as high blood pressure, diabetes or cancer.

www.hhs.gov/homeless/research/index.html

The price of hospital services:

I went to the U.S. Agency for Healthcare Research and Quality to find an average cost of an emergency room visit and doctor's visit.

Efficacy of supportive housing

Lewin Group. "Costs of Serving Homeless Individuals in nine cities." Nov. 19, 2004.

Culhane, Dennis, et al. "The Impact of Supportive Housing for Homeless People with Severe Mental Illness on the Utilization of the Public Health, Corrections, and Emergency Shelter Systems: The New York-New York Initiative." May 2001.

Other Reporting Resources

Corporation for Supportive Housing, an Oakland-based nonprofit that works with governments to build supportive housing. Will provide experts for interviews.

HomeBase, The Center for Common Concerns, a San Francisco-based advocacy law firm works with governments at all levels to create 10-year plans to end chronic homelessness.

U.S. Department of Health and Human Services' Homeless Programs Branch

U.S. Department of Housing and Urban Development, homelessness division

National Alliance to End Homelessness, has several fact sheets and can provide experts for interviews

National Law Center on Homelessness and Poverty, also will provide experts for interviews and legal analysis.

Partnership to End Long-Term Homelessness, has a section listing case studies. You may be able to find one in your area.

Article available at: <http://www.reportingonhealth.org/resources/lessons/million-dollar-homeless-patient>



Mental Health First Aid

Mental Health First Aid is an adult public education program designed to improve participants' knowledge and modify their attitudes and perceptions about mental health and related issues, including how to respond to individuals who are experiencing one or more acute mental health crises (i.e., suicidal thoughts and/or behavior, acute stress reaction, panic attacks, and/or acute psychotic behavior) or are in the early stages of one or more chronic mental health problems (i.e., depressive, anxiety, and/or psychotic disorders, which may occur with substance abuse).

The intervention is delivered by a trained, certified instructor through an interactive 12-hour course, which can be completed in two 6-hour sessions or four 3-hour sessions. The course introduces participants to risk factors, warning signs, and symptoms for a range of mental health problems, including comorbidity with substance use disorders; builds participants' understanding of the impact and prevalence of mental health problems; and provides an overview of common support and treatment resources for those with a mental health problem. Participants also are taught a five-step action plan, known as ALGEE, for use when providing Mental Health First Aid to an individual in crisis:

- A--Assess for risk of suicide or harm
- L--Listen nonjudgmentally
- G--Give reassurance and information
- E--Encourage appropriate professional help
- E--Encourage self-help and other support strategies

In addition, the course helps participants to not only gain confidence in their capacity to approach and offer assistance to others, but also to improve their personal mental health. After completing the course and passing an examination, participants are certified for 3 years as a Mental Health First Aider.

In the studies reviewed for this summary, Mental Health First Aid was delivered as a 9-hour course, through three weekly sessions of 3 hours each. Participants were recruited from community and workplace settings in Australia or were members of the general public who responded to recruitment efforts. Some of the participants (7%-60% across the three studies reviewed) had experienced mental health problems.

Descriptive Information

Areas of Interest	Mental health promotion
Outcomes	<p>Review Date: May 2012</p> <p>1: Recognition of schizophrenia and depression symptoms</p> <p>2: Knowledge of mental health support and treatment resources</p> <p>3: Attitudes about social distance from individuals with mental health problems</p> <p>4: Confidence in providing help, and provision of help, to an individual with mental health problems</p> <p>5: Mental health</p>
Outcome Categories	<p>Mental health</p> <p>Social functioning</p>
Ages	<p>18-25 (Young adult)</p> <p>26-55 (Adult)</p> <p>55+ (Older adult)</p>
Genders	<p>Male</p> <p>Female</p>
Races/Ethnicities	Non-U.S. population
Settings	<p>Workplace</p> <p>Other community settings</p>

Geographic Locations	Urban Suburban Rural and/or frontier
Implementation History	Mental Health First Aid was developed in 2001 at the Australian National University. The program was first used in the United States in 2007, and since then, the program has trained over 1,500 instructors in 45 States, the District of Columbia, and Puerto Rico. These instructors have taught the course to more than 38,000 people in a variety of communities. The program has been implemented internationally in Australia, Cambodia, China, England, Finland, Hong Kong, Ireland, Japan, Nepal, New Zealand, Scotland, Singapore, South Africa, Sweden, Thailand, and Wales.
NIH Funding/CER Studies	Partially/fully funded by National Institutes of Health: No Evaluated in comparative effectiveness research studies: No
Adaptations	Mental Health First Aid has been adapted for youth participants (i.e., those under age 18), using age-appropriate examples and format. The program has been translated into Vietnamese for use in Vietnamese communities in Australia.
Adverse Effects	No adverse effects, concerns, or unintended consequences were identified by the developer.
IOM Prevention Categories	Universal Selective Indicated

Quality of Research

Review Date: May 2012

Documents Reviewed

The documents below were reviewed for Quality of Research. The research point of contact can provide information regarding the studies reviewed and the availability of additional materials, including those from more recent studies that may have been conducted.

Study 1

Kitchener, B. A., & Jorm, A. F. (2002). Mental Health First Aid training for the public: Evaluation of effects knowledge, attitudes and helping behavior. *BMC Psychiatry*, 2(10), 1-6. [PubMed](#)

Study 2

Kitchener, B. A., & Jorm, A. F. (2004). Mental Health First Aid training in a workplace setting: A randomized controlled trial. *BMC Psychiatry*, 4(23), 1-8. [PubMed](#)

Study 3

Jorm, A. F., Kitchener, B. A., O'Kearney, R., & Dear, K. (2004). Mental Health First Aid training of the public in a rural area: A cluster randomized trial. *BMC Psychiatry*, 4(33), 1-9. [PubMed](#)

Supplementary Materials

Overview of intervention fidelity

Outcomes

Outcome 1: Recognition of schizophrenia and depression symptoms

Description of Measures	Recognition of schizophrenia and depression symptoms was assessed using vignettes and items from the National Survey of Mental Health Literacy, a self-completed survey. Participants were presented with a vignette of a person who had major depression ("Mary") and/or a vignette of a person who had schizophrenia ("John"). After reading the vignette, participants were asked the following open-ended question: "From the information given, what, if anything is wrong with Mary/John?" The percentage of participants who correctly identified the disorder described was calculated on the basis of the responses.
Key Findings	A study was conducted with members of the public who responded to recruitment information distributed within a community in Australia to participate in Mental Health First Aid. All participants received the intervention. Participants were randomly assigned to receive the schizophrenia vignette or the depression vignette, and the same vignette was presented to each participant at three

assessment points: before (pretest) and after (posttest) the intervention and 6 months after the posttest (follow-up). Combined data from both vignette groups indicated that over time, there was an increase in the percentage of participants who correctly recognized symptoms of schizophrenia or depression ($p < .001$). Data from the schizophrenia vignette group indicated that over time, there was an increase in the percentage of participants who correctly recognized symptoms of schizophrenia ($p < .001$). Although data from the depression vignette group indicated that over time, there was an increase in the percentage of participants who correctly recognized symptoms of depression, these findings were not statistically significant.

In another study, community residents in a large rural area in southern Australia were matched and grouped into pairs and then randomly assigned to the intervention group, whose participants received Mental Health First Aid immediately, or the wait-list control group. Participants in the intervention group also were randomly assigned to receive the schizophrenia vignette or the depression vignette, and the same vignette was presented to each participant at two assessment points: approximately 2 months before the intervention (pretest) and approximately 6 months after the pretest (at a follow-up occurring approximately 4 months after the intervention). Combined data from both vignette groups indicated that the percentage of participants who improved from incorrectly recognizing symptoms of schizophrenia or depression at pretest to correctly recognizing them at the 4-month follow-up was greater for the intervention group than the control group ($p < .001$). Data from each individual vignette group were not analyzed.

Studies Measuring Outcome	Study 1, Study 3
Study Designs	Experimental, Preexperimental
Quality of Research Rating	2.7 (0.0-4.0 scale)

Outcome 2: Knowledge of mental health support and treatment resources

Description of Measures

Knowledge of mental health support and treatment resources was assessed using vignettes and items from the National Survey of Mental Health Literacy, a self-completed survey. Participants were presented with a vignette of a person who had major depression ("Mary") and/or a vignette of a person who had schizophrenia ("John"). Participants were then given a list of people, treatments, and actions that the person described in the vignette might use as a resource. Using a response of "helpful," "harmful," or "neither," participants rated each item in the list (e.g., "a typical GP [general practitioner] or family doctor"; "a chemist or pharmacist"; "a psychiatrist"; "Mary/John tries to deal with her/his problem on her/his own"; "pain relievers such as aspirin, codeine or panadol"; "antidepressants"; "courses on relaxation, stress management, meditation or yoga"; "a special diet or avoiding certain foods"). To assess this outcome, a scale was created showing the extent of the participant's knowledge of which support and treatment resources were helpful, as agreed on by health professionals. Six of the list items were classified as helpful for schizophrenia, and participants received a score ranging from 0 to 6, depending on the number of items correctly classified; five of the list items were classified as helpful for depression, and participants received a score ranging from 0 to 5, depending on the number of items correctly classified. Because of the difference in the total number of helpful items (i.e., 6 vs. 5), participants' scores were converted to percentages.

Key Findings

A study was conducted with members of the public who responded to recruitment information distributed within a community in Australia to participate in Mental Health First Aid. All participants received the intervention. Participants were randomly assigned to receive the schizophrenia vignette or the depression vignette, and the same vignette was presented to each participant at three assessment points: before (pretest) and after (posttest) the intervention and 6 months after the posttest (follow-up). Combined data from both vignette groups indicated that over time, there was an increase in the percentage of items correctly classified by participants as helpful for schizophrenia and depression ($p < .001$), although there was a slight decrease from posttest to the 6-month follow-up in the percentage of items correctly classified. There were no statistically significant changes in participants' knowledge of mental health support and treatment resources over time when data from each individual vignette group were analyzed.

In a second study, employees from two large government departments in Australia were randomly assigned to the intervention group, whose participants received Mental Health First Aid immediately during work time, or the wait-list control group. Participants in the intervention group were presented with both the depression and schizophrenia vignettes and assessed approximately 1 month before (pretest) and approximately 5 months after (follow-up) Mental Health First Aid was received. Combined data from both vignette groups indicated that from pretest to the 5-month

	<p>follow-up, compared with participants in the control group, those in the intervention group had a greater improvement in the percentage of items correctly classified as helpful for schizophrenia and depression ($p = .036$). There were no statistically significant changes between groups in regard to participants' knowledge of mental health support and treatment resources over time when data from each individual vignette group were analyzed.</p> <p>In a third study, community residents in a large rural area in southern Australia were matched and grouped into pairs and then randomly assigned to the intervention group, whose participants received Mental Health First Aid immediately, or the wait-list control group. Participants in the intervention group also were randomly assigned to receive the schizophrenia vignette or the depression vignette, and the same vignette was presented to each participant at two assessment points: approximately 2 months before the intervention (pretest) and approximately 6 months after the pretest (at a follow-up occurring approximately 4 months after the intervention). Combined data from both vignettes indicated that from pretest to the 4-month follow-up, compared with participants in the control group, those in the intervention group had a greater improvement in the percentages of items correctly classified as helpful for schizophrenia or depression ($p = .001$). Data from each individual vignette group were not analyzed.</p>
Studies Measuring Outcome	Study 1, Study 2, Study 3
Study Designs	Experimental, Preexperimental
Quality of Research Rating	2.6 (0.0-4.0 scale)

Outcome 3: Attitudes about social distance from individuals with mental health problems

Description of Measures	<p>Attitudes about social distance from individuals with mental health problems were assessed using the 4-item Social Distance Scale, a self-report questionnaire. Participants were presented with a vignette of a person who had major depression ("Mary") and/or a vignette of a person who had schizophrenia ("John"). Using a scale ranging from 1 (definitely willing) to 4 (definitely unwilling), participants responded to four questions regarding how willing they would be to move next door to, socialize with, become friends with, or work with the individual described in the vignette.</p>
Key Findings	<p>A study was conducted with members of the public who responded to recruitment information distributed within a community in Australia to participate in Mental Health First Aid. All participants received the intervention. Participants were randomly assigned to receive the schizophrenia vignette or the depression vignette, and the same vignette was presented to each participant at three assessment points: before (pretest) and after (posttest) the intervention and 6 months after the posttest (follow-up). Combined data from both vignette groups indicated that over time, participants had an improvement in attitudes about social distance from individuals with mental health problems ($p < .001$). There were no statistically significant changes in attitudes about social distance from individuals with mental health problems over time when data from each individual vignette group were analyzed.</p> <p>In a second study, employees from two large government departments in Australia were randomly assigned to the intervention group, whose participants received Mental Health First Aid immediately during work time, or the wait-list control group. Participants in the intervention group were presented with both the depression and schizophrenia vignettes and assessed approximately 1 month before (pretest) and approximately 5 months after (follow-up) Mental Health First Aid was received. Combined data from both vignette groups indicated that from pretest to the 5-month follow-up, compared with participants in the control group, those in the intervention group had a greater improvement in attitudes about social distance from individuals with mental health problems ($p = .020$). Data from the depression vignette group indicated that over time, compared with participants in the control group, those in the intervention group had a greater improvement in attitudes about social distance from individuals with mental health problems ($p = .005$). There were no statistically significant changes between groups in regard to attitudes about social distance from individuals with mental health problems over time when data from the schizophrenia vignette group were analyzed.</p> <p>In a third study, community residents in a large rural area in southern Australia were matched and grouped into pairs and then randomly assigned to the intervention group, whose participants received Mental Health First Aid immediately, or the wait-list control group. Participants in the intervention group also were randomly assigned to receive the schizophrenia vignette or the depression vignette, and the same vignette was presented to each participant at two assessment points: approximately 2 months before the intervention (pretest) and approximately 6 months after</p>

	the pretest (at a follow-up occurring approximately 4 months after the intervention). Combined data from both vignette groups indicated that from pretest to the 4-month follow-up, compared with participants in the control group, those in the intervention group had a greater improvement in attitudes about social distance from individuals with mental health problems ($p = .032$). Data from each individual vignette group were not analyzed.
Studies Measuring Outcome	Study 1, Study 2, Study 3
Study Designs	Experimental, Preexperimental
Quality of Research Rating	3.1 (0.0-4.0 scale)

Outcome 4: Confidence in providing help, and provision of help, to an individual with mental health problems

Description of Measures	Confidence in providing help, and provision of help, to an individual with mental health problems was measured with items from a self-assessment questionnaire. Using a scale ranging from 1 (not at all) to 5 (extremely), participants responded to the first item: "How confident do you feel in helping someone with a mental health concern?" Confidence in helping someone with mental health problems was defined as a response of 3 (moderately), 4 (quite a bit), or 5. Using a choice of "yes," "no," or "don't know," participants responded to a second item: "In the last 6 months have you had contact with anyone with a mental health problem?" Participants who responded "yes" were asked to respond to additional items: "How many people?"; "Have you offered any help?" (using a scale ranging from 1, not at all, to 4, a lot); and "What type of help?" (which had an open-ended response).
Key Findings	<p>A study was conducted with members of the public who responded to recruitment information distributed within a community in Australia to participate in Mental Health First Aid. All participants received the intervention. Participants, who were randomly assigned to receive a schizophrenia vignette or a depression vignette (both of which were used as part of the measures of other outcomes), were assessed before (pretest) and after (posttest) the intervention and 6 months after the posttest (follow-up). Combined data from both vignette groups indicated that over time, more participants were confident in providing help to an individual with mental health problems ($p < .001$) and more participants who had contact with someone with a mental health problem provided some or a lot of help to that individual ($p = .036$). Data for each individual vignette group were not analyzed.</p> <p>In a second study, employees from two large government departments in Australia were randomly assigned to the intervention group, whose participants received Mental Health First Aid immediately during work time, or the wait-list control group. Participants in the intervention group, who were presented with schizophrenia and depression vignettes (both of which were used as part of the assessment of other outcomes), were assessed approximately 1 month before (pretest) and approximately 5 months after (follow-up) Mental Health First Aid was received. Combined data from both vignette groups indicated that from pretest to the 5-month follow-up, compared with participants in the control group, more participants in the intervention group were confident in providing help to an individual with mental health problems ($p = .001$). Also from pretest to the 5-month follow-up, the percentage of participants advising professional help to anyone with a mental health problem increased in comparison with the percentage of those in the control group, which decreased ($p = .007$). Data from each individual vignette group were not analyzed.</p> <p>In a third study, community residents in a large rural area in southern Australia were matched and grouped into pairs and then randomly assigned to the intervention group, whose participants received Mental Health First Aid immediately, or the wait-list control group. Participants in the intervention group, who were randomly assigned to receive a schizophrenia vignette or a depression vignette (both of which were used as part of the assessment of other outcomes), were assessed approximately 2 months before the intervention (pretest) and approximately 6 months after the pretest (at a follow-up occurring approximately 4 months after the intervention). Combined data from both vignette groups indicated that from pretest to the 4-month follow-up, the percentage of participants in the intervention group offering help to a person with a mental health problem increased in comparison with the percentage of those in the control group ($p = .031$). Also from pretest to the 4-month follow-up, compared with participants in the control group, participants in the intervention group had a greater increase in confidence in providing help to an individual with mental health problems ($p = .001$). Data from each individual vignette group were not analyzed.</p>
Studies Measuring Outcome	Study 1, Study 2, Study 3

Study Designs	Experimental, Preexperimental
Quality of Research Rating	2.3 (0.0-4.0 scale)

Outcome 5: Mental health

Description of Measures	The mental health of participants was assessed using the mental health scale of the 12-item Short-Form Health Survey (SF-12), a self-report questionnaire. Using a yes/no response or a response on a Likert-type scale, participants responded to each item (e.g., whether they accomplished less than they would like or did work or other activities less carefully than usual during the past 4 weeks because of any emotional problems [such as feeling depressed or anxious]).
Key Findings	<p>In one study, employees from two large government departments in Australia were randomly assigned to the intervention group, whose participants received Mental Health First Aid immediately during work time, or the wait-list control group. Participants in the intervention group received a depression vignette and a schizophrenia vignette (both of which were used as part of the measures of other outcomes) and were assessed approximately 1 month before (pretest) and approximately 5 months after (follow-up) Mental Health First Aid was received. Combined data from both vignette groups indicated that from pretest to the 5-month follow-up, participants in the intervention group had a greater improvement in self-reported mental health compared with the wait-list group, which had a decline ($p = .035$). Data from each individual vignette group were not analyzed.</p> <p>In another study, community residents in a large rural area in southern Australia were matched and grouped into pairs and then randomly assigned to the intervention group, whose participants received Mental Health First Aid immediately, or the wait-list control group. Participants in the intervention group, who were randomly assigned to receive a schizophrenia vignette or a depression vignette (both of which were used as part of the assessment of other outcomes), were assessed approximately 2 months before the intervention (pretest) and approximately 6 months after the pretest (at a follow-up occurring approximately 4 months after the intervention). Combined data from both vignette groups indicated that from pretest to the 4-month follow-up, the percentage of intervention group participants who reported experiencing a mental health problem increased in comparison with the percentage of those in the control group ($p = .045$). Data from each individual vignette group were not analyzed.</p>
Studies Measuring Outcome	Study 2, Study 3
Study Designs	Experimental
Quality of Research Rating	3.3 (0.0-4.0 scale)

Study Populations

The following populations were identified in the studies reviewed for Quality of Research.

Study	Age	Gender	Race/Ethnicity
Study 1	18-25 (Young adult) 26-55 (Adult) 55+ (Older adult)	84% Female 16% Male	100% Non-U.S. population
Study 2	18-25 (Young adult) 26-55 (Adult) 55+ (Older adult)	78% Female 22% Male	100% Non-U.S. population
Study 3	18-25 (Young adult) 26-55 (Adult) 55+ (Older adult)	82% Female 18% Male	100% Non-U.S. population

Quality of Research Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the Quality of Research for an intervention's reported results using six criteria:

1. Reliability of measures
2. Validity of measures

3. Intervention fidelity
4. Missing data and attrition
5. Potential confounding variables
6. Appropriateness of analysis

For more information about these criteria and the meaning of the ratings, see [Quality of Research](#).

Outcome	Reliability of Measures	Validity of Measures	Fidelity	Missing Data/Attrition	Confounding Variables	Data Analysis	Overall Rating
1: Recognition of schizophrenia and depression symptoms	2.0	2.0	2.0	4.0	2.0	4.0	2.7
2: Knowledge of mental health support and treatment resources	2.0	2.0	2.0	3.5	2.0	4.0	2.6
3: Attitudes about social distance from individuals with mental health problems	3.5	3.5	2.0	3.5	2.0	4.0	3.1
4: Confidence in providing help, and provision of help, to an individual with mental health problems	0.5	1.5	2.0	3.5	2.0	4.0	2.3
5: Mental health	4.0	4.0	2.0	3.5	2.0	4.0	3.3

Study Strengths

The Social Distance Scale and Short-Form Health Survey are well-researched measures with strong psychometric properties. In one study, fidelity was measured with a checklist that was created by the program developers to assess intervention adherence, which was demonstrated to be very high. Attrition was low in the three studies. Two studies employed random assignment into study groups. A variety of appropriate analyses, including intent-to-treat analysis, were used across the studies.

Study Weaknesses

The National Survey of Mental Health Literacy and the self-assessment questionnaire regarding help provided to an individual with mental health problems had face validity, but other types of psychometric information were not provided. In two studies, no instrument was used to measure fidelity. Some potential confounds were introduced. One study lacked a control or comparison group. In another study, participants in the intervention group had a lower response rate to the follow-up questionnaires than control group participants. In a third study, information on participants' attendance was not collected by all instructors.

Readiness for Dissemination

Review Date: May 2012


Materials Reviewed

The materials below were reviewed for Readiness for Dissemination. The implementation point of contact can provide information regarding implementation of the intervention and the availability of additional, updated, or new materials.


Gibb, B., & Browning-McNee, L. (n.d.). Mental Health First Aid: Curriculum modules [PowerPoint slides].

Goon, E., & Dayak, M. (n.d.). Mental Health First Aid: Accomplishments and priorities 2010-2011 [PowerPoint slides].

Jorm, A. F., Kitchener, B. A., Kanowski, L. G., & Kelly, C. M. (2006). Mental Health First Aid training for members of the public. *International Journal of Clinical and Health Psychology*, 7(1), 141-151.

Kitchener, B. A., & Jorm, A. F. (2006). Mental Health First Aid Training: Review of evaluation studies. *Australian and New Zealand Journal of Psychiatry*, 40(1), 6-8. 

Kitchener, B. A., & Jorm, A. F. (2007). Mental Health First Aid [PowerPoint slides].

Kitchener, B. A., & Jorm, A. F. (2007). Mental Health First Aid: An international programme for early intervention. *Early Intervention in Psychiatry*, 2(1), 55-61. 

Kitchener, B. A., Jorm, A. F., Kelly, C. M., Maryland Department of Health and Mental Hygiene, Missouri Department of Mental Health, & National Council for Community Behavioral Healthcare. (2009). Mental Health First Aid USA [Participant manual]. Annapolis, MD: Anne Arundel County Mental Health Agency.

Kitchener, B. A., Jorm, A. F., Kelly, C. M., Maryland Department of Health and Mental Hygiene, Missouri Department of Mental Health, & National Council for Community Behavioral Healthcare. (2009). Mental Health First Aid USA: Teaching notes. Annapolis, MD: Anne Arundel County Mental Health Agency.

Mental Health First Aid handouts:

- ALGEE Jigsaw
- Auditory Hallucination Script
- Depression/Anxiety Scenarios
- Disability Weights Exercise
- Disability Weights Templates
- Eating Disorders Scenarios
- Eating Disorders Scenarios Answer Key
- Eating Disorders: Where Do You Stand?
- Eating Disorders: Where Do You Stand? Quiz
- Handouts & Exercises Overview
- Helpful Things to Say?
- Mental Health Opinions Quiz
- Myths & Facts About Suicide
- Panic Attack Scenarios
- Self-Injury: Fact, Fiction or Somewhere in Between
- Standard Drinks
- Standard Drinks Answer Key
- Substance Use Scenarios
- Suicidal Thoughts & Behaviors Scenarios
- Traumatic Event Scenarios
- What's Your Booze IQ?
- Wheel of Pour-tune
- Who Am I? Answer Key
- Who Am I? Worksheet

Mental Health First Aid USA: Course Films [DVD]

Mental Health First Aid USA Facebook page, <http://www.facebook.com/pages/Mental-Health-First-Aid-USA/262722766319>

National Institute of Mental Health. (2003). Real men: Real depression. Bethesda, MD: Author.

National Institute of Mental Health. (2007). Depression. Bethesda, MD: Author.

National Institute of Mental Health. (2007). Medications. Bethesda, MD: Author.

National Institute of Mental Health. (2008). Bipolar disorder. Bethesda, MD: Author.

Office of Applied Studies, Substance Abuse and Mental Health Services Administration. (2008). The National Survey on Drug Use and Health report: Major depressive episode and treatment for depression among veterans aged 21 to 39. Rockville, MD: Author.

Office on Women's Health, U.S. Department of Health and Human Services. (n.d.). Women's mental health: What it means to you. Washington, DC: Author.

Program Web site, <http://www.mentalhealthfirstaid.org>

Other dissemination materials:

- Mental Health First Aid Exam for Instructors
- Mental Health First Aid Instructor Training Course Agenda
- Mental Health First Aid: 12 Hour Course Evaluation Form
- Mental Health First Aid USA Certification Standards (May 2010)
- Presentation Schedule for 30
- 2nd Annual Mental Health First Aid USA Instructor Summit Agenda
- Tenets of Fidelity

Readiness for Dissemination Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the intervention's Readiness for Dissemination using three criteria:

1. Availability of implementation materials

- 2. Availability of training and support resources
- 3. Availability of quality assurance procedures

For more information about these criteria and the meaning of the ratings, see [Readiness for Dissemination](#).

Implementation Materials	Training and Support Resources	Quality Assurance Procedures	Overall Rating
4.0	4.0	4.0	4.0

Dissemination Strengths

The implementation materials for instructors are comprehensive and provide all resources needed to deliver the intervention, including teaching notes, a DVD, a participant handbook and handouts, and a USB flash drive with support resources. The teaching notes are filled with eye-catching icons that facilitate instruction. Three videos depict how to interact and intervene with people experiencing a mental health problem using the action plan presented throughout the curriculum. The program Web site is easy to navigate and is continuously updated with new materials, Webinars, and podcasts; it also includes a forum where instructors can have discussions and network. Initial and ongoing certification requirements and standards for instructors are presented in detail, and adherence to requirements are monitored to support fidelity. Participants must pass an examination at the conclusion of the course to become certified as a Mental Health First Aider. In addition, a participant course evaluation is available to provide feedback for ongoing program improvement.

Dissemination Weaknesses

No weaknesses were identified by reviewers.

Costs

The cost information below was provided by the developer. Although this cost information may have been updated by the developer since the time of review, it may not reflect the current costs or availability of items (including newly developed or discontinued items). The implementation point of contact can provide current information and discuss implementation requirements.

Item Description	Cost	Required by Developer
Participant manual	\$14.95 each	Yes
12-hour, off-site certification course (includes participant manual, handouts, and resources; certification is valid for 3 years)	Free or \$120-\$180 per person, if a fee is charged by the instructor	Yes
5-day, off-site instructor certification course (includes instructor manual and all course materials, as well as access to online technical assistance and support resources; certification is valid for 3 years)	\$1,850 per person	No
Implementation consultation	Free	No
Course evaluation	Free	Yes
Program audit conducted by the National Council for Community Behavioral Healthcare	Free	No

Additional Information

Groups that want to schedule an on-site training can contract with an instructor to conduct the training for a flat group fee.

Replications

Selected citations are presented below. An asterisk indicates that the document was reviewed for Quality of Research.

* Jorm, A. F., Kitchener, B. A., O'Kearney, R., & Dear, K. (2004). Mental Health First Aid training of the public in a rural area: A cluster randomized trial. *BMC Psychiatry*, 4(33), 1-9. [PubMed](#)

* Kitchener, B. A., & Jorm, A. F. (2004). Mental Health First Aid training in a workplace setting: A randomized controlled trial. *BMC Psychiatry*, 4(23), 1-8. [PubMed](#)

Contact Information

To learn more about implementation or research, contact:

Bryan V. Gibb, M.B.A.
(202) 684-7457 ext 243
bryang@thenationalcouncil.org

Consider these [Questions to Ask](#) (PDF, 54KB) as you explore the possible use of this intervention.

Web Site(s):

- <http://www.mentalhealthfirstaid.org>

This PDF was generated from <http://nrepp.samhsa.gov/ViewIntervention.aspx?id=321> on 2/25/2014



*Casting the Net
Upstream*

*Alaska
Statewide Suicide
Prevention Council
FY2011-FY2012
Annual Reports*

Governor Sean Parnell
State of Alaska

Commissioner William Streur
Department of Health & Social Services



Chairman William Martin (Alaska Federation of Natives)

Vice-Chair Meghan Crow, LCSW (Secondary Schools)

Teressa Baldwin (Youth)

Lowell Sage, Jr. (Clergy)

Phyllis Carlson (DEED)

Melissa Stone (DHSS)

Barbara Jean Franks (Suicide Loss Survivor)

Sharon Strutz-Norton (Public)

Alana Humphrey (Statewide Youth Organization)

Senator Fred Dyson (Legislature)

Brenda Moore, (AMHB)

Senator Johnny Ellis (Legislature)

Christine Moses (Rural Alaska)

Representative Anna Fairclough (Legislature)

Anna Sappah (ABADA)

Representative Berta Gardner (Legislature)

J. Kate Burkhart, Executive Director

Eric Morrison, Council Assistant

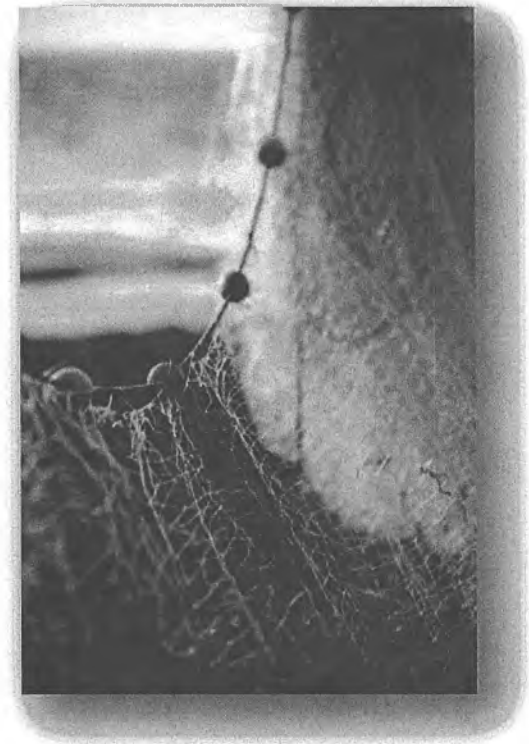
May, 2012

Introduction

The Statewide Suicide Prevention Council was established by the Alaska Legislature in 2001 and extended by the Legislature to June 30, 2013. The Council is responsible for advising legislators and the Governor on ways to improve Alaskans' health and wellness by reducing suicide, improving public awareness of suicide and risk factors, enhancing suicide prevention efforts, working with partners and faith-based organizations to develop healthier communities, creating a statewide suicide prevention plan and putting it in action, and building and strengthening partnerships to prevent suicide.¹

Each year, the Council provides an annual report on its activities and the impact of suicide prevention efforts over the past year. The FY2011-2012 reports take their title from the five-year state suicide prevention plan created and implemented over the past two years – *Casting the Net Upstream: Promoting Wellness to Prevent Suicide*.²

This report is different from the comprehensive data and suicide prevention system review provided in the FY2010 Annual Report. This report's focus is the work of the Council over the past two years. The majority of Council activities in FY2011 involved development of the 2012-2017 state suicide prevention plan. In FY2012, the Council finalized the plan and commenced implementation.



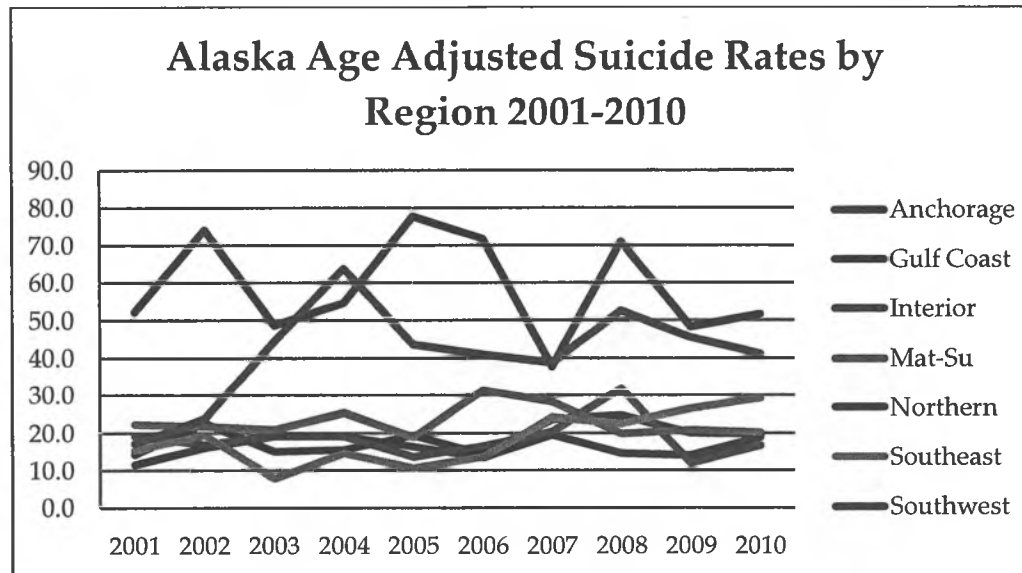
¹ AS 44.29.350. The Council's statutory authority is included in Appendix A.

² The plan is available online at http://www.hss.state.ak.us/suicideprevention/pdfs_sspc/SSPC_2012-2017.pdf.

Incidence of Suicide

Alaska continues to have a suicide rate twice the national average. In 2010, the age-adjusted rate was 23/100,000.³ The actual number of lives lost to suicide in 2010 was 163.⁴

A look at the age-adjusted rates over time helps provide a better picture of how Alaskan communities are affected by suicide.



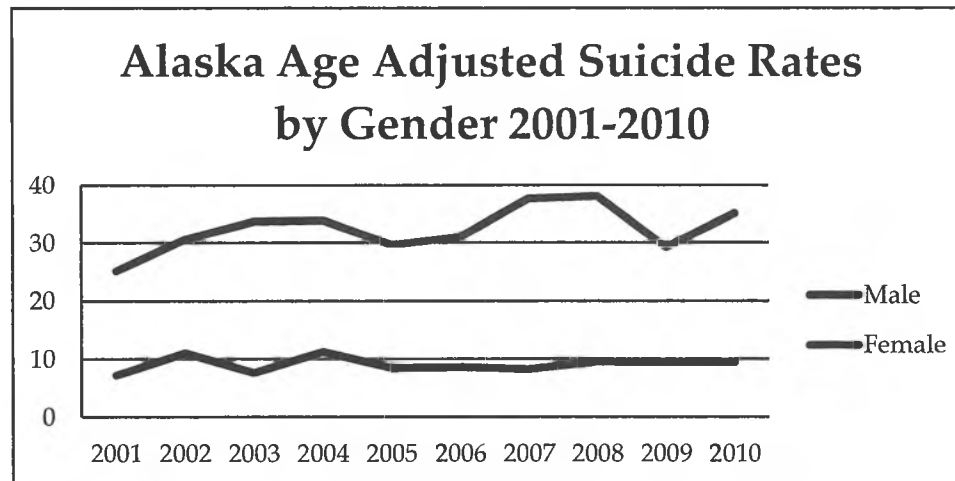
Source: Alaska Bureau of Vital Statistics (January 19, 2012)

³ Data provided by the Alaska Bureau of Vital Statistics.

⁴ Data provided by the Alaska Bureau of Vital Statistics.

It is important to note that the story behind suicide rates is not the same as the story behind suicide numbers. Alaska's rural regions have the highest rates of suicide, because the population of most communities is small. One suicide in a small community has not only a huge emotional and social impact, but also affects the statistical rates of the community and region. Alaska's largest metropolitan area, Anchorage-Wasilla-Palmer, has had the highest number of suicides for several years. The statistical impact may not be as great, due the concentrated population, but the loss to families and communities is still substantial.

Alaskan men continue to have a higher incidence of suicide, while suicide rates for Alaskan women remain relatively flat.



Source: Alaska Bureau of Vital Statistics (January 19, 2012)

Alaskan youth continue to show higher rates of suicide than other age groups. In 2010, the rate for youth age 15-24 was 46/100,000.⁵ For adults over age 25, the rate dropped significant to a range of 24.4-28.1 per 100,000.⁶

Suicide attempts occur at a higher rate than completed suicides. In 2007 (the most recent year's data available from the Alaska Trauma Registry), the suicide attempt rate was 99.3/100,000 people.⁷ More recent data from the 2011 Youth Risk Behavior Survey shows that, among high school students surveyed, 14.5-21.2% of students reported considering suicide in the past year and 8.7-13.2% reported attempting suicide in the past year.⁸

Risk Factors for Suicide

Suicide is the result of a complex confluence of events and experiences. The “web of causality” must be recognized in order for prevention efforts to be effective.

There are many warning signs and risk factors that can indicate that someone is at risk of suicide. Not every person will present with the same signs, but there are common indications of risk that can help in identifying when someone is at risk and intervening to prevent suicide.

⁵ Data provided by the Alaska Bureau of Vital Statistics.

⁶ Data provided by the Alaska Bureau of Vital Statistics. This range does not include the rate for age groups in which there were fewer than 20 suicides (ages 35-44 and ages 65-74).

⁷ Data provided by the Alaska Trauma Registry, Division of Public Health.

⁸ *2011 Alaska Youth Risk Behavior Survey Highlights* (DHSS), comparing traditional and alternative high school students surveyed, at 2.

Risk factors for suicide include:

- ❖ Depression or other mental illness;
- ❖ A suicide attempt in the past;
- ❖ Having been exposed to the suicide of another person;
- ❖ Needing but not receiving mental health care;
- ❖ Increasing use of drugs or alcohol, including binge drinking; and
- ❖ Access to a firearm or other means in the home.⁹



Warning signs for suicide include:

- ❖ Talking about wanting to die or to kill oneself;
- ❖ Looking for a way to kill oneself, such as searching online or buying a gun;
- ❖ Talking about feeling hopeless or having no reason to live;
- ❖ Talking about feeling trapped or in unbearable pain;
- ❖ Talking about being a burden to others;
- ❖ New or increased use of alcohol or drugs;
- ❖ Acting anxious or agitated;
- ❖ Behaving recklessly or taking more risks than usual;
- ❖ Sleeping too little or too much;
- ❖ Displaying extreme mood swings or changes in mood (whether happier or sadder).¹⁰

⁹ Information provided by the American Association of Suicidology, www.suicidology.org.

¹⁰ Information provided by the National Suicide Prevention Lifeline.

A history of adverse childhood experiences can also contribute to risk for suicide. Adverse childhood experiences include child abuse and neglect, parental mental illness, parental substance abuse, death of a parent, incarceration of a parent, and other traumatic events.¹¹

Extensive research has been conducted on the mental and physical consequences of adverse childhood experiences.¹² A link has been documented between adverse childhood experiences and suicide, with the risk for suicide increasing by two (2) to five (5) times, regardless of the nature of the adverse childhood experience that occurred.¹³

Adverse childhood experiences also increase the risk for mental and physical health problems that contribute to the web of causality for suicide. Research has shown a link between multiple adverse childhood experiences and substance abuse and addiction, depression, risk for intimate partner violence (domestic violence), and risky sexual behaviors.¹⁴

¹¹ A complete list of adverse childhood experiences is available at <http://www.cdc.gov/ace/prevalence.htm#ACED>.

¹² The Centers for Disease Control and Prevention provide information about the original study as well as subsequent research into adverse childhood experiences at <http://www.cdc.gov/ace/index.htm>.

¹³ *Childhood Abuse, Household Dysfunction, and the Risk of Attempted Suicide Throughout the Life Span: Findings From the Adverse Childhood Experiences Study*, Shanta R. Dube, MPH et al., *Journal of the American Medical Association* (2001; 286(24):3089-3096).

¹⁴ For an overview of the findings from the ACE Study, see *Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study*, Felitti VJ, et al., *American Journal of Preventative Medicine* (1998 May; 14(4):245-58). A bibliography of published research on adverse childhood experiences and health outcomes is available from the Centers for Disease Control and Prevention online at <http://www.cdc.gov/ace/outcomes.htm>.