



Mental Health First Aid and Emotional CPR are the two most popular approaches to training laymen to support people in distress. Some say there are both pros and cons.
(Patrick Hruby / Los Angeles Times)

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A fact of life is that at some point, at many points, we all suffer. Every single one of us knows what it's like to be completely overwhelmed by a situation, a feeling, the state of our minds or the messiness of our lives.

What we've come to name as mental health conditions, such as anxiety, depression and even psychosis, are part of this vast spectrum of distress. These conditions are as human as living, loving and dying, especially in our present-day world where 10 things might stress our sweet little nervous systems at any given moment.

Yet even though we may be well-acquainted with such distress and have an innate desire to help others, we're taught to fear strong emotions — which sets us up to also fear people in crisis. Our cultural default then is to turn away instead of toward.

But what if we were given the skills and confidence to turn toward those in crisis? A 35-year-old Group Therapy reader had this question: “Does mental health training for an everyday person exist?”

In this newsletter, we'll explore the two most popular approaches to training laymen to support people in distress: Mental Health First Aid and Emotional CPR. I spoke with Betty Kitchener and Anthony Jorm, the creators of Mental Health First Aid, and Braunwynn Franklin, president of the National Coalition for Mental Health Recovery and an Emotional CPR trainer.

What is Mental Health First Aid?

Kitchener and Jorm came up with the idea for Mental Health First Aid in the late 1990s during evening walks in Canberra, Australia.

Kitchener, a nurse specializing in health education who had experienced several intense bouts of depression, loved teaching First Aid for the Red Cross and wondered why there wasn't an equivalent for mental health challenges. And Jorm, a mental health literacy professor at the University of Melbourne, [knew from his own research](#) that the average Australian wasn't sure what to do when they encountered someone in the throes of emotional distress.

The husband and wife delivered the first Mental Health First Aid course in 2000 to people in their hometown. “Our vision was to have one or two courses during the weekend as a community service activity,” Jorm told me. “It got much much bigger than either of us expected.”

MHFA trainings are now being given in over 25 countries, and are a widespread model in the United States. The program has expanded to courses for [adults helping teenagers](#), for [teens helping teens](#) and for [folks supporting older adults](#).

“Our vision is that everyone in the world, from primary school onward, has some basic skill in what they can do to help someone in a crisis,” Jorm said. “Mental health professionals are fully occupied with people with severe, recurrent relapsing problems. We all need to play a role in reducing the impact of mental illness in society.”

People in helping professions, such as first responders, librarians and teachers, are the most likely to have gotten MHFA training. But these trainings are increasingly available to anyone who’s interested in taking them, especially if you live in a metropolitan area; a quick search of the L.A. area [yielded many training opportunities](#) over the next two months, mostly sponsored by nonprofits and offered on a sliding scale.

The training usually lasts a few hours and covers how to recognize, understand and respond to crises involving mental health conditions, including anxiety and depression disorders, psychosis, eating disorders and substance use disorders.

The MHFA action plan has [five steps](#), which can be used in any order:

- **Approach the person and assess for suicidality or harm.** Look for signs of suicidal thoughts or behaviors.
- **Listen nonjudgmentally.** Let the person share without interrupting them, and express empathy for what they’re going through.
- **Give reassurance and information.** “Communicate that people can and do get better from mental illness and do not blame the person for the situation,” as [one organization put it](#).
- **Encourage help from professionals,** including doctors, psychologists and social workers.
- **Encourage self-help and other support strategies,** such as helping the person identify their support network, participating in a peer support group, and creating a personalized emotional and physical self-care plan.

I asked Jorm and Kitchener for an example of MHFA in action. Jorm recalled a time when he and Kitchener were near a pharmacy in town and a man was waving at the trams, clearly upset and talking to himself.

“I didn’t feel he was safe on the road, and I was concerned for his safety,” Jorm recalled. “Betty went to talk to him and asked, ‘What are you upset about?’

What can we do for you? It was something very simple; he had gone into a shop to buy a drink, and because he was behaving oddly, a security told him to leave. And he was very upset about it. Betty asked what we could do to help, and he wanted a drink. So Betty went in the shop and bought him some good food and a drink, and gave it to him. We didn't avoid him, we didn't judge him."

In this case, the man wasn't connected to professional help, but that is often a part of MHFA.

The program's guidelines for supporting someone with depression, for example, state that "professional help is warranted when depression lasts for weeks and affects a person's functioning in daily life." Trainees are encouraged to discuss the benefits of seeking professional help and to ask the person whether they think it would benefit them. If the person does want that kind of support, the trainee offers to help connect them to services. The guidelines also advise seeking immediate help if a person is experiencing hallucinations or delusions.

"If you suspect the person may be a risk to themselves or others, contact emergency services immediately," reads the guidelines for helping someone who is experiencing psychosis. "If the police respond, be prepared that the person may be restrained or face charges. As other people arrive, explain to the person who they are, that they are there to help and how they are going to help."

Critiques of Mental Health First Aid

Over the past 23 years, MHFA has trained an estimated 2.6 million in the U.S. to respond to people in psychiatric crises. Its impact [has been repeatedly studied](#). But the program has drawn criticism from researchers and advocates with a variety of concerns.

For one, MHFA has been criticized for relying too heavily on psychiatric frameworks and the [medical model](#) of diagnosing distress. "MHFA trains citizens to pathologize human suffering rather than critique the consequences of unjust social structures and power relations," Jane DeFehr of the University of Winnipeg wrote in [a 2016 paper](#).

Mental Health First Aid training doesn't promote seeking professional help without the consent of the person in crisis, but it's baked into MHFA's steps in a way that implicitly asserts that someone in distress *needs* the help of the medical establishment.

[Others have charged](#) that the approach is absent of input from people with lived experience of mental health struggles.

To the latter critique, Kitchener and Jorm responded that the MHFA course curriculum is developed with the help of expert panels that include people with lived experience of mental health challenges (like Kitchener herself), their caregivers and mental health professionals.

Kitchener also clarified that it's "not for a Mental Health First Aid-er to diagnose at all." Still, she and Jorm acknowledged that MHFA trains people to spot the signs and symptoms of different diagnoses, meaning this is inevitably the lens through which trainees are supporting people.

Jorm said he understands the criticism of psychiatric labels. "The reason we debated whether to do this — and the reason that we did — is that people just know these words. You can't ignore that this knowledge already exists."

The MHFA centers evidence-based practices are backed by research, Jorm said. "What we're doing is making people informed consumers of services, and that includes pharmaceuticals," Jorm said. "Anyone who just gets medication and nothing else, that's not good care."

What is Emotional CPR?

Diagnostic labels are just one (imperfect) way to think about and respond to emotional distress. It's been [harmful](#) and stigmatizing for many, which is why a decade or so after MHFA hit the scene, Daniel Fisher, an American psychiatrist who [recovered from a schizophrenia diagnosis](#), developed an alternative to the approach called Emotional CPR.

The idea of eCPR was developed by Fisher and other people who learned from their own mental health crises and were able to integrate those experiences into a broader understanding of themselves and others.

The model isn't as commonly used as Mental Health First Aid, but the training is regularly [held for organizations across the U.S.](#) and in some international locations.

These are the three principles of eCPR:

- **Connect:** Trainees are instructed to be humble, curious and respectful, believe that people can overcome all kinds of distress, and to “listen with the heart instead of the head.” This sometimes involves sharing what *you're* feeling in the moment. How are you affected by this person's story? Be mindful of a person's body language, posture and tone, and be aware of your own. Relax your body so you can help the person in crisis relax as well.
- **Empower:** Tell the person in distress that they are helping *you* by allowing you to help them, which sets a tone of “power with” the person versus “power over” the person. Support them in shifting out of hopelessness by helping them plan for the future, with questions like “What's the next important thing you can do now? What's worked for you before? How can I help you?”
- **Revitalize:** Encourage the person in crisis to consider what brings meaning and purpose to their life. This step acknowledges that the crux of eCPR itself — connection and empathy — is healing and life-giving. The person reestablishes confidence to resume social roles, responsibilities and relationships.

I asked Braunwynn Franklin, a peer support specialist and eCPR trainer, to explain what it looks like in motion.

“I used to be a cashier at Dollar Tree,” she told me. “A lot of times, customers would come in upset. One lady had just had an issue with Child Protective Services and she was worried about losing her children. She just started talking. I stood there and listened to her. She started to cry, and I continued to listen to her. She eventually was able to say, “It's going to be OK. I know what I could have done better and I know what I'll do better in the future.” I didn't have to say very much of anything, other than, ‘Wow, I feel you. What you just shared made my heart heavy.’ I witnessed her and validated her experience.”

Franklin knows what it's like to be harmed instead of helped by our systems. As a young person, she was stuck in a cycle of suicide attempts, hospitals and medication that wasn't working. During a four-month manic cycle, she was suicidal, and in her darkest moment, arrested for assault with intent to commit murder — an experience she recently [shared openly in this podcast episode](#). She was incarcerated for 10 years. Franklin believes that if she had been supported through the principles of eCPR, her life could have been different.

“I'm not anti-hospital or anti-therapist; I'm for empowering people into their own strengths, helping people realize that people are the experts of their own lives,” she said. “I want to see people in fewer institutions.”

Franklin acknowledges that in some cases, such as when someone plans to harm themselves or someone else, professional help may be needed. She will ask the person, “How do you want this to proceed? What do you want this to look like?”

“Nine times out of 10, you can calm a person down enough that they're willing to go to a hospital or a doctor,” she said. “They still have a choice. They have agency.”

It can feel intimidating to approach a stranger who's so upset that they're yelling in public, which is, unfortunately, a common occurrence in cities like L.A. In those instances, a person trained in eCPR would ask the person what they need and assess from there, Franklin advised. “Personally, I don't see it as an emergency situation unless the person asks or says that is what they need or want,” she said.

Choosing how best to help

Going back to the original question, you'll see that, yes, mental health training for the everyday person very much exists. MHFA and eCPR both offer participants approaches, tools and insight into how to help our friends, family members and unhoused neighbors when they're struggling.

One interesting question that came up in our research was, what situations fall outside the scope of the training you'd receive in these programs? It's a complicated question to untangle. Part of the answer lands on you and your comfort level. Some people will get trained in MHFA or eCPR and be comfortable interacting, for example, with strangers in distress. Others will not.

We asked Amanda Myers, a lead researcher of [one of the few published papers assessing eCPR](#), about the programs' limitations. We gave Myers the scenario of a stranger behaving erratically, potentially in psychosis, screaming at a transit stop. She said this could feasibly fall outside the scope of training for both MHFA and eCPR.

If someone is in imminent danger, Myers said, you might consider calling emergency services and asking that social workers be sent to the location — in L.A. County, that would be a psychiatric mobile response team, or social workers paired with law enforcement or paramedics. “You don't want to have them institutionalized or potentially arrested if the situation escalates, so those social workers can advocate for what the best course of action is,” Myers said. (It should be noted that, if you do call 911 or 988, a person could still end up involuntarily hospitalized [through a 5150](#)).

Myers recommends assessing which program you might want to be trained in based on your values and principles.

“I think that both programs have benefits, and both programs could be helpful, and frankly, whether it's Emotional CPR or Mental Health First Aid, just getting the community talking about mental health and working toward destigmatization is beneficial in itself, no matter which program they're taking,” said Myers, also a research associate at Brandeis University.

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It's important to remember that 25 years ago, these models didn't even exist. They're a work in progress and worth being examined. As you can see from our interviews, there is sometimes no one right answer, but with the training you'll at least have the tools to not turn away. I ultimately feel better knowing there are pathways for people to learn how to support their neighbors, family members and friends.

Please let us know if you decide to take one of these courses, and if so, how you feel about the process.

Until next week,

Laura

If what you learned today from these experts spoke to you or you'd like to tell us about your own experiences, please email us and let us know if it is OK to share your thoughts with the larger Group Therapy community. The email GroupTherapy@latimes.com gets right to our team. As always, find us on Instagram at [@latimesforyourmind](https://www.instagram.com/latimesforyourmind), where we'll continue this conversation.



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