SN Social Sciences (2024) 4:171
https://doi.org/10.1007/s43545-024-00962-1

ORIGINAL PAPER

Mental Health First Aid experiences: a qualitative investigation into the emotional impact of Mental Health First Aid responsibilities and the significance of self-compassion

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Received: 4 November 2022 / Accepted: 8 August 2024 / Published online: 11 September 2024

Abstract

Mental illness is increasingly imposing significant economic burdens, manifesting in various ways such as elevated business expenses due to absenteeism and staff turnover, as well as heightened pressure on healthcare services. Mental Health First Aid (MHFA) is an effective tool to support people with ill mental health. This study explored the experiences of MHFA volunteers with the aim of enhancing understanding of how best to provide support for them. Twelve students who had completed the two-day MHFA training course participated in a semi-structured interview. Results indicated that being a Mental Health First Aider (MHFAer) was a responsibility highly valued by participants; however, data highlighted that anxiety associated with this role was of utmost significance. The study revealed the inherent compassion of MHFA volunteers; however, it also underscored that for many participants, this compassion came at the cost of neglecting self-compassion. This study suggests a need to enhance the support materials for MHFA volunteers, alongside a model of compassionate self-care for enhancing personal coping, health and wellbeing.

Keywords Mental Health First Aid · Self-compassion · Health and wellbeing

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Introduction

At any one time, one in six adults (17%) meet the criteria for a common mental health disorder (e.g., anxiety, depression). Consequently, the likelihood that members of the general public will come into close contact with someone experiencing a mental health disorder is high, creating an opportunity to intervene positively. Mental health difficulties carry burdensome and impaired functioning in societal roles, including low work performance (Kessler 2012). Given the cost to organisations when members of their workforce are going on sick leave or not working as efficiently due to mental health difficulties, many employers have funded mental health training for their employees. Many of these employees become volunteers in their workplace to identify and support peers who are experiencing ill mental health. As the number of trained volunteers increases, it is becoming imperative to understand the experiences of those who are providing this support, as without this knowledge it is difficult to appropriately support, train and value those who help individuals going through mental health difficulties (Mancini 2018; Sunkel and Sartor 2022; Søvold et al. 2021).

One such training course that teaches members of the public how to identify and assist someone developing a mental illness or mental health crisis is the MHFA course (see Jorm and Kitchener 2011). This course was designed in response to research demonstrating that the general public often has an inadequate understanding of mental health illnesses and disorders. The initial research further uncovered that the general public often has limited mental health literacy, possesses stigmatizing attitudes, and lacks the confidence and knowledge of how to help a person with a mental health problem (Jorm et al. 2005; Kitchener and Jorm 2008).

The MHFA course was built on the structure of physical first-aid training, whereby people are equipped with the necessary skills needed to attend to a crisis as the first point of contact. The MHFA course is an educational programme that not only addresses the lack of knowledge surrounding mental health disorders and behaviours (i.e., depression, panic disorders, self-harm and suicidal behaviour), but also informs of available treatment options and early interventions (Kitchener and Jorm 2008). MHFA training began in 2000 and has now spread to over 25 countries reaching over four million people globally.

MHFA's successful dissemination is the use of evidence-based training that resides within the content of the course (Jorm et al. 2019) and the strong emphasis on rigorous evaluation of each course that is delivered. There have been 18 controlled trials of MHFA courses conducted around the world, where findings propose that the course improved mental health literacy, reduced stigma, and increased confidence and support for those with mental health problems up to 6 months after the initial training (Morgan et al. 2018). More recent studies have shown that even three years after training, trainees maintained their improved knowledge about mental health difficulties (Morgan et al. 2020). The MHFA training program has demonstrated similar success within a range of environments such as educational settings (Jorm et al. 2010) and workplace environments (Kitchener and Jorm 2004), with trainees reporting that the course strengthened the trainee's awareness of their own mental health. The findings from a randomised control trial with trainee nurses to enhance mental health literacy, increase first-aid intentions, boost confidence in assisting others,

and maintain their own mental health, suggested that the MHFA course could help the trainees to identify their emotional and mental conditions. This could potentially assist them in the early detection of mental health symptoms and in seeking immediate support (Hung et al. 2021).

While these findings support the course's effectiveness, some key elements remain unexplored. The evaluation of the trainees is mainly based on significant changes in knowledge, confidence and stigma to mental health. However, only a few studies have investigated the experiences of the Mental Health First Aiders (MHFAers) actively supporting peers. Furthermore, many of the evaluations of MHFA have been carried out, at least in part, by the founders of MHFA. Therefore, it is significant for independent and unbiased research to explore and assess trainees' experiences and potential implications for future practices and policies. One particular study carried out by Rosetto et al. (2018) intended to investigate the process behind helping behaviours found that trainees often voiced concerns regarding their role as a MHFAer. That is, the depth of their role was often ambiguous to both themselves and the recipients, resulting in potential over-reliance (Rossetto et al. 2018). The training provided to MHFA volunteers may not explicitly clarify the level of responsibility placed on them. Trainees expressed that they felt uncomfortable involving themselves in situations where they were potentially the only helper; a situation that is not as uncommon amongst MHFAers. This raises further questions regarding who MHFAers are supported by, particularly as the personal sense of responsibility that comes with being a MHFAer was often cited by the trainees, and yet, has not been explored further by the researchers, nor have any potential practices changed in the delivery of the programme.

According to the founders of MHFA, the MHFA course covers the following crisis situations: how to help a suicidal individual, an individual suffering a panic attack, traumatic events, individuals experiencing psychosis episodes, eating disorders and substance misuse (Kitchener and Jorm 2006). These situations are often overwhelming, emotionally taxing and difficult for those involved to navigate. Consequently, it comes as no surprise that both trained professionals (e.g., psychiatrists, counselors) and volunteers often cite burnout and heightened anxiety as leading causes of dropout (Borritz et al. 2006; Claxton et al. 1998; Jiménez and Fuertes 2000; Kumar et al. 2011). While often, professionals who support individuals in crisis can access support networks (e.g., supervisory support through colleagues), MHFAers—who are arguably exposed to similarly distressing situations despite being equipped with less experience and training—do not have a clear support network or supervisory support (Mantzios et al. 2020). This deficiency poses a significant challenge within MHFA, as many trainees subsequently find themselves responsible for providing crisis support.

Therefore, the present study had several aims; to gain an insight into the situations that MHFAers have experienced since their training, and what they felt their responsibility was during their encounters with service users. All MHFAers were providing support in a Peer MHFA Scheme within a University setting. Importantly, a subsequent objective was to examine the emotions experienced by trainees during and after their encounters, as well as any emotional impacts these encounters may have had. Additionally, the aim was to explore the coping mechanisms employed by trainees in response to their role. Also, being compassionate (that is, responding to the suffering

of others to alleviate it—see Feldman and Kuyken 2011), as well as being self-compassionate (that is, caring for oneself in a healthier, more understanding and kinder way in the face of adversity) were further explored to investigate the potential for transforming coping mechanisms and addressing suffering into a form of caring that does not adversely affect either service users or MHFA volunteers (e.g., Moore et al. 2015; Tanner 2020; Vogus et al. 2021). The results of the present study aim to provide insight into where the MHFA course could be improved or expanded on, and whether the responsibility of MHFA as an organisation has been overlooked. While MHFA is an evidence-based and invaluable program, it's crucial to capture the potential emotional impact experienced by individuals becoming MHFA volunteers. This enables the organization to respond effectively to the needs of those they train, mitigate any potential risks of harm or distress, and collectively support mental health without compromising the well-being of volunteer MHFAers. The present research aimed to address the following research questions: How does MHFA training influence trainees' ability to address and challenge mental health, stigma and discrimination, both personally and in their professional roles? How effective is MHFA training in preparing trainees to confidently and competently assist individuals in mental distress?

Method

Participants

Adults aged 18 years or above, who had completed a two-day MHFA course at a West Midland University and were volunteer MHFAers with experience of utilising their training in a Peer MHFA Scheme at their University, were eligible to participate. Eligible participants were recruited via a University recruitment system, whereby students are able to take part in relevant studies in exchange for credits, as well as word of mouth. At the time of recruitment, there were approximately 550 Undergraduate/Postgraduate students who had completed the MHFA course at the University and approximately 300 of these students were volunteering in the Peer MHFA scheme. Recruitment ran until data saturation occurred.

In total, twelve participants (males: 4, age range: 19–29; mean age of participants: 21.83 years) were recruited (Table 1). Of the twelve, seven were studying a Psychology undergraduate course and five were studying a Psychology postgraduate course. Nine of the participants identified as white, British and three identified as global majority.

Semi-structured interview

As this research was qualitative, it allowed for exploration of the defined areas, and also elaboration by participants on other related topics (Gill et al. 2008), with question wording and order being contextual and in response to the participants' developing accounts (Braun & Clarke 2013; Rubin and Rubin 2011). The qualitative interviews enabled the research team to take an interpretive perspective on what it is like to be a

Table 1 Demographics of participants

Participant number	Pseudonym	Age	Undergraduate/ Postgraduate	Ethnicity
1	Violet	19	Undergraduate	White, British
2	Alice	19	Undergraduate	White, British
3	Jacob	19	Undergraduate	White, British
4	Maisy	28	Postgraduate	White, British
5	Lucy	25	Postgraduate	White, British
6	Harj	19	Undergraduate	Global Majority
7	Hardeep	19	Undergraduate	Global Majority
8	Natasha	29	Postgraduate	White, British
9	Joel	21	Undergraduate	White, British
10	Simon	21	Postgraduate	White, British
11	William	19	Undergraduate	White, British
12	Baljit	24	Postgraduate	Global Majority

MHFAer, with the research acknowledging the importance of individual differences (Yates et al. 2010).

The semi-structured interview schedule was developed through consulting existing literature and discussions that fellow MHFAers were having at the University. Due to the COVID-19 pandemic and social distancing guidelines, all interviews were conducted via the telephone, with the interviews lasting a maximum of 25 min ($M = 19$ min). Participants did not have to answer any questions they did not want to. All participation was voluntary and confidential, with participants being provided pseudonyms. Participants could withdraw from the research at any time; however, none chose to do so.

To offer directions to the participants on areas of focus and inquiry of the study, an interview guide was used during the semi-structured interviews. The interview guide consisted of open-ended questions that encouraged the participants to express their experiences of applying their MHFA training to practice, encouraging participants to provide details of what encounters they have experienced along with their attitudes and beliefs regarding such encounters. As participants were not explicitly required to have had a great deal of experience helping individuals in severe distress, hypothetical questions were asked e.g., "If you were to notice someone in significant distress, how would you feel approaching them?" The interview schedule (see Appendix A, Supplementary Materials) focused on participants' attitudes and beliefs regarding their preparedness as MHFAers, as well as how they are coping with their role (e.g., the impact their role is having upon their psychological wellbeing). During the interviews, probing questions were asked to prompt the participants to provide further information and clarification about their narratives and statements (Walsh and Bull 2015). The interviews were audio-recorded to ensure accuracy and facilitate recordings being transcribed verbatim for subsequent coding and thematic analysis.

Ethical approval

Ethical approval was obtained via the institutional Ethics Committee at a University located in the West Midlands in the United Kingdom (ref: PSY_MScH_Mar20_010).

Written informed consent was obtained from all individual participants included in the study.

Analysis

The recordings of the interviews were transcribed verbatim. The data was analysed using thematic analysis following Braun and Clarke's (2006) model and was used as a contextualist method, positioned between the two poles of essentialism and constructionism characterised by critical realism (Willig 1999). Thematic analysis acknowledged how participants made meaning of their experiences, alongside the impact the broader social context has upon those meanings; indicating that meanings and experiences are socially produced and reproduced rather than being inherent (Burr 1996). The thematic analysis provided a detailed inductive construction of the entire data set, providing valuable information to a currently under-researched area focusing upon MHFA.

To conduct thematic analysis, codes were initially generated by one researcher, and subsequently revised and evaluated by everyone on the research team until they reached an agreement for each code. Synonyms and varied expressions were the main reasons manual searches were necessary to capture all relevant responses, as software may miss nuanced expressions of similar ideas, may lack comprehensive coverage and avoid an overreliance on keywords (Brown et al. 1990, p.136). Therefore, combining capabilities of multiple authors with manual scrutiny ensured a comprehensive data analysis. Themes were constructed together and confirmed once agreement on data representation was reached. Similarly, researchers evaluated how each code fitted (or not) within the themes. These collaborations helped to ensure the inter-rater reliability of the data generated (Terry et al. 2017).

Results

Three themes were identified from the dataset, offering insights into participants' attitudes, beliefs, and experiences concerning their role as MHFA volunteers. These findings exemplify what it is like to be a MHFAer within a University and the challenges faced, providing insight into the support that is required for MHFAers themselves.

"We are not psychiatrists": perceived roles and responsibilities of MHFAers

This initial theme provides insight into participants' attitudes and beliefs regarding their roles and responsibilities since their MHFA training. Overall, there was the consensus that MHFAers are not there to provide advice, but instead they are there to listen and to signpost individuals to professional support services.

> William - "We aren't doctors, psychiatrists, nurses all that at all. We are just listeners; we are responsible to really take the information the person gives and check whether that person needs more help from a professional."

Participants agreed that often their role is to be the "first point of call" for individuals, particularly for those in a crisis. All individuals in this research explained that if they were to witness somebody experiencing a mental health crisis they should intervene (if it was safe to do so) and provide that initial support.

> Violet – "it's kind of applied, that I should step in when someone is clearly in a crisis. I mean that's what you're there to be trained for isn't it, to be that person that is responsible to help."

Participants saw it as their duty to help, and to be empathetic and understanding, regardless of how they were feeling themselves. Many explained how they would put the individual in crisis before their own anxieties and nerves, as they deemed it as their role to intervene.

> Alice – "I'm probably more likely to help if anything [regardless of being nervous / having anxiety] because I have that title of a MHFAer and like that's my role, to help"

Individuals felt that during a crisis they should "act fast and immediately" to ensure the person in distress is as safe as possible. It is clear the compassionate nature of MHFAers, and sometimes the lack of self-compassion MHFAers have for themselves during and after the time of support, where coping with one's own emotions is not part of the equation of support.

In addition to being a "first point of call", individuals within this research explained how they had become a "buddy" for fellow University students, with many students returning to them on numerous occasions for support. All participants in this research were trained within their University and therefore predominantly provided support to University students.

> Maisy – "90% of individuals I have given peer support to have returned for more support and ongoing support, so I think it is just like giving them a safety net so they can disclose how they're feeling to me as a peer supporter and not an academic or a doctor and someone who can understand where they're coming from"

Participants explained how individuals value hearing lived experiences from MHFAers, enabling them to generate rapport due to their shared identity (of being University students) and understanding of common humanity, that everyone suffers.

> Hardeep – "I found that they really value lived experience. I myself have anxiety, and when I talked to them about my anxiety and how I deal with it, they kind of realised that it's not just them"

Nonetheless, despite the success of the mental health initiative set up at the University and the Peer MHFA Scheme that was established, some participants did explain that this could harm such individuals by becoming over-reliant on the MHFAers.

> Baljit – "It can sort of be a negative, because you know really MHFA should be a one or two time thing, and students sort of become reliant on you. That has happened in the past where people become reliant on us in their support systems constantly, and they sort of come to you without even letting you know that they need support"

Individuals explained how this can have negative consequences for the individual who is seeking support, as well as the MHFAer, particularly when individuals turn up for support without formally arranging it and MHFAer is not emotionally resilient because they are having a bad day.

In addition to the challenge of dealing with individuals who become over-reliant on MHFAers, there was also confusion amongst participants regarding whether their role as a MHFAer is a recognised position, along with where their responsibility is recognised and expected to be used. Participants spoke about the support they have provided in their personal lives, explaining that since completing the course the support they provide their friends with has now changed.

> Alice – "I sometimes get friends come to me in some sort of distress mentally but I feel it's entirely different when you're close with someone. I do try to listen more and give my opinion less. I feel like it's better to just be encouraging and positive than try to give advice all the time, like I'm not a professional"

Nonetheless, whilst participants explained that the way they approach distress amongst their friends has now changed, there was agreement that they are not a MHFAer with their friends; instead, the support they provide is more personal.

Overall, it is clear from this theme that the general responsibility perceived by participants as a MHFAer is to listen and to signpost individuals to an appropriate organisation, however many expressed that this alone is perhaps not good enough, with many individuals wishing they could do more.

> Violet – "I feel like I should do more. I think anyone in a mental health crisis, do they really process information at the time? I feel like they don't and you're giving them information – is that going to be processed by them at the time? I feel like it's kind of just, maybe passing the person on"

The feeling of not doing enough and simply referring the person to someone else filled many participants with anxiety, with participants explaining how they carry this anxiety with them after they have finished providing support. Consequently, it is imperative that MHFAers themselves have a support system, with it being plausible that such support should focus on encouraging self-compassion and self-kindness to preserve the emotional wellbeing of MHFAers.

"MHFA is a big weight to have on your shoulders": navigating the psychological impact of being a MHFAer"

This second theme provides insight into the impact being a MHFAer can have upon an individual's psychological wellbeing. The consensus was that being a MHFAer is "a big weight on your shoulders", with many individuals within this research discussing the anxiety that accompanies the role, and the nerves they experience when approaching someone in distress.

> Violet – "Nervous [at the thought of helping someone] because ultimately you are dealing with someone's life potentially, so you know it's a big weight to have fall on you"

Participants attributed their anxiety to their strong desire to provide extensive assistance to others. However, their feelings of inexperience—compounded by their mental health challenges—hindered their perception of their effectiveness in offering support.

> Hardeep – "I don't have the authorities to kind of reassure them sometimes because I myself have that anxiety as well. It feels sometimes I'm just giving advice but I'm not actually taking my own advice, and sometimes I feel like with anxiety I can't really help very much because I struggle."

In terms of mental health, this research demonstrates the need for MHFAers to have their own support system to ensure their wellbeing is preserved whilst supporting others. Such support could focus on encouraging self-compassion in an attempt to discourage MHFAers from being self-critical as one form of intervention.

In addition to the nerves individuals feel when approaching someone in distress and providing support, many also spoke about the anxiety they experience after they have provided support. Participants explained that when reflecting on events they over-analyse what happened, and then worry about the outcome and whether they will have helped the individual.

> Alice – "I worry that I maybe said something wrong because they're sensitive subjects and you are there to make sure you help them get better not worse. I'd hate to be responsible for making them worse. I worry I said the wrong thing"

The anxiety surrounding "saying the wrong thing" or "making others worse" was very much prevalent within the data. This anxiety is intensified when individuals do not know the person they are supporting, and therefore cannot "check-in" on their progress as they would with friends. There was also the fear of blame amongst participants, worrying that if the individual they are supporting was to come to harm, the blame would lie with the MHFAers.

> Violet – "I felt anxious the first time like what if they do something bad and then the blame lies with me for not doing enough, or maybe not saying the right thing"

It is clear from participants' discourse that the support that is required for MHFAers to help them deal with the responsibility and pressure that accompanies their role, to protect their mental health. Participants did explain that over time and with experience you can disconnect from "encounters", being able to "take five minutes" after supporting someone and then move on with the rest of their day, being confident that they did their best for that person.

> Maisy – "I've been a MHFAer now for so long and working with students that are distressed and dealing with mental health difficulties. I sort of just get on with my day, and I know that sounds really bad but I also work for the NHS […] I'm older than most of the MHFAers, I've gone through some hard stuff in my life. I'm not really emotionally affected and I think that's why I'm good at supporting others cause I don't get emotionally attached"

Such individuals did approach their role differently and appeared less critical regarding their ability to provide support, explaining how positive they feel after providing support to others. Does this experience of detachment and potentially approaching the role with more of a self-compassionate and self-kind attitude (or less self-critical attitude) stem from additional roles and experiences within the NHS?

In terms of how individuals cope with their role as a MHFAer, many explained how their main coping mechanism is to talk to others, explaining that talking enables them to clear their mind and move on from the situation, being reassured by others that they have done and/or said the right thing.

> Hardeep – "I think my main mechanism is talking about it to other people. If I don't, I think about it too much […] if I dwell on it then it's worse for me and my mental health. I have to tell someone to get it out and then kind of forget about it after that"

Whilst the majority of participants discussed how beneficial talking to others is for their wellbeing, some did explain how they were unsure whether they could talk to others due to the issue of confidentiality.

> Alice – "I wouldn't want to keep any trauma to myself, but with confidentiality actually I don't really know, like if that is appropriate or would be appropriate for me to discuss someone else"

Consequently, there were barriers to seeking support. The participants in this research were all MHFAers within a University where a support system had been created compromising fellow MHFAers (academics and university students), with all participants praising this support mechanism. Accordingly, all participants in this research had someone they could talk to; however, the same support would not be available for all

MHFAers, especially those who have not undertaken training within an organisation. Some changes need to be employed to ensure support mechanisms are in place for all.

In addition to talking, other participants discussed the need for "me-time" after supporting individuals in their role as a MHFAer, explaining that they need time to relax and let go of the anxiety and stress that accompanies their role.

> Natasha – "After I've chatted with them I've had chocolate, have a nice hot bath, some sort of self-care. I make sure that I'm taking care of me as well because at the end of the day like you can't help somebody else, if you're not helping yourself"

Overall, the need for self-compassion is clearly illustrated within the data, with provisions needing to be in place to ensure MHFAers have access to appropriate sources of support, as well as understanding the need for self-kindness. MHFA training should not just focus on the support that MHFAers need to provide to others, but self-help techniques should be emphasised and integrated into the course for MHFAers to utilise for their wellbeing.

"More preparation is needed from MHFA training; the course should be longer, incorporate more role-play, and encourage MHFAers to care for themselves as well as others"

This final theme provides insight into participants' perceptions regarding whether MHFA training truly prepares individuals for the reality of being a MHFAer. All participants spoke positively regarding the training they had received, with many explaining that it gave them key information on how to help someone in distress and deliver MHFA by developing rapport with others. Several participants explained how the training course instilled confidence in them regarding their ability to help others in distress.

> Lucy – "If you want to do the course in the first place then you already are in that place where you want to help people. I think the course just instils that confidence in you to help someone. Before you might have just looked on and thought well I can't help or I don't want to say the wrong thing. When you've got the training you've got that badge of honour where you can help and say the right things"

Their confidence was improved further following "positive endings" for individuals they had provided support to, with participants explaining how reassuring it is to receive positive feedback on their ability to help others, with this encouraging them to continue providing mental health support. Participants who demonstrated the most confidence in their role explained how this is due to the course alongside their experiences in their personal lives. Predominantly, participants explained how age (and therefore life experience) improves your confidence to intervene in a crisis, as well as your professional roles outside that of being a MHFAer, with one participant explaining how their role within the NHS means they are confident in dealing with

mental health. Furthermore, some participants explained how their own experience with mental health has instilled their confidence to help others in a similar position, with the MHFA training providing them with the tools to do this effectively.

> Maisy – "I have actually experienced mental health […] I think the training sort of refreshed my memory if that makes sense and helped my understanding; a more in-depth understanding of how to approach people and students"

In particular, participants explained how the course has helped with their active listening, helping them be more present within a conversation and truly listen to what people are saying, rather than "trying to rush to find an answer"

Whilst all participants valued the mental health first aid training, some individuals did believe that the training can only prepare you so much; whilst the training explains how to approach someone who is in distress, in reality the situation can be completely different. Consequently, the majority of participants explained that whilst they were happy with the training, they did initially lack confidence in their ability to provide support.

> Violet – "At first I didn't feel confident at all and I sort of doubted my own ability. I don't think anything can ever set you up for someone who is experiencing a mental health crisis really"

Many outlined their beliefs that the course could be improved to prepare people more thoroughly for the reality of supporting others in a mental health crisis. The consensus was that the course should be longer than just two days to cover more disorders in-depth, with many believing that there was a large emphasis on anxiety and depression, and therefore they were not well equipped to deal with other mental health difficulties (e.g., eating disorders, bipolar). In addition, many believed that there should be refresher sessions to ensure that MHFAers have up-to-date knowledge regarding how to support individuals effectively.

> Violet – "It should be a bit longer […] there is so much to cover in such a short time and like regular review sessions. Like they could send out little quizzes and refreshers maybe. Things update all the time, you need to make sure you are fresh and up to date […] I think with the responsibility as a MHFAer there is so much that you could be faced with that two days seems like such a short period"

Another suggestion was that the course should entail more role-play, to help individuals understand more thoroughly what they should do and/or say when supporting others with their mental health, with participants believing that role-play would make the information more memorable.

> Baljit – "I think maybe there could have been more role-play rather than actually watching videos like doing it ourselves […] I think that could be developed especially around having those difficult conversations [e.g. regarding suicide]"

In addition to suggestions focusing on how to improve the course to improve the ability of the MHFAers to provide support to others, some individuals made suggestions on how the course could be improved to ensure the physical and psychological safety of MHFAers. Some participants explained that there needs to be more emphasis on when MHFAers should not intervene in a crisis e.g., due to the situation being unsafe for themselves, or because the MHFAer is not in a good place with their mental health. Participants believed there needed to be a discussion regarding what to do in such instances.

> Maisy – "I definitely think it [when not to intervene] should be spoken about a lot more in the MHFA training because obviously if someone was being discriminated against or in distress you don't know who's carrying knives and things like that. We have to take those things into consideration now"

Overall, there was the consensus that the MHFA training needs to make sure that MHFAers have support themselves.

> Baljit – "I had my MHFA training at University so I had the support of academics but I think somebody who's not in that environment who would support them? That's one of the things that always worries me because anybody can get mental health and it's quite difficult if you're experiencing a crisis to help somebody else in a crisis"

Consequently, it is suggested that the training course needs to ensure that MHFAers are cared for themselves, making them aware that they can access appropriate support. If we aspire for MHFA to be as prevalent as physical first aid, we need to take care of those who are undertaking the training and provide such support, creating a community where MHFAers support each other (not just when organisations set up this support themselves). It is admirable the compassion that MHFAers provide to others; however, this should not be at the expense of self-compassion and this should be instilled within the training course. We cannot expect individuals to care for others without caring for their psychological wellbeing.

Discussion

All participants in the present study were either Undergraduate or Postgraduate students and participated in the two-day MHFA training course at their University. They all volunteered in a Peer MHFA Scheme at their University where they provided support to other students, in an attempt to learn, develop and actively assist fellow peers as described in existing literature (Mantzios 2020; Mantzios et al. 2019). The data illustrated that all participants showed positive reactions and enthusiasm for the training. Consistent with previous literature, the data demonstrated that all participants found that the training increased their knowledge, improved their perception of mental health difficulties and provided them with the tools to approach and offer support to others.

While previous research has predominantly highlighted the advantages of MHFA training, the current study shifts its focus to explore the personal costs associated with fulfilling the public demand (and responsibility) of supporting others among those trained as MHFA volunteers. It became apparent that many MHFA volunteers perceived it as their obligation to exhibit empathy and understanding towards those they were assisting, irrespective of their own emotional state. Some MHFAers felt as though they had not done enough, and how referring the person to someone else filled them with anxiety and doubt. In particular, participants worried about whether individuals in a crisis are in a position to follow advice (e.g. regarding who to contact for support). The MHFA course has failed to address whether shifting the responsibility onto volunteers simply trades one issue for another. While trained MHFA volunteers are undoubtedly equipped with the necessary education, tools, and action plans to engage with individuals in crisis (Hadlaczky et al. 2014 for a meta-analysis), they are not adequately instructed on how to manage their own thoughts and feelings following MHFA encounters.

The data showed that the main coping mechanism for the MHFAers was talking to other volunteers in the Peer MHFA Scheme. Participants discussed how they would turn to other volunteers to be reassured that they acted appropriately given the situation, and to relieve themselves of the anxiety caused by questioning themselves regarding whether they said and did the right thing. While there is something to be said for a support scheme that may exist, the presence of a senior counsellor or clinician in guiding support sessions would have been more appropriate. For those volunteers who did not seek support, confusion surrounding confidentiality, and whether this would be breached, were significant factors of concern. Volunteers need clearer guidelines regarding confidentiality, and also a continued support network that volunteers can turn to for guidance. This is particularly important as volunteers move to different universities and organisations, without the network of support they had where they were trained, creating a discontinuation of support and self-care.

Compassionate care should be at the core of the MHFA training course and practice for both those who train as a MHFAer and those they support (Mantzios 2014; Rizal et al. 2020, 2021). Firstly, the MHFA course needs to teach trainees that compassion needs to be practised simultaneously with self-compassion to enable trainees to perceive themselves with understanding, kindness and a spectrum of caring for themselves to be able to care for others (Egan et al. 2017, 2019). Self-compassion is a healthier, kinder, more understanding perception of oneself, that can support individuals at times of personal inadequacy and distress (Neff et al. 2019); elements that were evident across the MHFAers in the present research where self-compassion can offer a variety of interventions and self-care practices (Mantzios and Giannou 2019; Mantzios et al. 2020, 2022). Secondly, the education and training of self-compassion and self-kindness must entail a holistic self-care model that ensures psychological and physiological health equally. Mantzios and Egan (2017) suggested that both the body and mind require nurturing in kind and compassionate ways. However, evidence indicates that psychological distress often leads individuals to exhibit self-kindness in manners that detrimentally impact their physical health. Integrating this insight into MHFA training will bolster the development of genuinely compassionate MHFA volunteers, ensuring that we prioritise the well-being of MHFA volunteers and foster a supportive community where those trained can care for themselves and for one another.

While compassion and self-compassion may offer some solutions, Universities have been struggling with overcrowded and understaffed counselling services, exacerbating the challenges students face in accessing mental health support (Eisenberg et al. 2011; Watkins et al. 2012). While digital mental health interventions, which deliver mental health support via technologies such as mobile apps, have been implemented to address these issues, the effectiveness of these remains inclusive and they fail to adequately respond to broader concerns surrounding isolation, exclusion, and institutional responsibility (Garrido et al. 2019; Lehtimaki et al. 2021). The digital divide and digital poverty experienced by students, coupled with the lack of personalised and holistic care offered by digital interventions, further underscore the limitations of virtual mental health services in addressing the complex needs of students. Universities must therefore explore comprehensive solutions that not only expand counselling resources, but also address systemic issues contributing to students' fluctuating and deteriorating mental health.

Conclusion

The current study aimed to better explore the experiences of MHFAers, particularly as existing literature often fails to consider the personal and emotional impact of MHFA training on actual trainees. The responsibility placed upon MHFAers is a source of added stress and anxiety, which paired with the additional emotional impact of providing MHFA to significantly distressed service users poses the question of who is taking responsibility for the MHFAers? The potential benefits of widespread implementation of MHFA are evident, and the aim of the current research is not to overlook the positive impact. However, these benefits cannot be fully realized if uncertainties persist regarding the potential consequences that MHFA volunteers may encounter resulting from their role. The provision of insights into experiences and coping mechanisms does raise questions about age requirements and the need of additional training that could safeguard MHFAers. Future research should strive to investigate further the emotional impact of MHFA training beyond a University setting, which is more of a protected environment, and investigate ways this can be effectively mitigated—perhaps through clear and structured support networks alongside proactive training that better prepares volunteers for self-care and coping with their role. For now, MHFA and its questionable utility within higher education institutions require further provisions if students take on such roles.

Supplementary Information The online version contains supplementary material available at https://doi.org/10.1007/s43545-024-00962-1.

Author contributions All authors contributed to the study's conception and design. Material preparation was performed by all authors. Data collection was performed by IS and AM. Data codes were initially generated by RK and subsequently revised and evaluated by the other authors until they reached an agreement for each code. The first draft of the manuscript was written by AC and all authors commented on previous versions of the manuscript. All authors read and approved the final manuscript.

Funding No funds, grants, or other support was received.

Data availability Data stored and accessible from One Drive.

Code availability Not applicable.

Declarations

Ethical approval Study approved by the Faculty of Business, Law and Social Sciences Ethics Committee at Birmingham City University.

Consent to participate All participants gave informed written consent to participate and for their data to be published under pseudonyms.

Consent for publication All authors agreed to the content, and all gave explicit consent to submit.

Competing interests The authors have no competing interests to declare that are relevant to the content of this article.

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