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Dissemination Challenges Associated With Mental Health First Aid in New Mexico: Insights From Instructors

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Mental Health First Aid (MHFA) has the potential to addresses health disparities, especially within rural communities that are underserved with respect to behavioral health services, through increasing mental health literacy among key community members. Because MHFA instructors play a key role in the dissemination of MHFA, their views on the challenges in delivering the MHFA course are important. The purpose of this study was to identify the type and extent of challenges that MHFA instructors have experienced, or expect to experience, when disseminating MHFA in New Mexico. An online survey on challenges encountered, or expected to be encountered, in the dissemination of MHFA was completed by 31 MHFA instructors. Challenges were classified into costs associated with the training, MHFA-specific issues, community-related issues, and implementation issues. Among 22 potential challenges, those related to costs were the challenges most likely to be identified by instructors. These costs include MHFA books for those being trained, snacks for the training, and instructor-related travel expenses. An understanding of the challenges will help increase the dissemination of MHFA in New Mexico as well as in other states. Further exploration of the value of instructor support (e.g., administrative, organizational, and financial) and importance of prerequisite skills (e.g., mental health expertise and training experience) in the dissemination process is warranted.

Keywords: Mental Health First Aid, health disparities, translational research

More than half of the counties in the United States have no behavioral health workers (Sebelius, 2012). According to the U.S. Department of Health and Human Services (2013a), as of January 9, 2013, there were 3,800 mental-health Health Professional Shortage Areas (HPSAs) across the United States. The lack of accessible health services is particularly acute for racial and ethnic minorities and low-income people who live in these shortage areas (American Psychological Association, 2012). The need for mental health professionals is especially severe throughout New Mexico (NM), which is one of the most rural and ethnically and racially diverse states in the country. Thirty-two of the 33 counties in NM have been designated as Mental Health HPSAs (U.S. Department of Health & Human Services, 2013b). Mental Health First

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Aid (MHFA), a mental health literacy program, has the potential to be particularly effective in rural underserved communities by increasing the capacity of the community to identify mental illness and substance use disorders, respond to someone in crisis, and direct individuals to appropriate services in nearby urban centers, if local specialized mental health services are unavailable (Jorm, Kitchener, Kanowski, & Kelly, 2007; Kitchener & Jorm, 2008).

Originally developed in Australia, MHFA has been replicated in over 21 countries. In the United States, MHFA has been managed, operated, and disseminated by three organizations since 2008: the National Council for Behavioral Health (hereafter "National Council"), the Maryland Department of Health and Mental Hygiene, and the Missouri Department of Mental Health. The National Council has released three additional versions of MHFA in the United States, including one specific to youth and a Spanish-language version. Although most of the research on the effectiveness of MHFA has been conducted outside of the United States, studies have shown that MHFA increases knowledge of mental disorders and perceived ability to help others, and decreases stigma (Jorm, Kitchener, O'Kearny, & Keith, 2004; Kitchener & Jorm, 2002, 2004, 2006; Morawska et al., 2013).

MHFA instructors deliver the curriculum through a face-to-face course, which was originally 12 hr but has been shortened to 8 hr. The original 12-hr course is the focus of this study. In order to obtain MHFA instructor certification, individuals must complete a 5-day (32-hr) instructor training program offered by the National Council. The first instructor training was in February 2008, and as of March 2014, the National Council has certified 4,200 instructors throughout the United States, including 49 states, the District of Columbia, and Puerto Rico. In a short time, MHFA instructors have been extremely busy. As of March 2014, MHFA instructors have trained nearly 180,000 people across the United States. The demand on MHFA instructors is going to increase. In the wake of recent mass shootings, in January 2013, President Obama released his plan, entitled "Now is the Time," calling for more MHFA training to support public education and training on how to reach out and help individuals experiencing a mental health or substance abuse crisis (White House, 2013). A Senate Companion Bill referred to as The Mental Health First Aid Act would authorize $20 million to put the President's plan into action (Senate Report No. 153, 2013).

The National Council has long recognized the vital role of MHFA instructors by stating that "instructors are on the frontlines of the program and help to train people in their communities" in MHFA (Mental Health First Aid USA., 2013, para. 2). Given the key role that MHFA instructors have in its dissemination, it is surprising that only one study has been published on the experiences of instructors. This qualitative study was conducted in Wales, and five general themes emerged from interviews with 14 MHFA instructors (Terry, 2010): (a) prerequisite skills, (b) support, (c) logistics of course delivery, (d) impact, and (e) expectations and perceptions. However, Terry (2010) only described the results for the first two themes, indicating that the remaining themes would be reported elsewhere. With respect to prerequisite skills and support, instructors in Wales identified (a) prior training experience and mental health expertise as essential for the successful delivery of MHFA, and (b) administrative and organization support, peer support, and national support from the MHFA network as vital for instructors, given the stress associated with course delivery (Terry, 2010).

The first objective of our study was to learn about the experiences of MHFA instructors in the United States, specifically NM. Because of the crucial role that MHFA instructors play in the dissemination of the program, we were especially interested in understanding their perceived challenges. Our primary research question for this study was "What are the challenges associated with the dissemination of MHFA in NM?" Given that instructors from Wales identified the importance of support, training experience, and mental health expertise, the second objective was to explore the relationship between these three variables and perceived challenges. To date, no other survey of challenges associated with the dissemination of MHFA has been published in the United States.

Method

A cross-sectional design was used and all data were collected via an online survey. All 55

MHFA instructors in NM were invited to participate in the study through e-mail. The e-mail included an overview of the purpose of the project, an invitation for participation, and a hyperlink to the survey on SurveyMonkey. The home page of the online survey provided an overview of the project and information on the consent process. Five reminders were e-mailed over a period of 2 months, with the same information that was sent in the original e-mail. Thirty-nine instructors completed the survey, representing a 71% response rate. Eight surveys were excluded from the analysis because of missing data on a key variable (i.e., whether they had experience in conducting MHFA trainings), leaving a final sample size of 31. An examination of the demographics for the 31 instructors who completed the entire survey compared with the eight who did not found no significant differences in terms of age, education, ethnicity, and primary area of work.

Study Sample

Table 1 provides a summary of the demographics for the final sample. The majority was female (84%), the mean age was 48 years ($SD = 9.5$), and 48.4% had a master's degree or higher. Instructors were diverse with respect to ethnicity/race: Hispanic (34.5%), White (24%), and Native American (21%) were the primary groups identified. The instructors came from various backgrounds, including mental health and addictions (26%), public health (22.5%), and social services (22.5%). Sixty-seven percent had formal training in mental health/addictions and 90% had experience leading or facilitating training before becoming MHFA instructors. Although the majority of the instructors lived and worked primarily in urban communities (77%), instructors conducted MHFA trainings throughout the state, giving those from urban centers experience with disseminating MHFA in rural communities.

The sample included two groups of MHFA instructors that differed on their experience with disseminating MHFA. One group, referred to as "newly certified," completed their instructor training just prior to the administration of the survey and therefore had no experience with disseminating MHFA (45%). The second group, referred to as "seasoned instructors," completed their MHFA instructor training one or more years prior to the study and had experience with disseminating MHFA (55%). The majority of the seasoned instructors completed between one and five trainings (71%).

Table 1
Demographics for MHFA Trainers

Demographics	Percent	*n*
Gender		
Male	16.0	5
Female	84.0	26
Race/ethnicity		
Hispanic/Latino	32.3	10
Native American	19.4	6
White	22.6	7
Black or African American	6.4	2
Two or more groups identified	12.9	4
Missing	6.4	2
Highest level of education		
Associate's degree	16.1	5
Bachelor's degree	32.3	10
Master's degree	38.7	12
MD	6.5	2
PhD	3.2	1
Missing	3.2	1
Primary area of work		
Consumer advocacy	6.5	2
Mental health addictions	26.0	8
Public health	22.5	7
Social services	22.5	7
Other	22.5	7
New or experienced trainers		
New trainer	45.0	14
Experienced trainer	55.0	17
Formal training in mental health?		
Yes	68.0	21
No	32.0	10
Previous experience leading trainings?		
Yes	90.0	28
No	10.0	3
When did you complete MHFA training?		
Less than a year ago	61.3	19
1 to 2 years ago	19.4	6
2 to 3 years ago	6.5	2
3 to 4 years ago	6.5	2
Missing	6.5	2

Note. MHFA = Mental Health First Aid.

Survey

The final survey included four sections. The first section included questions on demographics. The second section included questions on experiences with MHFA, such as the number and location of trainings completed. The third section included questions about agency and

organizational support. The fourth section included a list of 22 potential challenges associated with the dissemination of MHFA generated by four local MHFA experts: two instructors and two faculty members from the Center for Rural and Community Behavioral Health (CRCBH), Department of Psychiatry, University of New Mexico (UNM), who specialize in translating evidence-based practices into rural communities and addressing health disparities. The survey asked instructors to indicate the extent to which they have experienced the challenge (for those who have conducted trainings) or the extent to which they expect to experience the challenge (for those who have not yet conducted trainings) on a 4-point scale including *none of the time*, *some of the time*, *most of the time*, and *all of the time*. Perceived level of support was measured by two yes–no questions about the instructors' employer's cooperation with respect to delivering MHFA. The first question was whether his or her employer allowed time to prepare for MHFA training. The second question was whether his or her employer allowed time to conduct MHFA training. The survey was transferred to SurveyMonkey and pilot tested by faculty and staff from the CRCBH. Copies of the survey can be obtained from the lead author. This study was approved by the UNM Human Research Protections Office.

Analysis

The 22 challenges were collapsed into four categories based on common themes. The first category included five items on *costs associated with training*, such as costs of books and snacks. The second category included nine items related to *MHFA-specific issues*, such as the length of training and curriculum not available in other languages. The third category included three items specific to *community-related issues*, such as competing mental health awareness programs. The fourth category included three items related to *implementation issues*, such as the National Council's recommendation that all MHFA training be conducted by two instructors. Given the small sample size, responses from the third and fourth categories (i.e., *most of the time* and *all of the time*) on the 4-point Likert-type scale were combined, resulting in a 3-point Likert-type scale including *none of the time*, *some of the time*, and *most to all of the time*.

The analysis related to the examination of challenges was limited to frequencies with seasoned MHFA instructors differentiated from newly certified instructors. The homogeneity of the sample with respect to perceived level of support, expertise in mental health, and trainer/facilitator experience, in combination with the small sample size, prohibited the examination of relationships among these variables and perceived challenges.

Results

Table 2 provides a summary of the challenges experienced by instructors who have already conducted at least one MHFA training, and Table 3 shows the challenges expected to be encountered among newly certified instructors.

Costs Associated With Trainings

The costs associated with conducting MHFA trainings were the most often identified challenges for both groups. Instructors who had conducted trainings identified costs of snacks and travel expenses as the two most frequently experienced challenges. Among seasoned instructors, 88.2% and 82.3% reported that they experienced costs of snacks and travel-related expenses, respectively, at least some of the time or more. Instructors who had not yet conducted trainings were primarily concerned about the cost of books, with 92.8% expecting this to be a challenge at least some of the time or more.

MHFA-Specific Issues

Instructors who had conducted trainings identified the number of participants required for training as the most frequently experienced challenge, with 76.4% reporting that they experienced this challenge at least some of the time or more. Instructors who had not yet conducted trainings were especially concerned about the length of training, with 71.5% expecting this to be a challenge at least some of the time or more. Other challenges identified under this category included the "curriculum not available in other languages," "material not culturally appropriate or sensitive," and "scenarios dated or not relevant." More than 50% of seasoned instructors

Table 2
Challenges Identified Among Trainers Who Have Conducted MHFA Training (n = 17)

Challenges	None of the time (%)	Some of the time (%)	Most to all of the time (%)	Not sure (%)	Missing (%)
Costs associated with trainings					
Cost of books	23.5	41.2	35.3	0.0	0.0
Cost of snacks	11.8	41.2	47.0	0.0	0.0
Cost of meeting space	47.0	41.2	5.9	5.9	0.0
Cost of supplies	29.4	47.1	17.6	0.0	5.9
Cost of travel expenses	11.8	35.3	47.0	5.9	0.0
MHFA-specific issues					
Curriculum not available in other languages	35.3	23.5	29.4	5.9	5.9
Scenarios dated or not relevant	47.1	29.4	23.5	0.0	0.0
Material not culturally appropriate or sensitive	35.3	35.3	29.4	0.0	0.0
Length of training	23.5	35.3	35.3	0.0	5.9
Number of participants required for training	11.8	58.8	17.6	11.8	0.0
Lack of evidence regarding MHFA effectiveness	58.8	17.6	11.8	11.8	0.0
Training material too clinical	41.2	35.3	17.6	5.9	0.0
Too much material to cover in training	35.3	47.0	11.8	5.9	0.0
Curriculum adaptability	47.1	29.4	17.6	5.9	0.0
Community-related issues					
Competing mental health awareness	58.8	23.5	5.9	11.8	0.0
Communities lack resources to implement ALGEE	23.5	35.3	23.5	11.8	5.9
Communities lack timely crisis response service	17.6	35.3	29.4	11.8	5.9
Implementation issues					
Availability of room for meeting	35.2	41.2	11.8	11.8	0.0
People dropping out of training	41.2	52.9	0.0	0.0	5.9
Trainer knowledge	70.6	23.5	5.9	0.0	0.0
Cotrainer availability	41.2	29.4	17.6	5.9	5.9
Number of trainings required each year	70.6	5.9	17.6	5.9	0.0

Note. MHFA = Mental Health First Aid; ALGEE = Assess for risk of suicide or harm. Listen nonjudgmentally, Give reassurance and information, Encourage appropriate professional help and Encourage self-help and other support strategies.

reported that they experienced these three challenges at least some of the time or more (curriculum not available in other languages, 52.9%; material not culturally appropriate or sensitive, 64.7%; and scenarios dated or not relevant, 52.9%). Newly certified instructors also expected these three MHFA-specific issues to be challenges (curriculum not available in other languages, 35.7%; material not culturally appropriate or sensitive, 50.0%; and scenarios dated or not relevant, 42.8%).

Community-Related Issues

Instructors who had conducted trainings identified a community's lack of timely crisis response service as the most common challenge, with 64.7% reporting that they experienced this challenge at least some of the time or more. Instructors who had not yet conducted trainings were concerned about this, too, but they also identified a community's lack of resources to implement ALGEE (Assess for risk of suicide or harm, Listen nonjudgmentally, Give reassurance and information, Encourage appropriate professional help and Encourage self-help and other support strategies), a five-step action plan for assisting someone experiencing a mental health crisis, as a potential challenge as well. Among the newly certified instructors, 71.4% and 57.2% expected a community's lack of timely crisis response service and resources to implement ALGEE, respectively, to be challenges at least some of the time or more.

Implementation Issues

Overall, instructors who had conducted MHFA trainings did not report substantial challenges with respect to implementation. Newly certified MHFA instructors were concerned about the number of trainings required each year, with 71.4% indicating that they believed

Table 3
Challenges Identified Among Trainers Who Have Not Conducted MHFA Training (n = 14)

Challenges	None of the time (%)	Some of the time (%)	Most to all of the time (%)	Not sure (%)	Missing (%)
Costs associated with trainings					
Cost of books	7.1	7.1	85.7	0.0	0.0
Cost of snacks	14.3	7.1	78.6	0.0	0.0
Cost of meeting space	14.3	21.4	50.0	7.1	7.1
Cost of supplies	14.3	28.6	57.1	0.0	0.0
Cost of travel expenses	14.3	14.3	71.4	0.0	0.0
MHFA-specific issues					
Curriculum not available in other languages	21.4	21.4	14.3	35.7	7.1
Scenarios dated or not relevant	21.4	21.4	21.4	21.4	14.3
Material not culturally appropriate or sensitive	21.4	35.7	14.3	21.4	7.1
Length of training	7.1	28.6	42.9	7.1	21.4
Number of participants required for training	35.7	28.6	21.4	0.0	14.3
Lack of evidence regarding MHFA effectiveness	35.7	7.1	21.4	28.6	7.1
Training material too clinical	28.6	28.6	21.4	14.3	7.1
Too much material to cover in training	21.4	35.7	28.6	14.3	0.0
Curriculum adaptability	21.4	35.7	14.3	14.3	14.3
Community-related issues					
Competing mental health awareness programs	28.6	21.4	14.3	28.6	7.1
Communities lack resources to implement ALGEE	14.3	28.6	28.6	21.4	7.1
Communities lack timely crisis response service	14.3	35.7	35.7	7.1	7.1
Implementation issues					
Availability of room for meeting	35.7	7.1	21.4	21.4	14.3
People dropping out of training	21.4	21.4	7.1	42.9	7.1
Trainer knowledge	42.9	14.3	7.1	14.3	21.4
Cotrainer availability	21.4	28.6	7.1	28.6	14.3
Number of trainings required each year	7.1	50.0	21.4	7.1	21.4

Note. MHFA = Mental Health First Aid; ALGEE = Assess for risk of suicide or harm. Listen nonjudgmentally, Give reassurance and information, Encourage appropriate professional help and Encourage self-help and other support strategies.

this would be a challenge at least some of the time or more.

With respect to perceived level of support, 94% of seasoned and 79% of newly certified instructors indicated that his or her employer allowed or would allow time to prepare for and conduct MHFA trainings. Among seasoned MHFA instructors, 65% had expertise in mental health/addictions and 94% had experience as a trainer/facilitator. Among newly certified MHFA instructors, 71% had expertise in mental health and 86% had experience as a trainer/facilitator.

Discussion

MHFA instructors play a central role in the successful dissemination of MHFA. They are responsible for instructing community members to become mental health first-aiders, and in rural communities especially, they serve as a repository of information about behavior health resources. With 4,200 instructors in the United States, they are a valuable source of information about the challenges associated with transferring the program into communities. Given their important role and substantial number, it is surprising that our study is the first published survey of MHFA instructors in the United States. This study adds to the almost nonexistent body of literature on challenges experienced by MHFA instructors, with only one other study conducted in Wales (Terry, 2010).

Costs for items such as the MHFA books, snacks, meeting space, supplies, and travel were the most common challenges identified by all respondents. Newly certified instructors appeared to be more anxious about costs than were

seasoned instructors. For example, 86% of newly certified instructors expected the costs of books to be a challenge most to all of the time. In contrast, only 35% of seasoned instructors identified that the costs of books was a challenge most to all of the time. Although the identification of challenges for the newly certified group is based on expectations, compared with the seasoned group, for which the identification of challenges is based on experiences, the variation between the groups with respect to cost-related challenges may be related to differences among the groups in terms of support from employers. Seventy percent of the seasoned MHFA instructors were employed by an agency that covered all MHFA training-related expenses, including the costs of books. Newly certified instructors also were concerned about the length of the training, with the majority (71.4%) expecting this to be a challenge some of the time or more often. The change in the length of the MHFA course from 12 hr (requiring at least two days) to 8 hr should, to some extent, alleviate this challenge.

Among our list of 22 potential challenges, there are two MHFA-specific issues that are particularly relevant to NM because of its large Hispanic (46.7%) and Native American (10%) population (U.S. Census Bureau, 2013). The first challenge is "curriculum not available in other languages" and the second is "material not culturally appropriate or sensitive." More than 50% of seasoned instructors reported they experienced these challenges with the MHFA curriculum at least some of the time or more. The release of a Spanish version of MHFA by the National Council should be a relief to many MHFA instructors in NM. The importance of cultural competence and adaptations of best practices, especially for Native Americans, is well documented (e.g., Gone & Trimble, 2012). Thus far, culturally appropriate guidelines for providing MHFA have been developed for Asian countries (Jorm, Minas, Langlands, & Kelly, 2008) and Indigenous Australians (Hart, Jorm, Kanowski, Kelly, & Langlands, 2009), with the goal of improving the capacity of these communities to recognize and respond to mental health issues within their own communities. Based on the experiences of MHFA instructors in NM, culturally appropriate guidelines for providing MHFA to Native Americans should be developed.

Missing data and low response rates are common in survey research (Stuart, Azur, Frangakis, & Leaf, 2009) and our study was impacted by both. Although a qualitative methodology, such as focus groups, may have provided richer information regarding challenges, the target population resided throughout the state. NM is vast and commutes to attend focus groups would have been difficult for many of the instructors because of two-lane and unpaved roads. Knowing that focus groups would be poorly attended and that funds were not available to reimburse participants for their time or any travel-related expenses, it was decided that a survey method was in fact the best way to collect initial data concerning perceived challenges. A limitation with this approach, however, was that a survey needed to be developed. Although pilot tested, the wording associated with some of the challenges may have been vague, which could have resulted in different interpretations. In addition, the list of challenges may not have been comprehensive, even though respondents were asked to identify other challenges not included on the survey, and no other challenges were listed. The specificity of the challenges also limits the generalizability of the findings beyond NM. Researchers are encouraged to use the survey but to revise as necessary.

An understanding of the challenges that newly certified instructors expect to experience is helpful for planning and training purposes; the information that this group provided is limited because their responses were based on assumptions. A true understanding of the dissemination challenges associated with MHFA in NM can only come from the small number of experienced trainers. Unfortunately, the small sample size, in combination with the lack of heterogeneity in key variables, prevented the examination of associations between perceived challenges and support, mental health expertise, and training experience, leaving us unable to achieve our second study objective. We encourage future studies to examine these relationships.

The importance of MHFA instructor support has been recognized in NM and more globally through the National Council. In NM, a MHFA Task Panel was created in the summer of 2012 (after the survey in this study was administered) through the Behavioral Health Services Division to support the MHFA initiative and instructors throughout the state. Instructors communicate questions and needs through a Listserv created by

members of the task force. The National Council also has a MHFA instructor Listserv that provides support on a national level. Given the findings from Terry (2010) regarding the importance of prior training experience and mental health expertise, additional training opportunities should be made available for instructors without these perquisite skills. Training opportunities and support will be of particular importance for MHFA instructors from rural communities, who may be less likely than their urban counterparts to have prior training experience and mental health expertise, and more likely to feel isolated. Future research on the value of instructor support (e.g., administrative, organizational, and financial) and certain prerequisite skills in the dissemination process is warranted.

The findings are helpful in understanding some of the challenges faced by MHFA instructors trying to diffuse MHFA, particularly into rural communities. The following programmatic recommendations are based on what we learned from the instructors in NM. Given that costs were identified as the number-one barrier; whenever possible, agencies should provide organizational, administrative, and financial support. Although the change in the length of the MHFA training from 12 to 8 hr should reduce some of the training-related costs such as travel expenses, some expenses, such as the costs of the MHFA book, will not change. Finally, with more than 50% of the seasoned instructors identifying "scenarios dated or not relevant" as a challenge to dissemination some to most of the time, we also recommend that the National Council update the statistics and scenarios in the instruction materials to improve the relevance of the curriculum.

Widespread dissemination of MHFA has the potential to increase the mental health literacy among nonprofessionals, which, in turn, increases the capacity of communities to be more responsive to persons with mental health and substance abuse problems. This is especially important in rural underserved communities. Understanding the challenges that MHFA instructors experience, or expect to experience, in the dissemination of MHFA is key to the success of future delivery. It is only through this understanding that strategies to address the challenges can be identified. Given the paucity of literature in this area, however, additional research on the experiences of MHFA instructors in disseminating MHFA is needed.

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