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Development of a Mental Health First Aid Training Programme for students in the upper secondary school context and an outcome assessment instrument

Tiago Filipe Oliveira Costa

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Development of a Mental Health First Aid Training Programme for students in the upper secondary school context and an outcome assessment instrument

DOCTORAL STUDENT:

Tiago Filipe Oliveira Costa

THESIS DIRECTORS:

Antonio Rafael Moreno Poyato

Carlos Alberto da Cruz Sequeira

Francisco Miguel Correia Sampaio

THESIS TUTOR:

María Teresa Lluch Canut

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"Scientia potestas est" (knowledge is power) - Francis Bacon, 1597.

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ABSTRACT

Background: Mental Health First Aid Training Programmes empower their participants to recognise mental health problems in others, provide initial help and refer them to help resources. However, the existing programmes seem to address mental disorders, which can foster the psychiatrisation movement of human suffering. Nurses have the opportunity to facilitate these educational interventions, teaching about mental health problems that represent nursing diagnoses. These interventions may be suitable for upper secondary school students.

Objective: This thesis aimed to develop a Mental Health First Aid Training Programme, promoted by nurses and aimed at adolescents in Portuguese upper secondary schools. Furthermore, it sought to develop and evaluate the psychometric properties of a scale that measures an outcome of the intervention.

Methods: Four studies with different research methodologies were carried out. First, upper secondary school students' perceptions of training programmes were explored in a qualitative study. Snowball sampling was used to recruit adolescents. Semi-structured individual interviews were conducted and the interviewees' responses were subjected to content analysis. Secondly, experts' perspectives on the training programmes were explored in a qualitative study. Mental health nurses were intentionally recruited. Data were collected in focus group sessions and submitted to content analysis. Third, consensus on the characteristics of the training programme was created in a mixed study. A sample of mental health nurses was intentionally obtained. A modified e-Delphi technique was used and an analysis of the frequency and content of responses was performed. Finally, a scale to measure an outcome of the intervention was constructed and its properties were evaluated in a psychometric study. Health professionals from different disciplines were included in focus group sessions to generate the scale items. Data were subjected to content analysis. A modified e-Delphi was conducted to assess the content validity of the items. Health professionals gave their opinions on the items. The frequency of responses was analysed and several content validity indicators were calculated. The scale was pre-tested with adolescents through cognitive interviews. The data collected in the interviews were subject to content analysis. The scale was administered to a large sample of adolescents and the validity and reliability of the instrument were analysed. Based on the results of the studies, a Mental Health First Aid Training Programme was designed.

Results: Four papers were completed (three published and one submitted to scientific journals). In the first two studies, ideas about the relevance of training programmes, facilitators, intervention foci, evaluation methods, participants, implementation contexts, duration and frequency, intervention methods and contents were obtained. Fourteen themes were identified from interviews with adolescents and twelve themes from focus groups with mental health nurses. In the third study, fifty-five statements represented the ideas from the previous studies and four new ones were proposed. Experts reached a consensus on fifty-eight out of fifty-nine statements on training programmes. In the fourth study, the Self-Assessment Scale of Basic Mental Health Action Competencies was created and good psychometric properties were described. Finally, a guiding manual for facilitators of a Mental Health First Aid Training Programme was published, providing an intervention proposal.

Impact: This work encourages nurses to implement Mental Health First Aid Training Programmes and supports the role of these professionals in facilitating interventions in schools. Abandoning medical terms in these programmes and highlighting nurses' body of knowledge could be an alternative to existing interventions. These autonomous nursing interventions can improve the mental health competencies of their participants and, consequently, increase informal help resources for people with mental health problems.

Conclusions: This project made it possible to create a Mental Health First Aid Training Programme with a health-centred perspective. The programme is available for nurses to use on upper secondary school students.

Keywords: Adolescent, Education, First Aid, Health Literacy, Mental Health, Multimethod Research, Nursing, Schools.

RESUM

Antecedents: Els Programes de Formació en Primers Auxilis en Salut Mental capaciten als seus participants per a reconèixer problemes de salut mental en altres persones, prestar-los ajuda inicial i derivar-les a recursos d'ajuda. No obstant això, els programes existents semblen abordar trastorns mentals, la qual cosa pot fomentar el moviment de la psiquiatrització del sofriment humà. Les infermeres tenen l'oportunitat de facilitar aquestes intervencions educatives, ensenyant sobre problemes de salut mental que representen diagnòstics d'infermeria. Aquestes intervencions poden ser adequades per a estudiants de secundària.

Objectiu: Aquesta tesi va tenir com a objectiu desenvolupar un Programa de Formació en Primers Auxilis en Salut Mental, promogut per infermeres i dirigit a adolescents en escoles secundàries portugueses. A més, es va pretendre desenvolupar i avaluar les propietats psicomètriques d'una escala que mesura un resultat de la intervenció.

Mètodes: Es van dur a terme quatre estudis amb metodologies de recerca diferents. Primer, es van explorar les percepcions dels estudiants de secundària sobre els programes de formació en un estudi qualitatiu. Es va utilitzar un mostreig de bola de neu per a reclutar adolescents. Es van realitzar entrevistes individuals semiestructurades i les respostes dels entrevistats es van sotmetre a anàlisi de contingut. En segon lloc, es van explorar les perspectives dels experts sobre els programes de formació en un estudi qualitatiu. Es van reclutar intencionadament infermeres de salut mental. Les dades es van recollir en sessions de grups focals i es van sotmetre a anàlisi de contingut. En tercer lloc, es va crear un consens sobre les característiques del programa de formació en un estudi mixt. Es va obtenir intencionadament una mostra d'infermeres de salut mental. Es va utilitzar una tècnica e-Delphi modificada i es va realitzar una anàlisi de la freqüència i el contingut de les respostes. Finalment, es va construir una escala per a mesurar un resultat de la intervenció i es van avaluar les seves propietats en un estudi psicomètric. Es van incloure professionals de la salut de diferents disciplines en sessions de grups focals per a generar els ítems de l'escala. Les dades es van sotmetre a anàlisi de contingut. Es va realitzar un e-Delphi modificat per a avaluar la validesa de contingut dels ítems. Els professionals de la salut van donar les seves opinions sobre els ítems. Es va analitzar la freqüència de les respostes i es van calcular diversos indicadors de validesa de contingut. L'escala es va pretesar amb adolescents a través d'entrevistes cognitives. Les dades recollides en les entrevistes es van sotmetre a anàlisi de contingut. L'escala es va administrar a una àmplia mostra d'adolescents i es van analitzar la validesa i la confiabilitat de l'instrument.

Basant-se en els resultats dels estudis, es va dissenyar un Programa de Formació en Primers Auxilis en Salut Mental.

Resultats: Es van completar quatre articles (tres publicats i un enviat a revistes científiques). En els dos primers estudis, es van obtenir idees sobre la rellevància dels programes de formació, els facilitadors, els focus d'intervenció, els mètodes d'avaluació, els participants, els contextos d'implementació, la durada i freqüència, els mètodes d'intervenció i els continguts. Es van identificar catorze temes a partir d'entrevistes amb adolescents i dotze temes de grups focals amb infermeres de salut mental. En el tercer estudi, cinquanta-cinc declaracions representaven les idees dels estudis anteriors i es van proposar quatre noves. Els experts van arribar a un consens sobre cinquanta-vuit de cinquanta-nou declaracions sobre programes de formació. En el quart estudi, es va crear l'Escala d'Autoavaluació de Competències Bàsiques d'Actuació en Salut Mental i es van descriure bones propietats psicomètriques. Finalment, es va publicar un manual orientatiu per a facilitadors d'un Programa de Formació en Primers Auxilis en Salut Mental, que proporcionava una proposta d'intervenció.

Impacte: Aquest treball anima a les infermeres a implementar Programes de Formació en Primers Auxilis en Salut Mental i dona suport al paper d'aquests professionals a facilitar les intervencions a les escoles. Abandonar els termes mèdics en aquests programes i ressaltar el cos de coneixements de les infermeres podria ser una alternativa a les intervencions existents. Aquestes intervencions autònomes d'infermeria poden millorar les competències en salut mental dels seus participants i, conseqüentment, augmentar els recursos d'ajuda informals per a les persones amb problemes de salut mental.

Conclusions: Aquest projecte va permetre crear un Programa de Formació en Primers Auxilis en Salut Mental amb una perspectiva centrada en la salut. El programa està disponible perquè les infermeres l'utilitzin amb estudiants de secundària.

Paraules clau: Adolescent, Alfabetització en Salut, Educació, Escoles, Infermeria, Investigació Multimètode, Primers Auxilis, Salut Mental.

RESUMEN

Antecedentes: Los Programas de Formación en Primeros Auxilios en Salud Mental capacitan a sus participantes para reconocer problemas de salud mental en otras personas, prestarles ayuda inicial y derivarlas a recursos de ayuda. Sin embargo, los programas existentes parecen abordar trastornos mentales, lo que puede fomentar el movimiento de psiquiatrización del sufrimiento humano. Las enfermeras tienen la oportunidad de facilitar estas intervenciones educativas, enseñando sobre problemas de salud mental que representan diagnósticos de enfermería. Estas intervenciones pueden ser adecuadas para estudiantes de secundaria.

Objetivo: Esta tesis tuvo como objetivo desarrollar un Programa de Formación en Primeros Auxilios en Salud Mental, promovido por enfermeras y dirigido a adolescentes en escuelas secundarias portuguesas. Además, se pretendió desarrollar y evaluar las propiedades psicométricas de una escala que mide un resultado de la intervención.

Métodos: Se llevaron a cabo cuatro estudios con metodologías de investigación distintas. Primero, se exploraron las percepciones de los estudiantes de secundaria sobre los programas de formación en un estudio cualitativo. Se utilizó un muestreo de bola de nieve para reclutar adolescentes. Se realizaron entrevistas individuales semiestructuradas y las respuestas de los entrevistados se sometieron a análisis de contenido. En segundo lugar, se exploraron las perspectivas de los expertos sobre los programas de formación en un estudio cualitativo. Se reclutaron intencionadamente enfermeras de salud mental. Los datos se recogieron en sesiones de grupos focales y se sometieron a análisis de contenido. En tercer lugar, se creó un consenso sobre las características del programa de formación en un estudio mixto. Se obtuvo intencionadamente una muestra de enfermeras de salud mental. Se utilizó una técnica e-Delphi modificada y se realizó un análisis de la frecuencia y el contenido de las respuestas. Por último, se construyó una escala para medir un resultado de la intervención y se evaluaron sus propiedades en un estudio psicométrico. Se incluyeron profesionales de la salud de diferentes disciplinas en sesiones de grupos focales para generar los ítems de la escala. Los datos se sometieron a análisis de contenido. Se realizó un e-Delphi modificado para evaluar la validez de contenido de los ítems. Los profesionales de la salud dieron sus opiniones sobre los ítems. Se analizó la frecuencia de las respuestas y se calcularon varios indicadores de validez de contenido. La escala se pretestó con adolescentes a través de entrevistas cognitivas. Los datos recogidos en las entrevistas se sometieron a análisis de contenido. La escala se administró a una amplia muestra de adolescentes y se analizaron la validez y la confiabilidad del

instrumento. Basándose en los resultados de los estudios, se diseñó un Programa de Formación en Primeros Auxilios en Salud Mental.

Resultados: Se completaron cuatro artículos (tres publicados y uno enviado a revistas científicas). En los dos primeros estudios, se obtuvieron ideas sobre la relevancia de los programas de formación, los facilitadores, los focos de intervención, los métodos de evaluación, los participantes, los contextos de implementación, la duración y frecuencia, los métodos de intervención y los contenidos. Se identificaron catorce temas a partir de entrevistas con adolescentes y doce temas de grupos focales con enfermeras de salud mental. En el tercer estudio, cincuenta y cinco declaraciones representaban las ideas de los estudios anteriores y se propusieron cuatro nuevas. Los expertos llegaron a un consenso sobre cincuenta y ocho de cincuenta y nueve declaraciones sobre programas de formación. En el cuarto estudio, se creó la Escala de Autoevaluación de Competencias Básicas de Actuación en Salud Mental y se describieron buenas propiedades psicométricas. Finalmente, se publicó un manual orientativo para facilitadores de un Programa de Formación en Primeros Auxilios en Salud Mental, que proporcionaba una propuesta de intervención.

Impacto: Este trabajo anima a las enfermeras a implementar Programas de Formación en Primeros Auxilios en Salud Mental y apoya el papel de estos profesionales en facilitar las intervenciones en las escuelas. Abandonar los términos médicos en estos programas y resaltar el cuerpo de conocimientos de las enfermeras podría ser una alternativa a las intervenciones existentes. Estas intervenciones autónomas de enfermería pueden mejorar las competencias en salud mental de sus participantes y, consecuentemente, aumentar los recursos de ayuda informales para las personas con problemas de salud mental.

Conclusiones: Este proyecto permitió crear un Programa de Formación en Primeros Auxilios en Salud Mental con una perspectiva centrada en la salud. El programa está disponible para que las enfermeras lo utilicen con estudiantes de secundaria.

Palabras clave: Adolescente, Alfabetización en Salud, Educación, Enfermería, Escuelas, Investigación Multimétodo, Primeros Auxilios, Salud Mental.

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INTRODUCTION

This document sought to describe Tiago Costa's path in the doctoral programme in Nursing and Health at the University of Barcelona, attended between the academic years 2020/2021 and 2023/2024. The doctoral project follows the research carried out in the Master's Course in Mental and Psychiatric Nursing at the Nursing School of Porto (Costa et al., 2019, 2020a, 2020b).

The work was guided and supervised by Professor Antonio Moreno Poyato (Associate Professor at the Faculty of Nursing, University of Barcelona - Spain), Professor Carlos Sequeira (Full Professor at the Nursing School of Porto - Portugal) and Professor Francisco Sampaio (Assistant Professor at the Nursing School of Porto - Portugal). The journey was tutored by Professor Teresa Lluch Canut (Full Professor at the Faculty of Nursing, University of Barcelona - Spain).

All research was conducted in the Portuguese context, having been integrated into the larger project "Literacy and Positive Mental Health" of the research group "Innovation and Development in Nursing (NursID)" of the Center for Health Technology and Services Research: Health Research Network (CINTESIS:RISE). An international stay was also carried out between November 1, 2022 and March 1, 2023, with Professor Patrício Costa, at the Life and Health Sciences Research Institute (IICVS/UM and ICVS/EB's) in Portugal.

This thesis is organised into chapters. First, a theoretical and conceptual framework on the subject under study was presented. Concepts and epidemiological data related to mental health were exposed. The meaning and relevance of mental health first aid were explained. The definition and conceptual models of health literacy and mental health literacy were highlighted. Mental Health First Aid Training Programmes were explored as interventions that promote mental health literacy. These were seen as complex interventions, namely autonomous nursing interventions. Evidence on the topic was synthesised and gaps in this area of investigation were presented. These interventions were operationalised and supported by nursing theories. The pertinence of mental health education for adolescents in the school context was also expressed. A reflection on the instruments used to evaluate the outcomes of Mental Health First Aid Training Programmes was made and the convenience of developing a new one was highlighted. Secondly, the justification and starting point of the doctoral project were presented. Third, general and specific objectives of the research project were enumerated. Fourthly, the methods used to achieve the objectives were reported. The design of the studies was indicated and the sequence of conduction of the works was exposed. Ethical considerations were safeguarded. Fifth, the results of the doctoral project were presented. The

articles produced were made available. The training programme “Empower4MentalHelp” was revealed as a proposal to be implemented in Portuguese upper secondary schools. Sixth, the results were discussed and related to existing literature. The impact of scientific production on nursing and health and the limitations of the doctoral path were recognised. Finally, conclusions were drawn with the certainty that this is the beginning of a path of investigation.

1. THEORETICAL AND CONCEPTUAL FRAMEWORK

In this chapter, we introduce concepts, represent the current state of knowledge about the object of study and explain the topic in the light of models and theories.

1.1. Mental Health

Mental health has been defined as “a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (World Health Organization [WHO], 2021b, p.1). Mental health can be viewed as a continuum, involving different stages: being well, experiencing a mental health problem, experiencing a disorder and being recovered. Mental health problem is a broad term that includes both mental disorders and the symptoms of a mental disorder that do not yet justify the diagnosis of a disorder (Kitchener et al., 2017). Mental disorder is a syndrome characterised by clinically significant disturbance in an individual's cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning (American Psychiatric Association [APA], 2022). A mental health crisis is defined as "a subjective event in which a person evaluates their situation as uncontrollable and for which they do not possess the necessary resources or coping skills to deal with it" (Cassivi et al., 2023, p.1).

The prevalence of mental health problems appears to be increasing over time. According to GBD 2019 Mental Disorders Collaborators (2022), approximately 655 million people worldwide were living with a mental disorder in 1990, and 970 million people in 2019. Later, the COVID-19 pandemic emerged and was considered by a large number of studies and media stories as harmful to the mental health of the global population (Sun et al., 2023). Conflicts such as the Russian invasion of Ukraine (beginning on 24 February 2022) can still be considered a risk factor for the mental health of populations. According to Charlson et al. (2019), at least one in five people who have experienced wars or other conflicts in the last 10 years will have depression, anxiety disorder, post-traumatic stress disorder, bipolar disorder, or schizophrenia. Among European countries, Portugal has the second highest prevalence of psychiatric disorders (22.9%) (Conselho Nacional de Saúde [CNS], 2019).

Mental disorder was the second leading cause of years lived with disability worldwide in 2019 (125.3 million years lived with disability). According to WHO (2021a), suicide is the fourth leading cause of death among 15-29 year-olds. The increasing prevalence of mental health problems, and the disability and mortality they cause make mental health intervention

essential. Despite existing treatments, most people with mental health problems do not receive effective care (WHO, 2022). In Portugal, only 33.1% of people diagnosed with psychiatric disorders receive adequate care, according to the CNS report (2019).

1.2. Mental Health First Aid

The growing prevalence of mental health problems increases the likelihood that the general public will come into contact with people with this type of problem. Often, the resources for help that reach individuals with these problems first are people with no mental health expertise (e.g., family, friends). The initial help given to a person who is experiencing a mental health problem, until professional help is received or the crisis is resolved, can be called Mental Health First Aid (Jorm et al., 2019). This aid can be offered when the mental health problem is developing, getting worse or escalating to a crisis (Kitchener et al., 2017).

Mental Health First Aid makes it possible to: preserve life when a person may be a danger to herself/himself and/or others; provide help to prevent the mental health problem from getting worse; promote the recovery of good mental health; provide comfort to a person with problems of this nature (Kitchener et al., 2017). According to Wong et al. (2014), effectively seeking professional help is more likely with the suggestion of others.

1.3. Mental Health Literacy

An active role in the health of others is necessary to provide mental health first aid. People become more involved in health issues by improving health literacy (WHO, 2017).

Literacy is the “ability to identify, understand, interpret, create, communicate and compute, using printed and written materials associated with varying contexts”. (...) involves a continuum of learning in enabling individuals to achieve their goals, to develop their knowledge and potential, and to participate fully in their community and wider society” (UNESCO Institute for Statistics, n.d.). In turn, “health literacy” was a term first cited in 1974 by Simonds, relating to health education in schools. However, the concept was first clearly defined only in 1995, as “capacity of individuals to obtain, interpret, and understand basic health information and services and the competence to use such information and services in ways which enhance health” (Joint Committee on National Health Education Standards, 1995, p.11). It has evolved since then.

In 1998, WHO presented health literacy as “The cognitive and social skills which determine the motivation and ability of individuals to gain access to understand and use information in ways which promote and maintain good health” (Nutbeam, 1998). Nutbeam (2000) distinguished different levels of health literacy: functional health literacy, which refers to the basic reading and writing skills that are needed to function effectively in everyday situations; interactive health literacy, which refers to more advanced cognitive and literacy skills that, along with social skills, can be used to actively participate in everyday situations, extract information and meaning from different forms of communication, and apply this to changing circumstances; critical health literacy, which refers to the most advanced cognitive skills that, along with social skills, can be applied to critically analyse information and use it to exert greater control over life events and situations. Depending on the level of health literacy, individuals can assume different roles in terms of health, that is, a passive, active and proactive role when they have, respectively, functional, interactive and critical health literacy (Kickbusch, 2004). Kickbusch et al. (2005) emphasised the social component of the concept, describing it as the ability to make reasoned decisions in everyday life and in multiple contexts, the ability to seek information and to assume responsibilities, enabling people to increase their control over their health.

After analysing the content of the different definitions that existed until 2010, Sørensen et al. (2012) presented a comprehensive definition, stating that health literacy involves “people’s knowledge, motivation and competences to access, understand, appraise, and apply health information in order to make judgments and take decisions in everyday life concerning healthcare, disease prevention and health promotion to maintain or improve quality of life during the life course” (p.3). These authors also proposed an integrative model of health literacy (2012).

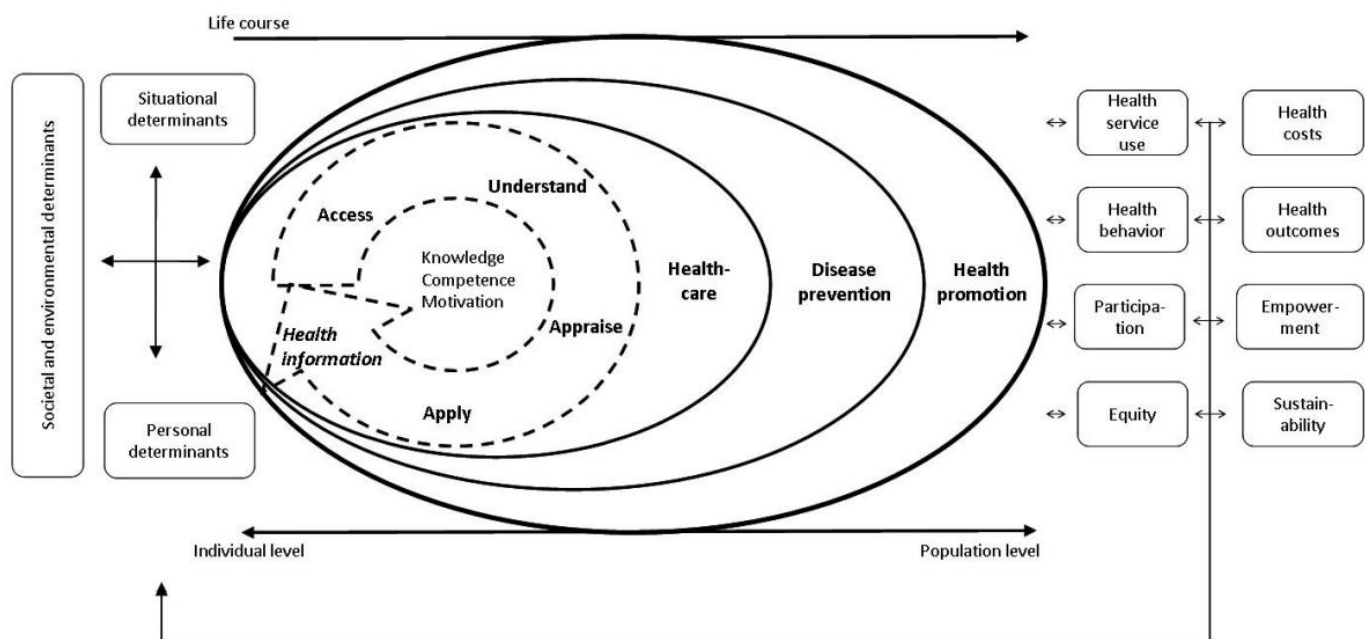


Figure 1: Integrated model of health literacy (source: Sørensen et al., 2012, p.9)

The model combines the different components of health literacy (knowledge, competence, motivation), ways of dealing with health information (access/obtain, understand, process/appraise, apply/use information) and domains of health literacy (healthcare, disease prevention and health promotion) (Sørensen et al., 2012). According to this model, health literacy is influenced by personal determinants (such as age, gender, race, socioeconomic status, education, occupation, employment, income, literacy), situational determinants (such as support, family and peer influences, media use and physical environment) and environmental determinants (such as demographics, culture, language, political forces, social systems) (Sørensen et al., 2012). In turn, it has an influence on people's lives (both at an individual and population level), namely in their health behaviours and use of health services, health gains and costs in society, participation in public and private dialogues about health, equity and sustainability of changes in public health, and personal autonomy and empowerment (Sørensen et al., 2012).

Considering the existing literature between 2010 and 2017, Liu et al. (2020) suggested that health literacy is “the ability of an individual to obtain and translate knowledge and information in order to maintain and improve health in a way that is appropriate to the individual and system contexts” (pp.6-7). These authors also listed three elements: the

knowledge of health, healthcare and health systems; the processing and using the information in various formats concerning health and healthcare; and the ability to maintain health through self-management and working in partnerships with health providers (2020).

Malloy-Weir et al. (2016) acknowledged that there is no "most accepted" definition of health literacy. They described the existence of multiple definitions and several possible interpretations, affecting communication between policymakers, practitioners and researchers, as well as patient care and the implementation of political initiatives in this area (Malloy-Weir et al., 2016).

Health literacy can be directed to the area of mental health, called mental health literacy. The concept of mental health literacy was introduced by Jorm et al. (1997), referring to this as "knowledge and beliefs about mental disorders which aid their recognition, management or prevention" (Jorm et al., 1997, p.182). Jorm (2012) suggested that mental health literacy has five components: knowledge of effective self-help strategies (for milder problems), knowledge of how to prevent mental disorders, recognition of developing mental disorders, first aid skills to support others experiencing mental health problems, and knowledge of help-seeking options and treatments available. Kutcher et al. (2016) describe four main elements: understanding how to obtain and maintain good mental health, understanding mental disorders and their treatments, decreasing stigma related to mental disorders, and enhancing help-seeking efficacy. Therefore, over time, the concept evolved and accompanied the definition of mental health (WHO, 2021b), that is, it ceased to be a literacy-focused only on mental disorders and began to include aspects related to well-being, optimal functioning and coping. Recently, the term "positive mental health literacy" emerged and it represents literacy aimed at promoting mental health (Bjørnsen et al., 2017).

Mental health literacy is an important determinant of the mental health of populations, improving mental health outcomes, early identification of mental disorders and the use of health services (Wei et al., 2015). Strategies to improve (mental) health literacy are crucial to achieving the ambitions of the 2030 Agenda for Sustainable Development (WHO, n.d. 2). People with greater health literacy are more likely to adopt healthier behaviours, protect themselves and those around them from risk factors for impoverishment, such as disability and health expenses (contribution to Objective 1 – No Poverty) (Rasu et al., 2015). They experience greater well-being and fewer health problems (contribution to Goal 3 – Good Health and Well-being) (Bjørnsen et al., 2019; Zhang et al., 2023). By adopting healthier behaviours and protecting themselves from health problems, school attendance is promoted and disparities in education are reduced (contribution to Goal 4 - Quality Education) (Lawrence et al., 2019).

People with greater health literacy can demand better and safer working conditions (contribution to Goal 8 - Decent Work and Economic Growth) and the existence of technologies that promote access to health information (contribution to Goal 9 - Industry, Innovation and Infrastructure) (WHO, n.d. 2). They can respond better to health situations, countering possible existing inequalities (contribution to Objective 10 - Reduced Inequalities) (Mantwill & Diviani, 2019). Finally, people with higher levels of health literacy have the power to demand better health care and living conditions from their governments (contribution to Goal 16 - Peace, Justice and Strong Institutions) (WHO, 2017).

Worldwide, mental health literacy levels are low (Tay et al., 2018). This trend has been reported in Portuguese youth (Loureiro et al., 2013, 2015). Therefore, educational interventions are necessary (Tay et al., 2018). In the Shanghai Declaration, WHO highlighted the importance of community empowerment strategies and considered mental health as a priority for health promotion (2017). The need for community-based health care (including mental health education) and collaboration with informal aid resources was reported in the Comprehensive Mental Health Action Plan 2013-2030 (WHO, 2021b). Portuguese health policies have also recommended training actions to increase mental health literacy among populations (Directorate-General for Health, 2015, 2017, 2018, 2023). The WHO calls on health professionals to carry out Mental Health First Aid Training Programmes (WHO, 2018).

1.4. Mental Health First Aid Training Programmes

Mental Health First Aid Training Programmes are interventions that teach individuals how to provide mental health first aid (Jorm et al., 2019). These seek to promote the recognition of signs and appreciation of symptoms of mental health problems, the provision of adequate initial help and referral to professionals and other appropriate supports (Kitchener et al., 2017). They aim to disseminate basic mental health skills (not clinical skills) in the community (Kitchener et al., 2017).

These training programmes originated in Australia in 2000 with the collaboration of Anthony F. Jorm and Betty A. Kitchener. In 2018, over 700,000 Australians were trained and the programme has expanded to 25 other countries, with over 2.7 million people trained globally (Jorm et al., 2019). Systematic reviews with meta-analyses focused on these interventions can be found in the literature (Richardson et al., 2023). These studies showed the effects of training programmes on trainees, namely the improvement of knowledge and beliefs in mental health, the reduction of negative attitudes and stigma, confidence in helping a person with a mental

health problem, the intention to provide first aid, the increase in helping behaviours towards people with mental health problems and an improvement in their mental health (Hadlaczky et al., 2014, Morgan et al., 2018, Maslowski et al., 2019, Richardson et al., 2023).

1.5. Complex Intervention

Health interventions can have different levels of complexity, and few of them can be considered truly simple (Craig et al., 2008). The complexity of an intervention is expressed by “the number of components involved; the range of behaviours targeted; expertise and skills required by those delivering and receiving the intervention; the number of groups, settings, or levels targeted; or the permitted level of flexibility of the intervention or its components” (Skivington et al., 2021, p.2). Thus, Mental Health First Aid Training Programmes can be considered complex interventions.

In research on complex interventions, it is important to consider four phases: development or identification of the intervention, feasibility, evaluation, and implementation (Figure 2).

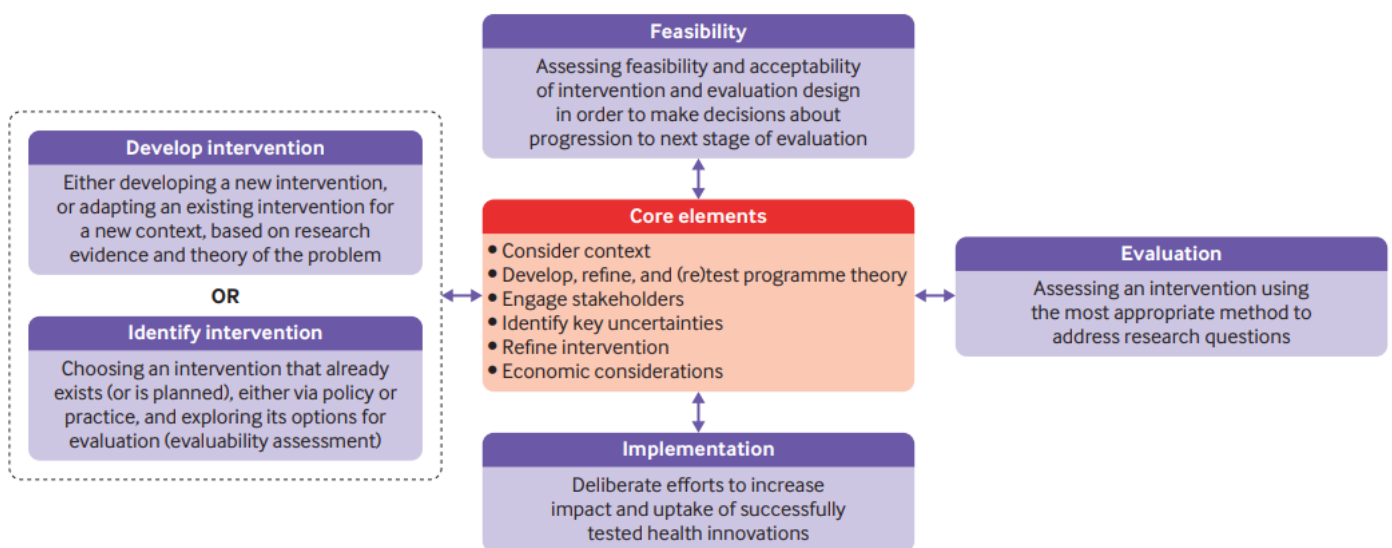


Figure 2: Framework for developing and evaluating complex interventions (source: Skivington et al., 2021, p.4)

1.5.1. Identification of an Evidence Base

Costa et al. (2020b) recognised that numerous studies described different interventions that could be included in the concept of Mental Health First Aid Training Programmes. For example, “Mental Health First Aid”, “Psychological First Aid” and “Emotional First Aid” trainings were some of the designations of this type of intervention. In addition, these programmes were carried out for different participants and contexts (Costa et al., 2020b). Considering the dispersion of knowledge about these educational interventions, a mapping (scoping review) was carried out by these authors. The evidence base created facilitates the choice of an existing intervention or justifies the development of a new one (Skivington et al., 2021).

Costa et al. (2020b) indicated that programmes seem to respond positively to nursing foci and the characteristics of the facilitators of the intervention are identical to those of mental health nurses. Thus, nurses can explore these trainings. In addition, interventions found in the literature taught their trainees about mental disorders (Costa et al., 2020b). The learning of medical labels by the general public can promote the psychiatrisation of human suffering (DeFehr, 2016). Lay people can view a mental problem as if it were always a mental disorder. In this way, a salutogenic perspective of mental health literacy is essential in Mental Health First Aid Training Programmes. Nurses can teach about mental health problems that represent nursing diagnoses (for example, anxiety rather than anxiety disorder) (Costa et al., 2020b).

1.5.2. Nursing Intervention

Mental Health First Aid Training Programmes can be seen as autonomous nursing interventions of a psychoeducational nature (Costa et al., 2020b).

Nursing practice involves interdependent and autonomous interventions (International Council of Nurses [ICN], n.d.; Ordem dos Enfermeiros [OE], 2015). According to the Regulation of the Nurse's Professional Practice, interdependent interventions are actions performed by nurses resulting from the prescription/decision of another professional; autonomous interventions are the responsibility of nurses and result from their decision/conception (OE, 2015).

Health education can be considered an autonomous nursing intervention and provides learning experiences to individuals, families, groups or communities, facilitating their adaptation to health conditions (Wagner et al., 2023). Nurses can implement this intervention to provide citizens with skills that help them make appropriate health decisions (ICN, n.d.; OE, 2012). In turn, psychoeducation is a specific form of health education and aims to increase people's

mental health literacy (OE, 2023). Therefore, mental health and mental health problems, factors influencing well-being, self-help and helping others strategies, and available help resources can be content taught in this type of intervention (OE, 2017, 2023; Sarkhel et al., 2020). According to the International Council of Nurses, psychoeducation is part of the scope of practice for mental health nurses (Stewart et al., 2024). In Portugal, among the different nurses, only mental health nurses have regulated psychoeducational competencies (OE, 2023). These specialised nurses provide psychoeducational care throughout people's life cycle to maintain, improve and recover health (Regulation No. 515/2018).

Considering Mental Health First Aid Training Programmes as an autonomous practice of (mental health) nurses, it is important to have an underlying systematic process of initial assessment of the patient(s), attribution of nursing diagnosis(s), planning, implementation and evaluation of intervention(s) (Toney-Butler & Thayer, 2023). This nursing process is usually documented with the support of classifications such as NANDA International, Inc. (Herdman et al., 2021), the Nursing Interventions Classification (Wagner et al., 2023), the Nursing Outcomes Classification (Moorhead et al., 2023), the International Classification for Nursing Practice (ICN, 2019). In Portugal, the International Classification for Nursing Practice (ICNP) was advocated as a language reference for Nursing Information Systems by the Ordem dos Enfermeiros (2007). Thus, the present work considers the different stages of the nursing process and, whenever applicable, uses the ICNP language.

1.5.3. Identification of an Explanatory Theory

Mental Health First Aid Training Programmes can be supported by nursing theories. Peplau's Theory of Interpersonal Relations (1991) and Meleis' Theory of Transitions (2010) explain these intervention programmes, as outlined in Figure 3.

Patients have educational needs and can call on a nurse. In this way, a therapeutic relationship begins. The problem data is collected and needs are determined. Educational strategies are applied and the therapeutic relationship is consolidated. There is a growing capacity and independence achieved in the therapeutic process. The needs are being exceeded and reviewed, culminating in the separation and breaking of ties between the nurse and the patient. Therefore, the movement of the personality towards creative, constructive, productive, personal and community experiences is promoted throughout educational intervention (Peplau, 1991).

These training programmes can have a positive influence on the personal conditions of the participants when they experience a transition process (Meleis, 2010). On the other hand, the recipients of the intervention have more “tools” to facilitate the process for other people experiencing a transition (Meleis, 2010).

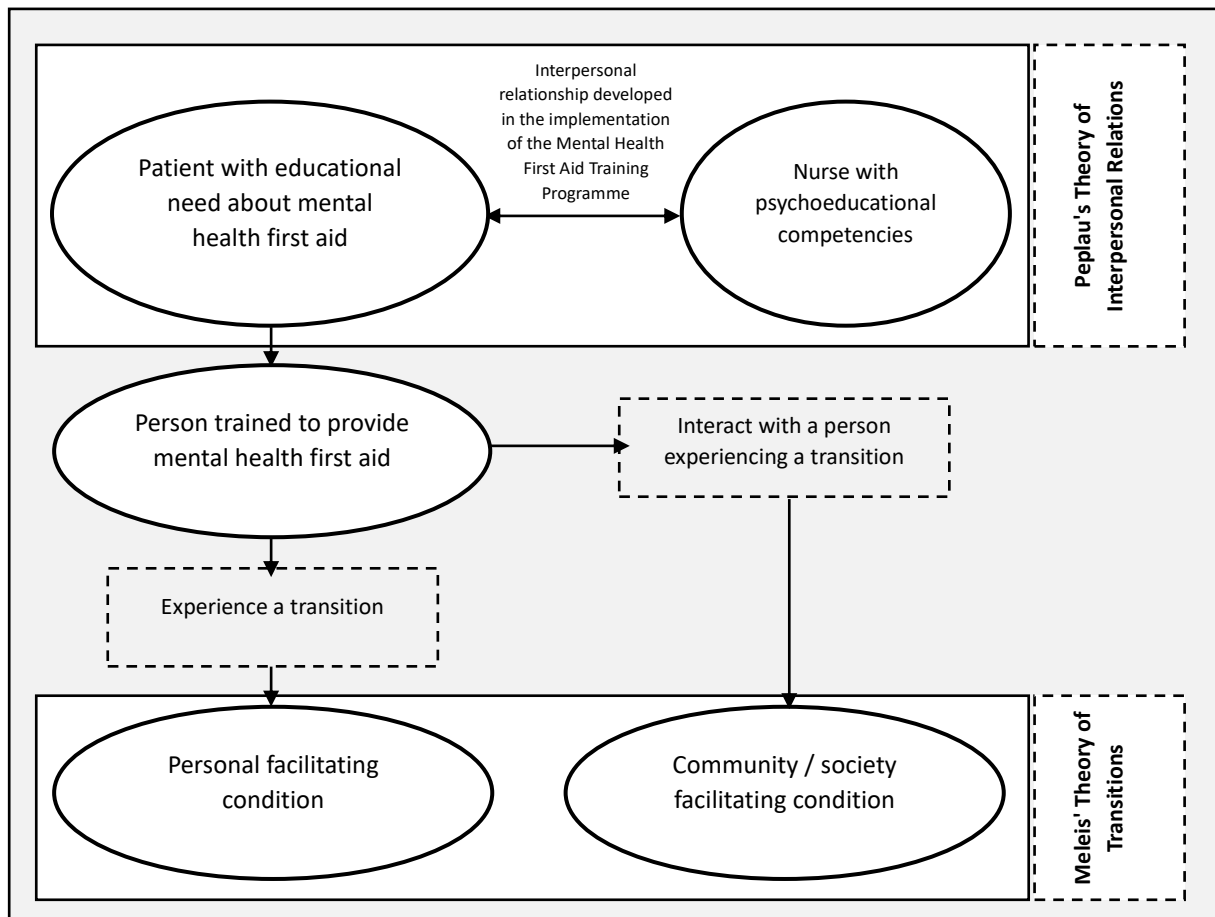


Figure 3: Mental Health First Aid Training Programmes explained by Peplau's Theory of Interpersonal Relations (1991) and Meleis' Theory of Transitions (2010)

1.6. Education of Adolescents in Schools

Mental Health First Aid Training Programmes described in the literature were implemented for different targets, including adolescents in schools (Costa et al., 2020b). Therefore, these specific participants and contexts are potentially suitable for carrying out this type of intervention.

An adolescent is someone aged between 10 and 19, who is experiencing a transitional phase in physical and psychological development (WHO, n.d. 1). According to Jean Piaget, people usually reach the formal operational stage in adolescence (Scott & Cogburn, 2023). Adolescents develop logical and systematic, hypothetical-deductive thinking (obtaining and

synthesising general information from the world to apply to particular hypotheses and deducing solutions through reasoning), propositional thinking (manipulating multiple variables and abstracting results without testing the specific variable), and learn to isolate variables and examine combinations of variables (Scott & Cogburn, 2023). Therefore, this phase of cognitive development may be suitable for effective learning of aspects related to mental health and first aid. In addition, Erik Erikson's works suggest that identity acquisition/confusion is experienced in adolescence, in which people reflect on their current and future social roles and develop fidelity as a social virtue (Orenstein & Lewis, 2022). In this way, Mental Health First Aid Training Programmes can encourage adolescents to adopt the role of “aider” in relation to people with mental health problems.

School is a privileged context to promote health literacy, as it involves people with different social backgrounds (WHO, 2017, 2021c). In Portugal, education is universal, compulsory and free until upper secondary education is completed or people reach the age of 18 (European Commission, 2023b). In adolescence, Portuguese people usually attend the second cycle of basic education (International Standard Classification of Education [ISCED] 1 / 5th and 6th year of schooling), the third cycle of basic education (ISCED 2 / 7th to 9th year of schooling) or upper secondary education (ISCED 3 / 10th to 12th grade) (European Commission, 2023b). The expected ages for ISCED 1, ISCED 2 and ISCED 3 are respectively 10-12 years, 12-15 years and 15-18 years (European Commission, 2023b). Different learning outcomes are expected for each qualification level (European Commission, 2023a).

In ISCED 1 and 2, adolescents are expected to acquire basic knowledge and elementary skills for simple tasks, and carry them out under supervision (European Commission, 2023a). In ISCED 3, students are expected to: know facts, principles, processes and general concepts, in a field of work or study; acquire a range of cognitive and practical skills necessary to perform tasks and solve problems (selecting and applying basic methods, tools, materials and information); take responsibility for completing tasks in an area of work or study, and adapt one's behaviour to circumstances when solving problems (European Commission, 2023a). Mental Health First Aid Training Programmes seem to be more appropriate to carry out from ISCED 3 onwards, taking into account the expected level of knowledge, skills and attitudes for each qualification.

The school represents a target for primary health care (Decree-Law No. 52/2022; WHO, 2023). The teams that provide care in this context are multidisciplinary and mental health nurses have been recommended to join them (Ordem dos Enfermeiros, 2019).

1.7. Instruments for Assessing Intervention Outcomes

The outcomes of Mental Health First Aid Training Programmes with a pathogenic literacy perspective were evaluated by instruments that also used medicalised terms (Costa et al., 2020b). Interventions without medicalised terminology require assessment tools without these terms. Likewise, evaluation measures must be adapted and validated for the population and context for which they are intended (Boateng et al., 2018). A review of the literature on assessment instruments can support choosing one (Mokkink et al., 2018).

Tools that measure mental health literacy or related constructs (e.g., perceived mental health competence) should be considered, as they will be used to evaluate educational interventions (Costa et al., 2020b, 2023). Health literacy includes the competence to apply health information (Sørensen et al., 2012). This competence refers to "the ability to communicate and use the information to make a decision to maintain and improve health" (Sørensen et al., 2012, p.9). Therefore, it involves the competence of individuals to act on personal and collective health. "Basic competencies perceived to act in mental health" can be an adequate construct to measure. It was conceptualised as "the importance attributed by laypeople to caring for their mental well-being and that of others, alongside the perception of ability in these activities" (Costa et al., under review). An instrument that evaluates the perception of educational need or mental health competence is essential to prescribe a psychoeducational intervention. According to Peplau (1991), nurses must provide care considering the perceived needs of their patients.

In March 2022, literature on instruments that assessed perceived basic competencies to act in mental health was searched (Costa et al., under review). Different scientific databases and repositories were used. An apparent lack of adequate instruments that measured this construct was found (Costa et al., under review). In the absence of suitable instruments, the development of a new one can be considered, evaluating the respective psychometric properties (Boateng et al., 2018).

2. RATIONALE AND RESEARCH QUESTION

The previously presented theoretical and conceptual framework makes clear an opportunity for nursing: nurses can explore Mental Health First Aid Training Programmes (with a health-centred perspective), implementing them for adolescents in upper secondary schools.

A question emerged as the starting point for the doctoral project: “What should Mental Health First Aid Training Programmes be like, led by nurses and aimed at adolescents in Portuguese upper secondary schools?”. This appeared to be a Feasible, Interesting, Novel, Ethical and Relevant research question (FINER criteria) (Fandino, 2019).

The starting question was considered feasible because it could be answered within the time allotted for the doctoral programme and with the material and human resources available. The question could be considered interesting since the doctoral student showed an intrinsic individual impulse for this specific scientific area. In addition, the guidance team (directors and tutor) and stakeholders in this research (nurses and adolescents) were consulted in an exploratory way (before proceeding with the research) and expressed that the topic was attractive.

The question is novel as it addresses a literature gap - existing Mental Health First Aid Training Programmes have a pathogenic perspective on mental health literacy. Interventions with a salutogenic perspective can provide different results.

The starting point is ethical since it responds to a potential consequence of existing training programmes – the psychiatrisation of human suffering. In addition, it focuses on an intervention that can benefit its participants and the surrounding community, as well as a greater appreciation of the role of the professionals involved in its implementation. The question is compatible with compliance with ethical principles for research with human beings.

The question seems relevant, insofar as it involves a concept/intervention widely disseminated around the world and with important results described and hypothesised for society. The shift to a health-focused paradigm in this type of intervention is a new research direction that can contribute to improving clinical practice and enhancing the discipline of nursing.

According to WHO (2017), efforts to increase (mental) health literacy are key to fulfilling the ambitions of the 2030 Agenda for Sustainable Development. In turn, the ICN (2020) calls on nurses to promote health literacy in their communities.

3. RESEARCH OBJECTIVES

The research objectives were defined considering the framework for developing and evaluating complex interventions (Skivington et al., 2021).

The research project focused mainly on the development of a Mental Health First Aid Training Programme promoted by nurses and aimed at students in Portuguese upper secondary schools. In this regard, the following research objectives were established:

- Objective 1 - To determine the characteristics of this type of training programme;
 - Objective 1.1 - To explore the opinion of upper secondary school students about the training programmes;
 - Objective 1.2 - To explore the opinion of experts about the training programmes;
 - Objective 1.3 - To establish a consensus on the characteristics of training programmes;
- Objective 2 - To create and model the educational materials of a Mental Health First Aid Training Programme.

The choice of psychometric instruments is fundamental for the evaluation of a complex intervention (Skivington et al., 2021). In this way, a secondary objective was defined:

- Objective 3 - To develop and evaluate the psychometric properties of an assessment instrument.

4. METHODOLOGICAL FRAMEWORK

4.1. Study Design and Flow

Various methods were employed to achieve the objectives. Objective 1 was achieved by carrying out three studies, objective 2 by developing an intervention manual and objective 3 by conducting another study.

First, a qualitative, exploratory study was implemented (objective 1.1). Twelve Portuguese upper secondary school students were recruited using non-probability snowball sampling. Semi-structured, in-depth and individual interviews were conducted with adolescents via telephone calls from March to April 2021 (Kallio et al., 2016). Opinions on the relevance, content and intervention methods of training programmes were explored until data saturation (Saunders et al., 2018). The audio of the interviews was recorded and the recordings were transcribed. From May to June 2021, transcripts were subjected to content analysis (Graneheim & Lundman, 2004). This study was published in November 2021.

Secondly, a qualitative, descriptive and exploratory study was carried out (objective 1.2). Seven experts / Portuguese mental health nurses were selected from a non-probabilistic, intentional sampling. They participated in two focus group sessions that took place in July 2021 via video conference (Krueger & Casey, 2015). The characteristics of the training programmes were discussed, namely facilitators, intervention foci, outcomes assessment methods, process assessment methods, participants, implementation context, duration and frequency, intervention methods and strategies, and contents. Data saturation was achieved (Saunders et al., 2018). The sessions had audio and video recorded. Transcriptions of the recordings were made. They were submitted to content analysis between August and September 2021 (Graneheim & Lundman, 2004). This work was published in January 2022.

Thirdly, a mixed, descriptive study was implemented (objective 1.3). Seventy-eight experts / Portuguese mental health nurses were recruited from a non-probabilistic, intentional sampling. A modified e-Delphi technique was applied, with two rounds of responses being carried out between October and December 2021 (Keeney et al., 2011). Statements that represented insights gained from previous studies were included in a structured online questionnaire. The experts responded to the questionnaire, indicating their level of agreement with the statements using Likert scales. A pre-determined level of consensus (at least 75%) on the statements was sought (Diamond et al., 2014). The questionnaire also provided an open space for experts to suggest new ideas about the topic under study and/or to justify the answers given. The frequency of responses given in closed questions was analysed with IBM SPSS

Statistics 27 software. The justifications were subject to content analysis (Graneheim & Lundman, 2004). The data was analysed between January and February 2022. The study was published in March 2023.

Based on the ideas generated and agreed upon in previous studies, a proposal for a Mental Health First Aid Training Programme was developed. A descriptive report of the intervention was carried out, culminating in a guiding manual for facilitators (objective 2). Its writing began in March 2022.

Finally, a psychometric study with a multimethod approach was conducted (objective 3). It had four stages: generation of items, assessment of content validity, pre-test and application of the scale (Boateng et al., 2018). To generate the scale items, nine experts / Portuguese health professionals from different disciplines were selected through non-probabilistic, intentional sampling. Between May and June 2022, two focus group sessions were held via videoconference (Krueger & Casey, 2015). The experts discussed until data saturation was reached about the psychometric instrument construct and the way of classifying the items (Saunders et al., 2018). The sessions had their audio and video recorded. The recordings were transcribed and the transcripts were subjected to content analysis in June 2022 (Graneheim & Lundman, 2004). To assess the content validity of the scale, ninety-seven experts were recruited through non-probabilistic, intentional sampling. A modified e-Delphi technique was conducted (Keeney et al., 2011). In July 2022, experts responded in a single round to a structured online questionnaire. They positioned themselves in relation to the essentiality, relevance and clarity of the items generated and the agreement with the scale's classification method. Between August and September 2022, data was analysed using IBM SPSS Statistics 27 software. The Content Validity Ratio, the Content Validity Index (with respective Kappa Statistic Coefficient) and the average clarity score for each item were calculated (Rodrigues et al., 2017). The frequency of responses regarding the scale's classification method was also examined, considering agreement/disagreement in at least 75% of responses as consensus (Diamond et al., 2014). Next, a pre-test of the scale was carried out. Eight Portuguese upper secondary students were selected through non-probabilistic, intentional sampling. They participated in cognitive interviews between September and November 2022. Interview questions focused on the mental process underlying the scale response, the content and the form of the instrument. Data collection occurred until data saturation (Saunders et al., 2018). The audio of the interviews was recorded and transcribed. The transcripts were subjected to content analysis between December 2022 and January 2023 (Graneheim & Lundman, 2004). To test the scale and better understand its psychometric properties, five hundred and fourteen adolescents /

Portuguese upper secondary students were selected with a non-probabilistic, snowball sampling. The scale was administered online to adolescents between March and September 2023. The data obtained was analysed using IBM SPSS Statistics 27 and JASP 0.18.0 software between October 2023 and February 2024. Descriptive statistics, exploratory factor analysis and confirmatory factor analysis, internal consistency and test-retest reliability measures, average variance extracted and the square of the Pearson correlation between factors were used. This study is still under review in an international scientific journal.

The developed instrument was added to the manual for training programme facilitators as a recommendation for an outcome evaluation instrument. The manual for facilitators was published in April 2024.

4.2. Ethical Considerations

All ethical assumptions of the Declaration of Helsinki (World Medical Association, 1964) and the Oviedo Convention (Resolution of the Assembly of the Republic No. 1/2001) for research with human beings were respected. Approval of the doctoral project was given by the Bioethics Committee of the University of Barcelona (Appendix 1) and approval of study 4 (scale administration step) by the Ethics Committee of the Portuguese Society of Mental Health Nursing (Appendix 2). The assessment instruments used in the studies were all developed by the research team.

Information about each study and the doctoral student's contact details was made available to participants so that their participation resulted in an informed, free and enlightened decision-making process. Informed consents were collected from all participants and, in the case of minors, authorisations from their legal guardians were obtained.

All data were coded, allowing anonymity. The person responsible for processing and storing the collected data was the doctoral student, under the supervision of their directors/tutors/supervisors. All data were stored and/or processed on the doctoral student's computer and an external disk, used exclusively for the work. Individual data has not been made available to third parties. They were kept during the doctoral programme and at the end of this course they were irreversibly destroyed.

The studies potentially benefited their participants and did not pose any risk. On the one hand, the development of the interventions allowed the enhancement of nurses' skills in the field of

intervention in mental health and psychiatry. On the other hand, the training programmes can contribute to improving the community's competencies in mental health first aid.

The doctoral project did not have any type of funding. However, the larger project ("Literacy and positive mental health" of the research group NursID of the CINTESIS:RISE) where it was integrated was funded.

5. RESULTS

Five documents emerged from this doctoral process. Three studies were published in scientific journals and one is under review. An intervention proposal to be promoted by nurses was presented.

5.1. Article 1: A qualitative study exploring adolescents' perspective about Mental Health First Aid Training Programmes promoted by nurses in upper secondary schools

The first article represented the opinion of upper secondary school students about the training programmes (Costa et al., 2021). Their opinion was summarised into fourteen themes.

Adolescents expressed that these interventions are relevant, as mental health is an emerging topic (theme 1) and that the interventions focus on their mental health competencies (theme 2). They recognised the opportunity to provide mental health training in schools (theme 3), highlighting the potential role of nurses in its implementation (theme 4).

The adolescents expressed that the intervention should teach about the physical and relational approach with the person being helped (theme 5), the assessment of the person, the problem and the help resources (theme 6), mental health problems (theme 7), the factors influencing mental health and strategies for preventing mental health problems (theme 8), helping others focused on identifying, relieving and resolving the problem (theme 9), referral to formal and informal help resources (theme 10), and self-help and seeking help for oneself (theme 11).

They considered the use of varied training strategies essential (theme 12) and indicated their preference for in-person delivery of the intervention (theme 13). They suggested that raising awareness among the school community could enhance their learning (theme 14).

This article was published in the International Journal of Mental Health Nursing (IJMHN). Details about the manuscript are summarised in Table 1.

Authors: Costa, T. F. O., Sampaio, F. M. C., Sequeira, C. A. C., Lluch Canut, M. T., & Moreno Poyato, A. R.				
Title: A qualitative study exploring adolescents' perspective about Mental Health First Aid Training Programmes promoted by nurses in upper secondary schools				
Date: 25 November 2021				
Type: Paper				
Journal: International Journal of Mental Health Nursing				
ISSN: 1445-8330 (eISSN 1447-0349)		DOI: 10.1111/inm.12959		
Volume: 31		Number: 2		
Start Page: 326		End page: 338		
Number of citations: 2 (according to CrossRef)				
Quality indicators:				
Type	Area	Impact factor	Position	Quartile
Web of Science (WOS)	Science Citation Index (SCI) – Nursing	5.6	2/125	Q1
	SCI – Psychiatry		39/155	Q2

Table 1: Information about the publication of Article 1

Permission was obtained from the journal to reuse the article in this doctoral thesis. This journal is indexed in the following databases: Academic Search, Academic Search Alumni Edition, Academic Search Elite, Academic Search Premier, CINAHL: Cumulative Index to Nursing & Allied Health Literature, Current Contents: Social & Behavioral Sciences, Health Source Nursing/Academic, HEED: Health Economic Evaluations Database, Journal Citation Reports/Science Edition, Journal Citation Reports/Social Science Edition, MEDLINE/PubMed, Psychology & Behavioral Sciences Collection, Psychology Collection, PsycINFO/Psychological Abstracts, Science Citation Index Expanded, SCOPUS, Social Sciences Citation Index, and Violence & Abuse Abstracts (IJMHN, 2024). In 2022, it obtained a CiteScore (Scopus) of 6.5, a Journal Citation Indicator (Clarivate) of 1.39 and a Journal Impact Factor (Clarivate) of 5.6 (IJMHN, 2024).



ORIGINAL ARTICLE

A qualitative study exploring adolescents' perspective about Mental Health First Aid Training Programmes promoted by nurses in upper secondary schools

Tiago Filipe Oliveira Costa,^{1,2,3,4}  Francisco Miguel Correia Sampaio,^{4,5} 
Carlos Alberto da Cruz Sequeira,^{2,4}  Maria Teresa Lluch Canut³  and
Antonio Rafael Moreno Poyato³ 

¹Centro Hospitalar de Vila Nova de Gaia / Espinho, Vila Nova de Gaia, Portugal, ²Nursing School of Porto, Porto, Portugal, ³Department of Public Health, Mental Health and Maternal and Child Health Nursing, Nursing School, Universitat de Barcelona, Barcelona, Spain, ⁴NursID: Innovation & Development in Nursing, Center for Health Technology and Services Research (CINTESIS), Vila Nova de Gaia, Portugal, and ⁵Higher School of Health Fernando Pessoa, Porto, Portugal

ABSTRACT: Mental Health First Aid Training Programmes are educational interventions that aim to disseminate basic first aid skills in the community. Adolescents in the context of their secondary school education are a particularly appropriate population for literacy promotion interventions. This study explores adolescents' perspectives on Mental Health First Aid Training Programmes promoted by nurses in Portuguese upper secondary schools. A qualitative and exploratory study was conducted. Data were collected through semi-structured interviews with 12 adolescents who participated voluntarily and with the consent of their parents. Data were analysed using content analysis. Fourteen themes were identified around three main areas: (i) Relevance of training programmes, (ii) Content of training programmes and (iii) Intervention methods of training programmes. The results obtained indicate that adolescents consider Mental Health First Aid Training Programmes in school relevant and necessary. Adolescents identified the content they deemed most appropriate and how it could be taught. These results can guide the development of training programmes. Nurses should take the lead in implementing these

Correspondence: Tiago Filipe Oliveira Costa, NursID: Innovation & Development in Nursing, Center for Health Technology and Services Research (CINTESIS), Rua Conceição Fernandes, 4434-502, Vila Nova de Gaia, Portugal. Email: tiagofilipeoliveiracosta@gmail.com

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Tiago Filipe Oliveira Costa, RMN, MSc.

Francisco Miguel Correia Sampaio, RMN, MSc, PhD.

Carlos Alberto da Cruz Sequeira, RMN, MSc, PhD.

Maria Teresa Lluch Canut, RMN, MSc, PhD.

Antonio Rafael Moreno Poyato, RN, MHN, MSc, PhD.

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interventions in schools. Adolescents can take a more active role in mental health issues by improving their literacy.

KEY WORDS: *adolescent, education, first aid, mental health, nursing.*

INTRODUCTION

A mental health problem is a broad term that includes both mental disorders and the symptoms of a mental disorder that do not yet justify the diagnosis of a disorder (Kitchener *et al.* 2017). In 2016, mental and addictive disorders affected more than 1 billion people globally, causing 7% of all global burden of disease as measured in Disability-Adjusted Life Years and 19% of all years lived with disability (Rehm & Shield 2019). Silva *et al.* (2020) found a high worldwide prevalence of common mental disorders among adolescents (25.0–31.0%). Furthermore, the COVID-19 pandemic appears to have increased mental health problems of the global population (Wu *et al.* 2020). This high prevalence of mental health problems increases the likelihood of people having contact with individuals with these problems (Morgan *et al.* 2018). In turn, it is more likely that these individuals would seek professional help at the suggestion of others (Cusack *et al.* 2004; Wong *et al.* 2014). Therefore, mental health first aid skills seem to be essential. Mental health first aid is the support given to a person in a crisis or with a mental health problem until the person receives professional help or the crisis is resolved (Kitchener *et al.* 2017).

Providing first aid requires people to take an active role in the health of others. In turn, citizens can become more actively involved in their personal and community health, improving their health literacy (World Health Organization 2016). Mental health literacy involves five components: knowledge of how to prevent mental disorders, recognition of when a disorder is developing, knowledge of help-seeking options and treatments available, knowledge of effective self-help strategies and knowledge and skills to provide first aid and support others (Jorm 2012). Mental Health First Aid Training Programmes are important to promote the last component. These educational intervention programmes aim to disseminate basic first aid skills in the community (Kitchener & Jorm 2017), training individuals to aid people with mental health problems. They are different from crisis interventions because they do not include the therapist's direct actions

towards people with mental health problems and/or in crisis.

BACKGROUND

Numerous studies described various interventions with the concept of 'Mental Health First Aid Training Programmes'. Therefore, a comprehensive literature review on these intervention programmes was performed (Costa *et al.* 2020). These authors mapped these interventions, identifying their characteristics, participants and implementation contexts. One of the findings indicated that Mental Health First Aid Training Programmes seem suitable for adolescents in upper secondary schools (Costa *et al.* 2020).

The school is indicated as an appropriate context to intervene in the literacy promotion (Directorate-General for Health 2018; McDaid 2016). In Portugal, upper secondary education became universal, free and compulsory, following Law No. 85/2009. 85/2009. Thus, the school has people from a wide age range and diverse economic, social and cultural backgrounds. In upper secondary education, students are expected to acquire multiple factual and theoretical knowledge, cognitive and practical skills necessary to perform tasks and solve problems, assume responsibilities and adapt behaviour to circumstances (European Commission 2018).

In Portugal, upper secondary school students (10th, 11th and 12th grades) are normally aged 15–18 (European Commission 2019). People who are 10 to 19 are called adolescents (Organisation for Economic Co-operation and Development/World Health Organization 2020). Adolescents are expected to be in the formal operational stage of cognitive development (Halpenny & Pettersen 2014). At this phase, people have logical and systematic reasoning and hypothetical-deductive thinking, enabling the assimilation and accommodation of learning (Halpenny & Pettersen 2014). From the perspective of psychosocial development, these are in the stage of identity acquisition/confusion (Ferrer-Wreder & Kroger 2020). Adolescents reflect on their current roles and the roles they will play in the world, achieving a sense of identity (Ferrer-

Wreder & Kroger 2020). Therefore, this is an important moment for them to incorporate the role of 'the first aider'.

Different studies describe and evaluate classroom-based Mental Health First Aid Training Programmes for students aged 15–18 years. Using this type of training, Hart *et al.* (2016) found improvements in mental health literacy, confidence to help, intentions to seek help, attitudes and health of the participants. Also, Guajardo *et al.* (2019) reported positive effects on the mental health literacy and helping intentions of a group of students after receiving Mental Health First Aid Training. Likewise, Hart *et al.* (2020) found increased recognition of problems and improved aid intentions in a group of students after receiving training on mental health. However, no studies were found that described this type of intervention in the Portuguese upper secondary education setting.

Mental Health First Aid Training Programmes address mainly pathologies (Costa *et al.* 2020). These interventions entitle their participants to informal diagnostic practices, where all problems can be seen as disorders (Costa *et al.* 2020; DeFehr 2016). Thus, they can promote the medicalization and psychiatrization movement of human suffering (DeFehr 2016). Therefore, Costa *et al.* (2020) suggest that nurses could develop these training programmes, addressing mental health nursing problems (e.g. 'anxiety' instead of the medical diagnosis of 'anxiety disorder'). The concept of 'mental health nursing problems' seems to refer to mental health problems that represent nursing diagnoses. Nursing diagnoses are descriptive labels of patients' health states assigned by nurses (International Council of Nurses 2019). These can be found, for example, in the International Classification for Nursing Practice (International Council of Nurses 2019). This terminology is a reference for Portuguese nurses and their information systems (Ordem dos Enfermeiros 2007).

The process of developing and evaluating a healthier intervention can be guided by the UK Medical Research Council (Richards & Hallberg 2015). One step includes modelling the interventions, and their potential participants should be considered (Richards & Hallberg 2015). Thus, this study aims to explore the perspective of adolescents about Mental Health First Aid Training Programmes promoted by nurses in Portuguese upper secondary schools. The research questions are: 'What is the relevance that adolescents attach to these training programmes?'; 'What is the opinion of adolescents about the contents of these training

programmes?'; 'What is the opinion of adolescents about the intervention methods of these training programmes?'.

METHODS

Design

We carried out a qualitative exploratory study. The study report was guided by the *Consolidated criteria for reporting qualitative research (COREQ) checklist* (Tong *et al.* 2007).

Selection of participants

The participants are Portuguese upper secondary school students. A non-probabilistic snowball sampling was used to select the participants. Thus, it was possible to access adolescents with ease/efficiency, speed and low cost (Frey 2018; Johnson 2014). First, one student was directly selected by the researchers using the following inclusion criteria: a 15–18 years old adolescent, enrolled in Portuguese upper secondary education (target of the intervention), with membership in a student association (more likely to meet colleagues with different characteristics). Then, an invitation to the student to participate in the study was sent via e-mail. After participating, the student was asked to forward the invitation to two schoolmates with different personal characteristics. After those two students had participated in the study, they were asked to invite other students. The process continued until reaching the total number of participants. Figure 1 illustrates the recruitment process.

Potential study participants were asked to fill out an informed consent and a sociodemographic characterization form online. The telephone number of each adolescent was requested, and their availability for an interview was surveyed. In addition, their legal guardians were asked to fill in authorization for the minors to participate in the study. There was no prior relationship between the investigators and the participants. The participants did not receive compensation for their participation.

Data collection

Semi-structured, in-depth and individual interviews were carried out. This type of interview allows participants to answer in a focused, systematic and comprehensive way to pre-defined questions about the topic

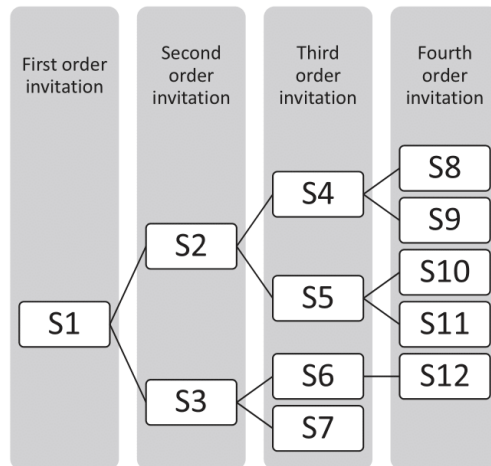


FIG. 1 Flow of recruiting participants for the study ('S' stands for 'Student'; the numbers express the order of participation in the study).

(Kallio *et al.* 2016). In addition, the data collection was carried out in the native language of the researchers and study participants (European Portuguese).

The interview guide was developed in response to the objective of the study and the research questions (Kallio *et al.* 2016). The interview guide was pretested by applying it to 4 Portuguese upper secondary school students. The students reported that the interview guide was understandable, clear, unambiguous, well-structured, without bias and did not need any changes. Appendix S1 includes the interview guide used.

The first author performed the data collection. The participants' availability was considered. The data collection took place via a telephone call. Thus, the social distancing required by the COVID-19 pandemic was respected. The interviews lasted 43 min on average. The data collection took place in March and April 2021. The interviews were audio-recorded for a reliable report of their content. The audio recordings were transcribed immediately after the interview. The transcripts were returned to the participants for comments and/or corrections.

After analysing the data from each interview, the recruitment of new participants was considered. We recruited participants until no new relevant knowledge was being added. According to Saunders *et al.* (2018), data saturation refers to the extent to which new data repeats what was expressed in previous data.

Therefore, data saturation was obtained and discussed among investigators.

Data analysis

The collected data were subjected to content analysis (Graneheim *et al.* 2017; Graneheim & Lundman 2004). Thus, the transcriptions of the audio recordings were considered units of analysis. The analysis focused on the manifest and latent content of the meetings. The text under analysis was classified deductively in the following content areas: relevance, contents and intervention methods of training programmes. The content analysis was performed by the first author and verified by the other authors. There were no disagreements in the process, and no software was used.

Firstly, the text under analysis was read several times to get a sense of the whole. Then, the text was divided into meaning units. In turn, the meaning units were condensed and labelled with a code. The International Classification for Nursing Practice (International Council of Nurses 2019) was consulted to facilitate assigning a 'label' to each described mental health problem. The various codes were compared based on their differences/similarities and classified into subcategories and categories. Finally, the underlying meanings of the categories formed themes at an interpretive level. The participants provided positive feedback on the results.

Ethical considerations

In this study, all ethical assumptions contained in the Declaration of Helsinki (World Medical Association 1964) and the Oviedo Convention (Resolution of the Assembly of the Republic No. 1/2001) for research with human beings were fulfilled. The ethics committee of the University of Barcelona approved the research proposal to carry out the study (Institutional Review Board: IRB00003099).

Informed consents were collected from all participants and authorizations from legal guardians. They were notified of the right to voluntarily participate and withdraw from the study at any time without penalty. In addition, they were advised of the right to access, rectify, limit processing and delete your data.

Each student's data was coded with the letter S and a number to preserve confidentiality. Moreover, the data was stored in a computer and external disk (with login credentials) used exclusively for this study.

RESULTS

Twelve adolescents participated in the study. The percentage of male and female adolescents was the same (50%). They were single and aged 15–18 years old (mean: 16.42 years, $SD = 1.08$). According to the Family Social Notation – Adapted Graffar (Amaro 1990), 42% of adolescents were Middle class, 50% Upper Middle Class, 8% Upper class. Only 8% of the adolescents were also workers. The percentage of students in the 10th, 11th and 12th grades was the same (33%), and 17% had repeated at least one school year. The percentage of students in Arts, Sciences and Technology, Socioeconomic Sciences and Languages and Humanities was the same (25%). The aspects related to mental health and health literacy are shown in Table 1.

Fourteen themes were identified in response to the research questions (Table 2). The codes and categories that support each theme can be consulted in the material Appendix S2.

Relevance of training programmes

The adolescents revealed that programmes can be important due to 'Relevance of mental health'. The high prevalence of problems among young people and the importance of mental health 'especially considering the pandemic' (S9) were described.

In addition, these training programmes focus on 'Mental Health Competencies'. According to the interviewed adolescents, these programmes can influence mental health knowledge, mental health awareness, mental health capacity, autonomy in mental health,

confidence in mental health, attitude towards mental health and relationships with people with mental health problems. Each of these competencies can be illustrated by exemplar quotes (Table 3).

The adolescents expressed the 'Opportunity for mental health training in schools'. School is a learning setting ('because we are at school to learn things that can be useful later'. (S8)). However, adolescents perceived a lack of mental health training. S4 stated that 'Usually, we don't learn about mental health at school.' Although almost half of the adolescents had already experienced a mental health problem and most had contact with people with mental health problems, none had participated in a Mental Health First Aid Training Programme (Table 1).

Finally, the adolescents expressed the 'Opportunity for nurses to respond to the training need in mental health'. They identified the lack of mental health training, and nurses can play an important role in mental health education in schools. S2 stated, 'As (nurses) often go to schools to teach about other subjects, they could also talk about this (mental health first aid).' and added, 'And nurses also study about mental health'.

Contents of training programmes

The adolescents revealed that the programmes can address the 'Physical and relational approach to the person helped'. The physical approach refers to accompanying the person, including taking them to a different and safe place and touching them. For example, S10 mentioned that 'being close to the person (with mental health problems)' and 'hugged him/her' can be actions to be taught in the programmes. The relational approach involves the expression of availability and the establishment of a relationship for help. For instance, S5 said that 'it makes sense to show these people that we are there for them.' S7 indicated that 'we have to get along with the person or try to make them feel that they can trust us.'

The participants verbalized that these training programmes can address the 'Assessment of the person, the problem and resources for help'. The adolescents mentioned that the general assessment of the person and the situation should be explored (e.g. 'First, I would have to find out what is going on' (S2)). The assessment of the problem and help resources should also be addressed. S9 indicated that 'I would try to understand the problem' and 'I would try to understand the consequence (of the problem)'. S5 added, 'we have to find the cause of the problem'. S11 said

TABLE 1 Characteristics of the participants related to mental health and health literacy

Questions	Answers	n (%)
Have you ever experienced mental problems/disorders?	No	7 (58%)
	Yes	5 (42%)
Did you look for help?	No	9 (75%)
	Yes	3 (25%)
Have you ever contacted people with mental problems/disorders?	No	3 (25%)
	Yes	9 (75%)
Did you provide them with any help?	No	9 (75%)
	Yes	3 (25%)
Have you ever participated in a first aid training programme?	No	8 (67%)
	Yes, I only participated in first aid training programmes for physical health problems	4 (33%)

TABLE 2 Themes obtained from the data analysis

Relevance of training programmes	Contents of training programmes	Intervention methods of training programmes
• Theme 1: Relevance of mental health • Theme 2: Focus on Mental Health Competencies • Theme 3: Opportunity for mental health training in schools • Theme 4: Opportunity for nurses to respond to the training need in mental health	• Theme 5: Physical and relational approach to the person helped • Theme 6: Assessment of the person, the problem and help resources • Theme 7: Mental health problems • Theme 8: Influencing factors of mental health and strategies for the prevention of mental health problems • Theme 9: Helping others focused on identifying, alleviating and solving the problem • Theme 10: Referral to formal and informal resources for help • Theme 11: Self-help and seeking help for oneself	• Theme 12: Varied training strategies enhance learning • Theme 13: Preferably face-to-face intervention • Theme 14: Awareness of the school community enhances learning

TABLE 3 Quotes that represent mental health competencies

Mental Health Competencies	Exemplar quotes
Knowledge	'These programmes would be important because information and knowledge in mental health is never too much'. (S7)
Awareness	'The programme makes us aware of mental problems'. (S1)
Capacity	'it may be important to improve our capacity to help (people with mental health problems)'. (S8)
Autonomy	'to be alone and not depend on others (to help people with mental health problems)'. (S10)
Confidence	'(People with mental health problems) will be more confident in their recovery'. (S6)
Attitude	'people won't look at mental health issues as a taboo' (S7)
Relationship	'It will even establish better bonds between people (who helped and who were helped)'. (S6)

that 'I would assess whether (the person with mental health problems) spoke to someone'.

According to the adolescents, 'Mental health problems' are content to be addressed in training programmes. S5 stated that this type of programme 'should address the main mental health problems'. The mental health problems described by the adolescents were emotional, cognitive, behavioural and relational (Table 4).

For the adolescents, the theme 'Influencing factors of mental health and prevention strategies for mental health problems' was reported as an important content of the training programmes. From the adolescents' perspective, mental health can be influenced by the individual's characteristics, general health status or other health problems, family, community and social interaction, the individual's culture and lifestyle, and environmental factors. The individual's characteristics include congenital alterations, genetics, hormonal regulation, gender, age, personality, sexual orientation and skin colour. For example, S7 suggested that 'age may be a risk factor (for dementia). We are all at risk, but it is more frequent in older people.' Physical health was referred to as protective of mental health problems and physical problems as a risk factor. For instance, S5 stated, 'Physical well-being protects our mental health' and 'Mental health problems can be caused by changes in the brain'. Mental health problems were listed as risk factors for other mental health problems. S9 said, 'I think fear can also lead to anxiety.' The influence of family interaction, community interaction and social interaction on mental health was highlighted. For example, S7 indicated, 'Social pressure is (a risk factor) for anxiety'. Concerning the individual's culture and lifestyle, self-knowledge, physical exercise, food, sleep schedules, management of work and rest, leisure activities, daily activity, religion, culture, education and mental health knowledge were described as influencing factors in mental health. For instance, S1 said, 'I think if people have an idea of mental health problems, how to help and how to prevent them, they can prevent problems.' In addition, the environmental influences considered by the adolescents were: economic status, personal growth and development, experiences, everyday stimuli, everyday events, adverse events. S5 stated, 'Our environment influences the person we are and the problems we have.' In addition to the influencing factors, S4 noted that the programmes should address 'how to deal with situations... that result in certain problems later on.'

TABLE 4 *Mental health problems described by the participants*

Emotional Problems	Cognitive Problems	Behavioural Problems	Relational Problems
-Depressed Mood	-Impaired Memory	-Compulsive Behaviour	-Social Isolation
-Sadness	-Impaired Attention	-Compulsive Eating Behaviour	-Impaired Socialization
-Grief	-Impaired Concentration	-Impaired Eating Behaviour [Anorexia]	
-Euphoria	-Dyslexia	-Bulimia	
-Stress	-Dysphasia	-Alcohol Abuse	
-Anxiety	-Hallucination	-Drug Abuse	
-Fear	-Impaired Thinking	-Tobacco Abuse	
-Trauma	-Impaired Learning	-[Gambling] Abuse	
-Ambivalence	-Suicidal Ideation	-Aggressive Behaviour	
-Anger	-Obsession	-Aggressive Behaviour	
-Jealousy	-Delirium	[Harassment]	
-Shame	-Dementia	-Violence	
-Loneliness	-Confusion	-Violence [Cybernetics]	
	-Disturbed Personal Identity	-Violence [Sexual]	
	-Disturbed Body Image	-Self-Destructive Behaviour	
	-Low Self Esteem	-Self-Mutilation	
	-[Excessive] Self Esteem	-Impaired Sexual Behaviour	
		-Insomnia	
		-Disorganized Behaviour	
		-Hyperactivity	

In the theme 'Helping others focused on identifying, alleviating and solving the problem', S1 highlighted that 'it should be taught... when the other needs help.' In addition, all participants considered different ways to help. S5 mentioned that 'each strategy (of help) is applicable depending on the type of personality (that the person being helped has)'. Actions to raise awareness of the situation, to project a positive state, to avoid the problem and causes, to alleviate the person's problem, to respond and solve the mental health problem were reported. Exemplar quotes in Table 5 illustrate these actions.

Participants described that the training programme can address the theme 'Referral to formal and informal help resources'. This referral to formal resources comprises actions to refer specialized professionals and actions to seek specialized professionals. S10 said, 'it is important to forward it to a professional', and S4 stated, 'I was probably also looking for help from someone more specialised in the area.' Adolescents listed

TABLE 5 *Quotes that represent different actions to help others*

Actions	Exemplar Quotes
To raise awareness (of the person with the mental health problem and their social network) towards the situation	'(if I was anxious) I wanted at least people to tell me the reality'. (S5) 'I would talk to the people closest (to the person with mental health problems) so that they try to understand the other person's situation better and be more understanding with the person'. (S11)
To project a positive state	'...I told him/her that everything would be fine...' (S11)
To avoid the problem and causes	'I was going to suggest that he/she avoids situations that provoke anger'. (S3)
To alleviate the problem of the person	'I started to take a deep breath. I told him/her to follow my breathing' (S11)
To respond to the mental health problem	'Some kind of initial instruction of what should do'. (S4)
To solve the problem	'Maybe it gave him/her advice on how to solve the problem'. (S12)

Note: 'him/her' or 'he/she' refers to the person with mental health problems.

help from conventional therapy professionals: psychologists, psychiatrists, general practitioners/family doctors, nurses, mental health nurses. Participants also mentioned the potential help of alternative therapy professionals: non-specific therapy professionals, Reiki professionals and coaches. S10 suggested remote help ('Phone and internet platforms can be helpful resources').

Regarding the informal resources of help, the adolescents highlighted the importance of help from the family, from the social network, people who have experienced the problem, and professionals from different areas (such as teachers, religious ministers). The importance of help from significant people of the person with a mental health problem and people known by the aider was described. S4 added, 'Preferably, help resources with a good level of knowledge in this area (mental health) should be considered.' S9 defended the continuity of contact between the person who helped and the person who was helped ('I would try to communicate daily').

Concerning 'Self-help and seeking help for oneself', S1 stressed that 'we help others, but we also have to know when we need help'. Adolescents suggested different strategies to address in training programmes. S5 explained that '(Self-help strategies) depend a lot on the person and the personality'. S1 understands that

TABLE 6 *Self-help strategies described by the participants*

Strategies for processing the situation	Negative stimuli avoidance strategies	Leisure activities and healthy lifestyles
-Self-reflection -Rationalization -Monologue	-Resumption of routine -Change of environment	-Relaxation activities -Distraction -Leisure activities -Physical exercise and sports -Reading (including self-help books) -Listening to music -Painting and drawing -Religion -Regular sleep schedule -Food healthy -Socialization

'we have to see what we suggest to others and learn and reflect on strategies for ourselves.' The self-help strategies described considered the processing of the situation, the avoidance of negative stimuli, leisure activities and healthy lifestyles (Table 6). S7 emphasized that 'It may be necessary to talk to a professional' in case the aider 'gets too involved' or 'is hurt'.

Intervention methods of training programmes

In the theme 'Varied training strategies enhance learning', the following were described: expository methods such as lectures; interactive methods such as discussions, debates and quizzes; educational methods through contact with people with mental health problems and with people who helped others with mental health problems; demonstration methods and experimental learning methods such as role-plays, games and group work. The strategies to be used depend on the participants, namely, their preferences and their courses. Adolescents report that expository strategies may have little effectiveness because they do not capture the participants' attention. Expository strategies should be used to present the background of the theme. S4 recommends merging different strategies.

Upon delivery of the intervention, the adolescents described a 'preferably face-to-face intervention'. They reported that a face-to-face delivery is more effective, with a better relationship between trainer and trainee and greater attention capture. The adolescents stated that it is difficult to concentrate and acquire knowledge in a virtual intervention. However, a virtual intervention can be safer and more accessible. Thus, S6

mentioned, 'I think that virtual interventions should be seen as an alternative or a complement to the face-to-face interventions'.

Finally, S1 stated that the 'Awareness of the school community enhances learning'. This student indicated, 'I think it is important to train young people, but also try to raise awareness among older people'. S1 also explained, 'they learn and are more understanding in certain situations.' However, 'separate interventions' (S1) should be carried out using different methods of intervention.

DISCUSSION

This study aimed to explore the adolescents' perspective on Mental Health First Aid Training Programmes promoted by nurses in Portuguese upper secondary schools. Our results show that Mental Health First Aid Training is relevant and necessary for adolescents in a school education setting. Furthermore, they identified the most appropriate content, how it should be taught, and the relevance of nurses promoting these training programmes.

First and foremost, it should be noted that the relevance attached to mental health issues by the participants is understandable because mental health and the high prevalence of problems are considered priority areas of Portuguese and international policies (Directorate-General for Health 2017; World Health Organization 2013). The adolescents indicated that Mental Health First Aid Training Programmes can be important to their mental health competencies. Mental health literacy levels are low worldwide (Tay *et al.* 2018). In Portugal, pioneering studies by Loureiro *et al.* (2013, 2015) supported this trend in youth. Loureiro *et al.* (2013, 2015) assessed the level of mental health literacy of 4938 young Portuguese people regarding depression and schizophrenia. In both studies, it was found that a significant percentage of the participants failed to recognize the mental health problem described in a vignette, some important aid resources and interventions were not considered useful, and there was some difficulty in identifying appropriate first aid strategies. Therefore, interventions that improve mental health literacy are relevant (Loureiro *et al.* 2013, 2015; Tay *et al.* 2018). The adolescents also confirmed the opportunity for mental health training in schools. The World Health Organization (2018) emphasizes the relevance of community-based mental health interventions, and it suggests the school as a universal and low-cost option to improve mental health literacy.

Furthermore, the adolescents expressed that the nurses can respond to their mental health training needs. Nurses play key roles in health literacy and can lead public education actions (Tay *et al.* 2018; World Health Organization 2018).

Concerning the content of training programmes, the adolescents reported that the physical and relational approach to the person to be helped must be addressed in this training programme. This approach can be seen as establishing a therapeutic relationship between the aider and the person helped. Moreno-Poyato and Rodríguez-Nogueira (2020) explain that this relationship aims to improve the health situation of the person being cared and it is closely related to taking a perspective (cognitive empathy) of the person who helps. Zhao *et al.* (2014) add that establishing a connection and proximity between the agents of an interaction also involves positive facial expression, mutual attention and behaviour coordination with the other person. The adolescents indicated that the assessment of the person with the mental health problem should be addressed in training programmes. This assessment can make it possible to understand the need and adequacy of aid. They also mentioned that mental health problems should be taught. The problems described were cognitive, emotional, behavioural and relational, as in Costa *et al.* (2020) review. These authors refer to Mental Health Training Programmes addressing mainly pathologies (e.g. schizophrenia, anxiety disorder, obsessive-compulsive disorder, disruptive behaviour disorder). In this study, the interviewees' reports allowed the attribution of non-pathological labels. The adolescents explored several factors influencing mental health. These factors are in line with those described by Dahlgren and Whitehead (2007). According to these authors, individual factors (age, gender and genetic factors), lifestyles, social and community support networks, economic, environmental and cultural aspects are determinants of health.

Knowledge of influencing factors can facilitate the avoidance of modifiable risk factors and the promotion of protective factors. The adolescents highlighted that helping others focused on identifying, alleviating and solving the problem should be addressed in training programmes. People who are not aware of their problems may need help identifying and recognizing them (e.g. in the case of delusions and hallucinations). According to Meleis (2010), awareness is the key to achieving a new state of health stability. Moreover, an aware person may want to respond to the problem but needs help to solve or minimize it. Community

members can help the person with a mental health problem to overcome the situation, providing support, information and advice (Meleis 2010). Another content described in the interviews was the referral to formal and informal help resources. If the problem is not resolved after the help of an aider, it may be necessary to mobilize other help (Kitchener *et al.* 2017). Non-professional resources can develop an informal helping relationship with the person with the mental health problem. There is a tendency to look for informal sources of help rather than professional help (Jorm 2012). Formal resources can be important as they have advanced and certified mental health skills. However, there is often a lack of knowledge about available health professionals and treatments and negative beliefs about them (Jorm 2012). The adolescents reported that training programmes should address self-help and seeking help. People can vary their position in mental health at different times in their lives (Kitchener *et al.* 2017). Therefore, they must know adaptive and non-adaptive self-help strategies to adopt conscious behaviours. When people experience mental health problems, they may need to seek help. Mental health literacy can favour demand (Jorm 2012).

According to the adolescents, varied training strategies can enhance their learning. Townsend (2014) refers to advantages for each of the different methodologies: expository strategies promote considerable amounts of information to large groups; demonstrations activate the senses and clarify underlying principles; discussions can lead to continuous feedback and are flexible and encourage networking; the use of simulated environments, games, activities and role-playing enable a more transferable practice; contact-based education allows active learning and bypasses defences. The intervention should preferably be in-person, according to the opinion of the interviewees. The literature describes numerous advantages and disadvantages for face-to-face and virtual education. Galy *et al.* (2011) explained that face-to-face intervention can have a better impact than e-learning intervention, as online students may lose focus and miss deadlines for different tasks.

On the other hand, e-learning allows for more flexibility and no need to travel to school (Naveed *et al.* 2017). Furthermore, e-learning strategies can be safe, as they allow for emergency distance learning in the face of natural disasters or situations that require distance (Hodges *et al.* 2020). The adolescents also highlighted that the awareness of the school community enhances learning. According to Spier *et al.* (2018),

schools, families and community settings play vital roles in learning. Therefore, it is important to involve the entire school community in education and raise awareness inside and outside the school about the subjects to be taught.

LIMITATIONS

The recruitment of students in schools was hampered by the COVID-19 pandemic (school interruptions and online classes). Thus, we opted for a non-probabilistic snowball sampling. The participants suggested other students join the study. The social relationships of the participants conditioned the characteristics of the sample and the corresponding responses. Therefore, there is a risk that the characteristics of the sample are homogeneous and specific. However, the suggestion of adolescents with different personal characteristics was requested to avoid this risk of bias. This strategy allowed us to obtain a sample with diversified characteristics. It should be noted that this study used a small sample size due to its qualitative methodology. Survey data collection may be relevant in future studies to obtain a perspective on these training programmes that can be extended to the rest of the population.

CONCLUSION

Adolescents were interviewed about the relevance, content and intervention methods of Mental Health First Aid Training Programmes promoted in upper secondary schools. These programmes were shown to be relevant for their focus on mental health and mental health competencies. In addition, the possibility for nurses leading these interventions in schools to meet the adolescents' educational needs was highlighted.

The approach and assessment of the person with a mental health problem, the way of assistance and the referral to help resources were described as contents to be addressed in the programmes. Factors influencing mental health, mental health problems, self-help and problem prevention strategies, and seeking help were also considered.

The adolescents expressed that these programmes should take place in person (preferably) and should use varied training strategies. They stressed that their learning can be promoted with the awareness of the school community.

RELEVANCE FOR CLINICAL PRACTICE

This study provides an exploratory view of the perspective of adolescents about Mental Health First Aid Training Programmes promoted by nurses in Portuguese upper secondary schools. The relevance attached by the participants seems to give the 'green light' to the development of training programmes promoted by nurses. Therefore, this study evidences the development of these interventions as a new research direction.

Potential contents of these training programmes were reported. Thus, future constructed interventions can be more in line with what adolescents need to learn. Guidelines regarding intervention methods were also described. Therefore, the dynamization of the intervention can be improved.

This study highlights the perspective of potential participants in these training programmes (adolescents/upper secondary education students). In developing an intervention, it may be relevant to explore the facilitators' perspective (nurses). Qualitative studies must be carried out for this purpose.

This report stresses the potential autonomous role of nurses in mental health work. Implementing these training programmes can enhance adolescents' mental health competencies and foster a more active role in health issues. Furthermore, it also shows the importance of highlighting these interventions in nursing education curricula.

Mental Health First Aid Training Programmes can address mental health nursing problems, emphasizing the discipline's body of knowledge. Furthermore, they can promote the identification, assistance and/or adequate and timely referral of people with mental health problems, without any mistaken attribution of 'medical labels'. Therefore, they can improve mental health literacy and, at the same time, combat the psychiatrization of human suffering.

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ETHICS APPROVAL

This study is part of a project that received ethical approval from the Bioethics Committee of the University of Barcelona (Institutional Review Board: IRB00003099).

PATIENT CONSENT FOR PUBLICATION

Not available. Guaranteed to students and legal guardians that personal data would not be shared with third parties. Details that might disclose the identity of the subjects under the study were omitted in the documents sent.

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SUPPORTING INFORMATION

Additional Supporting Information may be found in the online version of this article at the publisher's website:

Appendix S1

Appendix S2

5.2. Article 2: Nurses' perspective about the Mental Health First Aid Training Programmes for adolescents in upper secondary schools: A focus group study

The second article described the opinion of experts about the training programmes (Costa et al., 2022). Their opinion was organised into twelve themes.

The experts indicated that mental health nurses should lead these training programmes with a health-centred perspective. However, professionals from different disciplines and backgrounds can be considered for co-facilitation (theme 1). They expressed that these interventions focus on adolescents' mental health competencies (theme 2) and the outcomes can be evaluated over time with validated instruments based on knowledge in the area of nursing (theme 3). Valid and adapted methods for measuring adolescent satisfaction at each training session must be used (theme 4).

According to experts, the implementation of this type of intervention is suitable for classes with identified nursing diagnoses, as well as availability and willingness to learn about the subject (theme 5). These training programmes must be conducted in a classroom context during school periods (theme 6) in regular sessions depending on school availability (theme 7).

The use of different training strategies and educational resources was recommended (theme 8). The relevance of awareness-raising sessions for the school community (theme 9) was also emphasised.

The different components of mental health literacy suggested by Jorm (2012) were suggested by experts as essential contents of the intervention (theme 10). However, they highlighted the need to teach participants about various mental health problems that represent nursing diagnoses (theme 11). Furthermore, a dynamic mental health first aid plan should be addressed (theme 12).

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Table 2: Information about the publication of Article 2

This journal is indexed in the following databases: Abstracts in Anthropology, Abstracts in Social Gerontology, Academic Search, Academic Search Alumni Edition, Academic Search Elite, Academic Search Premier, British Nursing Database, CINAHL: Cumulative Index to Nursing & Allied Health Literature, Current Contents: Clinical Medicine, Current Contents: Social & Behavioral Sciences, Health Research Premium Collection, Health Source Nursing/Academic, Hospital Premium Collection, Journal Citation Reports/Science Edition, Journal Citation Reports/Social Science Edition, MEDLINE/PubMed, Nursing & Allied Health Database, ProQuest Central, Psychology Collection, PsycINFO/Psychological Abstracts, PubMed Dietary Supplement Subset, Science Citation Index Expanded, SCOPUS, and Social Sciences Citation Index (JPMHN, 2024). In 2022, it obtained a CiteScore (Scopus) of 3.7, a Journal Citation Indicator (Clarivate) of 0.73 and a Journal Impact Factor (Clarivate) of 2.7 (JPMHN, 2024).



Nurses' perspective about the Mental Health First Aid Training Programmes for adolescents in upper secondary schools: A focus group study

Tiago Filipe Oliveira Costa^{1,2,3,4} | Francisco Miguel Correia Sampaio^{4,5} |
Carlos Alberto da Cruz Sequeira^{2,4} | María Teresa Lluch Canut^{3,6} |
Antonio Rafael Moreno Poyato³

¹Centro Hospitalar de Vila Nova de Gaia / Espinho, Vila Nova de Gaia, Portugal

²Nursing School of Porto, Porto, Portugal

³Department of Public Health, Mental Health and Maternal and Child Health Nursing, Nursing School, Universitat de Barcelona, Hospitalet de Llobregat, Spain

⁴NursID: Innovation & Development in Nursing* of the Center for Health Technology and Services Research (CINTESIS), Porto, Portugal

⁵Higher School of Health Fernando Pessoa, Porto, Portugal

⁶GEIMAC (Consolidated Group 2014-1139: Group of Studies of Invariance of the Instruments of Measurement and Analysis of Change in the Social and Health Areas), Barcelona, Spain

Correspondence

Tiago Filipe Oliveira Costa, Centro Hospitalar de Vila Nova de Gaia / Espinho, Vila Nova de Gaia, Portugal.
Email: tiagofilipeoliveiracosta@gmail.com

Accessible Summary

What is known on the subject?

- Mental Health First Aid Training Programmes with a pathogenic perspective are implemented worldwide for different participants and contexts. These interventions can promote the medicalization and psychiatrization movement of human suffering.
- Training programmes should teach about mental health nursing problems rather than disorders. However, there seem to be no studies describing these healthier interventions targeting adolescents in upper secondary schools. Nurses can explore these interventions and target them towards these participants and contexts.

What the paper adds to existing knowledge?

- The perspective of nurses on the characteristics of Mental Health First Aid Training Programmes for adolescents in Portuguese upper secondary schools is reported.
- Experts recognize that the nurses who perform these interventions must have personal, pedagogical and mental health competencies. Therefore, mental health nurses may be considered. The components of mental health literacy, mental health nursing problems and a dynamic first aid plan can be taught using different classroom training strategies.

What are the implications for practice?

- The role of mental health nurses in promoting health literacy is highlighted. They have the opportunity to lead multidisciplinary teams in using these healthier training programmes.
- These expert opinions can shape the planning, implementation and evaluation of these interventions. In turn, training programmes can promote the

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identification, assistance and/or adequate and timely referral of people with mental health nursing problems.

Abstract

Introduction: Mental Health First Aid Training Programmes performed by nurses can empower adolescents to aid people with mental health problems. There do not appear to be any studies that describe these healthier interventions aimed at adolescents in upper secondary schools. The development of these educational interventions benefits from the input of their participants and facilitators.

Aim: To explore the perspective of nurses about Mental Health First Aid Training Programmes for adolescents in upper secondary schools.

Method: A qualitative, descriptive and exploratory study was conducted. Data were collected from seven mental health nurses during two focus group sessions. Data were analysed using content analysis.

Results: Twelve themes were identified around nine main areas: facilitators, intervention foci, outcomes assessment methods, process assessment methods, participants, implementation context, duration and frequency, intervention methods and strategies, and contents.

Discussion: Mental health nurses can regularly perform these classroom interventions to improve the mental health competencies of adolescents. Various educational methods can facilitate learning related to mental health literacy components, mental health nursing problems and the first aid plan. Valid and appropriate assessment methods enhance a good representation of these interventions.

Implications for Practice: This evidence can guide the creation and modelling of these first aid training programmes.

KEYWORDS

adolescent, education, first aid, mental health, nursing, qualitative research

1 | INTRODUCTION

Mental health problem is a broad term that includes both mental disorders and the symptoms of a mental disorder that do not yet justify the diagnosis of a disorder (Kitchener et al., 2017). The high prevalence of mental health problems increases the likelihood of people having contact with individuals with these problems (Morgan et al., 2018). The general public could provide first aid until they receive professional help or the crisis is resolved (Kitchener et al., 2017).

First aid provision requires people to take an active role in the health of others. In turn, citizens can become more actively involved in their personal and community health, improving their health literacy (World Health Organization [WHO], 2016). Mental health literacy comprises five components: knowledge of how to prevent mental disorders, recognition of when a disorder is developing, knowledge of help-seeking options and treatments available, knowledge of effective self-help strategies, and knowledge and skills to provide first aid and support others (Jorm, 2012). The levels of mental health literacy are low worldwide (Tay et al., 2018). For example, pioneering studies by Loureiro et al. (2013, 2015) supported this trend in

Portuguese youth. Therefore, Mental Health First Aid Training Programmes are important. These educational interventions aim to disseminate basic first aid skills in the community (Kitchener & Jorm, 2017). These programmes involve the training of individuals to aid people with mental health problems. They do not include the therapist's direct actions towards people with mental health problems and should not be confused with Crisis Interventions.

Nurses are professionals who have been reported as vital in promoting health literacy (World Health Organization [WHO], 2018). Costa et al. (2020) suggest that nurses develop these training programmes, addressing mental health nursing problems. These authors expressed three premises to support this recommendation. Firstly, existing first aid training programmes seem to respond positively to nursing foci (relevant care areas for nurses). Second, specialized training and experience in mental health, psychoeducational skills and proximity to the implementation context are characteristics of the facilitators of these interventions that can be found in mental health nurses. Finally, existing Mental Health First Aid Training Programmes in the literature mainly address pathologies. Therefore, these interventions can promote the medicalization and



psychiatrization movement of human suffering because their participants view mental health problems as disorders (DeFehr, 2016). Therefore, training programmes with a healthier perspective should be considered. For instance, the nursing diagnosis of "anxiety" can be addressed instead of the medical diagnosis of "anxiety disorder."

These interventions that address psychiatric terms and structures have been carried out for adolescents in the upper secondary schools. For example, Hart et al. (2016), Hart et al. (2020) and Guajardo et al. (2019) describe positive results of classroom-based Mental Health First Aid Training Programmes in students aged 15 to 18. In this way, these participants and contexts are suitable targets of this type of intervention. The school is identified as an appropriate context to intervene in the literacy promotion (Directorate-General for Health [DGS], 2018; McDaid, 2016). It encompasses people from a wide range of ages and with diverse economic, social and cultural characteristics. In upper secondary education, students are expected to acquire multiple factual and theoretical knowledge, cognitive and practical skills necessary to perform tasks and solve problems, assume responsibilities and adapt behaviour to circumstances (European Commission, 2018). In Portugal, upper secondary school students (10th, 11th and 12th grades) are normally aged 15 to 18 (European Commission, 2021). People aged 10 to 19 are called adolescents (Organisation for Economic Co-operation and Development [OECD] / World Health Organization [WHO], 2020). Adolescents are expected to have logical and systematic reasoning and hypothetical-deductive thinking, which enable the assimilation and accommodation of learning (Halpenny & Pettersen, 2014). During adolescence, people also reflect on the roles they are and will be playing in the world, achieving a sense of identity (Ferrer-Wreder & Kroger, 2020). Thus, this seems to be an important phase for them to incorporate the role of "first aider."

In an exploratory search, studies describing these healthier interventions for adolescents in upper secondary schools were not found. Therefore, the opportunity to develop this type of training programme for these specific participants and contexts was identified. This development process can be guided by the structure of the UK Medical Research Council (Richards & Hallberg, 2015). One of the steps includes modelling the interventions, and their potential participants and facilitators should be considered (Richards & Hallberg, 2015). Costa et al. (2021) explored adolescents' perspectives on Mental Health First Aid Training Programmes promoted by nurses in Portuguese upper secondary schools. Adolescents confirmed the relevance of these interventions and provided guidelines for their content and intervention strategies (Costa et al., 2021). However, it is still necessary to explore the perspective of the potential facilitators (nurses).

2 | AIM AND RESEARCH QUESTION

This study aims to explore the perspective of nurses about Mental Health First Aid Training Programmes for adolescents in Portuguese upper secondary schools. The research question is "What is the

opinion of nurses about the characteristics of Mental Health First Aid Training Programmes for adolescents in upper secondary schools?". The characteristics of intervention include their facilitators, foci, outcomes and process assessment methods, participants and specific implementation context, duration and frequency, intervention methods and strategies, and contents.

3 | METHODS

3.1 | Design

We carried out a qualitative, descriptive and exploratory study. The study report was guided by the *Consolidated criteria for reporting qualitative research (COREQ) checklist* (Tong et al., 2007).

3.2 | Selection of participants

Participants were mental health nurses with work developed in mental health literacy with adolescents aged 15 to 18 and in the Portuguese school context. Mental health nurses have been described by Costa et al. (2020) as nurses who should preferably perform these interventions. In addition, expertise in the research topic may be reflected in more thoughtful and appropriate opinions about the topic.

Participants were selected using a non-probabilistic, intentional sampling method. In this way, people with particular characteristics and the potential to provide rich, relevant and diverse data on the subject under study were involved (Robinson, 2014). The researchers discussed the potential participants and their expertise, mainly considering their productivity and the quality of their work (Caley et al., 2013). No relationship with the participants had been established before the beginning of the study.

The size of the expert panel usually varies from four to twelve, with the ideal number of participants being five to eight (Krueger & Casey, 2015). Due to the lack of guarantee of the attendance of potential participants, Nyumba et al. (2018) recommend over-recruiting 10–25%. Therefore, ten potential experts were invited, eight confirmed their presence, and seven finally participated. The potential participants who declined the invitation and those who withdrew from the study indicated personal reasons to justify their decisions.

Potential participants were invited, via e-mail, to participate in the study voluntarily and without any compensation. They were asked to fill out (online) an informed consent, a sociodemographic characterization form and a survey of availability to meet. Then, focus group sessions were scheduled.

3.3 | Data collection

Focus groups were held. This technique is based on the notion that group interaction encourages respondents to explore and clarify

TABLE 1 Themes obtained from content analysis

Content Areas	Themes obtained
Intervention Facilitators	Theme 1: Mental health nurses with co-dynamization of other professionals
Intervention Foci	Theme 2: Mental health competence
Outcomes assessment methods	Theme 3: Longitudinal evaluation with validated instruments based on knowledge in the nursing field
Process assessment methods	Theme 4: Valid and adapted assessment of satisfaction for each training session
Participants	Theme 5: Implementation for classes with a nursing diagnosis, availability and willingness to learn
Specific implementation context	Theme 6: Classroom implementation during school time
Duration and frequency	Theme 7: Regular sessions depending on school availability
Intervention methods and strategies	Theme 8: Mixture of different training strategies and educational resources Theme 9: Awareness sessions for the school community
Contents	Theme 10: Components of mental health literacy Theme 11: Mental health nursing problems Theme 12: Dynamic mental health first aid plan

individual and shared perspectives (Morgan, 1997). Data were collected in the native language of the researchers and study participants (European Portuguese).

The interview guide was developed in response to the objective of the study and the research questions (Kallio et al., 2016). The interview guide was pretested by applying it to three mental health nurses. The nurses reported that the interview guide was understandable, clear, unambiguous, well-structured, without bias and did not need any changes. Supporting information S1 includes the interview guide used.

In July 2021, the first author conducted two focus group sessions, and the second author supervised them. These took place by videoconference (using the Zoom platform), allowing easier, more flexible and safer access to experts from different parts of Portugal. Each meeting lasted approximately two hours. Audio and video recording of the experts' meetings were carried out to promote reliable reporting of the content discussed. The recordings were transcribed immediately after the meetings. The transcripts were returned to the participants for comments and/or corrections.

The characteristics of this type of intervention were discussed until participants did not produce new information and a clear pattern of responses was reached. Therefore, data saturation was obtained (Saunders et al., 2018).

3.4 | Data analysis

The collected data were subjected to content analysis (Graneheim & Lundman, 2004; Graneheim et al., 2017). Thus, the transcriptions of the recordings were considered units of analysis. The text under analysis was classified deductively in the following content areas: facilitators, intervention foci, outcomes and process assessment methods, participants and specific implementation context, duration and frequency, intervention methods and strategies, and contents of training programmes. The content analysis was performed by the first author and verified by the other authors. There were no disagreements in the process, and no software was used.

Firstly, the text under analysis was read several times to get a sense of the whole. Then, the text was divided into meaning units.

In turn, the meaning units were condensed and labelled with a code. The various codes were compared based on their differences/similarities and classified into subcategories and categories. Finally, the underlying meanings of the categories formed subthemes and themes at an interpretive level. The participants provided positive feedback on the results.

3.5 | Ethical considerations

In the present study, all ethical assumptions in the Declaration of Helsinki (World Medical Association, 1964) and the Oviedo Convention (Resolution of the Assembly of the Republic No (2001) No. 1/2001) for research with human beings were fulfilled. The ethics committee of the University of Barcelona approved the research proposal to carry out the study (Institutional Review Board: IRB00003099).

Informed consent was obtained from all participants. They were notified of the right to voluntarily participate and withdraw from the study at any time without penalty. Moreover, they were advised of the right to access, rectify, limit processing and delete their data.

Each expert's data were coded with the letter E and a number to preserve confidentiality. Furthermore, the data were stored in a computer and external disc (with login credentials) used exclusively for this study.

4 | RESULTS

Seven experts participated in the focus group sessions. Most mental health nurses were female and had children (86%). They were aged 36 to 56 years old (mean: 45.29, SD: 6.97). In addition, 86% of participants were married or in non-marital partnership, and 14% were divorced or separated. Participants had different academic degrees (29% Licentiate, 29% Master and 43% Doctorate). Most participants performed more than one role in nursing (86%). They played roles in care provision (71%), management (14%), education (86%) and research (71%). Participants were nurses in different regions of Portugal (43% in the North, 43% in the Centre and 14% in the

South). Their experience as non-specialized nurses ranged between 5 and 14 years (mean: 10.14, SD: 3.72) and as mental health nurses between 6 and 23 years (mean: 13.29, SD: 6.40).

Twelve themes were identified in response to the research questions (Table 1). The codes and categories that support each theme can be found in Supporting information S2.

4.1 | Intervention facilitators

According to the experts, these training programmes are likely to be carried out by "Mental health nurses with co-dynamization of other professionals." They reported different characteristics that nurses who implement the intervention must have (Figure 1). The profile described can be found in mental health nurses.

Although a facilitator can perform the intervention, the experts valued the co-dynamization of the intervention. E2 declared that "It is important to have co-facilitators because they support the implementation and evaluation of interventions." Therefore, they recommended the inclusion of professionals with different training (health professionals from different disciplines and specialities, education professionals) and from distinct contexts (primary and hospital care).

4.2 | Intervention foci

Experts expressed that these training programmes can respond to nursing foci related to mental health competencies (Figure 2).

4.3 | Outcomes assessment methods

The "Longitudinal evaluation with validated instruments based on knowledge in the nursing field" was shown to be important. Experts indicated that this longitudinal assessment should occur before the intervention, at the end and at the follow-up "with a

timing to be decided" (E4). In this measurement of outcomes, they suggested the use of validated assessment instruments. Among the instruments validated for the Portuguese population, the following were listed: the QuALiSMental (Loureiro, 2015), the MentaHLiS (Rosa et al., 2016) and the Mental Health Literacy Scale (Loureiro, 2018). Recognizing that these assessment instruments have a pathogenic perspective of mental health literacy, the development of valid instruments based on indicators of the Nursing Outcomes Classification (NOC) (Moorhead et al., 2018) was proposed.

4.4 | Process assessment methods

The experts recommended a "Valid and adapted assessment of satisfaction for each training session." The session assessment may involve observing participants' behaviours (e.g. use of observation grids/scales, homework monitoring) and a verbal evaluation (e.g. use of Likert questions and scales, assignment of defining expressions). E3 indicated that "validated assessment instruments of training satisfaction could be searched." More visual strategies should be considered. For example, E6 suggested, "emojis to classify the session."

4.5 | Participants

The intervention must have an "Implementation for classes with a nursing diagnosis, availability and willingness to learn." Experts expressed the importance of intervening for classes (up to 30 students) without excluding participants from the target population. However, they considered necessary the existence of nursing diagnoses that justify the intervention and willingness and availability to learn in training programmes. For example, E3 stated, "There must be areas to work on, diagnoses related to (mental health) competencies." They also stressed that special attention must be paid to participants with physical, mental and social health problems.

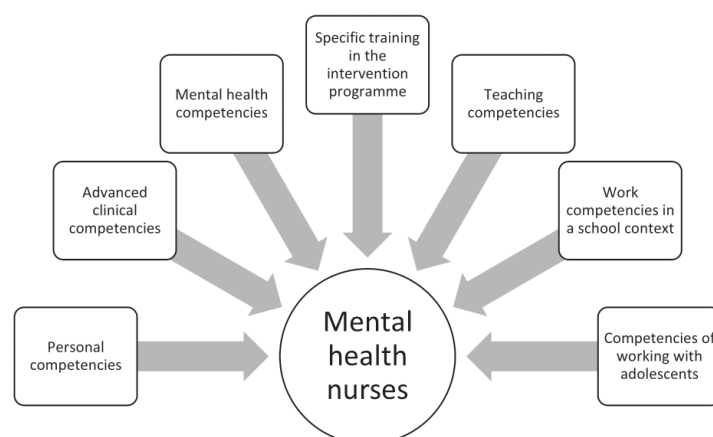


FIGURE 1 Characteristics of nurses who perform these interventions

4.6 | Specific implementation context

These training programmes must have a "Classroom implementation during school time." Several experts suggested the classroom as an implementation context. Due to the risk of infection (e.g. COVID-19), E1 stressed the importance of performing the intervention in large rooms. E1 also hypothesized that "it may be advantageous to do (the intervention) outdoors," but recognizes that "there will be many distractions." The students' usual academic period was recommended to carry out the intervention. E3 explained that "When it is included in school hours, we have more or less facilitated participation right from the start."

4.7 | Duration and frequency

According to the experts, these interventions should have "Regular sessions depending on school availability." When carrying out the interventions in school time, E1 mentioned that the frequency of sessions should be adjusted to the length of the academic year. In turn, E1 and E7 highlighted the importance of negotiating the duration and frequency of the intervention, considering the availability of teachers and schools. Experts expressed that the duration of each session should be adjusted to the duration of the class (usually 45–90 minutes). E3 suggested, "we can create flexible plans from 45 to 90 minutes." In addition, they proposed a break between sessions up to one week and the implementation of reinforcement/consultation sessions. E3 indicated that "(follow-up) evaluation moments can be clustered in the reinforcement sessions."

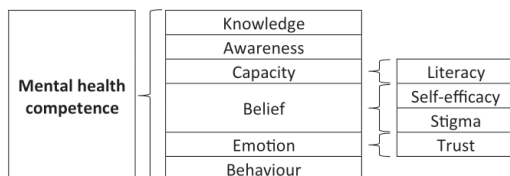


FIGURE 2 Intervention foci described by experts

Mental Health Literacy Components	Contents
Knowledge of effective self-help strategies	• Concept of health and mental health • Coping strategies
Knowledge of how to prevent mental disorders	• Risk and protective factors for mental health problems • Model by Dahlgren and Whitehead (1991)
Recognition of when a disorder is developing	• Mental problems and disorders • Experience of mental problems and stigma
Knowledge and skills to give first aid and support to others	• First aider role • Actions to aid others
Knowledge of help-seeking options and treatments available	• Help resources available, access and referral for help • Facilitating factors and barriers for seeking help

4.8 | Intervention methods and strategies

This type of intervention should use a "Mixture of different training strategies and educational resources." Experts recommended the use of expository, demonstrative, participatory strategies (such as quizzes, sharing and discussions), experimental learning methods (such as games, role-plays and homework) and contact-based education strategies (testimonials from reference persons). They highlighted the use of more active strategies, and E4 justified, "We must use many active methodologies especially because we are talking about first aid, of applying in practice knowledge that allows us to help others in a specific situation of suffering." They also stated that it is important to use educational materials, audiovisual resources (such as videos, movies and music) and technologies (such as computers and mobile phones, the Internet and websites).

In addition, "Awareness sessions for the school community" should be considered. Although the training target is adolescents, experts suggested clarification and awareness sessions on the subject for parents, teachers and non-teaching staff.

4.9 | Contents

Experts described the "Components of mental health literacy" as topics to be addressed in training programmes. The contents suggested by the experts are summarized in Table 2.

They emphasized the importance of addressing "Mental health nursing problems." The problems described were cognitive, emotional, behavioural and relational (Table 3).

The "dynamic mental health first aid plan" was exposed as an important content to be considered. E4 explains that "It is a key principle that the action plan is dynamic and that the order of steps can be changed depending on who we have in front of us." The aid actions to be taught are listed in Table 4.

Therefore, internal and external resources of people with mental health problems can be mobilized in this process. Self-help strategies that experts have indicated include healthy lifestyles (e.g. establishing routines, leisure activities). Help from family, social network (e.g. friends, colleagues), school (teaching and non-teaching staff), local

TABLE 2 General contents of training programmes described by experts

TABLE 3 Mental health problems to be addressed in training programmes, according to experts

Type of Problems	Problems Listed
Cognitive problems	Hallucination, Impaired thinking, Delirium, Suicidal ideation, Confusion, Negative self-image, Disturbed personal identity, Impaired concentration, Impaired attention
Emotional problems	Anxiety, Nervousness, Sadness, Depressed mood, Grief, Loneliness, Fear, Stress, Fatigue, Exhaustion, Distress, Despair, Jealousy, Guilt, Frustration, Insecurity, Envy, Anger, Powerlessness, Suffering, Shame, Euphoria, Lack of hope, Lack of trust, Lack of pride, Lack of pleasure
Behavioural problems	Self-care deficit, Impaired sleep, Impaired eating behaviour, Impaired eating behaviour [Anorexia], Bulimia, Compulsive eating behaviour, Compulsive behaviour, Impaired exercise behaviour, Substance abuse, [Video game] abuse, [Internet] abuse, Aggressive behaviour, Violence, Self-destructive behaviour, Self-mutilation, Attempted Suicide, Disorganized Behaviour
Relational problems	Impaired Communicating Act, Impaired Socialization

TABLE 4 Mental health first aid actions described by experts

General action plan	Specific actions
Approach the person and assess the situation	Introduce yourself; Explain the purpose of the aider's presence; Ensure confidentiality; Provide presence; Be present; Provide help; Actively listening with an expression of interest, respect, understanding and without judgement; Assess the person's cultural background; Observe behaviour; Coordinate behaviour with the person being helped; Physically approach the person, ensuring their own safety; Accompany the person to a quiet, safe, comfortable place that allows privacy; Ask about the situation; Ask about the problem, causes, aggravating and mitigating factors, and consequences
Assist and encourage the person to use self-help strategies	Assist in identifying the mental health problem; Inform about the mental health problem; Assist in identifying adaptive strategies; Encourage the use of adaptive strategies; Praise adaptive strategies already in use; Encourage abandonment of maladaptive strategies
Assist and encourage the person to seek formal and informal help	Assist in the seeking for informal and formal help; Inform about the role of help resources; Accompany in the seeking for informal and formal help; Asking for help in an extreme situation; Encourage the seeking for informal and formal help
Take care of oneself first (aider)	Use adaptive self-help strategies

health services (doctors, psychologists, nurses, self-help/mutual aid groups) and distance health services (telephone helplines, virtual therapies) were highlighted.

5 | DISCUSSION

This study aimed to explore nurses' perspectives on Mental Health First Aid Training Programmes for adolescents in Portuguese upper secondary schools. Our results expressed the characteristics of the facilitators and participants of these interventions. The experts listed intervention foci and evaluation methods that should be considered in training programmes. They identified the specific implementation context, duration and frequency of sessions. In addition, they gave their views on intervention methods and contents of training programmes.

Experts described the competencies of nurses who perform these interventions. They can be found in mental health nurses (International Council of Nurses [ICN], 2009; Regulation No, 2018. 515/2018). The Ordem dos Enfermeiros declares that a mental health nurse "has a high level of knowledge and self-awareness" and "provides psychoeducational care (...), mobilising the context and dynamics of individuals, families, groups or communities" (Regulation No, 2018 515/2018, pp. 21427). Nurses with other specialities (e.g. community health, paediatrics) have some of the competencies described (International Council of Nurses [ICN], 2009). Therefore, they can be considered in the co-dynamization of these interventions. The existence of co-facilitators in training programmes was valued in this study. Professionals from other disciplines (e.g. psychiatrists, psychologists, teachers) and contexts can also be included as they are important professionals in the intervention of mental health problems (Kitchener et al., 2017).

The intervention foci expressed by the experts were related to mental health competence. According to Salman et al. (2020), competence can be improved with training and involves knowledge, skill, attitude, performance and task execution. Experts recommended an evaluation of interventions over time with valid and appropriate methods. Longitudinal evaluation of the results allows us to understand the effectiveness and usefulness of the intervention (Richards & Hallberg, 2015). Outcome assessment instruments with a non-medicalized perspective of mental health literacy are needed to accompany these training programmes (Costa et al., 2020). Indicators of the Nursing Outcomes Classification (NOC) can be developed and used to assess the outcomes of an intervention promoted by nurses (Sampaio et al., 2017). Alternatively, another consensus among nurses can be considered. The assessment of satisfaction in each session allows identifying aspects to be improved in the intervention (Richards & Hallberg, 2015). The validity of the assessment instruments used is fundamental as it reflects the degree to which an instrument measures the construct it intends to measure (Mokkink et al., 2010).

This study highlighted the implementation of training programmes for classes with a nursing diagnosis, availability and willingness to learn. In schools, students are usually organized into classes. If a class is already well consolidated, it may already find itself in a phase of "work and productivity" (Åkerlund et al., 2021). Therefore, implementing training programmes in these pre-existing groups can enhance learning. Moreover, the interventions performed by nurses require participants to have nursing diagnoses (International Council of Nurses [ICN], 2008). Nursing diagnoses are labels assigned to patients by nurses, in which outcomes are sought (International Council of Nurses [ICN], 2008). Motivation has also been described as a key factor for learning (Grossman & Salas, 2011).

Experts recognized that interventions should be implemented in the classroom during school time. The classroom is a controlled setting with more limited stimuli (Guajardo et al., 2019; Hart et al., 2016, 2020). Health interventions could be carried out at school times or during rest periods. School times are predetermined periods for learning and curricular activities (Normative Order No. 2018 10-B/2018). Therefore, adherence to health training programmes can be promoted using regular teaching hours. Experts indicated that the implementation of interventions depends on the availability of schools. Flexible schedules can facilitate the implementation of interventions in different contexts (Mendenhall & Jackson, 2013). Moreover, breaks between sessions and/or supplementary meetings allow the participants to recognize and apply concepts in their daily lives and review their experiences in repeated contact with the facilitators.

According to the experts, different training strategies and educational resources can be used. Landøy et al. (2020) explain that the choice of teaching methods should be made, considering the training objectives, the skills of trainees and trainers and the information content to be mastered. These authors express that all teaching methods have advantages and disadvantages. Therefore, mixing methods can take advantage of each of them. Portuguese adolescents also

expressed a preference for face-to-face interventions and improved learning through various training strategies (Costa et al., 2021).

Moreover, the experts suggested the involvement and awareness of the entire school community about mental health issues. Schools, families and community environments play key roles in adolescents' learning (Spier et al., 2018). In the study by Costa et al. (2021), the adolescents agreed on the importance of raising awareness in the school community.

According to the experts, the training programmes should address the different components of mental health literacy described by Jorm (2012). They highlighted mental health nursing problems (cognitive, emotional, behavioural and relational). The listed problems can be found in nursing classifications, such as the International Classification for Nursing Practice (International Council of Nurses [ICN], 2019) and NANDA International (Herdman et al., 2021). Nurses can teach the community about their autonomous areas of intervention. Finally, the first aid behaviours proposed by the experts represent the action plan reported by Costa et al. (2020). As a result of a broad synthesis of evidence, this action plan can respond to different mental health problems. A dynamic action plan (e.g. with actions of flexible frequency and order) may be adequate considering that the people to be helped may find themselves in very different situations. For example, in the presence of a person with a mental health problem that manifests dysfunction, a first aider can assist in voluntarily seeking professional help. The same aider may need to ask for professional help for a person, without their consent, when identifying potential risk of harm to the person or third parties (Law No. 1998 36/1998). It should be noted that the perspective of experts about the contents of training programmes is in line with the opinion of Portuguese adolescents (Costa et al., 2021).

5.1 | Limitations

The results are not generalizable, as the sampling was non-probabilistic. Furthermore, the characteristics of the intervention facilitators were similar to those of the mental health nurses. However, the value of this finding can be considered limited, as the experts were mental health nurses.

6 | IMPLICATIONS FOR PRACTICE

This study provides an exploratory view of the perspective of nurses about Mental Health First Aid Training Programmes for adolescents in Portuguese upper secondary schools. Mental health nurses were recognized as preferred facilitators of interventions. Thus, the potential autonomous role of the mental health nurse in the education of populations was emphasized. This evidence can sensitize and encourage mental health nurses to lead multidisciplinary teams in planning, implementing and evaluating these interventions. Nursing education curricula should enable mental health nurses to



implement training programmes consistently. In addition, all "non-mental health" nurses can be made aware of this intervention, as they can assist in carrying it out or even participate in helping people with mental health problems.

This report provides recommendations that can contribute to the development of this type of intervention. However, the development of a valid training programme requires broad consensus on its characteristics. For instance, statements regarding the opinions of adolescents and nurses (participants and facilitators of the intervention respectively) can be submitted to Delphi studies. The perspective of potential co-facilitators of these training programmes can also be explored. Professionals from different specialities and disciplines should have the opportunity to express their role / contribution to the implementation of this type of training programmes led by mental health nurses. In addition, the lack of instruments valid to assess these healthier interventions was reported. The identification of assessment instruments requires literature reviews. If necessary, the construction of assessment tools and/or the development of studies regarding their psychometric properties and cultural adaptations should be considered.

The body of knowledge in nursing was highlighted, as training programmes can address mental health nursing problems. In this way, the participants learn to identify, assist and/or refer people with mental health problems in an adequate and timely manner, without any mistaken attribution of "medical labels." This approach can be a direction for improving populations' mental health literacy and combating the psychiatrization of human suffering.

7 | CONCLUSIONS

Mental health nurses discussed multiple characteristics of Mental Health First Aid Training Programmes for adolescents in Portuguese upper secondary schools. They considered that these interventions could focus on the mental health competencies of students and classes. Valid and longitudinal evaluations of interventions allow representing their processes and outcomes. In regular sessions, different training strategies and educational resources can be used to teach adolescents to help people with mental health nursing problems. A more active role in mental health issues can be promoted at school.

8 | RELEVANCE STATEMENT

Nurses play an important role in educating communities about mental health issues. They can promote Mental Health First Aid Training Programmes in upper secondary schools, enabling adolescents to help people with mental health problems. This paper gave voice to mental health nurses and shared their views on the topic. They expressed that a mix of educational methods should be used in the classroom to address the components of mental health literacy, various mental health nursing problems and a first aid plan. Longitudinal

evaluation of interventions requires appropriate instruments. The experts' recommendations can facilitate the development of autonomous interventions in this area.

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AUTHOR CONTRIBUTION

All authors made substantial contributions to the conception and design of the work. The first two authors contributed to acquisition, analysis and interpretation of data and drafting the work. All authors critically reviewed the intellectual content, approved the final version to be published and agreed to account for all aspects of the work.

ETHICS STATEMENT

This study is part of a project that received ethics approval from the Bioethics Committee of the University of Barcelona (Institutional Review Board: IRB00003099).

DATA AVAILABILITY STATEMENT

The data sets generated and/or analysed during the current study are not publicly available due to ethical considerations, but are available from the corresponding author on reasonable request.

ORCID

Tiago Filipe Oliveira Costa <https://orcid.org/0000-0002-6379-7390>

Francisco Miguel Correia Sampaio <https://orcid.org/0000-0002-9245-256X>

Carlos Alberto da Cruz Sequeira <https://orcid.org/0000-0002-5620-3478>

Maria Teresa Lluch Canut <https://orcid.org/0000-0002-2064-8811>

Antonio Rafael Moreno Poyato <https://orcid.org/0000-0002-5700-4315>

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SUPPORTING INFORMATION

Additional supporting information may be found in the online version of the article at the publisher's website.

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5.3. Article 3: Nurses' promotion of Mental Health First Aid Training Programmes for upper secondary students: a modified Delphi approach

The third article provided valid consensus on the characteristics of training programmes (Costa et al., 2023). Expert opinion was obtained on 59 statements (55 represented the ideas of previous studies and 4 were suggestions from this panel of experts). 58 out of 59 statements reached the previously defined level of consensus. Considering impaired sexual behaviour as a content of training programmes has raised differences of opinion. Some experts considered it important to promote competencies to act on this problem due to its relevance to participants. In contrast, others indicated that it was inappropriate learning for adolescents.

The article was published open access in BMC Nursing. Details about the manuscript are summarised in Table 3.

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RESEARCH

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Nurses' promotion of Mental Health First Aid Training Programmes for upper secondary students: a modified Delphi approach

Tiago Filipe Oliveira Costa^{1,2,3,4*}, Antonio Rafael Moreno Poyato¹, Francisco Miguel Correia Sampaio^{4,5},
Mária Teresa Lluch Canut^{1,6} and Carlos Alberto da Cruz Sequeira^{4,5}

Abstract

Background Mental Health First Aid Training Programmes can be carried out by nurses in schools. Adolescents have reported the importance of these interventions, the contents to be addressed, and intervention strategies that should be used. Mental health nurses have also discussed the characteristics of these training programmes. This study sought to create a consensus on the features of Mental Health First Aid Training Programmes promoted by nurses aimed at upper secondary students.

Methods A descriptive mixed method study was developed using the modified e-Delphi technique. Original statements on the topic were drawn from the results section of previous studies with nurses and adolescents. The statements were included in a structured online questionnaire. An expert panel of 78 mental health nurses participated in the two-rounds online survey from October to December 2021. Absolute and relative frequencies of responses were analysed. The experts' comments were also considered.

Results In the first round, experts suggested 4 new ideas about training programmes. Experts took a position on a total of 59 declarations. At least 75% of participants agreed with 58 statements about training programmes, namely about facilitators, intervention foci, evaluation methodology, participants, the implementation context, period and regularity, intervention strategies and content. The experts' opinions differed only in one statement that expressed the impaired sexual behaviour as a mental health problem to be addressed in the training programmes.

Conclusions Mental health nurses can lead the delivery of training programmes in upper secondary schools, improving adolescent competencies in mental health. Several educational approaches can be used to teach about mental health, related problems and actions underlying these conditions. Valid and appropriate assessment methods must be used. Our findings guide the planning, implementation and evaluation of these interventions in upper secondary schools and encourage nurses to explore these programmes and include them in their educational curricula.

Keywords Adolescent, Delphi technique, Education, First Aid, Mental Health, Nursing, Schools

*Correspondence:
Tiago Filipe Oliveira Costa
tiagofilipeoliveiracosta@gmail.com

Full list of author information is available at the end of the article



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Background

The prevalence of mental health problems has increased over time. In 1990, approximately 655 million people worldwide were living with a mental disorder and, in 2019, the prevalence was already 970 million people [1]. In this way, the general public is increasingly closer to individuals with mental health problems and has the opportunity to provide first aid. This initial help is usually given by someone from the social network of the person with mental health problems (such as friends and family) and not by mental health professionals. Initial support given to a person with a mental health problem (until professional help arrives or the situation is resolved) can be called Mental Health First Aid [2]. Supporting the use of relaxation strategies and assisting in seeking a mental health nurse are examples of mental health first aid behaviours. According to Wong et al., the suggestion of members of the social network makes individuals with mental health problems more likely to seek professional help [3].

Citizens need to be actively involved in the health of others when providing first aid. The World Health Organization expresses that improving health literacy can promote citizens' involvement in individual and community health actions [4]. The concept of health literacy comprises the cognitive and social skills needed to access, understand and use the information to promote and maintain good health [5]. Mental health literacy involves knowing strategies to promote positive mental health and how to prevent mental disorders, recognizing mental disorders and the associated stigma, efficacy in seeking help resources and knowing how to provide first aid and support to others [6]. Thus, promoting mental health first aid skills is one way of intervening in fostering mental health literacy [7]. According to Tay et al., low levels of mental health literacy have been reported worldwide [8]. Therefore, Mental Health First Aid Training Programmes are very relevant. These specific interventions aim to empower individuals with basic skills to provide first aid to people with mental health problems [2]. These training programmes value their participants as an informal resource for help.

Several studies have described various interventions with the concept of "Mental Health First Aid Training Programmes". Costa et al. identified these interventions and their features, participants and implementation contexts. These authors expressed that Mental Health First Aid Training Programmes can target upper secondary students [9]. For example, Hart et al. reported positive outcomes from the classroom implementation of these educational interventions for adolescents aged 15 to 18 years [10].

School is a privileged environment to promote health literacy because it accommodates people from diverse

social backgrounds. School interventions are associated with greater cost-effectiveness and positive health outcomes for populations [11]. Regarding Portugal, upper secondary education (level 3 of the International Standard Classification of Education) is universal, compulsory and free. During this educational phase, students must acquire comprehensive knowledge and skills to respond, adapt to situations, and assume responsibilities [12]. Therefore, these school goals overlap with those of Mental Health First Aid Training Programmes.

Portuguese secondary students are generally 15 to 18 years old [12]. Adolescents are expected to achieve hypothetical-deductive, logical and systematic thinking [13]. This achievement allows them to assimilate and accommodate learning. In addition, they are expected to acquire a sense of identity from reflecting on their current and future role in the world [14]. Therefore, this can be a sensitive time for them to incorporate the role of "the first aider".

The existing literature shows that most Mental Health First Aid Training Programmes address disorders [9]. Such interventions may induce participants to view mental health problems as disorders, promoting the medicalisation and psychiatrisation movement of human suffering [15]. DeFehr indicates that a mental disorder diagnosis is considered by many to be useful and validating, but it can also cause serious harm, such as stigma or stereotype [16]. Therefore, using medical labels to refer to mental health problems in the context of Mental Health First Aid Training Programmes seems inadequate. Alternatively, Costa et al. suggest that mental health nurses develop Mental Health First Aid Training Programmes centred on mental health problems that represent nursing diagnoses (such as anxiety, hallucinations, and substance abuse) [9]. Nursing diagnoses describe human responses to actual or potential health problems and life processes [17]. A nursing diagnosis is a label assigned by a nurse to a decision about a phenomenon that is an area of nursing intervention [18]. These labels are expressed in taxonomies such as the NANDA International's Nursing Diagnoses and International Classification for Nursing Practice (ICNP) [17, 18]. In contrast, medical diagnoses represent diseases or medical conditions with specific symptoms and signs. These are expressed by terms defined in taxonomies such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD) [19, 20].

In Portugal, school health interventions are carried out by school health teams. These teams are action-oriented in different areas, such as mental health and first aid [21]. The Ordem dos Enfermeiros (the association that regulates the nursing profession in Portugal) recommended the existence of mental health nurses in the context of primary health care [22]. Thus, school health

teams are often made up of mental health nurses. Mental health nurses can lead these healthier interventions (not focused on disorders) for adolescents in upper secondary schools. In turn, adolescents can play the role of “first aiders” (people who help others with problems). However, these healthier interventions for upper secondary school students were not found in the literature. Thus, Costa et al. explored the perspective of the target population (adolescent students) and experts (mental health nurses experienced in mental health literacy, working with adolescents aged 15 to 18 years, and within a school environment) on the features of Mental Health First Aid Training Programmes [23, 24]. The opinions of potential facilitators and targets of the intervention were different. For example, adolescents identified some mental health problems that could be addressed in the training programme, such as ambivalence, obsession, impaired sexual behaviour and social isolation [23]. Mental health nurses highlighted other specific problems such as frustration, self-care deficit and impaired communicating act [24]. Thus, it is important to have an expert judgment that considers the ideas of adolescents. In addition, the studies have small samples (12 adolescents and 7 mental health nurses). These participants interacted with each other, influencing their personal opinions. Obtaining judgments from a wider, heterogeneous and quasi-anonymised sample of experts may allow greater validity and reliability in opinions about these training programmes [25]. More valid and reliable views can increase the consistency of interventions’ planning, implementation and evaluation. Therefore, this study has sought to establish a consensus (content validity) on the characteristics of Mental Health First Aid Training Programmes promoted by mental health nurses and aimed at adolescents in Portuguese upper secondary schools. Training programmes’ characteristics include aspects of facilitators, foci of intervention, methodology for assessing the produced outcomes and process, participants, the specific context of implementation, duration and frequency, intervention strategies, and content. Guided by the structure of the UK Medical Research Council for the development and evaluation of complex interventions [26], this work contributes to the modelling of this type of intervention.

Methods

Design

The research question was: “What features of these interventions are consensual among experts?” A descriptive mixed method study was developed using the modified e-Delphi technique [25]. On the one hand, the technique was considered “modified” because the ideas on the topic were obtained from qualitative studies previously carried out with the target population and experts [23, 24]. On the other hand, the technique was deemed “e-Delphi”

because the questionnaires run online. This option was taken as it is more convenient for researchers and participants, more economical and easier to manage the data. We consider that the existence of a quantitative component in the study guarantees an objective judgment regarding the characteristics of the intervention. The qualitative component of the study allows for a deeper and more consistent view of the topic. The study was reported following the Recommendations for the Conducting and Reporting of Delphi Studies (CREDES) [27].

Participants

A non-probabilistic purposive sampling permitted the selection of participants. Experts who fit the following criteria were chosen: to be a Portuguese mental health nurse; to have work experience in mental health literacy (identification of educational needs in mental health, planning, implementation or evaluation of mental health training programmes) with adolescents aged 15 to 18 (direct provision of any nursing care to this population) and/or in a school context (intervention in public or private schools and underlying community); to express willingness and availability to participate in the study.

Costa et al. have described mental health nurses as the most suitable to implement these interventions [8, 24]. Moreover, expertise in this area is likely to produce more pondered and appropriate opinions about the topic. Potential experts were identified by searching the topic in search engines, databases, scientific repositories, books and conference programmes and by analysing the researchers’ contact lists. In addition, the researchers subjectively analysed the expertise of potential participants, considering the quality of work performed and productivity.

An e-mail was sent to the potential participants inviting them to participate in the study. They were asked to complete an online informed consent and a sociodemographic characterization form. The sample size was designed to balance the ability to generate a definitive conclusion and the difficulty of managing a larger panel [25]. Seventy-eight participants were recruited.

Data collection

An online structured questionnaire was developed, taking into account the objective of the study (see Additional file 1). The ideas generated in the studies by Costa et al. [23, 24] were listed and compared. Based on these ideas, the researchers created several statements on the topic (see Fig. 1).

The statements were associated with a 5-point Likert agreement scale (1 - Strongly disagree; 2 - Disagree; 3 - Neither agree nor disagree; 4 - Agree; 5 - Strongly agree). The questionnaire also included an open response space, enabling the suggestion of new ideas and the justification

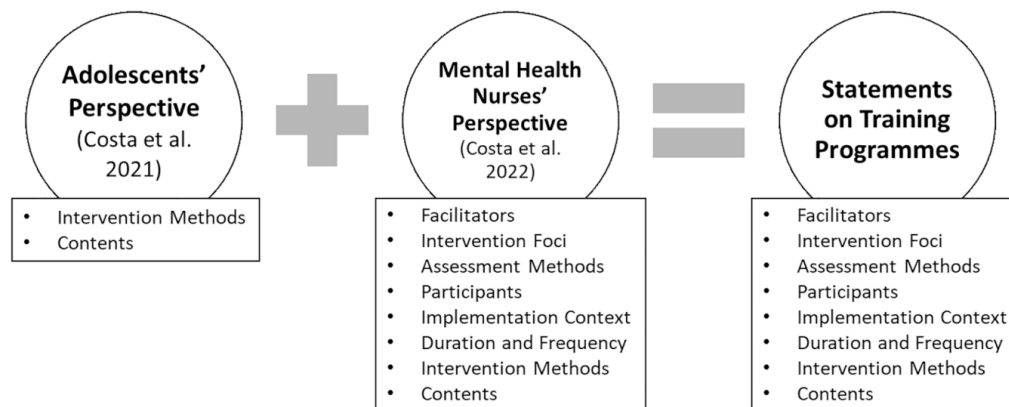


Fig. 1 Process followed to create the statements on training programmes

of the answers. The questionnaire was pre-tested. The following pre-test questions were asked: "Is the language used in the questions understandable?", "Is the meaning of the questions clear and unambiguous?", "Does each question focus on a single topic?", "Do the questions reflect any bias or "induce" the answers?", "Is the form of the questions adequate?". Ten nurses meeting the inclusion criteria completed the questionnaire and reported that it was intelligible and without bias, and no changes were necessary. These ten people were further considered to participate in the following stages of the study.

The questionnaire (see Additional file 1) was sent to the expert panel to fill out. After the first round of responses, a statistical summary of the group's options (relative frequency of responses) was made available to the experts to consider their individual responses [25]. Then, the questionnaire was revised (see Additional file 2). A second-round questionnaire was produced that included only non-consensual statements and new ideas suggested by the experts in the first round. The frequencies of responses from the first round were appended (when applicable) to each response option in the new questionnaire to facilitate their consideration. After sending and completing the revised questionnaire, a new statistical summary was made available to the participants.

The data collection took place in two response rounds from 12 October to 14 December 2021. The number of response rounds was not defined a priori. One closed round of responses would have been enough if there had been early consensus on all statements and no new ideas had been suggested. Two closed rounds of responses are common practice in the literature because it allows the participants to review their individual opinions while maintaining a high response rate [25]. More than two closed response rounds could have been carried out,

but response rates could have decreased. A minimum of a 70% response rate for each round was established to maintain the study's rigour [25].

Data analysis

A consensus level of at least 75% was determined a priori [25, 28]. The consensus among experts was considered positive when at least 75% of the responses were classified as 4 or 5 on the Likert scale. There was a negative consensus among experts when at least 75% of the responses were classified as 1 or 2 on the Likert scale. Therefore, the absolute and relative frequencies of the responses were analysed using IBM SPSS Statistics 27 software.

Any statement for which consensus was reached was withdrawn from the next round. This decision was taken because the initial number of statements in the questionnaire was very large. In this way, the questionnaires became shorter as the rounds went on, and the risk of losing expert panel members was reduced [25]. Whenever an open response emerged from the participants, the researchers discussed whether the idea was new or redundant. When a new idea was identified, the researchers wrote a new statement and included it in the questionnaire for the next round.

Whenever consensus was not reached on a sentence, it was submitted to another round. The justifications for the expert opinion were considered whenever consensus was not reached in two consecutive rounds. A content analysis of the justifications of the experts' options was performed [29, 30]. Units of meaning (set of words with the same central meaning) were identified. They were subjected to a condensation process (text shortening with core preservation). Each unit of meaning was assigned a label (code). In turn, the codes with similarities were grouped and classified into categories (groups

of internally homogeneous and externally heterogeneous content). Finally, the categories' meanings and relationships were interpreted, and themes were formed [29]. No software was used for content analysis. The first author conducted this analysis with the supervision of the others.

Ethical considerations

The Declaration of Helsinki and the Oviedo Convention for research with human beings were followed throughout the study [31, 32]. The ethics committee of the University of Barcelona (Institutional Review Board: IRB00003099) approved the study.

The participants completed informed consent and took part in the study voluntarily and without compensation. They were informed of the right to withdraw without penalty and access, rectify, limit processing, and delete their data.

The data from each expert was coded with the letter E followed by a number. This coding prevented the attribution of responses to the expert panel members. This way, quasi-anonymity was fulfilled [25], and social pressure and the conformity of responses with a dominant view were avoided.

Validity, reliability and rigour

The iterative process of the Delphi technique promotes the validity of the results. Setting a response rate of at least 70% supports the study's validity. The transparency in the methodological choices and the questionnaires' presentation (see Additional files 1 and 2) ensured the study's credibility.

The generation of ideas about the topic was separated from this study. However, participants were able to give open responses in the rounds, increasing the reliability of the results. The pre-test of the questionnaires ensured their adequacy. Quasi-anonymity also decreased the risk of bias in participants' responses. Regarding statements without consensus in the first round of responses, it was mandatory to justify any option taken in the second round. In this way, an attempt was made to reduce the risk of participants having a certain position on the topic simply because other elements of the group have it (bandwagon effect).

The justifications for the lack of consensus in a statement were obtained from a large and heterogeneous sample. In this way, we obtained good coverage of variations in opinion, guaranteeing the credibility of the results. The diversity of characteristics of the study participants and their detailed descriptions also fostered the transferability of the findings. The participation of different authors in the content analysis ensured the rigour of its realization. The presentation of some quotes from the original

text, different codes, categories and themes ensured the credibility and authenticity of the results.

Results

Seventy-eight experts participated in the first round of response (response rate: 100%) and sixty-one experts in the second round (response rate: 78%). Most of the mental health nurses recruited were female (76%). They were aged 25 to 63 years (mean: 43.91; SD: 8.82). Of these, 82% were married or in a non-marital partnership, 10% were single, and 8% were divorced or separated. Most experts had children (79%), but only 17% had children aged 15 to 18. They had different academic backgrounds (21% Licentiate, 53% Master and 27% Doctorate). Some participants were engaged in more than one nursing activity (40%). These activities included care provision (72%), management (12%), education (44%), and research (28%). The nurses were from different regions of mainland Portugal (North (40%), Centre (35%), South (24%), and the Islands (1%)). Their experience as non-specialised nurses ranged from 2 to 31 years (mean: 10.97; SD: 6.32) and as mental health nurses from 0 to 32 years (mean: 10.23; SD: 7.88). It is important to highlight that being a mental health nurse in Portugal requires training in non-specialized nursing plus a specialization course in mental health and psychiatric nursing. The experts also had work experience in the field of mental health literacy (94%), with adolescents aged 15 to 18 years (69%) and in the school context (68%).

The process of data collection and analysis is summarised in Fig. 2.

Changes in individual experts' responses from the first to the second round may have occurred by reviewing the responses in light of the group's opinion. The "neutrality" option was consistently abandoned in the repeated statements in the second round.

Facilitators

In the first round of responses, the experts agreed that Mental Health First Aid Training Programmes should preferably be promoted by mental health nurses and co-facilitated by professionals with different backgrounds and work contexts (see Table 1).

Intervention foci and assessment methods

In the first round of responses, the experts agreed that these training programmes should focus on the participants' mental health competencies, and the outcomes and intervention processes should be evaluated longitudinally (see Table 2).

Participants

In the first round of responses, the expert panels' opinions about the participants in the interventions diverged

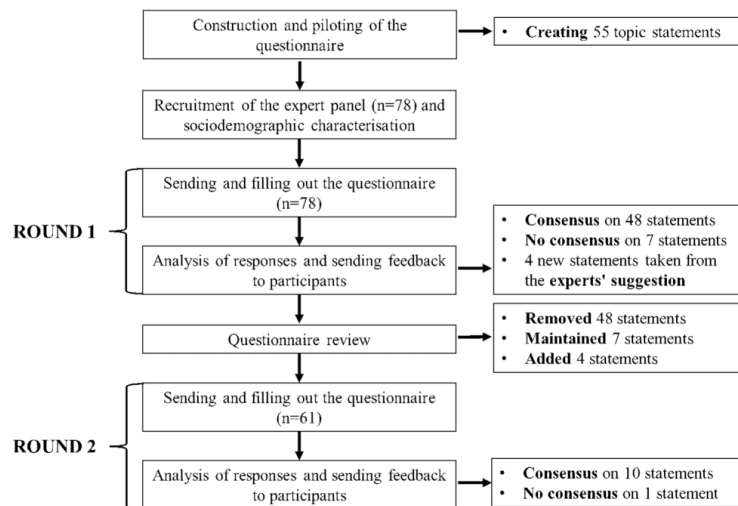


Fig. 2 Flowchart of the data collection and analysis

Table 1 Distribution of responses given by the experts about the facilitators of training programmes

Statements	Responses	n (%)
		Round 1
This type of programme should be promoted, preferably, by mental health nurses.	Agreement	73 (94%)*
	Neutral	3 (4%)
	Disagreement	2 (3%)
This type of programme should preferably be carried out with the co-facilitation of professionals with different training (e.g., education, psychology, psychiatry, child and pediatric health, community health) and work contexts (e.g., school, healthcare hospitals, primary care).	Agreement	70 (90%)*
	Neutral	3 (4%)
	Disagreement	5 (6%)

Legend: * - Consensus obtained

(see Table 3). A consensus was reached on all statements in a second round. The division of classes into groups emerged and was agreed upon as a strategy for managing the number of participants.

Implementation context

In the first round of responses, the experts highlighted the preference for face-to-face delivery of training programmes (see Table 4).

Duration and frequency

The experts converged in their responses regarding the duration and frequency of the training sessions. However, the statement about the interval between sessions

Table 2 Distribution of responses given by the experts on intervention foci and assessment methods of training programmes

Statements	Responses	n (%)
		Round 1
The intervention foci should be nursing foci related to mental health competencies (e.g., knowledge about first aid aimed at people with mental health problems).	Agreement	76 (97%)*
	Neutral	2 (3%)
	Disagreement	0 (0%)
The intervention outcomes should be evaluated over time with measurement instruments based on nursing knowledge (e.g., indicators contained in the Nursing Outcomes Classification).	Agreement	67 (86%)*
	Neutral	10 (13%)
	Disagreement	1 (1%)
At the end of each session, a formal and verbal assessment of the participants' satisfaction with the training should be carried out.	Agreement	73 (94%)*
	Neutral	4 (5%)
	Disagreement	1 (1%)
Facilitators should consider the participants' satisfaction with the training by observing their behaviour.	Agreement	74 (95%)*
	Neutral	4 (5%)
	Disagreement	0 (0%)

Legend: * - Consensus obtained

obtained consensus in the second round of responses (see Table 5).

Intervention methods and strategies

In the first round of responses, there was agreement on using multiple educational strategies and resources and the importance of awareness sessions for the entire school community (see Table 6).

Table 3 Distribution of responses given by the experts about the participants in training programmes

Statements	Responses	n (%)	
		Round 1	Round 2
Facilitators must implement the intervention for classes (up to 30 students), not excluding participants.	Agreement	58 (74%)	49 (80%)*
	Neutral	12 (15%)	5 (8%)
	Disagreement	8 (10%)	7 (11%)
Facilitators must implement the intervention for classes, being able (whenever necessary) to divide them into groups.	Agreement		57 (93%)*
	Neutral		2 (3%)
	Disagreement		2 (3%)
In the classes, facilitators must identify students with nursing diagnoses related to mental health competencies.	Agreement	58 (74%)	54 (89%)*
	Neutral	15 (19%)	4 (7%)
	Disagreement	5 (6%)	3 (5%)
In the classes to intervene, the facilitators must identify availability and willingness to learn.	Agreement	68 (87%)*	
	Neutral	9 (12%)	
	Disagreement	1 (1%)	
Facilitators should pay special attention to participants who have health problems (physical, mental and/or social).	Agreement	72 (92%)*	
	Neutral	6 (8%)	
	Disagreement	0 (0%)	

Legend: * - Consensus obtained

Table 4 Distribution of responses given by the experts about the context of the implementation of training programmes

Statements	Responses	n (%)	
		Round 1	Round 2
The implementation of this type of intervention should preferably be in-person, in the classroom and during school time.	Agreement	70 (90%)*	
	Neutral	8 (10%)	
	Disagreement	0 (0%)	
The virtual implementation of this type of intervention should be considered alternative or complementary.	Agreement	59 (76%)*	
	Neutral	11 (14%)	
	Disagreement	8 (10%)	

Legend: * - Consensus obtained

Contents

The experts agreed on the statements on mental health and its influencing factors and self-help strategies in the first round of responses (see Table 7).

Furthermore, the experts agreed on the importance of addressing aspects concerning mental health problems (see Table 8). It was suggested to highlight the stigma affecting people with mental health problems in the first round of responses, and a statement on the subject was agreed upon in the second round.

The experts also reached a consensus on most statements about mental health problems to be specifically addressed in training programmes (see Additional file 3). As shown in Additional file 3, there was no consensus in two consecutive rounds in the statement "Behavioural

Table 5 Distribution of responses given by the experts about the duration and frequency of training programmes

Statements	Responses	n (%)	
		Round 1	Round 2
This type of intervention should have the session duration adjusted to the classes' duration (commonly 45–90 min).	Agreement	73 (94%)*	
	Neutral	3 (4%)	
	Disagreement	2 (3%)	
The frequency of intervention sessions should be adjusted to the school year and school availability.	Agreement	74 (95%)*	
	Neutral	3 (4%)	
	Disagreement	1 (1%)	
The interval between intervention sessions must be up to one week.	Agreement	54 (69%)	55 (90%)*
	Neutral	18 (23%)	3 (5%)
	Disagreement	6 (8%)	3 (5%)
In this type of intervention, reinforcement/consultation sessions should occur (e.g., at the time of the follow-up assessment).	Agreement	73 (94%)*	
	Neutral	5 (6%)	
	Disagreement	0 (0%)	

Legend: * - Consensus obtained

Table 6 Distribution of responses given by the experts about intervention methods and strategies of training programmes

Statements	Responses	n (%)	
		Round 1	Round 2
This type of intervention should use a mixture of different training strategies: expository (e.g., lectures), demonstrative, participatory (e.g., discussions), contact-based education (e.g., testimonials) and experimental learning (e.g., role plays).	Agreement	76 (97%)*	
	Neutral	2 (3%)	
	Disagreement	0 (0%)	
This type of intervention should use multiple educational resources, including informational, technological (e.g., internet, mobile) and audiovisual (e.g., music, video) materials.	Agreement	77 (99%)*	
	Neutral	1 (1%)	
	Disagreement	0 (0%)	
Although this type of intervention targets upper secondary school students, awareness sessions for the school community on the subject should be carried out.	Agreement	76 (97%)*	
	Neutral	2 (3%)	
	Disagreement	0 (0%)	

Legend: * - Consensus obtained

problems to be addressed in training programmes include problems in sexual behaviour (impaired sexual behaviour [paraphilias]). On the one hand, "Promotion of competencies to act on a problem relevant to the participants" was the justification for the agreement between experts regarding the statement (see Additional file 4). For example, E57 explained that paraphilias are an "Important topic in adolescence and in discovering sexuality". E68 added that "it is a matter of interest to adolescents".

On the other hand, "Inappropriate learning for adolescents" was the reason for disagreement (see Additional

Table 7 Distribution of responses given by the experts about the content of training programmes (aspects related to mental health and self-help)

Statements	Responses	n (%)	
		Round 1	Round 2
This type of intervention should address the concept of health and mental health, self-care / self-help / coping strategies.	Agreement	77 (99%)*	
	Neutral	1 (1%)	
	Disagreement	0 (0%)	
Participants can be taught the following examples of self-help strategies: establishing routines; changing environment; making a complete, varied and balanced diet; sleeping regularly; planning leisure and distraction activities; practising regular exercise; reading and writing (including about the problem and helps); perform plastic expression activities; perform body expression activities (theatre, dance); sing; listen to music/audio; perform relaxation and meditation strategies; practice religious worship; volunteering; socialise.	Agreement	76 (97%)*	
	Neutral	2 (3%)	
	Disagreement	0 (0%)	
This type of intervention should address mental health influencing factors (risk and protective factors for mental health problems).	Agreement	75 (96%)*	
	Neutral	3 (4%)	
	Disagreement	0 (0%)	

Legend: * - Consensus obtained

Table 8 Distribution of responses given by the experts about the content of training programmes (aspects related to mental health problems)

Statements	Responses	n (%)	
		Round 1	Round 2
This type of intervention should address mental health problems and mental disorders, namely their concepts, examples, incidence and prevalence rates, main manifestations (signs and symptoms), experiences and consequences related to mental health problems.	Agreement	62 (79%)*	
	Neutral	12 (15%)	
	Disagreement	4 (5%)	
These types of programmes should address stigma as an experience lived by people with mental health problems.	Agreement	54 (89%)*	
	Neutral	2 (3%)	
	Disagreement	5 (8%)	
In this type of training programme, cognitive, behavioural, emotional and relational problems experienced by the general public must be addressed.	Agreement	68 (87%)*	
	Neutral	8 (10%)	
	Disagreement	2 (3%)	

Legend: * - Consensus obtained

file 4). For example, E28 indicated, "I don't think this topic is essential in the Mental Health First Aid Training Programme." E66 added, "I don't know if addressing sexual problems can somehow influence the adolescent's experience, who is at the peak of his/her discovery".

Table 9 Distribution of responses given by the experts about the content of training programmes (aspects concerning the provision of help to people with mental health problems)

Statements	Responses	n (%)	
		Round 1	Round 2
These programmes should address the need for help, facilitating factors, and barriers to seeking help.	Agreement	77 (99%)*	
	Neutral	0 (0%)	
	Disagreement	1 (1%)	
These types of programmes should explore communication and interpersonal relationships.	Agreement		60 (98%)*
	Neutral		1 (2%)
	Disagreement		0 (0%)
These training programmes should address mental health first aid, namely its concept, importance, participants, implementation contexts and modes of action.	Agreement	77 (99%)*	
	Neutral	1 (1%)	
	Disagreement	0 (0%)	
These types of programmes should address the solidarity and civic ethics underlying the aider's role.	Agreement		56 (92%)*
	Neutral		5 (8%)
	Disagreement		0 (0%)
These training programmes should address key informal and formal resources for help.	Agreement	78 (100%)*	
	Neutral	0 (0%)	
	Disagreement	0 (0%)	
These training programmes should highlight help from family and social network members, school staff, local health services (nurses, psychologists, doctors, self-help and mutual aid groups) and distance health services (virtual therapies, telephone helplines).	Agreement	78 (100%)*	
	Neutral	0 (0%)	
	Disagreement	0 (0%)	
These training programmes should teach participants a dynamic action plan with the following steps: approach the person and assess the situation; assist and encourage the person to use self-help strategies; assist and encourage the person to seek formal and informal help; take care of oneself (first aider).	Agreement	77 (99%)*	
	Neutral	1 (1%)	
	Disagreement	0 (0%)	

Legend: * - Consensus obtained

In the first round of responses, the experts reached a consensus on the contents of the training programmes about providing help to people with mental health problems. In addition, they highlighted the importance of exploring communication and interpersonal relationships and the solidarity and civic ethics underlying the aider's role. Thus, the statements on the matter were created and agreed upon in the second round. Table 9 presents this distribution of responses.

The experts also obtained agreement on all statements regarding mental health first aid actions to be proposed in training programmes (see Additional file 3).

Discussion

This study sought to reach a consensus on the characteristics of Mental Health First Aid Training Programmes promoted by nurses and aimed at adolescents in upper secondary schools. The experts expressed their position regarding the facilitators of training programmes, intervention foci, outcomes and process assessment strategies, participants, implementation context, duration and frequency, intervention strategies, and contents. Our results show that experts agree on most of the ideas about the intervention, generated by them and in the qualitative studies by Costa et al. [23, 24]. Only impaired sexual behaviour did not obtain consensus as the training programme's content. In the literature, there does not seem to be consistent evidence about the appropriateness of talking about sexual deviance with adolescents and its potential influence.

The importance of professionals from different areas of training and work contexts participating in the implementation of these training programmes was highlighted. Fleury et al. indicate that multidisciplinary teams working in several health areas can be more beneficial to users when compared with care provided by a single professional [33]. Facilitators with diverse backgrounds can foster a complementary and successful approach.

It was agreed that these programmes respond to nursing foci (relevant care areas for nurses) related to mental health competencies. Thus, the experts also highlighted the need to identify diagnoses of this type in the participants that may justify the implementation of the intervention. According to Salman et al., competence involves knowledge, skill, attitude, performance and task execution and can be improved with training [34]. The availability and willingness of participants to learn were considered critical for implementing training programmes. Frey expresses that the motivation of adolescents influences their performance and involvement in the classroom [35].

The relevance of evaluating interventions over time with valid and appropriate methods was also consensual. The evaluation of outcomes determines the effectiveness and usefulness of the intervention [26]. Instruments that assess mental health competencies (intervention focus) can be considered. Educational needs and the gains obtained from the intervention can be determined by the participants and/or facilitators. Scales that measure the participants' real competencies and those perceived by them may be relevant. However, the evaluated construct should have a healthier perspective similar to the training programme. Potential limitations in the intervention can

also be hypothesized due to its ineffectiveness. The evaluation of the process allows for identifying and improving less positive aspects of the intervention [26]. The satisfaction verbalized by the participants and observed in their behaviour, and the aspects recognized by them as more and less positive in the intervention can be relevant to detect gaps and adjust the training programme. A checklist and a questionnaire with open and closed questions can be prepared for this purpose. The adoption of assessment instruments should be based on evidence of their psychometric properties and the feasibility of their use [36].

The experts agreed that interventions should be carried out according to the existing groups. In schools, students are commonly organized into groups called classes. Classes are more likely to be consolidated groups and already in a phase of "work and productivity" [37]. Moreover, it is easier to access the participants in their usual organization. Thus, the implementation of the intervention can be more efficient. School time was also considered adequate for implementing training programmes. School times are predetermined periods for learning. Therefore, school availability must be considered, and flexible intervention plans must be provided to facilitate the operationalisation of training programmes.

The experts preferred face-to-face education to virtual learning. Both modes of delivery of training have advantages and disadvantages. Gherhes et al. explain that face-to-face education seems to have more impact than virtual learning [38]. Face-to-face learning facilitates interaction between trainers and trainees and between trainees. However, it is important to emphasise the flexibility and low cost of virtual education.

The experts agreed that varied training strategies and educational resources should be used in the interventions. Mixing teaching methods can be useful, as all strategies have advantages and disadvantages [39]. Although the target of the intervention was adolescents, the experts confirmed the importance of raising awareness in the school community about mental health issues. According to Spier et al., families and communities have an important influence on the education of adolescents [40].

The experts agreed on the importance of addressing mental health, influencing factors and self-help strategies in training programmes. The concept of mental health must be seen as a continuum: being well, having a mental health problem, having a mental disorder and being recovered [2]. In this continuum, the mental health of individuals can always be promoted [41]. In this way, these learning experiences can be useful for adolescents, enabling them to self-manage their mental health status, even after helping another person.

The experts agreed that training programmes should mainly address mental health problems and aspects of

helping people experiencing them. The consensual mental health problems were emotional, cognitive, behavioural and relational, in line with those addressed in existing training programmes [9]. However, they reflected nursing diagnoses listed in nursing taxonomies [17, 18]. The problems to be deepened in each context must consider the educational needs of the participants. Concerning helping people with mental health problems, it was agreed that participants need to learn about seeking help resources and providing mental health first aid. Gulliver et al. express the factors influencing help-seeking: the level of mental health literacy, recognition of the mental health problem, beliefs regarding mental disorders and seeking help, accessibility, previous experiences and relationship to help resources [42]. Kitchener et al. describe that Mental Health First Aid Training Programmes teach how to recognise signs and value symptoms of mental health problems to provide adequate initial help and refer them to professionals and other support [2]. Therefore, the first aid actions and information supporting them must be explored.

This study had some limitations that should be highlighted. Although the attrition rate between rounds was low, it may have influenced the results. The removal of the statements in the questionnaires after consensus also made it impossible to observe the stability of the responses in different rounds. An intrinsic limitation of the Delphi technique is the risk of the bandwagon effect.

The consensus on the facilitation of training programmes by mental health nurses should be viewed with caution, as the panel of experts was only made up of nursing professionals. In addition, the sample intentionally had particular characteristics. Therefore, it cannot be considered representative of all mental health nurses in Portugal.

Conclusion

Experts reached a consensus on the characteristics of Mental Health First Aid Training Programmes for upper secondary students. They agreed that mental health nurses can promote these training programmes, improving adolescents' mental health competencies. A valid evaluation of the process and the outcomes of the interventions is essential over time. They considered that different educational methods should be used in the classroom to teach adolescents to act towards people with mental health problems. Several cognitive, behavioural, emotional and relational problems should be addressed. Research on teaching adolescents about impaired sexual behaviours/paraphilias should be carried out to support the adoption or not of this content in training programmes.

This report provides a "consensual outline" of this type of training programme promoted by nurses. However,

feasibility and piloting studies of the interventions must be carried out. The need for some adjustment in the characteristics of the interventions can be identified by testing the procedures, estimating the recruitment and retention of participants and determining the sample size. Furthermore, it is important to identify appropriate assessment instruments to represent the process and results of interventions. Literature reviews on assessment tools should be considered. Studies to develop/adapt assessment instruments and explore their psychometric properties should be considered.

The evidence obtained may instigate mental health nurses to lead Mental Health First Aid Training Programmes in schools. In addition, it can encourage the collaboration of mental health nurses with professionals from other disciplines (e.g., psychologists, physicians/psychiatrists, teachers) and with other nurses (non-specialists or non-specialists in mental health) in the promotion of these interventions. The nursing education curriculum should raise awareness about these Mental Health First Aid Training Programmes, as any nurse can participate in their implementation or assist people with mental health problems. The education curriculum for mental health nurses must ensure that these professionals consistently implement these training programmes.

This study systematises the characteristics of the training programmes. Therefore, it is an asset for professionals working in schools, as it guides the development of this type of intervention. It highlights the mental health problems representing nursing diagnoses that should be addressed in these educational actions. Adolescents who these training programmes will target will be able to recognise, help and refer people with mental health problems without inappropriately assigning "medical labels".

Supplementary Information

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Supplementary Material 1

Supplementary Material 2

Supplementary Material 3

Supplementary Material 4

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Authors' contributions

All authors made substantial contributions to the conception and design of the study, and T. Costa performed the acquisition, analysis and interpretation of data. T. Costa wrote the manuscript, and all authors critically reviewed its content. All authors approved the final version of the manuscript and agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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Data availability

The datasets generated and/or analysed during the current study are not publicly available due to privacy or ethical restrictions but are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate

This study is part of a project that received ethical approval from the Bioethics Committee of the University of Barcelona (Institutional Review Board: IRB00003099). The Declaration of Helsinki was followed throughout the study. The participants completed informed consent.

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Author details

¹Department of Public Health, Mental Health and Maternal and Child Health Nursing, Nursing School, Universitat de Barcelona, Barcelona, Spain

²Centro Hospitalar de Vila Nova de Gaia/Espinho, Vila Nova de Gaia, Portugal

³Portuguese Red Cross Northern Health School, Oliveira de Azeméis, Portugal

⁴Center for Health Technology and Services Research of the Health Research Network: From the Lab to the Community (CINTESIS@RISE), Porto, Portugal

⁵Nursing School of Porto, Porto, Portugal

⁶Research Group GEIMAC (Consolidated Group 2014-1139: Group of Studies of Invarianza of the Instruments of Measurement and Analysis of Change in the Social and Health Areas), Barcelona, Spain

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5.4. Article 4: Self-Assessment Scale of Basic Mental Health Action Competencies: Development and Evaluation of the Psychometric Properties

The fourth study provides a scale that measures the basic competencies perceived by adolescents aged 15 to 18 years to act on mental health issues (Costa et al., under review).

First, the scale items were generated. Experts suggested items related to the competence to relate to other people, to recognise one's own and others' mental health status, for self-care and helping others to care for themselves and to seek mental health help and support others in seeking help. Furthermore, they recommended the use of the 5-point Likert Scale of Agreement. The first version of the scale with 50 items emerged.

Secondly, the content validity of the scale was assessed. Most items were considered essential, relevant and clear. Only one item about willingness to relate to people with good mental health had a low Content Validity Ratio and Item-Content Validity Index. Still, the item was not removed. The scale's classification method also reached a consensus.

Thirdly, the pre-test of the scale highlighted the need to review the introduction, items 6 and 40 of the scale. Furthermore, it revealed that no changes to the content and the form of the scale were necessary. The scale has been updated accordingly.

Finally, the scale was administered/tested. All scale items showed good sensitivity. As a result of the factor analyses, the final version of the scale was reduced to 20 items, organised into a 4-factor structure: 1) Perception of mental health first aid, 2) Perception of knowledge about mental health, 3) Perception of mental health self-care, and 4) Perception of interpersonal relationships. Adequate values of internal consistency (Cronbach's Alpha Coefficient, McDonald's Omega Coefficient and Composite Reliability values between 0.70 and 0.92) and test-retest reliability (Intraclass Correlation Coefficients values between 0.77 and 0.80) were obtained. The scale demonstrated good divergent and convergent validity (adequate Composite Reliability values, Average Variance Extracted limited but always higher than the square of the correlation between factors).

1 **TITLE:** Self-Assessment Scale of Basic Mental Health Action Competencies:
2 Development and Evaluation of the Psychometric Properties

3

4 **AUTHOR LIST**

5 **Authors name:** Tiago Filipe Oliveira Costa ^{1,2,3,4}; Francisco Miguel Correia Sampaio ^{4,5};
6 Carlos Alberto da Cruz Sequeira ^{4,5}; Patrício Ricardo Soares Costa ^{6,7,8}; María Teresa
7 Lluch Canut ^{1,9}; Antonio Rafael Moreno Poyato^{1,9}

8

9 **Affiliations:**

- 10 ^{1.} Department of Public Health, Mental Health and Maternal and Child Health
11 Nursing, Faculty of Nursing, Universitat de Barcelona, Barcelona, Spain;
12 ^{2.} Unidade Local de Saúde de Gaia/Espinho, Vila Nova de Gaia, Portugal;
13 ^{3.} Portuguese Red Cross Northern Health School, Oliveira de Azeméis, Portugal;
14 ^{4.} Center for Health Technology and Services Research: Health Research Network
15 (CINTESIS:RISE), Porto, Portugal.
16 ^{5.} Nursing School of Porto (ESEP), Porto, Portugal.
17 ^{6.} Life and Health Sciences Research Institute (ICVS), School of Medicine,
18 University of Minho, Braga, Portugal;
19 ^{7.} ICVS/3B's - PT Government Associate Laboratory, Braga/Guimarães, Portugal;
20 ^{8.} Faculty of Psychology and Education Sciences, University of Porto, Porto,
21 Portugal.
22 ^{9.} Research Group NURSEARCH (Research Group in Mental Health, Psychosocial
23 and Complexity Nursing Care), Barcelona, Spain.

24

25 **Corresponding Author:** Tiago Filipe Oliveira Costa; E-mail:
26 tiagofilipeoliveiracosta@gmail.com; Postal address: Carrer de la Feixa Llarga, s/n, 08907
27 L'Hospitalet de Llobregat, Barcelona, Spain.

28

29

30 **ABSTRACT**

31 **Background:** The assessment of adolescents' mental health competencies requires
32 validated instruments. Thus, we sought to develop and evaluate the psychometric
33 properties of a scale in which adolescents self-assess their competencies to act in mental
34 health.

35 **Methods:** A psychometric study was conducted. The data was collected in Portugal,
36 between May 2022 and September 2023. Firstly, a focus group was held with 9 experts
37 to generate the scale items. The data was examined using content analysis. Secondly, a
38 modified e-Delphi technique was used to obtain the opinion of 97 healthcare workers on
39 the scale statements and the classification method. An analysis of response frequencies
40 was carried out. Thirdly, cognitive interviews about the scale were conducted with 8
41 adolescents. Content analysis was performed. Finally, the scale was applied to 514
42 adolescents. Item sensitivity assessment and factor analysis were performed. The scale's
43 convergent and divergent validity, internal consistency and test-retest reliability were also
44 examined.

45 **Results:** A 20-item scale emerged, featuring four factors: perception of knowledge about
46 mental health, mental health self-care, interpersonal relationships and mental health first
47 aid. Cronbach's alpha and McDonald's omega varied from 0.79 to 0.92, the composite
48 reliability from 0.70 to 0.89, and the intraclass correlation coefficient from 0.77 to 0.80.

49 **Conclusions:** The scale was created and demonstrated good validity and reliability. It
50 facilitates the assessment of adolescents' mental health needs and the results of
51 educational interventions.

52 **KEYWORDS:** Adolescent, Competence, Educational Measurement, Mental Health,
53 Psychometric Evaluation, Scale Development

54

55

56 **BACKGROUND**

57 Competence is a term generally used to define a set of knowledge, skills and attitudes that
58 enable the successful performance of tasks [1]. According to Salman et al., the concept
59 of competence involves individual visible characteristics (knowledge, skills and
60 behaviour) and hidden features (traits, motives, attitudes, values and self-image) [2].

61 Competencies can be improved with training [2]. In turn, populations usually have access
62 to training in schools. Worldwide, compulsory education begins at age 6 and lasts 10
63 years (on average) [3]. In Portugal, 12 years of schooling must be completed by law
64 (upper secondary education) [4]. Thus, adolescents aged 15 to 18 are expected to acquire
65 knowledge and skills to carry out tasks, solve problems, and take responsibility for their
66 actions [4]. At 18, individuals commonly reach the age of majority, assuming full
67 responsibility for their actions [5]. Therefore, it is crucial to understand the level of
68 competence of people in this period (15 to 18 years old), including in mental health
69 matters.

70 Developing health competencies can promote involvement in individual and collective
71 health issues [6]. Adolescents can be empowered with basic/generic competencies in
72 mental health, actively participating in self-care and supporting those with mental health

73 problems [7]. Laypeople can maintain or improve their mental well-being, respond to
74 mental health problems to prevent mental disorders, and manage and recover from mental
75 illnesses [8]. Hence, they need the competencies to recognise their mental health status,
76 choose and use adaptive self-care strategies, seek assistance and comply with therapeutic
77 regimens [9,10]. Furthermore, people without mental health expertise often encounter
78 individuals experiencing problems, playing a significant role in their stabilisation [11].
79 Consequently, they must be able to recognise signs and symptoms of mental distress in
80 others, offer initial help and refer them to appropriate support services [9,11].

81 The actual mental health competencies of laypeople (including adolescents) have been
82 studied [12]. Several instruments assess these actual competencies (e.g., mental health
83 literacy measures [13]). However, the competencies perceived by individuals can also be
84 explored.

85 Perceived competence has been defined as the need to master a personally challenging
86 task [14]. Therefore, it includes the perception of the ability to perform a task and the
87 assessment of the personal importance of the activity [14]. Competence can be viewed in
88 light of Self-Determination Theory as a fundamental psychological need that motivates
89 human behaviour, alongside autonomy and relatedness [15]. Perceived competence
90 differs from self-efficacy and perceived behavioural control. Self-efficacy, rooted in
91 Social Cognitive Theory, involves the belief in one's ability to organise and execute
92 actions necessary for achieving specific goals [16]. Perceived behavioural control,
93 aligning with the Theory of Planned Behaviour, is the perception of ease or difficulty in
94 performing a behaviour, encompassing self-efficacy and perceived controllability (belief
95 in the behaviour's volition) [17]. Perceived competence can be associated with generic
96 areas of action in mental health. In this way, we conceptualise perceived basic
97 competence to act in mental health as the importance attributed by laypeople to caring for

98 their mental well-being and that of others, alongside the perception of ability in these
99 activities.

100 Perceived health competence (not specific to mental health) has positively affected health
101 behaviours and outcomes [18,19]. Furthermore, Peplau highlighted that health
102 professionals care for their patients based on what the latter consider they need [20].
103 Therefore, it is essential to determine patients' perceptions of mental health competence
104 or educational needs. Psychometric instruments should be considered for this purpose.
105 However, there appears to be a lack of tools that assess perceived basic competencies to
106 act on mental health issues. An exploratory search focused on instruments for assessing
107 these perceived competencies was conducted in March and April 2022. This search was
108 conducted in several databases: Web of Science Core Collection, MEDLINE complete,
109 CINAHL complete, PsycINFO, SciELO, Scopus, COSMIN Database of Systematic
110 Reviews, Cochrane Library, JBI Evidence Synthesis and PROSPERO. Only one
111 instrument was found to assess the perceived competence of students and teachers to
112 support the mental health of university students (College Mental Health Perceived
113 Competency Scale) [21]. We recognise limitations in this scale, such as a factor with only
114 two items and the lack of a more comprehensive assessment of psychometric properties
115 (e.g., reliability was only supported by Cronbach's Alpha). Moreover, given its specificity
116 in supporting others, we believe it is still pertinent to construct and validate a self-
117 assessment scale of different basic competencies to act on mental health issues.

118 Costa et al. highlighted the importance of developing instruments to assess perceived
119 competencies in mental health to determine the educational needs of adolescents and the
120 outcomes of mental health training programmes [9]. Thus, this study aimed to develop a
121 scale that measures the basic competencies perceived by adolescents aged 15 to 18 to act
122 on mental health issues and evaluate its psychometric properties. We called the instrument

under study the Self-assessment Scale of Basic Mental Health Action Competencies (Basic-MAC scale).

METHODS

Design

A psychometric study with a multimethod approach was carried out. It was divided into four main stages [22], represented in Figure 1.

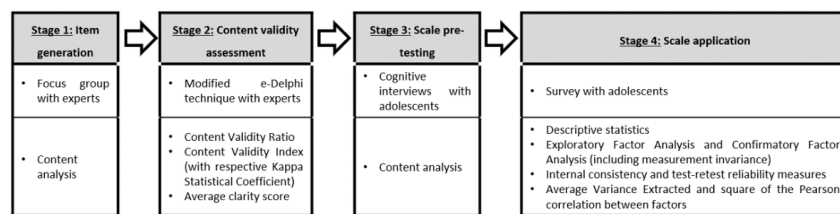


Figure 1: Study stages

A guideline for reporting studies on measurement properties of patient-reported outcome measures was followed [23] (Additional File 1).

Stage 1: Item Generation

A qualitative methodology was used to generate Basic-MAC scale items.

Participants

Experts were selected using purposive sampling. They needed to meet all the following criteria for inclusion: being Portuguese health professionals, having experience working

142 in mental health education and with adolescents, regularly using validated assessment
143 instruments or having developed one. Health professionals from different disciplines
144 were considered to better define the construct, distinguishing it from clinical
145 competencies in mental health. We sought out an expert panel consisting of four to twelve
146 experts [24]. Potential participants were identified by consulting our contact lists and
147 literature on the topic. They were invited to join the study via email.

148 ***Data collection***

149 An interview guide was developed and then pre-tested for three eligible healthcare
150 workers. The script did not require changes. Focus group sessions were conducted via
151 videoconference [24]. They were recorded (audio and video) and transcribed. Transcripts
152 were shared with participants. After each session, participants were able to send, via
153 email, suggestions on the topic and comments regarding the session transcripts. The
154 discussions occurred until data saturation (until the participants produced no new
155 information) [25].

156 ***Data analysis***

157 The collected data underwent content analysis [26]. Transcripts of discussion sessions
158 and expert feedback messages were considered units of analysis. The content was
159 organised into two meaning areas: psychometric instrument construct and rating scale.
160 The units of meaning about the construct guided the writing of the items. The codes and
161 categories expressed the core of the items. The themes indicated the possible domains of
162 the scale.

163

164 **Stage 2: Content Validity Assessment**

165 A quantitative methodology was used to evaluate the content validity of the Basic-MAC
166 scale and its items.

167 *Participants*

168 Experts were recruited in a similar way to the previous stage. However, a larger and more
169 heterogeneous sample was sought to ensure greater validity of the results [27]. Portuguese
170 health professionals with experience working in mental health education and/or with
171 adolescents were recruited.

172 *Data collection*

173 A modified e-Delphi technique was performed [27]. The insights gained from the focus
174 group sessions were included in a structured online questionnaire. The essentiality,
175 relevance and clarity of ideas about the construct and agreement with ideas about the
176 rating scale were assessed. Likert scales of essentiality with 3 points, relevance with 4
177 points, clarity with 3 points and agreement with 4 points were used [28]. Suggestions to
178 improve the scale and its items were possible.

179 Pre-tested with ten eligible healthcare professionals, the questionnaire received no
180 suggested changes. Subsequently, the questionnaire was emailed to the panel of experts
181 for actual completion.

182 *Data analysis*

183 Frequencies of responses were analysed using IBM SPSS Statistics 27 software.
184 Considering the responses concerning the ideas about the construct to be measured, the
185 Content Validity Ratio (CVR), the Content Validity Index (CVI) (with respective Kappa
186 Statistical Coefficient (κ)) and the average clarity score for each item were calculated
187 [28]. Firstly, the critical CVR value was calculated using the formula proposed by Ayre
188 & Scally [29]. Whenever the CVR values obtained for each item did not reach the critical

189 CVR value, we discussed the possibility of eliminating the item. Secondly, the CVI was
190 represented by the Item-CVI (I-CVI) and the Scale-level-CVI (S-CVI). The S-CVI was
191 based on the average of the I-CVI scores of all scale items (S-CVI/Ave). I-CVIs $\geq$ 0.78
192 and S-CVI/Ave $\geq$ 0.9 were considered appropriate values for the scale [30]. Whenever the
193 I-CVI value was lower than 0.78, the item was considered to be eliminated or revised. In
194 turn, κ values between 0 and 0.20 indicated no agreement, 0.21–0.39 minimal agreement,
195 0.40–0.59 weak agreement, 0.60–0.79 moderate agreement, 0.80–0.90 strong agreement
196 and above 0.90 almost perfect agreement beyond chance [31]. Finally, a mean clarity
197 score ≤ 2 signalled unclear items. Revising the item based on participants' comments was
198 considered in these situations. Regarding ideas about the rating scale, a consensus of at
199 least 75% was determined a priori [32]. The consensus was deemed positive when at least
200 75% of the responses were rated 3 or 4 on the Likert scale and negative when at least 75%
201 were rated 1 or 2.

202 If a new idea emerged from the participants' open-ended responses, we discussed its
203 relevance and considered submitting it to the expert panel's opinion.

204

205 **Stage 3: Scale Pre-Test**

206 A qualitative methodology was used to evaluate the adequacy of the scale items to the
207 target population and the strength of the responses.

208 ***Participants***

209 Participants were selected using purposive sampling. Portuguese adolescents aged 15 to
210 18 (upper secondary school students) with different sociodemographic characteristics
211 were recruited until data saturation was reached [25].

212 ***Data collection***

213 Cognitive interviews were conducted in person. The questions focused on the content and
214 form of the scale, as well as the mental process underlying its response. The interviews
215 were audio recorded and transcribed shortly after they ended. Transcripts were returned
216 to participants for comment.

217 *Data analysis*

218 The transcripts obtained in the pre-test were subjected to content analysis [26]. The units
219 of meaning guided the improvement of the items. The content was organised into three
220 areas of meaning: mental process underlying the response, content and form of the scale.

221

222 **Stage 4: Scale Application**

223 A quantitative methodology was used to test the Basic-MAC scale and assess its
224 psychometric properties.

225 *Participants*

226 Upper secondary school students aged 15 to 18 living in Portugal were recruited using
227 snowball sampling. We disseminated the study to groups (school, cultural, religious and
228 sporting) potentially comprised of adolescents and groups of guardians. We invited
229 adolescents to participate and share the study with their social network. A sample of at
230 least 500 adolescents was sought (10 participants for each item on the scale) [22].

231 *Data collection*

232 The scale was administered online to adolescents. It was requested to be completed in 2
233 moments, spaced 7-14 days apart [33]. We provided a QRCode/link to potential
234 participants that allowed them to access the scale for the first time. A notification was

235 sent via email/SMS 7 days after the first completion of the scale to invite the second
236 completion.

237 *Data analysis*

238 The answers given by the participants were analysed with descriptive statistics. The
239 sensitivity of the items was examined based on the analysis of skewness and kurtosis.
240 Serious deviations from the normal distribution of items were considered absolute values
241 of skewness and kurtosis greater than three and 10, respectively [34].

242 Exploratory Factor Analysis (EFA) was performed to reduce the complexity of the data,
243 identify underlying patterns and understand the relationships between variables [35].
244 Confirmatory Factor Analysis (CFA) was conducted to confirm the factor structure
245 obtained in the EFA and evaluate its adjustment to the observed data [36]. For this
246 purpose, the sample was pseudo-randomly divided (using IBM SPSS Statistics 27) into
247 two equal-sized sub-samples. Difference tests were applied between the two subsamples
248 for different sociodemographic characteristics (Students' t-test for age and Mann-Whitney
249 test for the remaining features).

250 The suitability of the data for EFA was assessed using the Kaiser-Meyer-Olkin (KMO)
251 sampling adequacy measure and Bartlett's test of sphericity [37,38]. $KMO \geq 0.5$ and
252 $p < 0.05$ in the Chi-Square test were necessary assumptions [37,38]. Considering this is
253 exploratory research, we opted for the principal axis factoring method to extract factors
254 in the EFA [39]. A Direct Oblimin rotation was used as the factors were expected to
255 correlate [35]. Only factors with eigenvalues greater than 1.0 were considered [35]. Items
256 with factor loading greater than 0.50 and extraction communality greater than 0.40 were
257 retained [35,40]. After finding an acceptable factor solution, the researchers discussed the
258 meaning of the pattern of factor loadings and assigned labels to each factor.

259 Cronbach's Alpha Coefficient (α), McDonald's Omega Coefficient (ω) and Composite
260 Reliability (CR) were measures of reliability/internal consistency calculated for each
261 factor [41]. Values above 0.70 were considered acceptable [42].

262 The CFA was performed with the maximum likelihood estimator. The factorial goodness
263 of fit was assessed with global model fit indices. Chi-square (χ^2), Root Mean Square Error
264 of Approximation (RMSEA) and Standardised Root Mean Squared Residual (SRMR)
265 were used to understand how well the model fits the data compared to no model.
266 Comparative Fit Index (CFI) was used to compare the model fit with the assumption of
267 variable independence. The following values were considered acceptable: $\chi^2 \leq 3df$ (df:
268 degrees of freedom), $p \geq 0.01$; $RMSEA \leq 0.10$; $SRMR \leq 0.10$; $CFI \geq 0.90$ [34,36,43].
269 Measurement invariance was also verified between male and female participants.
270 Configural, metric, scalar and strict invariance were estimated [36]. Acceptable values
271 were $\Delta CFI \leq 0.01$, $\Delta RMSEA \leq 0.015$ and $\Delta SRMR \leq 0.03$ for metric invariance, and
272 $\Delta SRMR \leq 0.015$ for scalar or strict invariance [44].

273 Convergent validity was assessed by the Average Variance Extracted (AVE), with
274 $AVE \geq 0.5$ indicating adequacy [45]. If $AVE < 0.5$, acceptability remains with a $CR > 0.6$
275 [45]. Divergent validity was examined by comparing each factor's AVE with the square
276 of the Pearson correlation between factors. AVE greater than the square of the correlation
277 between factors demonstrated appropriate divergent validity [45].

278 The scale's test-retest reliability was assessed using Intraclass Correlation Coefficients
279 (ICC) with a two-way mixed effects model, absolute agreement type and multiple
280 raters/measurements relationship [46]. $ICC < 0.5$ reveals poor reliability, 0.5-0.75
281 moderate, 0.75-0.9 good and > 0.90 excellent [46].

282 IBM SPSS Statistics 27 and JASP 0.18.0 software were used for data analyses.

283

284

285 **RESULTS**

286 **Stage 1: Item Generation**

287 Nine participants engaged in two focus group sessions (May 2 and June 14, 2022).
288 Sessions lasted an average of 80 minutes. The sociodemographic characteristics of the
289 experts can be consulted in Additional File 2.

290 Four themes about the construct were identified (Theme 1: Interpersonal relationship
291 competence; Theme 2: Competence to recognise one's own and others' mental health
292 status; Theme 3: Competence for self-care and helping others to care for themselves;
293 Theme 4: Competence to seek mental health help and support others in seeking help). A
294 theme on the rating scale was obtained ("5-point Likert Scale of Agreement"). The
295 content analysis process is presented in Additional File 3. A first version of the Basic-
296 MAC scale was developed (Additional File 4) and returned to the participants. They
297 expressed that the version covered all the ideas discussed.

298

299 **Stage 2: Content Validity Assessment**

300 Ninety-seven participants completed the questionnaire between July 4th and 31st, 2022.
301 The sociodemographic characteristics of the experts can be consulted in Additional File
302 5.

303 The experts' opinion on the scale items' essentiality, relevance and clarity is summarised
304 in Additional File 6. The critical CVR value was 0.177 for n=97. The experts expressed
305 that most scale items were essential, relevant and clear. Only the item "I am willing to

306 relate to people with good mental health" had a CVR and I-CVI value lower than the
307 reference values. However, we considered it appropriate to maintain this item, as it
308 allowed us to discriminate between willingness to relate to people with good mental
309 health and people with mental health problems. Additionally, without the item deletion,
310 the S-CVI remained an excellent value.

311 A positive consensus (97.9%, n=95) was also obtained on the idea about the rating scale
312 ("Each item on the scale must have 5 response options (1 – Strongly Disagree, 2 –
313 Disagree, 3 – Neither Agree nor Disagree, 4 – Agree, 5 – Strongly Agree)"). No new and
314 relevant ideas about scale were suggested. Therefore, no changes were made to the scale,
315 preserving all its items.

316 A summary of the results was sent to participants.

317

318 **Stage 3: Scale Pre-Test**

319 Eight participants were interviewed between September 26 and November 14, 2022.
320 Interviews lasted an average of 52 minutes. The sociodemographic characteristics of the
321 adolescents can be consulted in Additional File 7.

322 The content analysis process is presented in Additional File 8. Three themes emerged
323 from the adolescents' cognitive interviews (Theme 1: Need to review the introduction,
324 items 6 and 40 of the scale; Theme 2: No need to change the content; Theme 3: No need
325 to change the form).

326 The scale was considered globally understandable, clear and without bias. The
327 adolescents recognised that all the items were distinct from each other despite identifying
328 similarities (for example, S7 expressed, "There are words that are similar, but I can
329 differentiate (the items)"). A preference for informal treatment of the responder was

330 reported when introducing the scale. The adolescents also mentioned the need to remove
331 the terms "verbal and non-verbal" in item 6 and to replace the term "conditions" with
332 "influences" in item 40 to improve understanding of the items. Regarding the content of
333 the scale, the adolescents indicated that each item addressed only one topic and that the
334 scale "as a whole" focused on the intended construct. Furthermore, the form of the scale
335 and items was considered adequate.

336 Based on the themes obtained, changes were made to the Basic-MAC scale. The revised
337 version of the scale was returned to the participants, who expressed that it was adequate
338 and met their opinions.

339

340 **Stage 4: Scale Application**

341 Responses to the scale took place between March 12 and September 5, 2023. Five
342 hundred and fourteen adolescents responded initially. The sociodemographic
343 characteristics of the sample and subsamples can be consulted in Additional File 9. There
344 were only significant differences between the subsamples regarding the territory where
345 the participants lived and studied ($p < 0.01$). The descriptive analysis of the responses
346 given by the participants is presented in Additional File 10 (section "Item Sensitivity").
347 The items showed good sensitivity since adequate values of skewness (between -2.45 and
348 -0.33) and kurtosis (between -0.94 and 7.67) were verified.

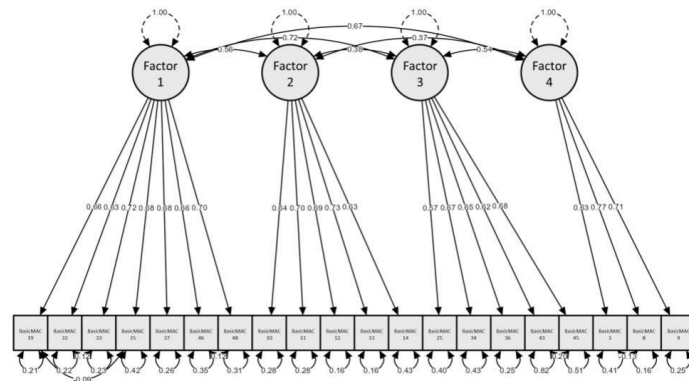
349 Items with lower factor loadings were iteratively eliminated (sequentially, items 27, 42,
350 7, 5, 6, 28, 4, 1, 30, 29, 41, 40, 23, 20, 26, 22, 31, 17, 18, 38, 16 and 44) until only items
351 with pre-determined factor loadings remained. Communalities ranged between 0.41 and
352 0.75, justifying the maintenance of items.

353 Throughout this item reduction process, the KMO test showed appropriate values (0.93-
 354 0.90), and the Bartlett test indicated significant differences ($p < 0.01$). A 5-factor matrix
 355 was obtained. The factors had reasonable ω , α and CR values. However, this matrix did
 356 not have satisfactory fit levels in the CFA. In this way, we sought to understand the
 357 existing problems in the CFA matrix. Item 2 had a low factorial load in the CFA (0.30),
 358 justifying its exclusion. Moreover, several items had high residual variances (> 2.5) [35].
 359 In this way, the potential exclusion of items was discussed, considering the value of the
 360 residual variance and the impact of its removal on the factor matrix (in EFA and CFA).
 361 Items 49, 50, 39, 15, 21, 47 and 24 were excluded.

362 A new four-factor structure emerged: 1) Perception of mental health first aid, 2)
 363 Perception of knowledge about mental health, 3) Perception of mental health self-care,
 364 and 4) Perception of interpersonal relationships (see Additional File 10, section "EFA").
 365 These factors together represented 68% of the cumulative variability in the original
 366 variables and 60% of the cumulative variability in the extracted solution. The
 367 communalities remained adequate (0.41-0.77). The correlation matrix was suitable for
 368 factor analysis (KMO test of 0.89; Bartlett test with $p < 0.01$). The factors had adequate
 369 values of ω (0.79-0.92), α (0.79-0.92) and CR (0.70-0.89) (see Additional File 10, section
 370 "Internal Consistency").

371 It was hypothesised that there would still be residual covariances between items of the
 372 same factors, as relationships between attitude-motivation, attitude-self-efficacy and
 373 motivation-self-efficacy have been described [15,16]. Residual covariances could also be
 374 due to similarities between items reported in the pre-test (Additional File 8). Modification
 375 indices were applied with a cutoff of 11 (critical chi-square value for 1 degree of freedom
 376 with a significance level of 0.001). We recognised covariances between items 19-35, 32-
 377 33, 46-48, 43-45, 3-8. Thus, adequate fit indices were obtained, except for the χ^2 (see

378 Additional File 10, section "CFA"). The factorial model of the scale is represented in
 379 Figure 2.



380

381 Figure 2: Factor model of the Basic-MAC scale

382

383 Limited invariance was found between male and female adolescents. Adequate fit values
 384 were obtained, except in the χ^2 test and ΔCFI in all forms of invariance and also in the
 385 CFI and $\Delta SRMR$ of strict invariance (see Additional File 10, section "Invariance for
 386 sex").

387 Limited AVE values (0.43-0.56) were obtained (see Additional File 10, section
 388 "Convergent & Divergent Validity"). However, convergent validity was supported by
 389 good CR values. An adequate divergent validity was also verified since the AVE values
 390 were consistently higher than the square of the correlation between factors (see Additional
 391 File 10, section "Convergent & Divergent Validity").

392 The scale was later responded to by 198 out of the 514 participants (retention rate: 39%).

393 They responded at both times with an average interval of 9.35 days (SD: 2.68). The ICC

394 varied between 0.77 and 0.80 (see Additional File 10, section "Temporal Stability"),
395 expressing good test-retest reliability of the scale.

396 A final version of the Basic-MAC scale is presented in Additional File 11.

397

398

399 **DISCUSSION**

400 This study sought to develop a scale that assesses the competencies perceived by
401 adolescents to act in mental health (Basic-MAC scale) and evaluate its psychometric
402 properties.

403 Experts recommended that the scale's statements focus on competencies such as
404 interpersonal relationships, recognition of mental health status, self-care, helping others,
405 and seeking mental health help. These areas have been reported as constituents of the
406 broader construct of "Mental Health Literacy" [10]. Health literacy involves knowledge,
407 competence, and motivation to access, understand, process and use health information
408 [8]. The competence to act in health corresponds to the competence to use health
409 information.

410 Experts expressed that the scale statements were globally essential, relevant and clear,
411 enabling adequate representation of the construct to be measured [22]. They suggested
412 and agreed that the classification of statements should occur with a 5-point Likert scale
413 of agreement. Five-point scales seem appropriate for this target population, as they are
414 commonly used in school assessments [47].

415 Adolescents pre-tested the scale and suggested minor sentence revisions. These changes
416 may have facilitated the processing and response to items, minimising misunderstandings
417 and measurement errors [22]. Subsequently, a broader group of adolescents responded to

418 the scale. Thus, it was possible to determine that the instrument detected specific
419 differences/variations in the intended construct (good sensitivity of all items).
420 Furthermore, the underlying structure of the scale was also explored, and the existence of
421 4 latent factors was confirmed. It has a broader scope than the College Mental Health
422 Perceived Competency Scale [21], enabling a more comprehensive identification of
423 educational needs. The scale's content does not appear to overlap with perceived clinical
424 mental health competencies scales (e.g., the Perceived Competence Scale for Disaster
425 Mental Health Workforce [48]).

426 The factorial structure obtained showed a good fit in the CFA. In the case of the χ^2 test,
427 the test's sensitivity is influenced by the sample size [49]. The p was significant, but the
428 χ^2/df was appropriate. Therefore, the differences may not be significant in practice,
429 although they are statistically significant [49]. The factorial structure showed limited
430 equivalence between male and female adolescents, and caution should be taken when
431 generalising results between groups.

432 The scale demonstrated adequate convergent and divergent validity. In this way, the
433 different items on the scale consistently measure the same construct, discriminating it
434 from others [22]. Good scale internal consistency indicators express that the Basic-MAC
435 scale items are correlated with each other, measuring the same construct reliably [41].
436 The number of participants allowed the detection of ICCs $\geq$ 0.60 between the two
437 observations, considering a confidence level of 95% and an assurance of 90% in a
438 bilateral comparison [50]. Adequate ICC levels expressed measurement stability over
439 time. In this way, the scale can measure real and stable variations in the construct and not
440 merely random temporal fluctuations or measurement errors [46].

441 From the initial to the final version, the Basic-MAC scale items were related to the
442 perception of knowledge, capacity, behaviour, attitude and motivation to act in mental

443 health. The content of this scale partly converges with assessment instruments based on
444 the Self-Determination Theory, such as the Perceived Competence Scale [51]. Despite
445 several modifications for different non-mental health areas, the Perceived Competence
446 Scale presents a generic model with 4 items relating to confidence perception, ability,
447 goal achievement, and overcoming challenges [51]. The Basic-MAC scale goes deeper
448 into the concept of "competence", covering various elements that Salman et al. identified
449 [2]. It captures the perception of task performance ability through items on knowledge,
450 capacity and behaviour while gauging the personal importance of the task through items
451 on attitude and motivation [14].

452 This study has limitations. Firstly, only an inductive method was used to generate items
453 (focus group with experts). A deductive method such as, for example, a literature review
454 on the concept could have been carried out. Secondly, non-probability sampling was used
455 at the different stages, limiting the generalisability of the results. In the scale application
456 stage, snowball sampling and the possibility of remote response made it difficult to
457 control the environment in which the adolescents filled out the scale. Environments with
458 distractors may have influenced the appropriate completion of the scale. Thirdly, the time
459 interval between test-retest can be considered small. Although this interval is frequently
460 reported in the literature, short periods can induce greater levels of reliability by
461 remembering the questions and answers given in the test when retesting.

462

463

464 **CONCLUSIONS**

465 The Basic-MAC scale was developed and its psychometric properties were explored. The
466 experts' opinions allowed the generation and consensus of the scale items. The instrument

467 classifies adolescents' agreement with statements about relating to others, recognising
468 mental health status, taking care of themselves and supporting others, and seeking help
469 resources.

470 The scale was pre-tested by adolescents and its wording was improved. The response of
471 a large number of adolescents made it possible to determine the validity and reliability of
472 the scale. A 4-factor structure was found in the instrument. The scale showed good item
473 sensitivity, internal consistency and test-retest reliability, as well as adequate divergent
474 and convergent validity. The favourable attributes of this instrument suggest it can
475 effectively assess the construct in adolescents.

476 This study introduces a scale that represents visible and hidden components of
477 competence, emphasising the perspective of the adolescent evaluated. The Basic-MAC
478 scale quantifies the presence/absence of mental health action competencies and can
479 provide evidence regarding the construct. Healthcare workers can consider the instrument
480 to support assessments of their patients and show the convenience of educational
481 interventions. The scale can also inform researchers, managers and policymakers about
482 the needs of adolescents, guiding their decisions and actions. It may measure the
483 outcomes of mental health training programmes. Data on the effectiveness of
484 interventions guide the adoption of one. Better identification of educational needs and
485 responses can improve the role of patients concerning mental health.

486 The complementary use of actual competencies assessment instruments (e.g., knowledge
487 tests) may be relevant. However, adolescents' perception of competence can be influenced
488 by comparison with measures of actual competence. Future psychometric studies with
489 this scale are essential to better understand the instrument's properties (e.g., invariance in
490 the "sex" variable and other grouping variables). Adaptations and validations are needed
491 for its application in diverse populations and contexts.

492

493

494 **LIST OF ABBREVIATIONS**

495 α - Cronbach's Alpha Coefficient

496 κ - Kappa Statistical Coefficient

497 χ^2 - Chi-square

498 ω - McDonald's Omega Coefficient

499 **AVE** - Average Variance Extracted

500 **Basic-MAC scale** - Self-assessment Scale of Basic Mental Health Action Competencies

501 **CFA** - Confirmatory Factor Analysis

502 **CFI** - Comparative Fit Index

503 **CR** - Composite Reliability

504 **CVI** - Content Validity Index

505 **CVR** - Content Validity Ratio

506 **df** - Degrees of Freedom

507 **EFA** - Exploratory Factor Analysis

508 **ICC** - Intraclass Correlation Coefficients

509 **I-CVI** - Item-CVI

510 **KMO** - Kaiser-Meyer-Olkin

511 **RMSEA** - Root Mean Square Error of Approximation

512 **S-CVI** - Scale-level-CVI

513 **S-CVI/Ave** - Scale-Level Content Validity Index based on the Average method

514 **SRMR** - Standardised Root Mean Squared Residual

515

516

517 **DECLARATIONS**

518 **Ethics approval and consent to participate:**

519 This study was performed in line with the principles of the Declaration of Helsinki.

520 Approval was granted by the Bioethics Committee of the Universitat de Barcelona

521 (Institutional Review Board: IRB00003099; date: 21 February 2021) and the Ethics

522 Committee of the Portuguese Society of Mental Health Nursing (Institutional Review

523 Board: CEASPESM_1/2023; date: 10 March 2023).

524 Informed consent was obtained from all individual participants included in the study. In

525 the case of the participation of minors, authorisations from legal guardians were obtained.

526 Data from all participants were coded: each Expert or Student was assigned a letter (E or

527 S, respectively) followed by a number.

528 **Consent for publication:** Not applicable.

529 **Availability of data and materials:** The datasets generated and/or analysed during the

530 current study are not publicly available due to privacy or ethical restrictions but are

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536 and design of the study, and the first author (TC) performed the acquisition, analysis and
537 interpretation of data. The first author (TC) wrote the manuscript, and all authors critically
538 reviewed its content. All authors approved the final version of the manuscript and agreed
539 to be accountable for all aspects of the work in ensuring that questions related to the
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690 **ADDITIONAL FILES**

691 Additional file 1 - COSMIN Reporting Guideline

692 Additional file 2 - Sociodemographic characterisation of focus group participants

693 Additional file 3 - Content analysis of focus group data

694 Additional file 4 - Initial version of Basic-MAC scale

695 Additional file 5 - Sociodemographic characterisation of Delphi participants

696 Additional file 6 - Essentiality, relevance and clarity of scale items

697 Additional file 7 - Sociodemographic characterisation of participants in the scale pretest

698 Additional file 8 - Content analysis of the data obtained in the scale pretest

699 Additional file 9 - Sociodemographic characterisation of participants in the scale
700 administration

701 Additional file 10 - Assessment of the validity and reliability of the Basic-MAC scale

702 Additional file 11 - Final version of Basic-MAC scale

703

704

705 Additional Files are available at:

706 [https://drive.google.com/file/d/1BBHmOTuXARjVxRICxmo7MgCEU009ZLxV/view?](https://drive.google.com/file/d/1BBHmOTuXARjVxRICxmo7MgCEU009ZLxV/view?usp=drive_link)

707 [usp=drive_link](https://drive.google.com/file/d/1BBHmOTuXARjVxRICxmo7MgCEU009ZLxV/view?usp=drive_link)

708

5.5. Educational materials from the training programme “Empower4MentalHelp!” aimed at adolescents

A Mental Health First Aid Training Programme with a health-centred perspective was developed and named “Empower4MentalHelp”. The respective educational materials were constructed. They were written in European Portuguese, as it was the language spoken by the facilitators and the targets of the intervention. A guidance manual for training programme facilitators can be found in Appendix 3 (Costa et al., 2024). The manual shows the pertinence of this type of intervention, presents the characteristics of this training programme and the planning of sessions/modules, and provides educational and evaluative resources. It was edited by the Portuguese Society of Mental Health and Health Nursing and published in e-book format. The manual was made available on the scientific society website.

6. DISCUSSION

In this doctoral path, a Mental Health First Aid Training Programme, promoted by nurses and aimed at adolescents in Portuguese upper secondary schools, was developed. The intervention evaluation stage was limited to obtaining an outcome evaluation instrument.

Four studies were conducted. The first two studies gave voice to the intervention stakeholders, namely potential participants (upper secondary school students) and facilitators (mental health nurses).

Adolescents considered these training programmes relevant. This way, they will probably be receptive to these interventions. Similar programmes such as “Teen Mental Health First Aid” have been successful in their implementation (Hart et al., 2016, Wilcox et al., 2023). Adolescents identified the potential role of nurses in facilitating training programmes. The recognition of nurses as “health educators in schools” is in line with the role described by ICN and OE (ICN, n.d., OE, 2012, Regulation No. 515/2018, Stewart et al., 2024). This perception may be due to the effective work carried out by these professionals. However, the literature review conducted by Glerean et al. (2017) showed that young people's perceptions do not reflect the reality of the nursing profession and they need to be worked on continuously.

The adolescents suggested varied content that could support their role as aiders. The physical and relational approach to the person being helped, the assessment of the person, the problem and the help resources, the factors influencing mental health, and some mental health problems are content that can guide adolescents to approach another person and evaluate the situation (Kitchener et al., 2017). Information related to helping others with a focus on identifying, relieving and resolving the problem would enable adolescents to assist and encourage the use of self-help strategies (Costa et al., 2020b). Explanations about referral to formal and informal help resources would promote assistance and encouragement from others in seeking help (Kitchener et al., 2017). Teaching about factors influencing mental health, strategies for preventing mental health problems, and ways of caring and seeking help for oneself can support self-care (Costa et al., 2020b).

Adolescents suggested the use of multiple educational strategies and resources. The combination of training methods can promote the transfer of information of different natures and complexities (Martin et al., 2013). Furthermore, it can be effective for groups, as trainees may possess varied characteristics and interests (Martin et al., 2013). Adolescents recommended in-person learning, going against the trend of virtualisation of education (Lampropoulos, 2024). Pros and cons of virtual and/or in-person delivery of interventions

should be examined (e.g., the relationship established in the learning process, accessibility) (Alarifi & Song, 2024). They warned of the importance of raising awareness among the school community on mental health issues. Learning cannot consider the student in isolation but must take into account the factors that potentially influence them (Spier et al., 2018).

In contrast, mental health nurses gave their opinions on different aspects of the planning, implementation and evaluation of Mental Health First Aid Training Programmes. Despite designing an intervention led by mental health nurses, multidisciplinary facilitation was considered important. The participation of different professionals can foster a more comprehensive approach, a better understanding of participants and contexts, and a more effective mobilisation of resources (WHO, 2019). In addition to supporting the implementation of the intervention, they can explain the role of their professional group as a resource for mental health help.

Mental health nurses indicated that the intervention focuses on participants' mental health competencies. Therefore, related nursing diagnoses must be identified in students/classes, using ICNP and NANDA (Herdman et al., 2021, ICN, 2019). Based on ICNP, the diagnoses of "Potential to improve knowledge to respond [to mental health problems]", "Potential to improve ability to respond [to mental health problems]" and "Potential to improve self-efficacy to respond [to mental health problems]" may be appropriate (Costa et al., 2024). This learning potential requires availability and willingness from adolescents and the school (Ford et al., 2018). In addition, mental health nurses expressed that an evaluation of the process and outcomes of this type of intervention requires a longitudinal use of valid and adapted methods. Assessment tools can be identified in the literature and their psychometric properties should be examined (Mokkink et al., 2018).

The implementation of the intervention was considered appropriate for classes in a classroom setting. Adolescents are typically arranged at school this way (Normative Order No. 10-A/2018). Thus, access to adolescents can be easier and less disruptive to school dynamics. The perspective of mental health nurses was similar to that of adolescents regarding the delivery method of the intervention. This was a point of convergence, which demonstrated the understanding of adolescents by health professionals. The different components of mental health literacy by Jorm (2012) were highlighted as important contents of this type of intervention. This finding was in line with existing programmes in the literature (Costa et al., 2020b). Some cognitive, emotional, behavioural and relational problems that represent nursing diagnoses were suggested. These partially differed from those identified by the adolescents.

Mental health first aid actions were determined. They encompass the action plans outlined in other Mental Health First Aid Training Programmes (Costa et al., 2020b).

These ideas regarding the characteristics of the intervention were scrutinised by a broad panel of experts. Therefore, in a third study, consensus on the topic was obtained. Statements about intervention foci, intervention and evaluation methods, duration and frequency, contents, facilitators, participants and implementation context were validated and became guidelines for operationalising a training programme.

The fourth study responded to the need for instruments to assess the outcomes of the training programme. The Self-Assessment Scale of Basic Mental Health Action Competencies was developed and its psychometric properties were evaluated. It revealed good validity and reliability. Thus, the use of the instrument is appropriate (Boateng et al., 2018).

The programme “Empower4MentalHelp” was designed and a manual for intervention facilitators was proposed. In Table 4, the characteristics of the Mental Health First Aid Training Programmes mapped before the doctoral path and those of the intervention developed were summarised and compared.

Intervention Characteristics	Existing programmes in the literature (Costa et al., 2020b)	Programme “Empower4MentalHelp” (Costa et al., 2024)
Facilitator(s)	→ Adult(s) with various academic qualifications and occupations, but with educational and mental health skills	→ Mental health nurse(s) with possible co-facilitation of professionals with other training and from other work contexts
Intervention Foci	→ Varied foci that represented areas of nursing care	→ Nursing foci related to mental health competencies (knowledge, ability and self-efficacy)
Intervention Assessment	→ Multiple assessment methods and times. → Use of varied instruments, with and without validity, which frequently use psychiatric terms	→ Assessment of outcomes before the intervention, immediately after and in a follow-up, with the Self-Assessment Scale of Basic Mental Health Action Competencies and a mental health knowledge test → Assessment of the process throughout the intervention with a satisfaction questionnaire and behavioural observation

Participants	→ From laypeople to healthcare professionals, from adolescents to the elderly → Group intervention	→ Adolescents aged 15 to 18 → Intervention in classes (up to 30 students)
Implementation context	→ In-person and/or virtual → Numerous countries	→ Upper secondary schools, in the classroom → Portugal
Duration and frequency	→ 30 minutes to 24 hours, on 1 to 6 days → Interval between sessions of up to 1 week → With/without booster sessions	→ 8 hours and 25 minutes, in 6 to 11 days → Interval between sessions of up to 1 week → With a follow-up and reinforcement session → With a prior school community awareness session
Intervention Methods	→ Psychoeducation (with expository/demonstrative, participatory, experimental learning and/or contact education strategies) and/or use of informative materials	→ Psychoeducation (with a mix of educational strategies and resources)
Contents	→ Components of Mental Health Literacy described by Jorm (2012) → Mental health problems that mainly represent pathologies → Varied action plans, summarised in 4 actions: Approach the individual and evaluate the situation; Help the individual and encourage the use of self-help strategies; Assist in formal and informal help-seeking; Self-care	→ Components of Mental Health Literacy described by Jorm (2012) → Mental health problems that exclusively represent nursing diagnoses → Dynamic action plan with 4 actions: Approach the person and assess the situation; Assist and encourage the use of self-help strategies; Assist and encourage seeking help; and Self-care

Table 4: Comparison of Mental Health First Aid Training Programmes existing in the literature and the proposal developed

During the doctoral journey, new evidence produced on the topic was monitored. No other Mental Health First Aid Training Programme with a health-focused paradigm has been found.

6.1. Implications for Nursing and Health

This doctoral path had implications for Nursing and Health, namely in the practice of health care, resource management, politics, professional education and research. It can also impact the lives of patients and the context in which they live.

6.1.1. *Implications for Clinical Practice*

Mental Health First Aid Training Programmes were conceptualised by adolescents and mental health nurses. In this way, these interventions are more tailored to their intended recipients and facilitators. Medicalised terms were replaced by nursing terms (mental health problems that represent nursing diagnoses). Thus, these educational interventions were envisaged taking into account the nurses' body of knowledge and their regulated competencies. The works carried out emphasised the role of mental health nurses in leading these training programmes within multidisciplinary teams. Therefore, they can encourage and guide nurses to implement this type of intervention in the context of primary health care/school. Making an intervention's educational resources available can promote consistent delivery and replication.

The Self-Assessment Scale of Basic Mental Health Action Competencies can help measure patients' perceived competencies to act on mental health issues. It can support nurses' decision-making.

6.1.2. *Implications for Management*

The results of this doctorate inform health managers that there is this autonomous nursing intervention that potentially promotes mental health competencies. Managers can request more professionals and materials, or mobilise existing ones to explore this type of intervention.

6.1.3. *Implications for Policy*

This work can give politicians an alternative to promoting sustainability in healthcare, as the general public can become a better resource for mental health help. School health policies can guide professionals in the use of this type of intervention.

6.1.4. *Implications for Professional Education*

Nursing schools have the opportunity to introduce the intervention into nurses' training curricula. Mental health nurses must learn about this intervention to conduct it consistently. Non-mental health nurses should also be sensitive to the intervention since they can collaborate in co-facilitating the intervention or can be resources to help people with mental health problems. Complementarily, training or awareness courses on the topic could be carried out by researchers in the area (doctoral student or other members of the research team).

6.1.5. *Implications for Research*

The structure described by Skivington et al. (2021) for complex interventions can be an excellent guide to continue the development and evaluation process of this intervention.

It is important to conduct a feasibility study to determine whether the new intervention is feasible and has the potential for success. Conditions related to the evaluation design (e.g., recruitment, data collection, retention, outcomes, and analysis) or the intervention itself (e.g., content and delivery, acceptability, adherence, likelihood of cost-effectiveness, or ability of facilitators to implement) should be examined. Evaluating the effectiveness of the intervention is also essential. The intervention can first be applied on a smaller scale (pilot study) and then on larger samples. Adapting the proposed training programme to other participants and contexts is another research direction.

It was proposed a Mental Health First Aid Training Programme (with a health-centred perspective) that is different from the existing ones. Future studies should compare the process and outcomes of the proposed intervention and the training programmes with the pathogenic perspective.

The scale created can produce evidence about the mental health educational needs of populations and the outcomes of educational interventions (not just Mental Health First Aid Training Programmes). Validation and adaptation of the instrument for other populations can be conducted.

6.1.6. *Implications for the General Public*

This doctoral journey was made with the community and for the community. On the one hand, adolescents/upper secondary school students directly contributed to the development of the training programme and the scale. The adolescents' social network (legal guardians, leaders of

social groups, ...) were indirectly involved in the investigation process, raising awareness of the studies and/or authorising participation in them. On the other hand, potential benefits for them were obtained in this investigation path. Nurses will be able to carry out these training programmes for the community, in a school context. In turn, adolescents will improve their competencies to identify mental health problems, support and refer people who experience these conditions. They will probably have more tools to take care of their mental health as well. This way, they will be able to play a more active role in their health and that of those around them.

Adequate and timely help can be reflected in health gains. The focus on mental health problems (not disorders) in training programmes can be a way to promote mutual help in mental health in the community, going against the grain of “psychiatrisation of human suffering”.

6.2. Limitations

Each study had its specific limitations reported. However, it is important to recognise the general limitations of the research path. First, the doctoral project was implemented without funding. The lack of funding was reflected in the slowness in carrying out tasks and the impossibility of attending some training activities. Secondly, reconciling the academic path with the professional career (as a nurse and invited assistant professor) was sometimes difficult, resulting in a slower conduction/writing of studies. Finally, data collection with adolescents took place outside the schools, although the intervention was designed for the school environment. The COVID-19 pandemic, recurrent teacher strikes and the lack of a solid network of prior contacts in schools made it difficult to get closer to the context and justified this option.

The proposed intervention must be seen as a result of the research carried out. “Edges” may exist and can be “polished” in subsequent studies.

CONCLUSIONS

The objectives initially defined in the doctoral project were fulfilled. The characteristics of Mental Health First Aid Training Programmes were determined by their potential participants (adolescents) and facilitators (mental health nurses). In the first study, adolescents highlighted the relevance of these interventions. They recommended addressing various content underlying self-care, identifying mental health problems, providing initial help to others and referral to help resources. They suggested that the intervention should preferably be delivered face-to-face, using different educational strategies. The school community should also be made aware of the topic. In the second study, mental health nurses recognised that they could conduct these interventions in collaboration with professionals from other disciplines and specialities. They considered that they would improve the mental health competencies of students in a classroom setting. Valid and longitudinal evaluations of interventions would allow for the representation of their processes and outcomes. Mental health nurses highlighted that different training strategies and educational resources can be used regularly to teach adolescents how to help people with various mental health problems that represent nursing diagnoses. They also noted the importance of raising awareness within the school community. In the third study, a consensus was reached on most of the characteristics of the training programmes. Consequently, an intervention with a salutogenic mental health literacy perspective (Empower4MentalHelp) was created. Educational materials were made available in the guidance manual for intervention facilitators. In the fourth study, a scale that assesses perceived competencies to act in mental health was also developed and proved to be a valid and reliable option for measuring the outcomes of educational interventions like this one. In conclusion, this doctoral path was a starting point for exploring these training programmes as autonomous nursing interventions.

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DISSEMINATION AND SCIENTIFIC PRODUCTION

Throughout the doctoral course, scientific articles and monographs/book chapters were produced, as well as posters, oral communications and lectures were presented at scientific events.

Scientific production

- **Monographs/books**

Costa, T. (2021). Mental Health First Aid Training Programmes (in Portuguese). In Sequeira, C. Sequeira, C., Carvalho, D., Soares, J., Araújo, O., Valentim, O., & Pires, R. (Eds.), *I Encontro Internacional de Literacia e Saúde Mental Positiva - Conference Proceedings* (pp. 23-25). Oporto: Nursing School of Porto. ISBN: 978-989-54454-2-4

Morgado, T., Costa, T., Araújo, O., & Silva, R. (2022). Interventions for Better Mental Health Literacy. In C. Vaz de Almeida, & S. Ramos (Eds.), *Handbook of Research on Assertiveness, Clarity, and Positivity in Health Literacy* (pp. 187-207). Pennsylvania: IGI Global. <https://doi.org/10.4018/978-1-7998-8824-6.ch011>

Costa, T. F. O., Sampaio, F. M. C., Sequeira, C. A. C., Lluch Canut, M. T., & Moreno Poyato, A. R. (2024). *Manual for facilitators of the “Empower4MentalHelp” training programme (upper secondary education version 1.0) (in Portuguese)*. Oporto: Portuguese Society of Mental Health Nursing (ASPESM). ISBN: 978-989-54826-6-5

- **Articles in peer-reviewed journals**

Costa, T. F. O., Sampaio, F. M. C., Sequeira, C. A. C., Lluch Canut, M. T., & Moreno Poyato, A. R. (2021). A qualitative study exploring adolescents' perspective about Mental Health First Aid Training Programmes promoted by nurses in upper secondary schools. *International Journal of Mental Health Nursing*, 31(2), 326-338. <https://doi.org/10.1111/inm.12959>

Costa, T. F. O., Sampaio, F. M. C., Sequeira, C. A. C., Lluch Canut, M. T., & Moreno Poyato, A. R. (2022). Nurses' perspective about the Mental Health First Aid Training Programmes for adolescents in upper secondary schools: A focus group study. *Journal of Psychiatric and Mental Health Nursing*, 29(5), 721-731. <https://doi.org/10.1111/jpm.12823>

Costa, T. F. O., Moreno Poyato, A. R., Sampaio, F. M. C., Lluch Canut, M. T., & Sequeira, C. A. C. (2023). Nurses' promotion of Mental Health First Aid Training Programmes for upper secondary

students: a modified Delphi approach. *BMC Nursing*, 22(91), 1-12.
<https://doi.org/10.1186/s12912-023-01255-3>

Costa, T. F. O., Sampaio, F. M. C., Sequeira, C. A. C., Costa, P. R. S., Lluch Canut, M. T., & Moreno Poyato, A. R. (under review). Self-Assessment Scale of Basic Mental Health Action Competencies: Development and Evaluation of the Psychometric Properties.

Dissemination at Scientific Events

- **Posters**

Costa, T., Moreno Poyato, A. R., Sequeira, C., Lluch Canut, M. T., & Sampaio, F. (2020). *Development and evaluation of a Mental Health First Aid Training Programme for upper secondary school students: a research project (in Spanish/Castilian)*. Poster presented in AEESME 8ª Sesión: Seminario Permanente de Jóvenes Investigadores en Cuidados de Salud Mental, Online. Obtained special mention.

Costa, T., Moreno Poyato, A. R., Sequeira, C., Lluch Canut, M. T., & Sampaio, F. (2022). *Mental Health First Aid Training Programmes in upper secondary education institutes: giving voice to interested parties (in Spanish/Castilian)*. Poster presented in AEESME XXXIX Congreso Nacional de Enfermería de Salud Mental, Pamplona.

Costa, T. F. O., Sampaio, F. M. C., Sequeira, C. A. C., Costa, P. R. S., Lluch Canut, M. T., & Moreno Poyato, A. R. (2024). *Self-Assessment Scale of Basic Mental Health Action Competencies: Development and Evaluation of the Psychometric Properties (in Portuguese)*. Poster presented in International Nursing Research Congress - NursID 2024, Oporto.

Costa, T. F. O., Sampaio, F. M. C., Sequeira, C. A. C., Lluch Canut, M. T., & Moreno Poyato, A. R. (2024). *Empower4MentalHelp: The Emergence of an Educational Intervention (in Portuguese)*. Poster presented in International Nursing Research Congress - NursID 2024, Oporto.

- **Oral communications**

“Development and evaluation of a Mental Health First Aid Training Programme for students in the upper secondary school context”. Public video created for the 3 Minute-Thesis Competition (3MT) (2022), promoted by the University of Barcelona / Coimbra Group.
www.youtube.com/watch?v=3iuKouAFcG0

- **Lecture**

"Development and evaluation of a Mental Health First Aid Training Programme for students in the upper secondary school context" at the Encontro de Doutorandos 2021 - Seminário de Investigação em Enfermagem e Saúde "Saúde Mental em Construção" (January 8, 2021).

"Mental Health First Aid Training Programmes aimed at students in the upper secondary education context" (*in Portuguese*) in the Webinar "SeMenteVital VII — Reagindo para Promover" (October 13, 2021).

"Awareness raising for Mental Health First Aid" (*in Portuguese*) at the Encontros Pedagógicos da Escola Superior de Enfermagem do Porto (October 13, 2021).

"Characteristics of a Mental Health First Aid Training Programme aimed at upper secondary school students" (*in Portuguese*) at the XII Congresso da Sociedade Portuguesa de Enfermagem de Saúde Mental (ASPESM) - 2021 "Saber mais, fazer melhor!" & IV Seminário Internacional de Investigação em Saúde Mental (October 27 to 29, 2021).

"Development of a Mental Health First Aid Training Programme in the Upper Secondary School Context: the First Steps of a Doctoral Project" at the "Recerca infermera en temps de pandèmia" conferences of the Doctoral Programme in Nursing and Health at the University of Barcelona (2 and 3 December 2021).

"Mental Health First Aid Training Programmes: an intervention led by nurses" (*in Portuguese*) in a Seminar of the Curricular Unit "Promoção de Saúde Mental e Prevenção da Doença" of the Master's Course in Mental Health and Psychiatric Nursing at the Nursing School of Porto (April 19, 2022).

"Development of a Mental Health First Aid Training Programme for adolescents in upper secondary schools" (*in Portuguese*) at the II Encontro Internacional de Literacia e Saúde Mental Positiva (April 22, 2022).

"Mental Health First Aid Training Programmes: a social empowerment tool" (*in Portuguese*) at the VI Congresso dos Enfermeiros da Ordem dos Enfermeiros (May 5 to 7, 2022).

"Development of a Mental Health First Aid Training Programme for adolescents in upper secondary schools" (*in Portuguese*) no II Encontro do Núcleo de Enfermeiros Especialistas em Enfermagem de Saúde Mental e Psiquiátrica da ULSM (May 20, 2022).

"Differentiated intervention strategies in psychiatric emergency situations" (*in Portuguese*) in a Seminar of the Curricular Unit "Controlo e Compromisso dos Processos Mentais" of the

Master's Course in Mental and Psychiatric Health Nursing at the Nursing School of Porto (September 20, 2022).

"Stigma and Discrimination in mental health" (*in Portuguese*) in a Seminar of the Curricular Unit "Enfermagem de Saúde Mental e Psiquiátrica" of the Master's Course in Mental and Psychiatric Health Nursing at the Portuguese Red Cross Northern Health School (October 19, 2022).

"Structure of a Mental Health First Aid Training Programme for Adolescents" (*in Portuguese*) at the XIII Congresso Internacional ASPESM (October 26 to 28, 2022).

"Mental Health First Aid Training Programmes promoted by nurses" (*in Portuguese*) in a Seminar of the Curricular Unit "Promoção e Prevenção em Saúde Mental" of the Master's Course in Mental Health and Psychiatric Nursing of the Cooperative for Higher, Polytechnic and University Education (December 5, 2022).

"Differentiated intervention strategies in psychiatric emergency situations" (*in Portuguese*) in a Seminar of the Curricular Unit "Controlo e Compromisso dos Processos Mentais" of the Master's Course in Mental and Psychiatric Health Nursing at the Nursing School of Porto (February 14, 2023).

"Mental Health First Aid Training Programme for upper secondary school students" (*in Portuguese*) at NursID Spring School 2023 (May 8 to 12, 2023).

"Mental Health First Aid Training Programmes promoted by nurses" (*in Portuguese*) in a Seminar of the Curricular Unit "Promoção e Prevenção em Saúde Mental" of the Master's Course in Mental Health and Psychiatric Nursing of the Cooperative for Higher, Polytechnic and University Education (June 5, 2023).

"Mental Health First Aid Training Programmes" (*in Portuguese*) at the XIV Congresso Internacional ASPESM & VI Seminário Internacional de Investigação em Enfermagem de Saúde Mental (October 18 to 20, 2023).

"Mental Health: Shall we act?" (*in Portuguese*) in an initiative of the Youth Support Office of the Municipality of Tomar and the Médio Tejo Mental Health Association (March 23, 2024).

APPENDICES

**Appendix 1: Approval of the Doctoral Project by the Bioethics Committee of the University of
Barcelona**



UNIVERSITAT DE
BARCELONA

Oficina de Gestió de la Recerca
Pavelló Rosa (recinte Maternitat) primer pis
Travessera de les Corts, 131-159 93-4035398
08028 Barcelona

Bioethics Committee of the Universitat de Barcelona

Gemma Marfany Nadal, as Academic Secretary of the Committee of Bioethics of Universitat de Barcelona (CBUB).

CERTIFIES:

that the application for a project Thesis presented by Mr. **Tiago Filipe Oliveira Costa**, PhD student of the Department of Public Health Nursing, Mental and Maternal and Child Health, at Universitat de Barcelona, entitled **"Development and evaluation of a Mental Health First Aid Training Program for students in the upper secondary school context"** and supervised by Drs. **Antonio Rafael Moreno Poyato** and **Carlos Alberto da Cruz Sequeira**, has been evaluated by the CBUB. This Committee agreed on February 15, 2021 that this PhD project conforms to the bioethics directives of Universitat de Barcelona, and therefore, the CBUB considers favourably the Thesis project.

To this end, the Secretary of the CBUB signs this document, with the acknowledgement of the President of this Committee, in Barcelona, February 17, 2021.

Firmado por MARFANY NADAL, GEMMA
(FIRMA) el día 17/02/2021 con un
certificado emitido por AC DNIE 005

Acknowledged by
President of the Bioethics Committee of the
Universitat de Barcelona

Jordi Garcia-Fernández

35030054L
JORDI GARCIA
(R:
Q0818001J)

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Institutional Review Board (IRB00003099)

**Appendix 2: Approval of Study 4 (Scale Administration Stage) by the Ethics Committee of the
Portuguese Society of Mental Health Nursing**



A SOCIEDADE PORTUGUESA DE ENFERMAGEM DE SAÚDE MENTAL

COMISSÃO DE ÉTICA

**PROJETO DE INVESTIGAÇÃO
CEASPESM_1/2023**

DATA DE RECEÇÃO: 21/12/2022

PARECER DO RELATOR:

TÍTULO DO ESTUDO:

Competência para agir em saúde mental e o nível de saúde mental positiva de adolescentes portugueses.

PROMOTOR DO ESTUDO: N/A

EQUIPA DE INVESTIGAÇÃO:

INVESTIGADOR PRINCIPAL: Tiago Filipe Oliveira Costa (Enfermeiro Mestre ESMP)

INVESTIGADOR RESPONSÁVEL NA INSTITUIÇÃO:

Professor Doutor Carlos Alberto da Cruz Sequeira (Escola Superior de Enfermagem do Porto).

OUTROS INVESTIGADORES:

Professor Doutor Antonio Rafael Moreno Poyato (Universidade de Barcelona); Professora Doutora María Teresa Lluch Canut (Universidade de Barcelona); Professor Doutor Francisco Miguel Correia Sampaio (Escola Superior de Enfermagem do Porto); Professor Doutor Patrício Ricardo Soares Costa (Universidade do Minho).

LOCAL DO ESTUDO:

Projeto de investigação inserido no âmbito do Doutoramento em Enfermagem e Saúde da Universidade de Barcelona.

OUTRAS INSTITUIÇÕES PARTICIPANTES:

Centro de Investigação em Tecnologias e Serviços de Saúde da Universidade do Porto / Escola Superior de Enfermagem do Porto (CINTESIS/ESEP).

OBJETIVOS DO ESTUDO:

“Objetivos do Estudo: 1) Testar a Escala de autoavaliação de Competências Básicas para Agir em Saúde Mental [Basic-MAC scale] com adolescentes dos 15 aos 18 anos e aceder às propriedades da escala, 2) Validar o Questionário de Saúde Mental Positiva para população portuguesa com 15 a 18 anos de idade, e 3) Avaliar os fatores sociodemográficos, a competência percebida para agir em saúde mental e o nível de saúde mental positiva de adolescentes dos 15 aos 18 anos e a relação entre estas variáveis.”

PARTICIPANTES NO ESTUDO:

“Adolescentes dos 15 aos 18 anos de idade que vivam em Portugal serão recrutados a partir de uma amostragem não probabilística por bola de neve. Primeiramente, os investigadores divulgarão o estudo junto de grupos (escolares, culturais, religiosos e desportivos) potencialmente constituídos por adolescentes, e ainda por grupos de encarregados de educação.”

CRITÉRIOS DE INCLUSÃO/EXCLUSÃO:

Participam adolescentes entre os 15 e 18 anos de idade, com consentimento informado declarado pelo próprio (se 18 anos) ou pelo seu encarregado de educação (dos 15 aos 17 anos).



TAMANHO DA AMOSTRA:

"Considerando que a Escala de autoavaliação de Competências Básicas para Agir em Saúde Mental [Basic-MAC scale] tem 50 itens serão visados pelo menos 500 adolescentes."

DURAÇÃO DO ESTUDO:

Entre Janeiro de Junho de 2023 (6 meses)

METODOLOGIA:

"(...)Pessoas leigas podem ser dotadas de competências básicas/genéricas em saúde mental (Costa et al., 2020). Leigos podem ser encarados como agentes ativos no autocuidado e na procura de ajuda em saúde mental, assim como no socorro a pessoas com problemas de saúde mental (Costa et al., 2020). Uma pesquisa exploratória focada em instrumentos de avaliação de competência básicas para agir em assuntos de saúde mental evidenciou a inexistência aparente de instrumentos que mensurem o construto. Deste modo, optamos por desenvolver e avaliar as propriedades psicométricas da Escala de autoavaliação de Competências Básicas para Agir em Saúde Mental [*Self-assessment scale of Basic Mental health Action Competencies* (Basic-MAC scale)]."

"(...) optamos por desenvolver e avaliar as propriedades psicométricas da Escala de autoavaliação de Competências Básicas para Agir em Saúde Mental [*Self-assessment scale of Basic Mental health Action Competencies* (Basic-MAC scale)]. Foi planeado um estudo psicométrico com 4 etapas: geração de itens, avaliação da validade de conteúdo, pré-testagem da escala e aplicação da escala. (...) Este estudo envolverá a resposta de adolescentes a um questionário, em dois momentos (agora e daqui a 7/14 dias). Prevê-se que cada preenchimento do questionário não exija mais do que 10-15 minutos. O questionário avaliará aspetos sociodemográficos, a competência percebida para agir em saúde mental e o nível de saúde mental positiva. Asseguramos que o estudo não apresenta qualquer risco para os participantes.(...)

"(...)No que concerne à análise de dados, serão usados procedimentos de estatística descritiva e inferencial para analisar os resultados obtidos. Pretende-se aplicar diferentes testes de dimensionalidade, validade, confiabilidade em relação à Escala de autoavaliação de Competências Básicas para Agir em Saúde Mental [Basic-MAC scale] e ao Questionário de Saúde Mental Positiva (versão reduzida) (Sequeira et al., 2014)."

ASPETOS FINANCEIROS:

Não aplicável. "Não haverá lugar a qualquer pagamento pela participação dos adolescentes neste estudo. A participação deles é totalmente voluntária e poderão recusar ou abandonar o estudo a qualquer momento sem que haja qualquer prejuízo para si. Este trata-se de um estudo não financiado, relativamente ao qual os investigadores assumem a ausência de conflitos de interesse."

REQUISITOS PREENCHIDOS:

Cumpridos todos os requisitos da "Lista de Verificação para Realização de Estudo de Investigação." O estudo teve já um parecer favorável por uma comissão de ética: "Este estudo recebeu a aprovação da Comissão de Ética da Universidade de Barcelona (Conselho de Revisão Institucional: IRB00003099)."

Realça-se, no enquadramento ético do estudo, as garantias dadas pelo investigador, conforme declarado na "Sinopse"(a) e na "Nota Informativa do Estudo" (b):



a) “Os participantes só acederão aos instrumentos de colheita de dados (avaliação sociodemográfica, Basic-MAC scale, QSM+) depois de submeterem na Secção 2 do Formulário 1 (Anexo 3) o consentimento informado dos adolescentes e a autorização dos responsáveis legais para os menores de idade. Após o preenchimento da Secção 4 do Formulário 1 (Anexo 3), os investigadores validarão se os documentos submetidos são os solicitados e se estão devidamente assinados. Os participantes serão notificados (por e-mail/SMS) sobre a adequação dos documentos por eles disponibilizados e sobre a continuidade da sua participação. Se os documentos estiverem bem preenchidos, os participantes poderão aceder e responder aos instrumentos de colheita de dados. Se os documentos anexados não forem apropriados, não poderão avançar e os investigadores enviarão instruções das correções a realizar.”

b) “Confidencialidade: Todos os contactos serão feitos em ambiente de privacidade. Toda a informação será recolhida e tratada de forma confidencial. Um código será atribuído a cada participante, sendo ocultadas as suas identificações. Os dados recolhidos serão apenas utilizados para este estudo. Serão guardados num computador exclusivo para o trabalho com senha de acesso. Serão mantidos durante o doutoramento, sendo depois irreversivelmente destruídos. Apenas os investigadores envolvidos no projeto terão acesso aos dados colhidos e estão obrigados a sigilo profissional. Não haverá qualquer divulgação de dados individuais. No entanto, os resultados do estudo (devidamente tratados) serão publicados e disseminados em revistas científicas. Este estudo foi submetido e aprovado pela Comissão de Ética da Universidade de Barcelona. De acordo com as disposições em regulamento, a Universidade de Barcelona (com CIF Q0818001J e sede na Gran Via de les Corts Catalanes, 585 - 08007 Barcelona) como responsável pelo tratamento de dados pessoais, informa que pode contactar o Responsável pela Proteção de Dados por escrito para o endereço postal (Travessera de les Corts, 131- 159, Pavelló Rosa, 08028 - Barcelona), ou para o correio eletrónico protecciodedades@ub.edu. Os adolescentes terão o direito de aceder aos seus dados, de solicitar a retificação de dados incorretos e de pedir a sua exclusão, de limitar o processamento, de se opor e retirar o consentimento do seu uso para determinados fins. Poderão exercer esses direitos por escrito para o endereço postal ou para o endereço eletrónico mencionados acima. Informamos também sobre o direito dos adolescentes de apresentar uma reclamação junto da Agência Catalã de Proteção de Dados em caso de qualquer ação da Universidade de Barcelona que considerem violar os seus direitos.”

Submetido pedido de apreciação e parecer para o projeto de investigação no âmbito da literacia em saúde mental, intitulado “Competência para agir em saúde mental e o nível de saúde mental positiva de adolescentes portugueses.”, pelo promotor acima identificado, no âmbito do seu doutoramento em Enfermagem e Saúde, na Universidade de Barcelona. Tem como objectivo principal testar e validar a “Escala de Autoavaliação de Competências Básicas para Agir em Saúde Mental [Basic-MAC scale]”, junto de uma população de adolescentes dos 15 aos 18 anos.”

Resume-se a informação relevante deste projeto de investigação nas páginas anteriores, que enquadra e serve de fundamento a este parecer.



A SOCIEDADE PORTUGUESA DE ENFERMAGEM DE SAÚDE MENTAL

COMISSÃO DE ÉTICA

O projeto de investigação cumpre os requisitos éticos da investigação com pessoas e apresenta garantias de respeito pela dignidade e integridade dos participantes, bem como, de confidencialidade (privacidade e proteção de dados). A Comissão Ética emite parecer favorável para a realização da investigação, nos termos do projeto submetido.

Relator: LS

08/03/2023

Presidente da CE-ASPESM

Isilda Ribeiro

Assinado por: **ISILDA MARIA DE OLIVEIRA
CARVALHO RIBEIRO**
Num. de Identificação: B1080938302
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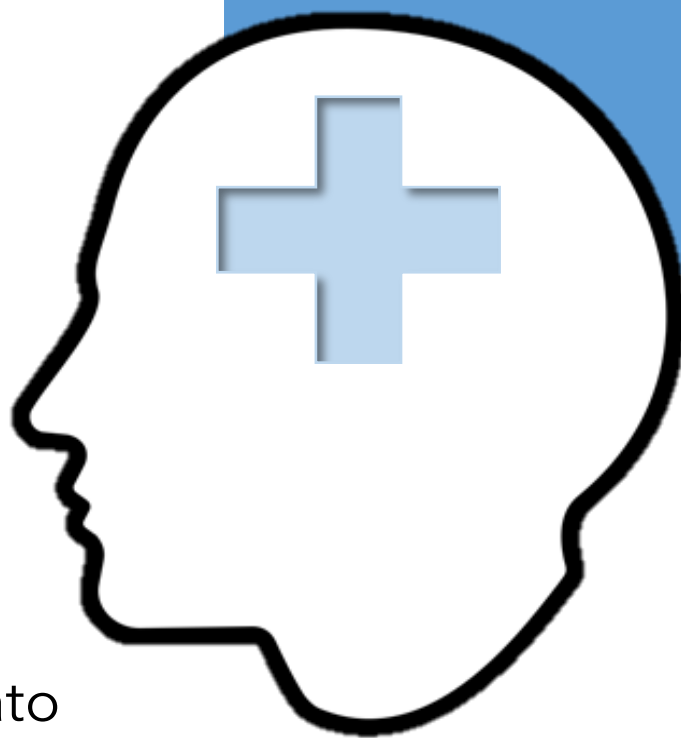
**Appendix 3: Manual for Facilitators of the “Empower4MentalHelp” Training Programme
(upper secondary education version 1.0)**

Manual para Dinamizadores do Programa de Formação

"**Empower4 MentalHelp**"

(*versão ensino
secundário 1.0*)

Tiago Costa
Francisco Sampaio
Carlos Sequeira
Teresa Lluch-Canut
Antonio Moreno-Poyato



FICHA TÉCNICA

TÍTULO

Manual para Dinamizadores do Programa de Formação "Empower4MentalHelp"
(versão ensino secundário 1.0)

AUTORES

Tiago Filipe Oliveira Costa - Doutorando em Enfermagem e Saúde na Universidade de Barcelona, Investigador Colaborador no grupo "NursID: Inovação e Desenvolvimento em Enfermagem" do CINTESIS:RISE, Enfermeiro na Unidade Local de Saúde Gaia e Espinho e Assistente Convidado da Escola Superior de Saúde Norte da Cruz Vermelha Portuguesa.

Endereço eletrónico: tiagofilipeoliveiracosta@gmail.com

Francisco Miguel Correia Sampaio - Professor Adjunto na Escola Superior de Enfermagem do Porto e Investigador Doutorado Integrado no grupo "NursID: Inovação e Desenvolvimento em Enfermagem" do CINTESIS:RISE.

Carlos Alberto da Cruz Sequeira - Professor Coordenador Principal na Escola Superior de Enfermagem do Porto e Investigador Principal no grupo "NursID: Inovação e Desenvolvimento em Enfermagem" do CINTESIS:RISE.

María Teresa Lluch-Canut - Professora Catedrática na Faculdade de Enfermagem da Universidade de Barcelona e Membro do Grupo de Investigação NURSEARCH.

Antonio Rafael Moreno-Poyato - Professor Associado na Faculdade de Enfermagem da Universidade de Barcelona e Coordenador do Grupo de Investigação NURSEARCH.

ANO DE PUBLICAÇÃO: 2024

EDIÇÃO: Sociedade Portuguesa de Enfermagem de Saúde Mental (ASPESM)

CONTEXTO DE DESENVOLVIMENTO DO MANUAL

Doutoramento de Tiago Costa na Universidade de Barcelona

Trabalhos do grupo “NursID: Inovação e Desenvolvimento em Enfermagem” do CINTESIS:RISE.

INSTITUIÇÕES ASSOCIADAS



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INTRODUÇÃO

O presente documento descreve um Programa de Formação em Primeira Ajuda em Saúde Mental dirigido a adolescentes em escolas secundárias, denominado de “Empower4MentalHelp”. Este relatório visa orientar os potenciais dinamizadores da intervenção na sua implementação e avaliação.

Este manual está organizado em três capítulos. Primeiramente, é apresentado um enquadramento sobre a ajuda inicial que os cidadãos podem prestar a pessoas com problemas de saúde mental. De seguida, são descritas as características do programa de formação “Empower4MentalHelp”, nomeadamente o seu objetivo, dinamizadores, participantes e contexto de implementação, focos de intervenção e métodos de avaliação, duração e frequência da intervenção, métodos de intervenção e conteúdos a abordar. Por fim, são detalhados os módulos/sessões de formação, explorando-se os conteúdos, estratégias de intervenção e de avaliação, recursos educativos e a duração de cada etapa.

As orientações disponibilizadas permitem a realização consistente da intervenção e a replicação em diferentes contextos escolares. Todos os recursos educativos poderão ser fornecidos aos profissionais interessados em implementar a intervenção. A disseminação em larga escala do programa de formação poderá conduzir a importantes evidências na intervenção em saúde mental. Portanto, os autores disponibilizam-se a ensinar sobre o programa de formação e assistir na sua condução. Contudo, pede-se a todos os dinamizadores a partilha autorizada dos dados colhidos. Deste modo, a adequada análise e a divulgação de dados será garantida.

Ressalva-se que o estudo da viabilidade e a pilotagem da intervenção não foram realizados à data da publicação do presente manual. Se ao implementar a intervenção reconhecer a necessidade de ajustes significativos, por favor, sugira aos autores. Eles considerarão as sugestões, podendo incluí-las em versões subseqüentes do manual. Além disso, existe a oportunidade de adaptar o programa de formação para outras populações e contextos específicos. Se pretender realizar a adaptação da intervenção, os autores têm todo o gosto em colaborar. Recomendam-se instrumentos de avaliação para mensurar o processo e os resultados do programa de formação. Todavia, o uso de outros pode ser considerado.

CAPÍTULO I - PRIMEIRA AJUDA EM SAÚDE MENTAL

Este capítulo apresenta os conceitos subjacentes ao programa de formação e destaca a pertinência da primeira ajuda em saúde mental e da promoção de literacia em saúde mental.

Da saúde mental ao problema

A saúde mental pode ser definida como um estado de bem-estar no qual a pessoa percebe o seu próprio potencial, é capaz de lidar com o stress normal da vida, trabalhar de forma produtiva e frutífera e de dar um contributo para a sua comunidade (Organização Mundial de Saúde [OMS], 2021). Pode ser vista como um *continuum*, envolvendo o estar bem, a vivência de um problema de saúde mental, de uma doença mental e o estar recuperado. “Problema de saúde mental” é um termo amplo que inclui tanto as doenças mentais como os sintomas destas doenças que ainda não são justificativos para a identificação do diagnóstico de doença mental (Kitchener et al., 2017). A doença mental define-se como a síndrome caracterizada por perturbação clinicamente significativa na cognição, na regulação emocional ou no comportamento de um indivíduo que reflete uma disfunção nos processos psicológicos, biológicos ou de desenvolvimento subjacentes ao funcionamento mental (American Psychiatric Association [APA], 2022).

A crescente prevalência de problemas de saúde mental e a potencial disfuncionalidade causada torna essencial a intervenção em saúde mental. Apesar de existirem tratamentos, apenas uma minoria de pessoas com problemas de saúde mental os recebe. Na literatura, têm sido descritos múltiplos fatores influenciadores da procura de ajuda (Figura 1).

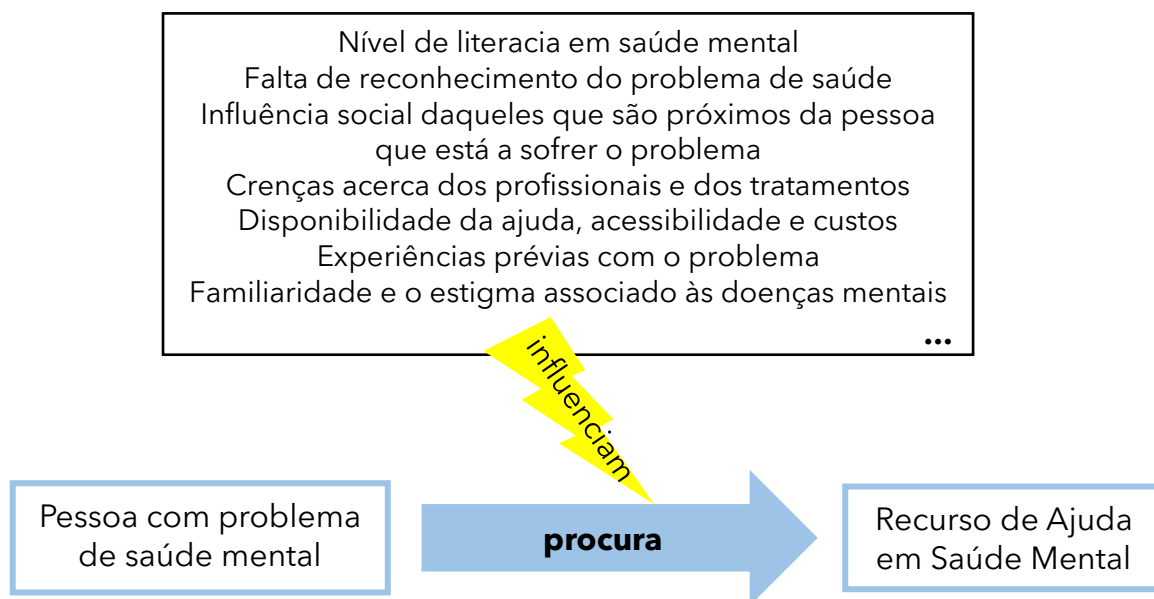


Figura 1. Fatores influenciadores na procura de ajuda em saúde mental

Do problema de saúde mental à primeira ajuda

A alta prevalência de problemas de saúde mental aumenta a probabilidade de as pessoas terem contato com indivíduos com esses problemas. O público em geral pode fornecer uma primeira ajuda a estes indivíduos até que eles recebam suporte profissional ou que a crise seja resolvida (Kitchener et al., 2017). Essa ajuda inicial costuma ser prestada por alguém da rede social de pessoas com problemas de saúde mental (como amigos e familiares) e não por profissionais de saúde mental. De acordo com Wong et al. (2014), a sugestão de membros da rede social torna os indivíduos com problemas de saúde mental mais propensos a procurarem ajuda profissional.

A prestação de primeira ajuda requer que as pessoas tenham um papel ativo na saúde de outras pessoas. Por sua vez, os cidadãos podem envolver-se mais em assuntos de saúde pessoal e comunitária, melhorando a sua Literacia em saúde (OMS, 2017).

Literacia em saúde mental

A literacia em saúde pode ser definida como o “conjunto de competências cognitivas e sociais e a capacidade dos indivíduos para acederem, compreenderem e usarem informação de forma que promovam e mantenham boa saúde” (OMS, 1998, p. 10). Por sua vez, a literacia em saúde mental envolve o conhecimento de como prevenir doenças mentais, o reconhecimento de quando uma doença se está a desenvolver, o

conhecimento sobre recursos de ajuda e tratamentos disponíveis, o conhecimento de estratégias eficazes de autoajuda, e o conhecimento e as habilidades para fornecer primeira ajuda e apoiar os outros (Jorm, 2012). Os níveis de literacia em saúde mental parecem ser baixos em todo o mundo (Tay et al., 2018). Portanto, os Programas de Formação em Primeira Ajuda em Saúde Mental são relevantes.

Os Programas de Formação em Primeira Ajuda em Saúde Mental visam divulgar competências básicas de primeira ajuda em saúde mental nas comunidades (Kitchener et al., 2017). Este tipo de intervenções procura capacitar indivíduos a ajudar pessoas com problemas de saúde mental. Não envolve as intervenções diretas do terapeuta às pessoas com problemas de saúde mental. A Figura 2 ilustra este tipo de intervenção.

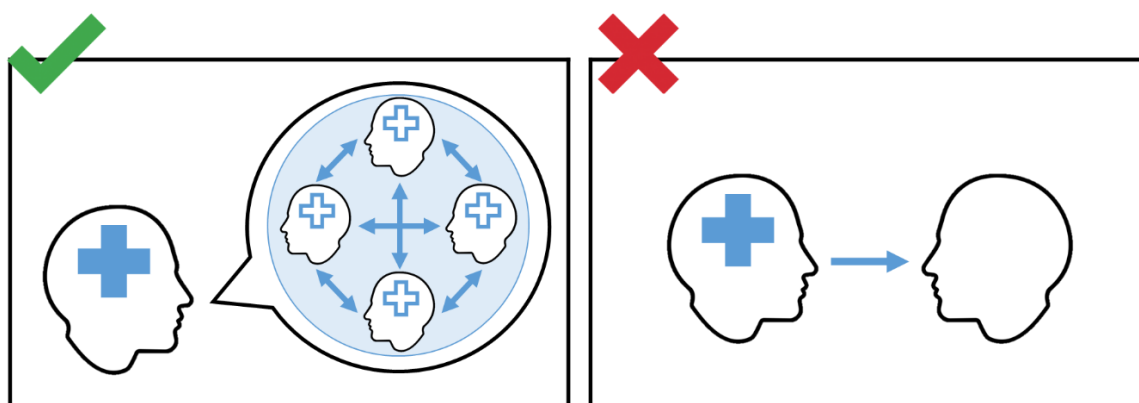


Figura 2. Conceito de Programa de Formação em Primeira Ajuda em Saúde Mental

CAPÍTULO II - CARACTERÍSTICAS DO PROGRAMA DE FORMAÇÃO "EMPOWER4MENTALHELP"

Este capítulo apresenta as principais características do programa de formação. O desenvolvimento desta intervenção foi suportado por um processo de investigação sintetizado na Figura 3.

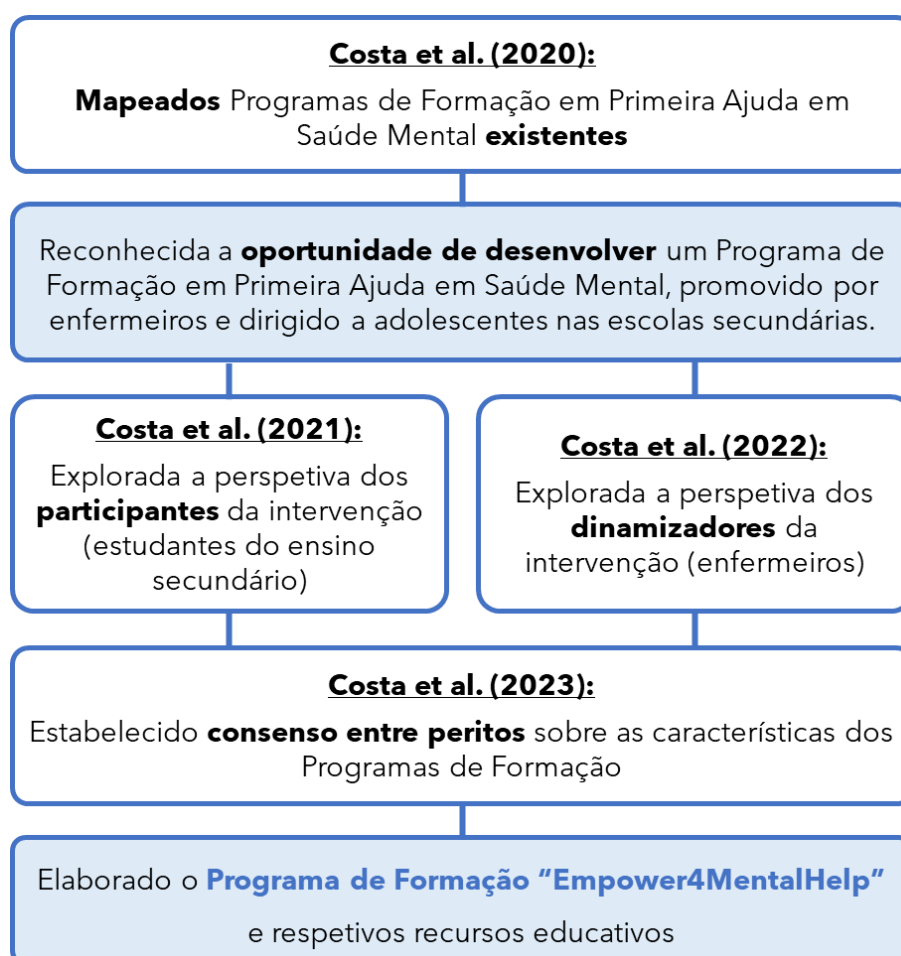


Figura 3. Processo de desenvolvimento do Programa de Formação

Objetivo da intervenção

A intervenção visa capacitar, em contexto escolar, adolescentes para socorrerem pessoas do público em geral (não apenas outros adolescentes) com problemas de saúde mental. A Figura 4 ilustra as ações subjacentes ao programa de formação.

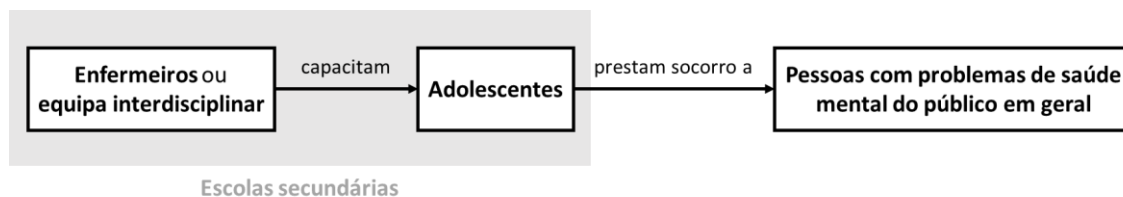


Figura 4. Sequência de ações subjacentes ao Programa de Formação

Dinamizadores da intervenção

O programa de formação deve ser promovido, preferencialmente, por Enfermeiros Especialistas em Enfermagem de Saúde Mental e Psiquiátrica. Estes profissionais possuem competências pessoais, pedagógicas e em saúde mental que apoiam o seu papel no planeamento, implementação e avaliação da intervenção (Regulamento n.º 515/2018).

Na co-dinamização do programa de formação podem ser considerados profissionais com diferentes formações (por exemplo, Educação, Psicologia, Psiquiatria, Saúde Infantil e Pediátrica, Saúde Comunitária) e contextos de trabalho (por exemplo, escola, cuidados de saúde hospitalares, cuidados de saúde primários).

Participantes e contexto de implementação

O programa de formação é dirigido a adolescentes nas escolas secundárias. Recomenda-se a implementação da intervenção para turmas, uma vez que esta é a organização habitual em meio escolar dos estudantes. Considerando que as turmas têm até 30 estudantes, sempre que necessário deve considerar-se a divisão em grupos (por exemplo, nas estratégias de ensino mais ativas). Qualquer estudante do ensino secundário (10º, 11º e 12º anos de escolaridade) pode ser incluído na intervenção. Usualmente, estudantes do ensino secundário têm 15 a 18 anos de idade. Portanto, a participação de indivíduos menores de idade nos programas de formação requer a autorização dos encarregados de educação.

Nas turmas devem ser identificados estudantes com diagnósticos de enfermagem relativos a competências de saúde mental. Deste modo, esta intervenção é justificada pelas necessidades educativas dos seus participantes. Importa ainda reconhecer nas turmas a disponibilidade e vontade de aprender sobre assuntos de saúde mental,

visto que a motivação é um aspeto chave na aprendizagem. De modo a ajustar as estratégias de intervenção (por exemplo, os cenários dos estudos de caso), deve-se ter atenção particular a participantes que tenham problemas de saúde (física, mental e/ou social). A implementação da intervenção para os adolescentes deve ser preferencialmente presencial, em sala de aula e durante períodos letivos.

Apesar de a intervenção ser para os adolescentes, deve considerar-se a realização de uma sessão de sensibilização prévia sobre o tópico para a comunidade escolar (adolescentes, professores, profissionais não docentes, encarregados de educação). Deste modo, a comunidade pode promover a adesão e a aprendizagem dos adolescentes no programa de formação. A combinação do formato presencial e virtual na sessão de sensibilização flexibiliza a comparência destes indivíduos com características diversas (horários, localizações, ...).

Focos de intervenção e métodos de avaliação

A intervenção procura melhorar as competências em saúde mental dos seus participantes. Portanto, podem-se identificar diagnósticos de enfermagem como os sugeridos no Quadro 1. Instrumentos de avaliação validados poderão facilitar a identificação desses diagnósticos (Quadro 1). As competências de saúde mental devem ser avaliadas ao longo do tempo de modo a mensurar-se a utilidade e eficácia da intervenção. Considerando a extensão dos períodos letivos, recomenda-se uma avaliação antes, imediatamente após a intervenção e 3 meses após a intervenção.

Diagnósticos da Enfermagem (International Council of Nurses [ICN], 2019, Ordem dos Enfermeiros, 2021)	Instrumentos de avaliação de resultados
— Potencial para melhorar o conhecimento para responder [a problemas de saúde mental]	Anexo I
— Potencial para melhorar a capacidade para responder [a problemas de saúde mental] — Potencial para melhorar a autoeficácia para responder [a problemas de saúde mental]	Anexo II

Legenda: [a problemas de saúde mental] - conteúdo substituível por problemas específicos de saúde mental

Quadro 1. Relação entre instrumentos de avaliação e os diagnósticos de enfermagem identificáveis

Pode também ser realizada uma avaliação da satisfação dos participantes a cada módulo de formação, permitindo identificar aspetos a ajustar na intervenção. Recomenda-se o preenchimento de um questionário de satisfação (Anexo III) pelos participantes no fim de cada módulo de formação. Esta avaliação deve ser complementada com a observação dos comportamentos dos participantes ao longo de cada módulo/sessão. Por exemplo, os dinamizadores podem estar atentos ao envolvimento dos participantes nas sessões, à expressão não-verbal de interesse e à realização dos trabalhos de casa.

Ao longo da intervenção, recomenda-se que o(s) dinamizador(es) reflita(m) sobre a adequação da mesma. Após a implementação do programa (no final do módulo 5), o(s) dinamizador(es) pode(m) responder a um questionário de satisfação em relação à intervenção dinamizada (Anexo IV). O questionário respondido pode ser encaminhado para os autores do programa de formação. Este *feedback* pode ser relevante para se equacionarem alterações “consensuais” na intervenção.

Duração e frequência da intervenção

O programa de formação deve ser precedido por uma sessão de sensibilização sobre o tópico para a comunidade escolar (Figura 5). A intervenção dirigida aos adolescentes é constituída por 6 módulos de formação, tendo uma duração total de 8 horas e 25 minutos (Figura 5). A duração dos módulos foi ajustada à duração comum das aulas. Portanto, cada módulo de formação tem duração de 45 ou de 90 minutos. Os módulos de 90 minutos podem ser realizados numa só sessão ou ser divisíveis em duas partes/sessões de 45 minutos. Cabe aos dinamizadores do programa de formação articular a duração e frequência das sessões ao ano letivo e à disponibilidade escolar. Deve existir um espaçamento entre sessões de até 1 semana. O espaçamento pode favorecer uma aprendizagem contínua e fluida sobre o tópico, ao mesmo tempo que pode proporcionar aos adolescentes o tempo necessário para reverem e integrarem os novos saberes no seu quotidiano. Recomenda-se uma sessão “extra” para avaliação da retenção das competências em saúde mental ao longo do tempo, acompanhamento dos participantes e reforço das suas aprendizagens (Figura 5). Considerando a extensão do ano letivo, esta sessão pode ocorrer aproximadamente 3 meses após a última sessão da intervenção.

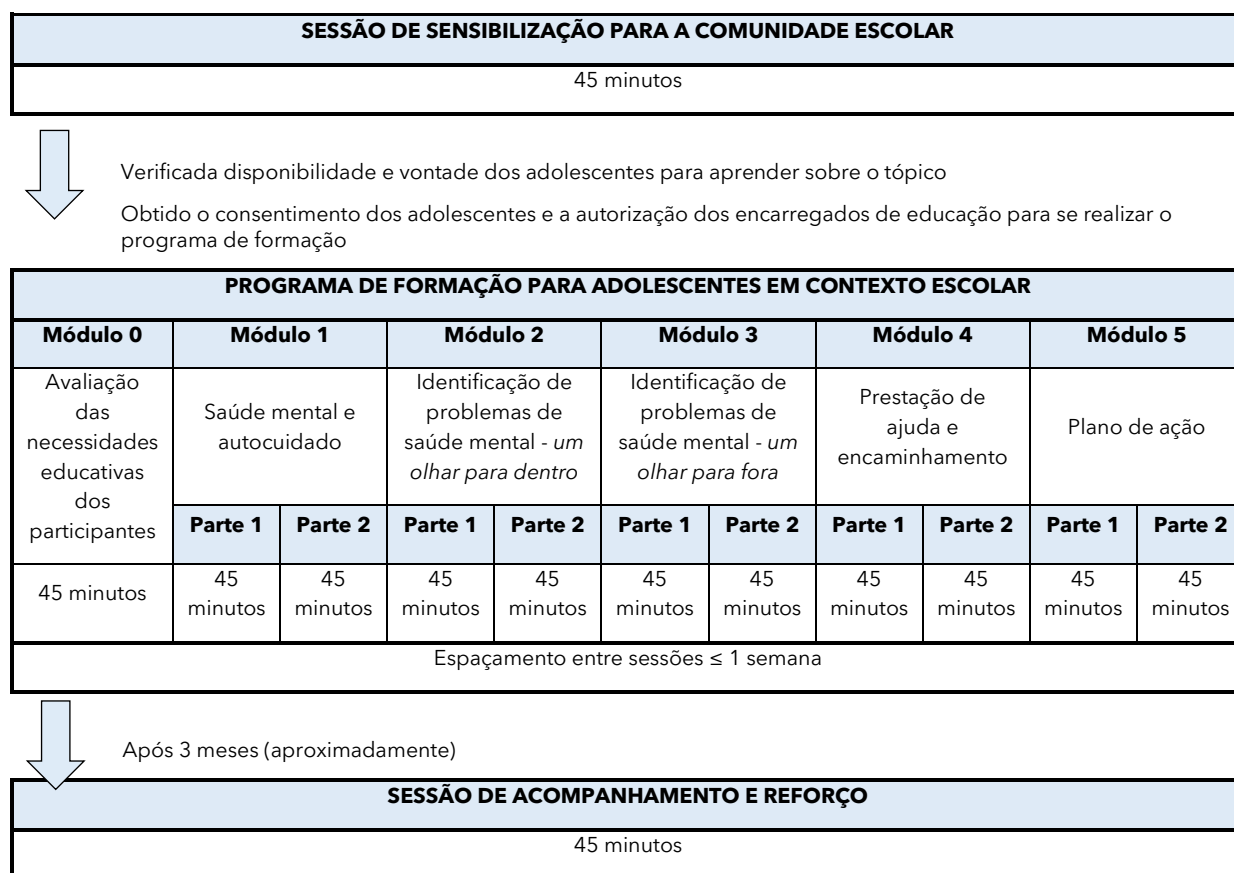


Figura 5. Distribuição temporal das sessões de formação

Métodos de intervenção

O programa de formação recorre a diferentes estratégias de formação: estratégias expositivas (por exemplo, palestras), demonstrativas, participativas (por exemplo, discussões), de educação por contacto (por exemplo, testemunhos) e de aprendizagem experimental (por exemplo, dramatizações). Do mesmo modo, exige múltiplos recursos educativos, inclusive materiais informativos (por exemplo, o folheto de síntese do programa de formação - Anexo V, o manual para os participantes - Anexo VI, a lista de recursos de ajuda profissional - Anexo VII), audiovisuais (por exemplo, as apresentações a usar nas sessões/módulos - Anexos VIII a XV) e tecnológicos (por exemplo, fórum *online*). Ao longo do programa de formação, a igualdade de acesso aos recursos deve ser garantida para todos os estudantes.

Conteúdos da intervenção

O programa de formação aborda diferentes condições de saúde mental (estar bem, ter um problema de saúde mental, ter uma doença mental). É incutido nos participantes o papel de socorrista de pessoas com problemas de saúde mental, mas também um papel de agente ativo na sua própria saúde. Explora 4 ações principais de primeira ajuda em saúde mental (os **4 As**): **A**proximar-se da pessoa e avaliar a situação; **A**ssistir e incentivar o uso de estratégias de autoajuda; **A**ssistir e incentivar a procura de ajudas; e **A**utocuidar. Estas ações são operacionalizadas num algoritmo (Figura 6).

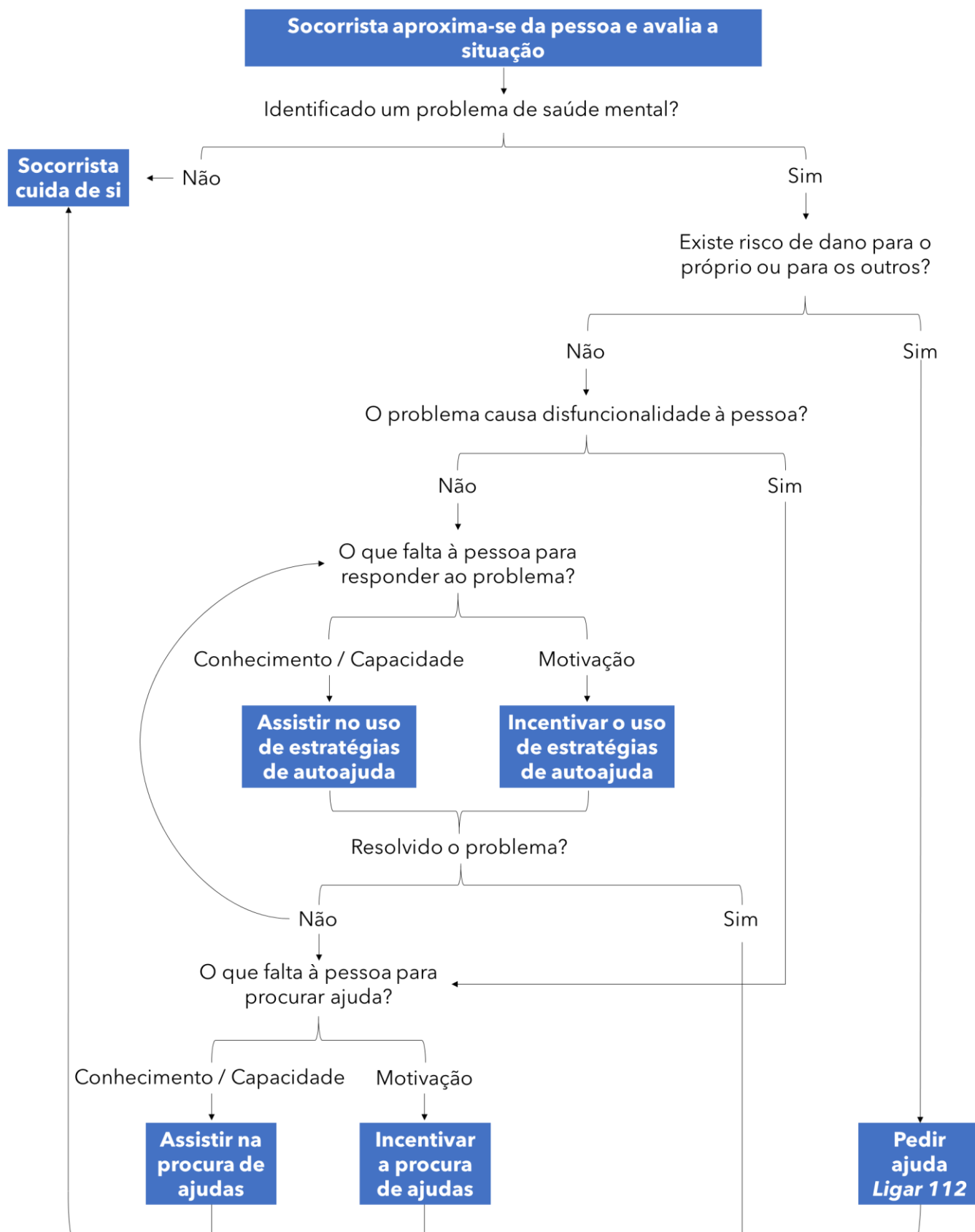


Figura 6. Algoritmo de primeira ajuda em saúde mental

A interação entre o socorrista e a pessoa ajudada representa uma relação de ajuda informal. Nesta tipologia de relação, a aproximação instala-se de forma natural (Sampaio & Sequeira, 2016). Uma relação de ajuda inicia-se habitualmente com a avaliação da situação da outra pessoa e definição das suas necessidades de ajuda (problemas de saúde mental) (Peplau, 1991). Portanto, também nas relações de ajuda informal deve ser considerada esta avaliação.

Sempre que uma pessoa com um problema de saúde mental representa risco de dano para si própria ou para os que a rodeiam, um socorrista pode pedir ajuda (Costa et al., 2023). Nesta situação, pessoas com problemas de saúde mental têm a sua autonomia comprometida, devendo as decisões da sua saúde serem assumidas por terceiros no melhor interesse e para bem da pessoa (Conselho Nacional de Ética para as Ciências da Vida, 2019). Portanto, o socorrista não precisa da tomada de decisão da pessoa com um problema de saúde mental, visto que o princípio da beneficência se sobrepõe ao respeito pela autonomia. Neste caso, recomenda-se a chamada para o número europeu de emergência (112), visto que é gratuita e possibilita entrar diretamente em contacto com os diferentes serviços de emergência (polícia, ambulância e/ou bombeiros) (Your Europe, 2022).

Os problemas de saúde mental podem ou não representar doenças (Kitchener et al., 2017). O critério que determina a existência de uma doença mental é a disfuncionalidade (APA, 2022). A disfuncionalidade envolve o compromisso de funções do corpo, nas atividades e na participação (OMS, 2004). Deste modo, são necessários recursos de ajuda (especialmente profissionais) que diminuam a disfuncionalidade com uma resposta mais diferenciada (Kitchener et al., 2017). Ainda assim mecanismos internos para a resolução dos problemas podem ser promovidos no caso de não se vivenciar disfuncionalidade (Kitchener et al., 2017). A permanência dos problemas de saúde mental pode justificar o encaminhamento para outras fontes de suporte.

Na promoção de estratégias de autoajuda e de procura de ajuda, os socorristas podem assistir ou incentivar as pessoas com problemas de saúde mental (Costa et al., 2023). “Assistir” refere-se à ação de “fazer parte do trabalho com ou para alguém” (ICN, 2019). Portanto, “assistir” traduz um papel ativo do socorrista a par com a pessoa ajudada, com a aquisição de aprendizagens ao longo da interação. Já “Incentivar” refere-se à ação de “levar alguém a atuar num sentido particular ou estimular o

interesse de alguém por uma atividade” (ICN, 2019). Deste modo, “incentivar” expressa um papel ativo da pessoa que vivencia os problemas, com a melhoria da motivação.

Apesar de os socorristas terem um papel ativo face à saúde mental dos outros, eles devem considerar cuidar de si antes e/ou após o contacto com a pessoa com um problema de saúde mental (Costa et al., 2020). O autocuidado é a habilidade de promover e manter a saúde, prevenir e lidar com a doença (OMS, 2019).

CAPÍTULO III - PLANEAMENTO DO PROGRAMA DE FORMAÇÃO

Este capítulo descreve o planeamento de cada sessão/módulo do programa de formação.

Após a autorização da Direção da escola para a implementação do programa de formação, inicia-se a intervenção.

Sessão de Sensibilização para a comunidade escolar

Esta sessão tem como objetivo promover a consciencialização da comunidade escolar para o programa de formação e encontra-se planeada no Quadro 2.

Momento	Conteúdos	Estratégias de intervenção	Recursos educativos	Estratégias de avaliação	Tempo
Introdução	— Identidade do(s) dinamizador(es) — Objetivos da sessão	Exposição	Computador, videoprojetor, rede de internet, aplicação de videochamadas, câmara, microfone, apresentação em formato multimédia (Anexo VIII), material de escrita (caneta e papel)		5 minutos
Desenvolvimento	— Importância da primeira ajuda em saúde mental — Importância dos programas de formação em saúde mental — Conceito de Programa de Formação em Primeira Ajuda em Saúde Mental — Importância da formação em saúde mental nas escolas para adolescentes — Aspetos éticos implícitos à participação na formação — Cronograma do programa de formação	Exposição		Avaliação do processo de formação - Observação de comportamentos	30 minutos
Conclusão	— Entrega de folhetos — Síntese final	Exposição	Folhetos de síntese do programa de formação (Anexo V)		10 minutos
	— Dúvidas	Interrogatório			

Quadro 2. Planeamento da Sessão de Sensibilização para a comunidade escolar

Os presentes na sessão de sensibilização terão o papel de divulgar o programa de formação e de aferir o interesse e disponibilidade dos adolescentes para participar. No caso de a intervenção ser querida, deve existir o consentimento informado dos adolescentes para participarem no programa de formação e a autorização dos encarregados de educação (no caso de os participantes serem menores de idade).

Módulo 0: Avaliação das necessidades educativas dos participantes

Este módulo visa determinar as competências dos adolescentes para agir face pessoas com problemas de saúde mental e melhorar o conhecimento deles sobre o programa de formação. Este encontra-se planeado no Quadro 3.

Momento	Conteúdos	Estratégias de intervenção	Recursos educativos	Estratégias de avaliação	Tempo
Introdução	— Identidade do(s) dinamizador(es) — Explicação do nome e do objetivo do programa de formação — Objetivos do módulo — Necessidades educativas identificadas	Exposição	Computador, videoprojetor, apresentação em formato multimédia (Anexo IX), material de escrita (caneta e papel)	Avaliação diagnóstica - Aplicação de instrumentos (Anexos I e II)	15 minutos
Desenvolvimento	— Importância da formação em primeira ajuda em saúde mental	Exposição		Avaliação do processo de formação - Observação de comportamentos	25 minutos
	— Identidade dos adolescentes — Expectativas face ao programa de formação	Interrogatório	Novelo de lã		
	— Cronograma do programa de formação — Recurso de informação: Manual para os participantes / os socorristas — Recurso de informação: Fórum de discussão	Exposição	Computador, videoprojetor, apresentação em formato multimédia (Anexo IX), manual para socorristas (Anexo VI impresso para cada participante e/ou disponível digitalmente a partir de link), <i>link</i> de um fórum de discussão, material de escrita (caneta e papel)		

Conclusão	— Síntese final com entrega de folheto — Dúvidas	Interrogatório	Folhetos de síntese do programa de formação impressos (Anexo V)	Avaliação do processo de formação - Aplicação do Questionário (Anexo III)	5 minutos
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Quadro 3. Planeamento do Módulo 0

Módulo 1: Saúde mental e autocuidado

Este módulo procura melhorar o conhecimento dos adolescentes sobre saúde mental e melhorar as competências deles para cuidarem da sua saúde mental. No Quadro 4 pode ser consultado o planeamento deste módulo.

Momento	Conteúdos		Estratégias de intervenção	Recursos educativos	Estratégias de avaliação	Tempo
Introdução	— Identidade do(s) dinamizador(es) — Objetivos do módulo		Exposição	Computador, videoprojetor, apresentação em formato multimédia (Anexo X), material de escrita (caneta e papel)		5 minutos
Desenvolvimento	Parte 1	— Conceito de saúde e saúde mental — Saúde mental como um <i>continuum</i>	Interrogatório	Computador, videoprojetor, apresentação em formato multimédia (Anexo X), quadro de grandes dimensões e respetivo marcador, material de escrita (caneta e papel)	Avaliação do processo de formação - Observação de comportamentos	30 minutos
		— Fatores de influenciadores da saúde mental	<i>Brainstorming</i>			
		— Síntese parcial	Interrogatório			
		— Conceito de problema de saúde mental e doença mental — Incidência e prevalência nacional e internacional de problemas de saúde mental — Importância das estratégias de autoajuda	Exposição			

	Parte 2	— Síntese dos conteúdos já lecionados no módulo	Interrogatório			30 minutos
		— Conceito de estratégias de autoajuda adaptativas e mal-adaptativas	Exposição			
		— Estratégias de autoajuda conhecidas — Distinção entre estratégias de autoajuda adaptativas e mal-adaptativas	Trabalho de grupo e discussão			
		— Síntese parcial	Interrogatório			
		— Estratégias de autoajuda adaptativas	Exposição / Demonstração			
Conclusão		— Síntese final — Dúvidas	Interrogatório	Computador, videoprojetor, apresentação em formato multimédia (Anexo X), material de escrita (caneta e papel)	Avaliação do processo de formação - Aplicação do Questionário (Anexo III)	10 minutos
		— Proposta de trabalho para casa: listar problemas de saúde mental	Exposição			

Quadro 4. Planeamento do Módulo 1

Módulo 2: Identificação de problemas de saúde mental - *um olhar para dentro*

Este módulo tem como objetivo melhorar as competências dos adolescentes para identificar problemas de saúde mental. No Quadro 5 está disponível o planeamento deste módulo.

Momento	Conteúdos		Estratégias de intervenção	Recursos educativos	Estratégias de avaliação	Tempo
Introdução	— Identidade do(s) dinamizador(es) — Objetivos do módulo		Exposição	Computador, videoprojetor, apresentação em formato multimédia (Anexo XI), material de escrita (caneta e papel)		5 minutos
	— Revisão do conceito de problema de saúde mental		Interrogatório			
Desenvolvimento	Parte 1	— Análise do trabalho para casa do módulo anterior: listar problemas de saúde mental	<i>Brainstorming</i>	Computador, videoprojetor, apresentação em formato multimédia (Anexo XI), quadro de grandes dimensões e respetivo marcador, material de escrita (caneta e papel)	Avaliação do processo de formação - Observação de comportamentos	30 minutos
		— Tipos de problemas de saúde mental	Exposição			
		— Principais problemas de saúde mental do foro cognitivo e respetivas manifestações	Exposição / Interrogatório			
		— Síntese parcial	Interrogatório			
		— Principais problemas de saúde mental do foro emocional e respetivas manifestações	Exposição / Interrogatório			

	Parte 2	— Síntese dos conteúdos já lecionados no módulo	Interrogatório	Computador, videoprojetor, apresentação em formato multimédia (Anexo XI), material de escrita (caneta e papel)		30 minutos
		— Identificação de problemas de saúde mental do foro cognitivo e emocional	Estudo de caso			
Conclusão		— Síntese final — Dúvidas	Interrogatório	Computador, videoprojetor, apresentação em formato multimédia (Anexo XI), material de escrita (caneta e papel)	Avaliação do processo de formação - Aplicação do Questionário (Anexo III)	10 minutos

Quadro 5. Planeamento do Módulo 2

Módulo 3: Identificação de problemas de saúde mental - *um olhar para fora*

Este módulo visa melhorar as competências dos adolescentes para identificar problemas de saúde mental e encontra-se planeado no Quadro 6.

Momento	Conteúdos		Estratégias de intervenção	Recursos educativos	Estratégias de avaliação	Tempo
Introdução	— Identidade do(s) dinamizador(es) — Objetivos do módulo		Exposição	Computador, videoprojetor, apresentação em formato multimédia (Anexo XII), material de escrita (caneta e papel)		5 minutos
Desenvolvimento	Parte 1	— Principais problemas de saúde mental do foro comportamental e respetivas manifestações	Exposição / Interrogatório	Computador, videoprojetor, apresentação em formato multimédia (Anexo XII), quadro de grandes dimensões e respetivo marcador, material de escrita (caneta e papel)	Avaliação do processo de formação - Observação de comportamentos	30 minutos
		— Síntese parcial	Interrogatório			
		— Principais problemas de saúde mental do foro relacional e respetivas manifestações	Exposição / Interrogatório			

	Parte 2	— Síntese dos conteúdos já lecionados no módulo	Interrogatório	Computador, videoprojetor, apresentação em formato multimédia (Anexo XII), vídeo com testemunho de pessoa com problema de saúde mental, material de escrita (caneta e papel)		30 minutos
		— Identificação de problemas de saúde mental do foro comportamental e relacional	Estudo de caso			
		— Experiências vivenciadas por pessoas com problemas de saúde mental	Educação por contacto			
		— Reconhecimento do estigma em saúde mental	Interrogatório			
		— Consequências dos problemas de saúde mental	Exposição			
Conclusão		— Síntese final — Dúvidas	Interrogatório	Computador, videoprojetor, apresentação em formato multimédia (Anexo XII), material de escrita (caneta e papel)	Avaliação do processo de formação - Aplicação do Questionário (Anexo III)	10 minutos
		— Proposta de trabalho para casa: identificar a importância de assumir o papel de socorrista de pessoas com problemas de saúde mental	Exposição			

Quadro 6. Planeamento do Módulo 3

Módulo 4: Prestação de ajuda e encaminhamento

Este módulo procura melhorar as competências dos adolescentes para prestar ajuda inicial a pessoas com problemas de saúde mental e para encaminhar estas pessoas para recursos de ajuda. O Quadro 7 apresenta o planeamento deste módulo.

Momento	Conteúdos	Estratégias de intervenção	Recursos educativos	Estratégias de avaliação	Tempo
Introdução	— Identidade do(s) dinamizador(es) — Objetivos do módulo	Exposição	Computador, videoprojector, apresentação em formato multimédia (Anexo XIII), material de escrita (caneta e papel)		5 minutos
Desenvolvimento	Parte 1 — Análise do trabalho para casa do módulo anterior: identificar a importância de assumir o papel de socorrista de pessoas com problemas de saúde mental	Brainstorming	Computador, videoprojetor, apresentação em formato multimédia (Anexo XIII), quadro de grandes dimensões e respetivo marcador, material de escrita (caneta e papel)	Avaliação do processo de formação - Observação de comportamentos	30 minutos
	— Necessidade de ajuda em saúde mental — Potenciais fatores facilitadores e barreiras na procura de ajuda profissional — Primeira ajuda em saúde mental: importância, conceito, intervenientes e contextos de implementação	Exposição			
	— Síntese parcial	Interrogatório			

		— Princípios da comunicação e da relação interpessoal	Exposição / Demonstração			
		— Aproximação e avaliação de pessoas com problemas de saúde mental — Promoção do autocuidado nas pessoas com problemas de saúde mental	Exposição / Interrogatório			
	Parte 2	— Síntese dos conteúdos já lecionados no módulo	Interrogatório	Computador, videoprojetor, apresentação em formato multimédia (Anexo XIII), material de escrita (caneta e papel), lista de recursos de ajuda profissional (Anexo VII)	30 minutos	
		— Importância do encaminhamento de pessoas com problemas de saúde mental para outros recursos de ajuda	Exposição / Interrogatório			
		— Recursos de ajuda em saúde mental: quem são, papel que desempenham e como contactar	Exposição e Discussão			
		— Alerta para a manutenção do autocuidado	Exposição			
		— Síntese parcial	Interrogatório			
		— Plano de ação de primeira ajuda em saúde mental — Operacionalização do plano de ação de primeira ajuda em saúde mental	Exposição			

Conclusão	— Síntese final — Dúvidas	Interrogatório	Computador, videoprojetor, apresentação em formato multimédia (Anexo XIII), material de escrita (caneta e papel)	Avaliação do processo de formação - Aplicação do Questionário (Anexo III)	10 minutos
	— Proposta de trabalho para casa: Planear a ajuda a uma pessoa com um problema de saúde mental	Exposição			

Quadro 7. Planeamento do Módulo 4

Módulo 5: Plano de ação

Este módulo visa melhorar as competências dos adolescentes para agir face pessoas com problemas de saúde mental e determinar a evolução dessas competências. O planeamento do módulo está disponível no Quadro 8.

Momento	Conteúdos	Estratégias de intervenção	Recursos educativos	Estratégias de avaliação	Tempo
Introdução	— Identidade do(s) dinamizador(es) — Objetivos do módulo	Exposição	Computador, videoprojetor, apresentação em formato multimédia (Anexo XIV), material de escrita (caneta e papel)		5 minutos
Desenvolvimento	Parte 1 — Análise do trabalho para casa do módulo anterior: Planear a ajuda a uma pessoa com um problema de saúde mental ▪ Correção de exemplos e esclarecimento de dúvidas	Discussão	Computador, videoprojetor, apresentação em formato multimédia (Anexo XIV), quadro de grandes dimensões e respetivo marcador, material de escrita (caneta e papel), papeis com casos de pessoas com problemas de saúde mental (Anexo XVI)	Avaliação do processo de formação - Observação de comportamentos	25 minutos
	— Operacionalização do plano de ação de primeira ajuda em saúde mental	Trabalho de grupo e estudo de caso			

	Parte 2	— Síntese dos conteúdos já lecionados no módulo	Interrogatório	Computador, videoprojetor, apresentação em formato multimédia (Anexo XIV), material de escrita (caneta e papel)		25 minutos
		— Operacionalização do plano de ação de primeira ajuda em saúde mental	Dramatização formador-formando e discussão			
		— Operacionalização do plano de ação de primeira ajuda em saúde mental	Dramatização formando-formando e discussão			
		— Futura adoção do papel de socorrista	Interrogatório			
Conclusão	— Síntese final — Dúvidas — Resultados obtidos com a formação — Certificação da formação — Despedida		Interrogatório	Computador, videoprojetor, apresentação em formato multimédia (Anexo XIV), material de escrita (caneta e papel), certificados de participação impressos ou virtuais (Anexo XVII)	Avaliação dos resultados da formação - Aplicação de instrumentos (Anexos I e II)	15 minutos
					Avaliação do processo de formação - Aplicação do Questionário (Anexo III)	

Quadro 8. Planeamento do Módulo 5

Sessão de Acompanhamento e Reforço

Esta sessão procura melhorar as competências dos adolescentes para agir face pessoas com problemas de saúde mental e determinar a evolução dessas competências. O Quadro 9 apresenta o planeamento da sessão.

Momento	Conteúdos	Estratégias de intervenção	Recursos educativos	Estratégias de avaliação	Tempo
Introdução	— Identidade do(s) dinamizador(es) — Objetivos da sessão — Resultados da formação ao longo do tempo	Exposição	Computador, videoprojetor, apresentação em formato multimédia (Anexo XV), material de escrita (caneta e papel)	Avaliação dos resultados da formação - Aplicação de instrumentos (Anexos I e II)	15 minutos
Desenvolvimento	— Experiência no uso do plano de primeira ajuda em saúde mental	Interrogatório	Computador, videoprojetor, apresentação em formato multimédia (Anexo XV), material de escrita (caneta e papel)	Avaliação do processo de formação - Observação de comportamentos	20 minutos
	— Revisão do plano de ação de primeira ajuda em saúde mental	Interrogatório			
	— Operacionalização do plano de ação de primeira ajuda em saúde mental	Dramatização formando-formando e discussão			
Conclusão	— Síntese final — Dúvidas	Interrogatório	Computador, videoprojetor, apresentação em formato multimédia (Anexo XV), material de escrita (caneta e papel)		10 minutos
	— Despedida	Exposição			

Quadro 9. Planeamento da Sessão de Acompanhamento e Reforço

No termo da intervenção educacional, o(s) dinamizador(es) pode(m) responder a um questionário de satisfação em relação à própria intervenção dinamizada (Anexo IV).

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ANEXOS

ANEXO I

Teste de Avaliação de Conhecimentos em Saúde Mental

Teste de Avaliação de Conhecimentos em Saúde Mental

Leia atentamente as seguintes afirmações e classifique-as como Verdadeiras (V) ou Falsas (F).

Afirmação	Resposta
1. Ter saúde mental é sinónimo de não ter doença mental.	
2. Fatores individuais, estilos de vida, apoio social, condições económicas, ambientais e culturais influenciam a saúde mental das pessoas.	
3. Existe uma doença mental sempre que uma pessoa vivencia problemas no modo de pensar, sentir, agir e/ou a relacionar-se com os outros.	
4. Os problemas de saúde mental repercutem-se em incapacidade e em morte prematura.	
5. As estratégias de autoajuda são fundamentais para se promover uma boa saúde mental. Consumir ocasionalmente substâncias (p.e., álcool, canábis) é uma boa estratégia para lidar com os problemas do dia-a-dia.	
6. Ignorar ou evitar um problema pode ser uma boa estratégia para lidar com problemas de saúde mental.	
7. Planear atividades de lazer e distração, realizar estratégias de relaxamento e de meditação são atividades promotoras de uma boa saúde mental.	
8. A percepção, o pensamento, a memória, a atenção e a linguagem são exemplos de funções cognitivas.	
9. Uma alucinação é uma crença errada mantida com absoluta convicção, mesmo com provas contrárias. Um delírio é a percepção real de um estímulo que não existe.	
10. Uma demência é a perda progressiva de funções cognitivas (p.e., memória, atenção, linguagem).	
11. Quando uma pessoa atribui um valor inapropriado a si mesma, vivencia problemas de autoestima.	
12. As pessoas vivenciam emoções, isto é, reações a estímulos internos e externos. Luto, ciúme, inveja e vergonha são exemplos de emoções negativas.	
13. O medo é um sentimento de antecipação de uma ameaça futura.	
14. A tristeza e o humor depressivo são sentimentos caracterizados pela falta de ânimo. Já a euforia consiste na sensação exagerada de bem-estar.	
15. A raiva é um sentimento de descontentamento por não possuir algo que outro indivíduo tem.	
16. Álcool, tabaco e drogas podem causar dependência, assim como jogos de apostas, videojogos e internet.	
17. As compulsões são ações desordenadas, confusas, não adequadas ao meio envolvente.	
18. A bulimia envolve diminuição ou ausência de consumo alimentar.	
19. A violência pode ser física, verbal e simbólica. Ocorre cara-a-cara e/ou virtualmente.	
20. A dificuldade ou ausência de interação com outras pessoas e de participação em atividades sociais representam problemas de socialização.	

21. Pessoas leigas podem cuidar da sua saúde mental e ajudar outros indivíduos a cuidarem-se. Ajudar pessoas com boa saúde mental e com problemas de saúde mental é uma responsabilidade cívica.	
22. A comunicação tem duas componentes: a verbal (oral, escrita) e a não-verbal (gestos, postura, tom de voz, ...).	
23. Quando uma pessoa vivencia um problema de saúde mental, devemos adotar uma postura protetora (por exemplo, dizendo "Deixa estar que eu faço, tu não estás em condições!").	
24. Quando uma pessoa vivencia um problema de saúde mental, devemos normalizar a situação (por exemplo, dizendo "É normal andar assim de vez em quando!", "Estás assim, mas isso passa!"). Devemos também incentivar para a mudança (por exemplo, dizendo "Tens que andar com a vida para a frente!", "Anima-te!").	
25. As pessoas com problemas de saúde mental são geralmente perigosas e/ou imprevisíveis. Deste modo, devemos ter alguma cautela quando nos aproximamos e relacionamos com elas.	
26. Apresentar-se, expressar disponibilidade e ouvir sem julgamento são ações que promovem uma boa relação com outras pessoas.	
27. Devemos questionar uma pessoa com problemas de saúde sobre a sua situação (problema vivenciado e respetivas causas, fatores agravantes/atenuantes e consequências) para conseguirmos ajudar.	
28. Uma pessoa leiga pode ajudar alguém com um problema de saúde mental a identificar o seu problema e adequadas estratégias de autocuidado.	
29. Devemos encorajar pessoas com problemas de saúde mental a abandonar estratégias de autocuidado prejudiciais ou pouco eficazes.	
30. É aconselhável encaminhar pessoas com problemas de saúde mental para ajuda profissional. Se os problemas afetarem o funcionamento normal da pessoa, devemos ligar para o 112 para assistência imediata.	
31. Os enfermeiros especialistas em enfermagem de saúde mental e psiquiátrica, psiquiatras e psicólogos são recursos de ajuda importantes para responder a pessoas com problemas de saúde mental.	
32. Profissionais de <i>coaching</i> e terapeutas energéticos são profissionais essenciais para responder a pessoas com problemas de saúde mental.	

Soluções							
1	F	9	F	17	F	25	F
2	V	10	V	18	F	26	V
3	F	11	V	19	V	27	V
4	V	12	V	20	V	28	V
5	F	13	F	21	V	29	F
6	F	14	V	22	V	30	F
7	V	15	F	23	F	31	V
8	V	16	V	24	F	32	F

ANEXO II

Escala de Autoavaliação de Competências Básicas para Agir em Saúde Mental
(Basic-MAC Scale)

Escala de autoavaliação de Competências Básicas para Agir em Saúde Mental

Por favor, avalia as tuas competências para agir em saúde mental. Tens 5 opções de resposta: **1** - Discordo totalmente, **2** - Discordo, **3** - Não concordo, nem discordo, **4** - Concordo, **5** - Concordo totalmente. Não há respostas certas, nem erradas. Responde de modo verdadeiro e espontâneo.

	1	2	3	4	5
Sei o significado de "saúde mental".					
Sei o que influencia a saúde mental.					
Sei o significado de "problema de saúde mental".					
Sei o significado de "doença mental".					
Sei os principais problemas de saúde mental que existem.					
Reconheço o meu estado de saúde mental.					
Sou capaz de usar estratégias para cuidar da minha saúde mental.					
Sinto-me motivado(a) para cuidar da minha saúde mental.					
Estou disposto(a) a procurar ajuda em saúde mental para mim.					
Sou capaz de procurar ajuda em saúde mental para mim.					
Estou disposto(a) a relacionar-me com pessoas com problemas de saúde mental.					
Sinto-me motivado(a) para me relacionar com pessoas, independentemente do seu estado de saúde mental.					
Relaciono-me com pessoas, independentemente do seu estado de saúde mental.					
Estou disposto(a) a estar atento(a) ao estado de saúde mental dos outros.					
Estou disposto(a) a ajudar os outros a melhorarem a sua saúde mental.					
Estou disposto(a) a ajudar os outros a gerirem os seus problemas de saúde mental.					
Sou capaz de ajudar outra pessoa a usar estratégias para cuidar da saúde mental.					
Sinto-me motivado(a) para ajudar os outros a cuidarem da sua saúde mental.					
Sou capaz de ajudar outra pessoa a procurar ajuda em saúde mental.					
Sinto-me motivado(a) a ajudar os outros a procurarem ajuda em saúde mental.					

ANEXO III

Questionário: Avaliação da Satisfação dos Participantes face ao Módulo de
Formação

Questionário: Avaliação da Satisfação dos Participantes face ao Módulo de Formação

O presente questionário visa avaliar as opiniões e níveis de satisfação dos participantes em relação ao módulo de formação.

Por favor, selecione uma das seguintes opções.

No que diz respeito ao módulo de formação, eu encontro-me...:

- 1.** Muito insatisfeito
- 2.** Insatisfeito
- 3.** Nem satisfeito, nem insatisfeito
- 4.** Satisfeito
- 5.** Muito satisfeito

Por favor, indique os aspetos mais positivos do módulo de formação:

Por favor, indique os aspetos menos positivos do módulo de formação:

ANEXO IV

Questionário: Avaliação da Satisfação dos Dinamizadores face à Intervenção

Questionário: Avaliação da Satisfação dos Dinamizadores face à Intervenção

O presente questionário visa avaliar as opiniões e níveis de satisfação dos dinamizadores em relação à intervenção.

Por favor, selecione uma das seguintes opções.

No que diz respeito ao programa de formação, eu encontro-me...:

- 1.** Muito insatisfeito
- 2.** Insatisfeito
- 3.** Nem satisfeito, nem insatisfeito
- 4.** Satisfeito
- 5.** Muito satisfeito

Por favor, indique os aspetos mais positivos da intervenção:

Por favor, indique os aspetos menos positivos da intervenção:

ANEXO V

Folheto de Síntese do Programa de Formação “Empower4MentalHelp”

[illegible]

ANEXO VI

Breve Manual para Participantes do Programa de Formação “Empower4MentalHelp”

Breve
Manual para
Participantes
do Programa
de Formação
"Empower4
MentalHelp"

Tiago Costa
Francisco Sampaio
Carlos Sequeira
Teresa Lluch Canut
Antonio Moreno Poyato



INTRODUÇÃO

O presente manual é dirigido aos participantes do Programa de Formação “Empower4MentalHelp”. Este visa sintetizar os principais conteúdos ensinados na intervenção, apoiando os adolescentes em todo o processo de aprendizagem (Costa et al., 2024).

SAÚDE MENTAL E AUTOCUIDADO

A “Saúde” é um estado de completo bem-estar físico, mental e social, e não apenas como a ausência de doença (Organização Mundial da Saúde [OMS], 2020). Por sua vez, a “Saúde mental” é um estado de bem-estar no qual um indivíduo percebe as suas próprias habilidades, pode lidar com o stress quotidiano, pode trabalhar produtivamente e é capaz de contribuir para a sua comunidade (OMS, 2021). Existem múltiplos fatores que influenciam a saúde mental. Fatores individuais (como a idade, o género e fatores genéticos), estilos de vida (como a alimentação, o exercício físico e o consumo de substâncias), redes de apoio social e comunitária (como a interação com pares), aspetos económicos, ambientais e culturais (como as condições de trabalho e o acesso a bens e serviços essenciais) são determinantes da saúde (Dahlgren e Whitehead, 2007).

A saúde mental pode ser vista como um continuum, envolvendo o estar bem, a vivência de um problema de saúde mental, de uma doença mental e o estar recuperado. “Problema de saúde mental” é um termo amplo que inclui tanto as doenças mentais como os sintomas destas doenças que ainda não são justificativos para a identificação do diagnóstico de doença mental (Kitchener et al., 2017). A doença mental é caracterizada pela perturbação significativa na cognição, na regulação emocional ou no comportamento de um indivíduo que se reflete em disfuncionalidade (American Psychiatric Association, 2022). A crescente prevalência de problemas de saúde mental e a disfuncionalidade causada torna essencial a intervenção em saúde mental. É importante que as pessoas usem estratégias para cuidar da sua saúde mental, visando manter e melhorar a saúde mental, responder a

problemas de saúde mentais e prevenir a doença mental, ou até mesmo gerir a doença mental e alcançar a recuperação.

Podem ser usadas diferentes estratégias de autoajuda, podendo estas ser adaptativas ou mal-adaptativas. Estratégias adaptativas de autoajuda são medidas saudáveis e eficazes tomadas pelos indivíduos. Podem-se enumerar diferentes estratégias adaptativas, tais como: estabelecer rotinas, mudar de ambiente, fazer uma alimentação completa, variada e equilibrada, dormir regularmente, planejar atividades de lazer e distração, praticar exercício físico regular, ler e escrever, realizar atividades de expressão plástica, realizar atividades de expressão corporal, cantar ou tocar um instrumento musical, ouvir músicas / áudios, realizar estratégias de relaxamento e de meditação, praticar culto religioso, fazer voluntariado, socializar. Em oposição, estratégias mal-adaptativas (por exemplo, beber álcool, agredir alguém) são medidas que causam prejuízo ao próprio e/ou aos outros. Apesar da importância do uso das estratégias de autoajuda adaptativas, as pessoas podem procurar recursos de ajuda (como profissionais de saúde mental) sempre que considerarem necessário.

IDENTIFICAÇÃO DO PROBLEMA DE SAÚDE MENTAL

Os problemas de saúde mental podem ser divididos em 4 tipos: problemas cognitivos, emocionais, comportamentais e relacionais. Os problemas cognitivos envolvem alterações na memória, na atenção, na linguagem, na percepção, no pensamento e no autoconceito (Quadro 1).

Problemas de memória	Envolvem a dificuldade de adquirir, armazenar e recuperar informações disponíveis no cérebro (alteração na memória).
Problemas de atenção	Abrangem a dificuldade de receber e processar intencionalmente informação (alteração na atenção) e a dificuldade em focalizar a atividade mental para armazenar e recordar informações (alteração na concentração).
Problemas de linguagem	Incluem a dificuldade na leitura (dislexia) e dificuldade para expressar palavras oralmente (disfasia).
Problemas de percepção	Envolvem a percepção real de um estímulo que não existe (alucinação).
Problemas de pensamento	Engloba a dificuldade em processar ideias concretas e/ou abstratas (alteração no pensamento), a dificuldade em adquirir competências por meio do estudo, formação e experiência (alteração na aprendizagem), a ponderação e/ou planeamento de suicídio (ideação suicida), as ideias, imagens ou impulsos recorrentes, persistentes, intrusivos e indesejados (obsessão), as crenças erradas/implausíveis mantidas com absoluta convicção, mesmo com provas contrárias (delírios), a perda progressiva de funções cognitivas (demência), e a alteração da memória com desorientação em relação à pessoa, local ou tempo (confusão).
Problemas de autoconceito	Compreendem a imagem mental negativa de si próprio (autoimagem negativa), a imagem mental negativa da aparência física do próprio (imagem corporal perturbada), o valor inapropriado que o próprio atribui a si (autoestima baixa ou excessiva) e a dificuldade em definir o "eu" (identidade pessoal perturbada).

Quadro 1: Principais problemas cognitivos

Os problemas emocionais compreendem a existência de emoções negativas e a falta de emoções positivas (Quadro 2).

Existência de emoções negativas	Sentimento de antecipação de uma ameaça futura (ansiedade).
	Sentimento de sobre-excitação (nervosismo).
	Sentimentos de incerteza (insegurança).
	Sentimento de falta de ânimo, pontual (tristeza) ou persistente (humor depressivo).
	Sentimento de pena associados a perda ou morte significativa (luto).
	Sentimento de exclusão e de falta de pertença (solidão).
	Sentimento de dor intensa e forte, pena e aflição com sensação de sufoco (angústia).
	Sentimento de profunda falta de esperança e valor, sentimento de vazio (desespero).
	Sentimento prolongado de pena associados a martírio e à necessidade de tolerar condições devastadoras (sofrimento).
	Sentimentos contraditórios e opostos perante uma pessoa ou coisa (ambivalência).
	Sentimento de alegria com uma sensação exagerada de bem-estar, não se baseando na realidade e não sendo proporcional à situação (euforia).
	Sentimento de ameaça real ou percebida (medo).
	Dano mental que ocorre como resultado de um evento angustiante (por exemplo: guerra) (trauma).
	Sentimento de estar “sob pressão” (stress).
	Sentimento de desgaste e cansaço, de diminuição da força (fadiga e exaustão).
	Sentimento de ameaça, provocado pela suspeita de que a pessoa amada dedique o seu afeto a outrem (ciúme).
	Sentimento de descontentamento por não possuir algo (por exemplo: qualidades, objetos) que outro indivíduo tem (inveja).
	Sentimento de ter procedido erradamente, de conflito de valores (culpa).
	Sentimento de perda do autorrespeito causado por um comportamento errado (vergonha).
	Sentimento de incapacidade para agir pela convicção de que as ações não afetarão significativamente o resultado (sentimento de impotência).
	Sentimento de descontentamento causado pela não concretização de um desejo (frustração).
	Sentimento de protesto contra alguém ou alguma coisa, que ocorre quando uma pessoa se sente ameaçada (raiva).
Falta de emoções positivas	Falta de sentir que é possível a ocorrência de algo (falta de esperança).
	Falta de sentir otimismo a respeito das intenções de outra pessoa (falta de confiança).
	Falta de sentir satisfação pela capacidade, realizações ou valor de si próprio ou de outros (falta de orgulho).
	Falta do sentimento de gratificação após a satisfação de necessidades (falta de prazer).

Quadro 2: Principais problemas emocionais

Os problemas comportamentais incluem alterações no cuidado com o próprio, na organização de comportamentos, compulsões, alterações alimentares, no padrão de exercício físico, na frequência de comportamentos, no sono, o consumo de substâncias, o abuso no jogo, videojogos, internet, a agressividade e comportamentos de autolesão (Quadro 3).

Problemas de cuidado com o próprio	Consistem na falta de cuidado com o próprio, não havendo a resposta adequada às necessidades do dia-a-dia (alteração no autocuidado).
Problemas na organização de comportamentos	Incluem ações desordenadas, confusas, não adequadas ao meio envolvente (comportamento desorganizado).
Problemas por compulsões	Envolvem atos repetitivos em resposta a pensamentos obsessivos (compulsão).
Problemas do comportamento alimentar	Engloba o consumo recorrente de grandes quantidades de alimentos com sensação de perda de controle (comportamento alimentar compulsivo), a diminuição ou ausência de consumo alimentar (anorexia) e os episódios de grandes excessos alimentares seguidos de vômito induzido, pelo próprio indivíduo (bulimia).
Problemas no padrão de exercício físico	Incluem a prática reduzida ou excessiva de exercício físico.
Problemas na frequência de comportamentos	Incluem o aumento anormal da atividade do corpo, a dificuldade para se manter na mesma posição (hiperatividade).
Problemas de sono	Envolvem alterações no sono (período de diminuição da atividade corporal e de consciência). Quando existe falta de sono nos períodos planeados pode-se dizer que a pessoa experiencia insónia.
Problemas relacionados com o consumo de substâncias	Englobam o abuso de álcool, tabaco e outras drogas.
Problemas com o jogo, videojogos, internet	Envolvem o abuso de jogo de apostas, de videojogos e de internet.
Problemas de agressividade	Compreendem comportamentos de imposição perante outra pessoa (comportamento agressivo). Quando os comportamentos procuram lesar outra pessoa são designados de violência. Podem ser expressos de forma física (inclusive sexual), verbal e simbólica. Podem ocorrer cara-a-cara e/ou virtualmente.
Problemas de autolesão	Consistem em ações com o objetivo de o próprio se agredir ou lesar (comportamento autodestrutivo). Quando a agressão é infligida pelo próprio e não é letal (por exemplo, cortes e queimaduras) pode ser chamada de automutilação. Quando o comportamento tem como objetivo acabar com a própria vida chama-se de tentativa de suicídio.

Quadro 3: Principais problemas comportamentais

Os problemas relacionais envolvem alterações na socialização e na comunicação (Quadro 4).

Problemas de socialização	Consistem na dificuldade em interagir com outras pessoas e de participar em atividades sociais (alteração na socialização). Quando existe ausência de contacto social pode-se dizer que a pessoa vivencia isolamento social.
Problemas de comunicação	Envolvem a dificuldade em dar e receber informações utilizando comportamentos verbais e não-verbais (alteração na comunicação).

Quadro 4: Principais problemas relacionais

Os problemas de saúde mental potenciam o aparecimento de outros problemas de saúde. Além disso, repercutem-se em necessidade de cuidados de saúde, em perda de produtividade, em incapacidade e em morte prematura e, por conseguinte, em custos (Conselho Nacional de Saúde, 2019).

PRESTAÇÃO DE AJUDA E ENCAMINHAMENTO

Apesar de existirem tratamentos, apenas uma minoria de pessoas com problemas de saúde mental os recebe. Na literatura, têm sido descritos múltiplos fatores influenciadores da procura de ajuda (Figura 1).

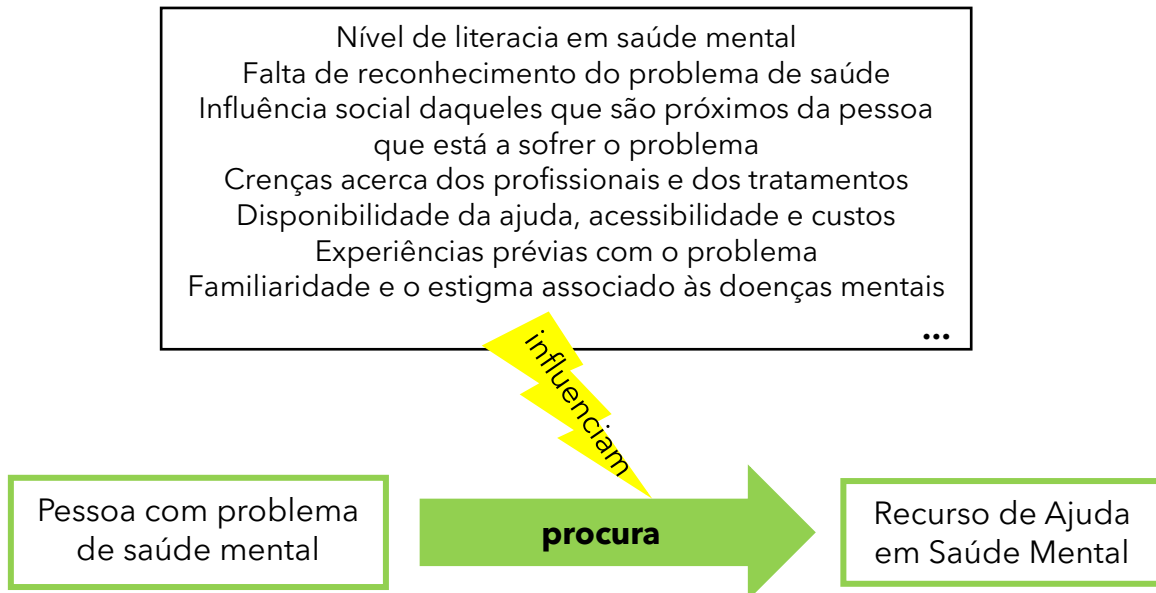


Figura 1. Fatores influenciadores na procura de ajuda em saúde mental

O público em geral pode agir face à saúde de pessoas com problemas de saúde mental. Podem prestar primeira ajuda em saúde mental, isto é, uma ajuda inicial até receberem cuidados profissionais ou à resolução do problema (Kitchener et al., 2017). De facto, há uma maior probabilidade de uma pessoa procurar ajuda se alguém lhe sugerir (Cusack et al., 2004; Wong et al., 2014).

PLANO DE AÇÃO DE PRIMEIRA AJUDA EM SAÚDE MENTAL

O modo de prestar uma primeira ajuda em saúde mental pode ser sintetizado com a Mnemónica “**4 As**”: **A**proximar-se da pessoa e avaliar a situação; **A**ssistir e incentivar o uso de estratégias de autoajuda; **A**ssistir e incentivar a procura de ajudas; e **A**utocuidar. Cada uma destas etapas pode ser operacionalizada em várias ações (Quadros 5 a 8).

Estratégias	Operacionalização
Apresentar-se	Indique “Eu chamo-me (indicar primeiro nome)...”.
Aproximar-se fisicamente da pessoa, garantindo a própria segurança	Se parecer existir risco de dano, mantenha alguma distância de segurança e/ou peça para se aproximar da pessoa (“Posso juntar-me a ti para falarmos?”). Procure manter uma posição ajustada à da outra pessoa (sentar, se ela estiver sentada; de pé, se ela estiver de pé).
Explicar o objetivo da presença do socorrista	Mostre estar preocupado com a pessoa e ser capaz de ajudar (“Eu estou preocupado contigo”, “Acho que posso ajudar-te”).
Expressar disponibilidade (para ouvir, estar presente e ajudar)	Mostre-se disponível para a pessoa (“Estou disponível para te ouvir”, “Falar é dividir o problema”, “Eu realmente quero perceber o que se passa contigo”, “Eu quero ajudar-te”, “Tens o meu apoio”).
Assegurar confidencialidade	Indique que não divulgará nenhuma informação relativamente ao que for falado (“Podes falar à vontade, tudo o que falarmos ficará apenas entre nós”).
Acompanhar a pessoa para um local calmo, seguro, confortável e que permita privacidade	Considere o local e o momento certo para falarem. Decida, se possível, com a pessoa.
Estar presente	Não deixe a pessoa sozinha, mesmo que queira chamar ajuda.
Observar comportamento	Esteja atento à linguagem corporal da outra pessoa.
Coordenar comportamento com a pessoa ajudada	Seja previsível e consistente na interação (por exemplo, se a outra pessoa procurar abraçá-lo, abraçe; se a outra pessoa se sentar, coloque-se no mesmo nível).

Ouvir ativamente com expressão de interesse, respeito, compreensão e sem julgamento	Ouvir com atenção e dar um retorno à mensagem ("Isto deve estar a ser complicado para ti", "Eu percebo pelo que estás a passar", "Não estou na tua situação, mas compreendo que ...").
Avaliar o enquadramento cultural da pessoa	Procure perceber e respeitar as crenças e os costumes da outra pessoa. Estes podem estar a influenciar a situação (por exemplo, "Na minha terra, ouvir vozes na cabeça é um dom divino").
Questionar sobre a situação	Considere a disponibilidade da pessoa para falar sobre o que está a acontecer ("Queres falar sobre o que se passa?").
Questionar sobre o problema	Foque as questões para identificar problemas cognitivos, emocionais, comportamentais e relacionais ("O que estás a pensar?", "O que estás a sentir?", "O que fizeste?", "Como está a tua relação com...?").
Questionar sobre as causas do problema	Explore o que originou o problema ("O que achas que provocou isto?").
Questionar sobre os fatores agravantes e atenuantes do problema	Explore o que influencia o problema ("O que achas que melhora/piora o problema?").
Questionar sobre as consequências do problema	Explore as repercussões do problema no dia-a-dia ("Que impacto é que isto tem tido na tua vida?").

Quadro 5: Operacionalização da ação "Aproximar-se da pessoa e avaliar a situação"

Estratégias		Operacionalização
Assistir no uso de estratégias de autoajuda	Assistir na identificação do problema de saúde mental	Pode sintetizar a situação para facilitar o reconhecimento do problema. Promova na outra pessoa a verbalização do problema ("Qual achas que é o problema?").
	Informar sobre o problema de saúde mental	Por vezes, as pessoas têm dificuldade em reconhecer o seu problema. Coloque a hipótese de existir um problema ("Penso que podes ter um problema de abuso de álcool"). Não afirme com total convicção que a pessoa tem um determinado problema! Pode rotular o problema, não a pessoa ("Podes ter um problema de abuso de álcool" ao invés de "És um bêbado!").
	Assistir na identificação de estratégias adaptativas	Promova a identificação de estratégias de autoajuda (O que achas que podes fazer para diminuir o problema?). Das estratégias identificadas, ajude a distinguir as adaptativas e mal-adaptativas, e destaque as potencialmente mais eficazes.
Incentivar o uso de estratégias de autoajuda	Incentivar o uso de estratégias adaptativas	Saliente que a própria pessoa é responsável pela sua saúde mental ("Tu podes agir face a tua saúde!"). Expresse a importância do uso de estratégias adaptativas para responder ao problema de saúde mental ("Estas estratégias são fundamentais para melhorares a tua saúde mental. Avança! Usa-as!").
	Incentivar o abandono de estratégias mal-adaptativas	Expresse o prejuízo das estratégias mal-adaptativas em uso ("Como disseste, essa estratégia prejudicou-te."). Encoraje a substituição ou o abandono das mesmas ("Poderias deixar de o fazer e optar por... Tu és capaz!").
	Elogiar as estratégias adaptativas já em uso	Reforce todas as ações da outra pessoa que são eficazes e saudáveis ("Essa é uma excelente estratégia!").

Quadro 6: Operacionalização da ação "Assistir e incentivar o uso de estratégias de autoajuda"

Estratégias		Operacionalização
Assistir na procura de ajudas	Assistir na procura de ajudas	Promova a identificação de recursos de ajuda em saúde mental (Quem é que achas que te pode ajudar?). Ajude a distinguir as ajudas recomendadas e as que deve considerar com precaução. Explore com a outra pessoa as ajudas disponíveis.
	Informar sobre o papel dos recursos de ajuda	Expresse que há pessoas que podem ajudar a responder ao problema, com a prestação de cuidados diferenciados ("Penso que estes profissionais podem ajudar-te a melhorar a tua saúde mental, porque fazem...").
	Acompanhar na procura de ajudas	Se a outra pessoa tem dificuldade de acesso aos recursos de ajuda, podes acompanhá-la. Faça-se de convidado: "Posso acompanhar-te até ao hospital?".
	Pedir ajuda	Sempre que a pessoa com o problema de saúde mental representar dano para si ou para os que a rodeiam, deve-se pedir ajuda.
Incentivar a procura de ajudas		Transmita esperança na recuperação, especificamente com ajudas adequadas e com o decorrer do tempo ("Procura ajuda! Com a ajuda de profissionais de saúde, tu vais melhorar ao longo do tempo.").

Quadro 7: Operacionalização da ação "Assistir e incentivar a procura de ajudas"

Estratégias	Operacionalização
Usar estratégias adaptativas de autoajuda	Identifique e aplique as estratégias de autoajuda mais convenientes e eficazes para si.
Procurar ajuda para si próprio	Identifique e recorra a ajudas profissionais e/ou não profissionais, sempre que considere necessário melhorar a sua saúde mental ou responder a um problema de saúde mental.

Quadro 8: Operacionalização da ação "Autocuidar"

As ações de primeira ajuda em saúde mental podem ser articuladas num algoritmo (Figura 2).

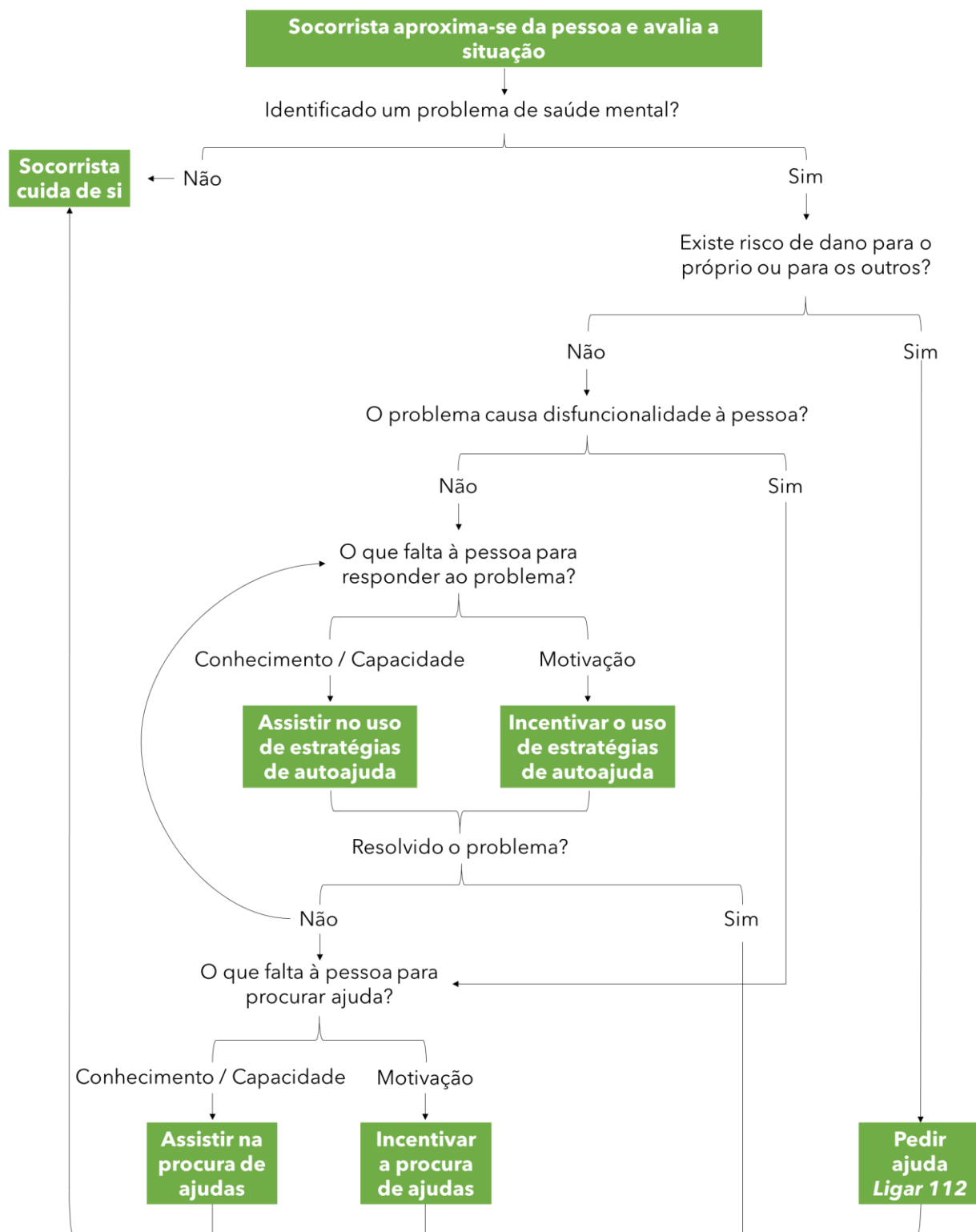


Figura 2. Algoritmo de primeira ajuda em saúde mental

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ANEXO VII

Lista de Recursos de Ajuda Profissional

Lista de Recursos de Ajuda Profissional

ESCOLA	
(Indicar nome do indivíduo e profissão ou nome da equipa)	(Contacto telefónico/e-mail, ponto de encontro presencial, horário)
(Indicar nome do indivíduo e profissão ou nome da equipa)	(Contacto telefónico/e-mail, ponto de encontro presencial, horário)

SERVIÇOS DE SAÚDE LOCAIS	
(Indicar nome do indivíduo e profissão ou nome da equipa)	(Contacto telefónico/e-mail, ponto de encontro presencial, horário)
(Indicar nome do indivíduo e profissão ou nome da equipa)	(Contacto telefónico/e-mail, ponto de encontro presencial, horário)

SERVIÇOS DE SAÚDE À DISTÂNCIA	
Linhas telefónicas de apoio	
Número europeu de emergência	Ligar 112 (24 horas por dia)
SNS 24 - Serviço de aconselhamento psicológico	808 24 24 24 (24 horas por dia)
Linha SOS Voz Amiga	213 544 545 / 912 802 669 / 963 524 660 (das 15h30 às 00h30)
Conversa Amiga	808 237 327 / 210 027 159 (das 15h00 às 22h00)
Telefone da Amizade	228 323 535 (das 16h00 às 23h00)
Voz de Apoio	225 506 070 (das 21h00 às 24h00)
Vozes Amigas de Esperança de Portugal	222 030 707 (das 16h00 às 22h00)
Linha do Serviço de Informação às Vítimas de Violência Doméstica	800 202 148 (24 horas por dia)
Associação Portuguesa de Apoio à Vítima (APAV) - Linha de Apoio à Vítima	116 006 (dias úteis das 8h00 às 22h00)
Linha SOS Droga	1414 (dias úteis das 10h00 às 18h00)
Linha SOS - Deixar de fumar	808 208 888 (dias úteis das 13h00 às 21h00)
Linha de Apoio na Demência	963 604 626 (dias úteis das 9h30 às 13h00 e das 14h00 às 17h00)
(Adicionar nome do recurso de ajuda)	(Adicionar contato telefónico do recurso de ajuda)
(Adicionar nome do recurso de ajuda)	(Adicionar contato telefónico do recurso de ajuda)

Terapia virtual	
Mindfirst	https://www.mindfirst.pt/
Rumo	https://pt.rumo.solutions/
(Adicionar nome do recurso de ajuda)	(Adicionar link do recurso de ajuda)
(Adicionar nome do recurso de ajuda)	(Adicionar link do recurso de ajuda)

ANEXO VIII

Apresentação a usar na Sessão de Sensibilização para a Comunidade Escolar do
Programa de Formação “Empower4MentalHelp”

Programa de Formação em Primeira Ajuda em Saúde Mental: “Empower4MentalHelp”



Sessão de sensibilização para a comunidade escolar

Formador:

(Especificar Nome do formador, afiliação e endereço eletrónico)

(Incluir logotipo da entidade formadora e formada)

1

Importância da primeira ajuda em saúde mental

A **elevada prevalência** de problemas de saúde mental aumenta a probabilidade de as pessoas terem **contato com indivíduos** com este tipo de problemas.



O **público em geral pode prestar primeira ajuda** a pessoas com problemas de saúde mental até estas receberem ajuda profissional ou até a situação de crise estar resolvida.

A sugestão de membros da rede social torna os indivíduos com problemas de saúde mental **mais propensos a procurar ajuda profissional**.



3

Objetivos da sessão

Promover consciencialização para o programa de formação

- Melhorar conhecimento sobre a importância da primeira ajuda em saúde mental
- Melhorar conhecimento sobre a importância dos programas de formação em saúde mental
- Melhorar conhecimento sobre o conceito de Programa de Formação em Primeira Ajuda em Saúde Mental
- Melhorar conhecimento sobre a importância da formação em saúde mental nas escolas para adolescentes
- Melhorar conhecimento sobre aspetos éticos implícitos à implementação do programa de formação
- Melhorar conhecimento sobre cronograma do programa de formação

2

Importância dos programas de formação em saúde mental

A prestação de primeira ajuda **exige** que as pessoas tenham um **papel ativo** na saúde dos outros indivíduos.



Os cidadãos podem envolver-se mais ativamente na sua saúde pessoal e comunitária, melhorando a sua **literacia em saúde**.

De acordo com a Organização Mundial da Saúde, a **literacia em saúde** é o conjunto de competências cognitivas e sociais e a capacidade das pessoas de **acederem, compreenderem e usarem informação** de forma a promover e manter uma boa saúde.



4

Importância dos programas de formação em saúde mental

Os níveis de literacia em saúde mental são baixos em todo o mundo.
Esta tendência tem sido verificada na juventude portuguesa.

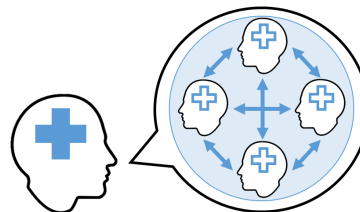


Programa de Formação em Primeira Ajuda em Saúde Mental

5

Conceito de Programa de Formação em Primeira Ajuda em Saúde Mental

Envolvem a **formação de indivíduos para ajudar** pessoas com problemas de saúde mental.



Os formandos aprendem essencialmente a **identificar** problemas de saúde mental, a **assistir** as pessoas os vivenciam e a **reencaminhar** para recursos de ajuda.

6

Importância da formação em saúde mental nas escolas para adolescentes

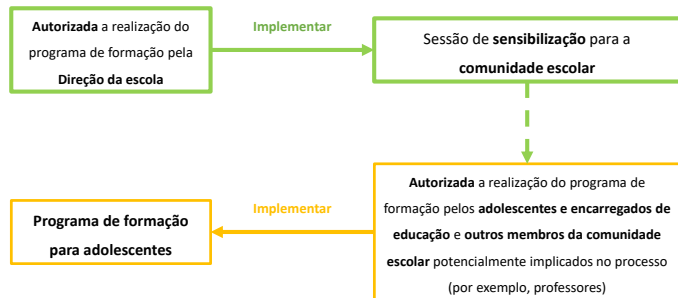
- Potencial interesse para os adolescentes e escolas
- Estadio de desenvolvimento “ideal”
- Escola como um local privilegiado de aprendizagem
- Resultados de aprendizagem esperados no nível de qualificação

7

Interessados na implementação do programa de formação?

8

Aspectos éticos implícitos à implementação do programa de formação



9

Empower 4 MentalHelp

Capacitar para a Ajuda Mental

- É um programa liderado por **enfermeiros de saúde mental**.
- **Ensina** sobre problemas de saúde mental e como podem **ajudar** pessoas que os vivenciam.

10

Cronograma do programa de formação

PROGRAMA DE FORMAÇÃO PARA ADOLESCENTES EM CONTEXTO ESCOLAR										
Módulo 0	Módulo 1		Módulo 2		Módulo 3		Módulo 4		Módulo 5	
Avaliação das necessidades educativas dos participantes	Saúde mental e autocuidado		Identificação de problemas de saúde mental - <i>um olhar para dentro</i>		Identificação de problemas de saúde mental - <i>um olhar para fora</i>		Prestação de ajuda e encaminhamento		Plano de ação	
	Parte 1	Parte 2	Parte 1	Parte 2	Parte 1	Parte 2	Parte 1	Parte 2	Parte 1	Parte 2
45 minutos	45 minutos	45 minutos	45 minutos	45 minutos	45 minutos	45 minutos	45 minutos	45 minutos	45 minutos	45 minutos

Espacamento entre sessões ≤ 1 semana

Após 3 meses (aproximadamente)
SESSÃO DE ACOMPANHAMENTO E REFORÇO
45 minutos

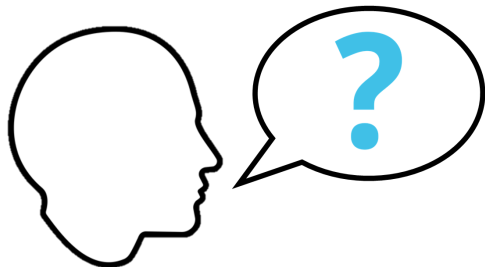
11

Síntese

- Cada um de nós pode **prestar uma ajuda inicial** a pessoas com problemas de saúde mental.
- Intervenções educativas (como os Programa de Formação em Primeira Ajuda em Saúde Mental) são fundamentais para a **melhoria da literacia em saúde** mental.
- **Adolescentes** e as **escolas** são alvos apropriados para Programas de Formação de Primeira Ajuda em Saúde Mental.
- O Programa de Formação “Empower4MentalHelp” tem uma duração total de **8 horas e 25 minutos** e é constituído por **6 módulos** de formação.

12

Dúvidas



13

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ANEXO IX

Apresentação a usar no Módulo 0 do Programa de Formação
"Empower4MentalHelp"

Programa de Formação em Primeira Ajuda em Saúde Mental: “Empower4MentalHelp”

Módulo 0: Avaliação das necessidades educativas dos participantes

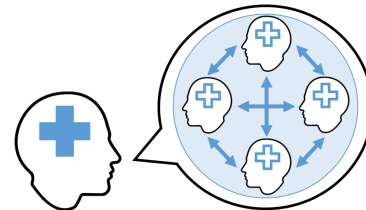
Formador:

(Especificar Nome do formador, afiliação e endereço eletrónico)

(Incluir logotipo da entidade formadora e formada)



Programa de Formação em Primeira Ajuda em Saúde Mental



Ensina a **identificar** problemas de saúde mental, a **assistir** as pessoas os vivenciam e a **reencaminhar** para recursos de ajuda.

Empower 4 MentalHelp

Capacitar para a Ajuda Mental



Objetivos da sessão

Determinar as competências para agir face pessoas com problemas de saúde mental

Melhorar conhecimento sobre o programa de formação

- Melhorar conhecimento sobre a importância da formação em primeira ajuda em saúde mental
- Melhorar conhecimento sobre o cronograma do programa de formação
- Melhorar conhecimento sobre recursos de informação sobre assuntos de saúde mental

Necessidades educativas

**Print dos
instrumentos de
avaliação a
preencher**

5

Importância da formação em primeira ajuda em saúde mental

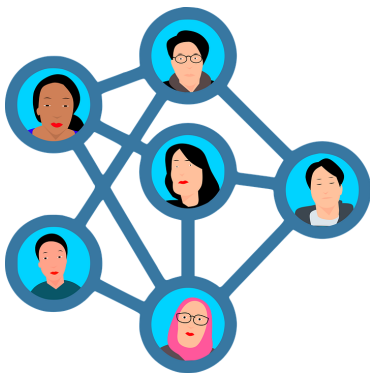
A elevada prevalência mundial de **problemas de saúde mental** torna mais provável que as pessoas tenham contacto com alguém que tenha problemas deste foro.



Precisas de saber como agir!

6

Apresentação e expectativas



7

Cronograma do programa de formação

Estamos
aqui!



PROGRAMA DE FORMAÇÃO PARA ADOLESCENTES EM CONTEXTO ESCOLAR										
Módulo 0	Módulo 1		Módulo 2		Módulo 3		Módulo 4		Módulo 5	
Avaliação das necessidades educativas dos participantes	Saúde mental e autocuidado		Identificação de problemas de saúde mental - <i>um olhar para dentro</i>		Identificação de problemas de saúde mental - <i>um olhar para fora</i>		Prestação de ajuda e encaminhamento		Plano de ação	
45 minutos	Parte 1	Parte 2	Parte 1	Parte 2	Parte 1	Parte 2	Parte 1	Parte 2	Parte 1	Parte 2
	45 minutos	45 minutos	45 minutos	45 minutos	45 minutos	45 minutos	45 minutos	45 minutos	45 minutos	45 minutos
Espaçamento entre sessões ≤ 1 semana										



Após 3 meses (aproximadamente)

SESSÃO DE ACOMPANHAMENTO E REFORÇO	
45 minutos	

8

Recursos de Informação

Print + Link do Recurso de informação: Manual para participantes/ socorristas

9

Recursos de Informação

Print + Link do Recurso de informação: Fórum de discussão

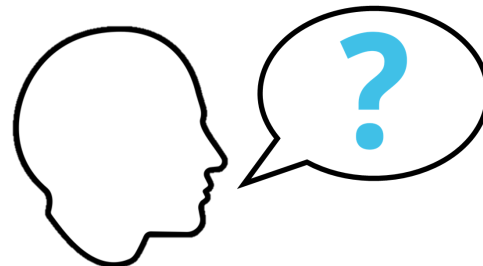
10

Síntese

- O Programa de Formação “Empower4MentalHelp” tem uma duração total de **8 horas e 25 minutos** e é constituído por **6 módulos de formação**.
- Serão realizadas **diferentes atividades** e terão disponíveis vários **recursos educativos** (por exemplo, o fórum e o manual).
- Aprenderão a **socorrer** pessoas com problemas de saúde mental.

11

Dúvidas



12

Referências Bibliográficas

Costa, T. F. O., Sampaio, F. M. C., Sequeira, C. A. C., Lluch Canut, M. T., & Moreno Poyato, A. R. (2024). *Manual para Dinamizadores do Programa de Formação “Empower4MentalHelp” (versão ensino secundário 1.0)*. Porto: Sociedade Portuguesa de Enfermagem de Saúde Mental (ASPESM). ISBN: 978-989-54826-6-5

Fontes das imagens usadas

No diapositivo 7: <https://images.app.goo.gl/tiG6JxgNHxYFQpym6>

ANEXO X

Apresentação a usar no Módulo 1 do Programa de Formação
"Empower4MentalHelp"

Programa de Formação em Primeira Ajuda em Saúde Mental: “Empower4MentalHelp”



Módulo 1: Saúde mental e autocuidado

Formador:

(Especificar Nome do formador, afiliação e endereço eletrónico)

(Incluir logotipo da entidade formadora e formada)

1

O que é a Saúde?



3

Objetivos da sessão

Melhorar conhecimento sobre saúde mental

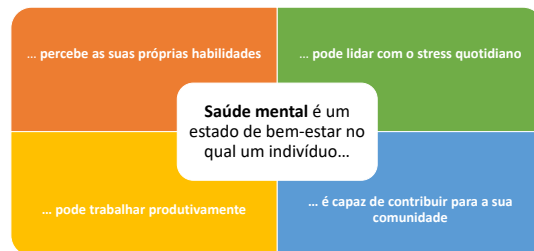
- Melhorar conhecimento sobre o conceito de saúde e saúde mental
- Melhorar conhecimento sobre os fatores de influenciadores da saúde mental
- Melhorar conhecimento sobre o conceito de problema de saúde mental e doença mental

Melhorar competências para cuidar da saúde mental

- Melhorar conhecimento sobre estratégias de autoajuda (importância, tipos e exemplos)
- Melhorar a capacidade para usar estratégias de autoajuda

2

O que é a Saúde Mental?



4

O que é a Saúde Mental?



5

O que influencia a saúde mental?



6

Síntese



7

O que é um problema de saúde mental?

Problema de saúde mental

Doenças mentais

Sintomas de doença mental
que ainda não justificam o
diagnóstico de doença

8

O que são doenças mentais?

São distúrbios clinicamente significativos nos processos mentais que causam **disfuncionalidade**.

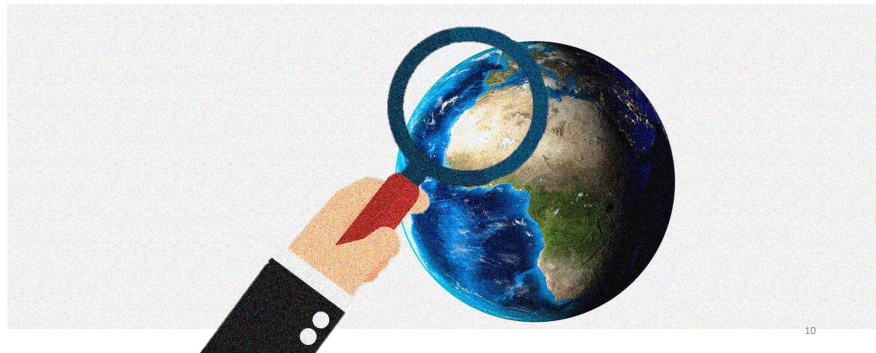
Não envolvem as **respostas esperadas** ou **aprovas culturalmente** a stressores ou perdas comuns.

Estão associados ao **sofrimento** ou **incapacidade significativos** que afetam **atividades** sociais, profissionais ou outras de relevo.

Não envolvem **desvios e conflitos** referentes ao indivíduo e à sociedade que **não causam disfunção**.

9

Problemas de saúde mental em Portugal e no mundo



10

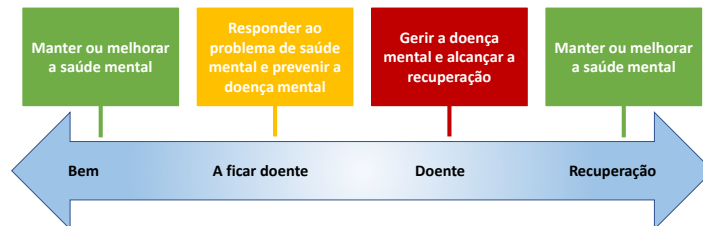
“Na saúde e doença”: O que podemos fazer?

Cuidar da
nossa
própria
saúde
mental

Agir face
à saúde
mental
dos que
nos
rodeiam

11

Importância de cuidar da saúde mental



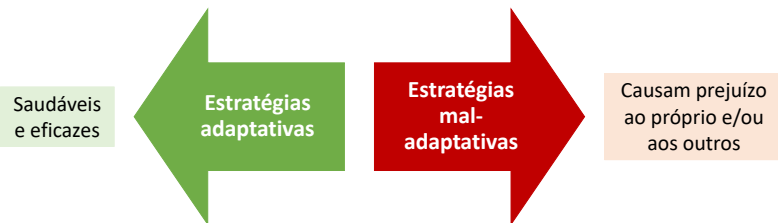
12

Síntese

- A **saúde mental** deve ser encarada como um **continuum**: estar bem, vivenciar um problema de saúde mental, ter uma doença mental e estar recuperado.
- A saúde mental é **influenciada** por características individuais, estilos de vida, rede social e comunitária, condições de vida e de trabalho, condições socioeconômicas, culturais e ambientais.
- “**Problema de saúde mental**” é um termo amplo que envolve doenças mentais e sintomas de doença mental que ainda não justificam o diagnóstico de doença.
- Os problemas de saúde mental têm uma **elevada incidência e prevalência** ao nível nacional e internacional.
- É fundamental as pessoas **agirem face a sua saúde** e face à saúde dos outros.

13

Como cuidar da saúde mental?



15

Continuamos?



14

Como cuidar da saúde mental?

Exercício 1: Em grupos, façam uma lista de estratégias que podem ser usadas para cuidar da saúde mental.

Exercício 2: A partir das listas realizadas, classifiquem as estratégias como adaptativas ou mal-adaptativas.

16

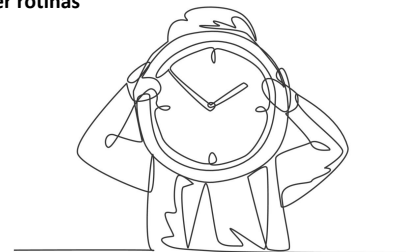
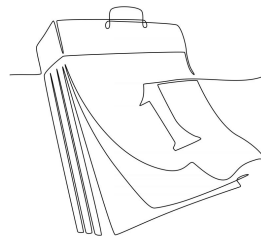
Síntese



17

Dicas de como cuidar da saúde mental

Estabelecer rotinas



18

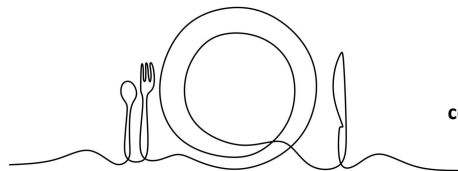
Dicas de como cuidar da saúde mental



Mudar de ambiente

19

Dicas de como cuidar da saúde mental



Fazer uma alimentação completa, variada e equilibrada

20

Dicas de como cuidar da saúde mental

Dormir regularmente



21

Dicas de como cuidar da saúde mental

**Planejar atividades de
lazer e distração**



22

Dicas de como cuidar da saúde mental

Praticar exercício físico regular



23

Dicas de como cuidar da saúde mental

Ler e escrever



24

Dicas de como cuidar da saúde mental



Realizar atividades de expressão plástica

25

Dicas de como cuidar da saúde mental

Realizar atividades de expressão corporal



26

Dicas de como cuidar da saúde mental

Cantar ou tocar um instrumento musical



27

Dicas de como cuidar da saúde mental

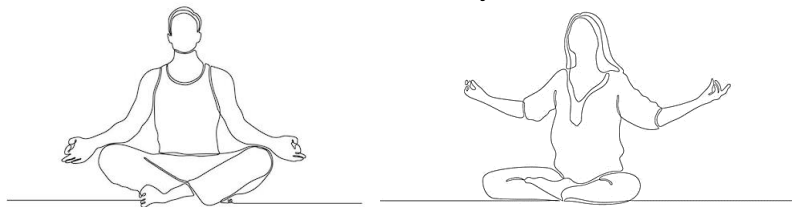
Ouvir músicas / áudios



28

Dicas de como cuidar da saúde mental

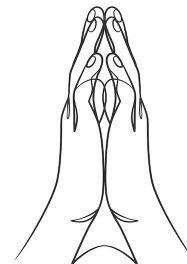
**Realizar estratégias de
relaxamento e de meditação**



29

Dicas de como cuidar da saúde mental

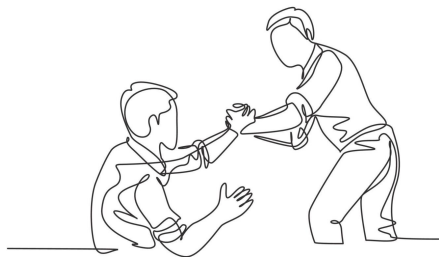
Praticar culto religioso



30

Dicas de como cuidar da saúde mental

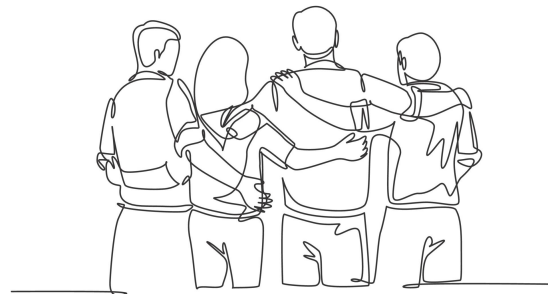
Fazer voluntariado



31

Dicas de como cuidar da saúde mental

Socializar



32

E se precisar de ajuda para promover a minha saúde mental?



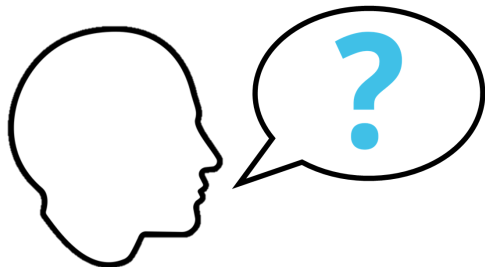
33

Síntese

- Cada um de nós **pode agir** face à sua saúde e face à saúde daqueles que nos rodeiam.
- Devemos **adotar estratégias adaptativas** no quotidiano e **evitar estratégias mal adaptativas**.
- Estratégias de relaxamento e planear atividades de lazer e distração são excelentes **exemplos de estratégias adaptativas**.

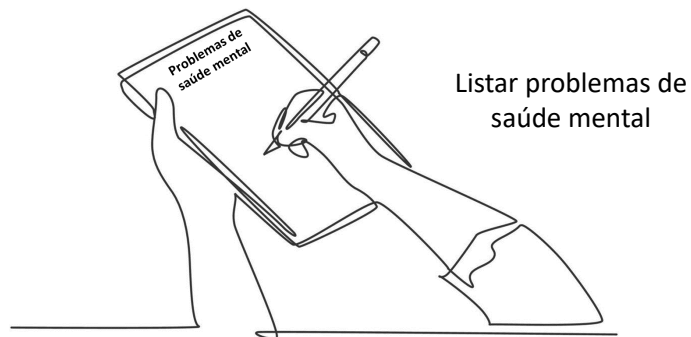
34

Dúvidas



35

Proposta de trabalho para casa



36

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Fontes das imagens usadas

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38

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ANEXO XI

Apresentação a usar no Módulo 2 do Programa de Formação
"Empower4MentalHelp"

Programa de Formação em Primeira Ajuda em Saúde Mental: “Empower4MentalHelp”



Módulo 2: Identificação de problemas de saúde mental - *um olhar para dentro*

Formador:

(Especificar Nome do formador, afiliação e endereço eletrónico)

(Incluir logotipo da entidade formadora e formada)

1

Objetivos da sessão

Melhorar competências para identificar problemas de saúde mental

- Melhorar conhecimento sobre os diferentes tipos de problemas de saúde mental
- Melhorar conhecimento sobre problemas de saúde mental (do foro cognitivo e emocional) e respetivas manifestações
- Melhorar capacidade para reconhecer problemas de saúde mental (do foro cognitivo e emocional)

2

Ainda se recordam do que é um problema de saúde mental?

Problema de saúde mental

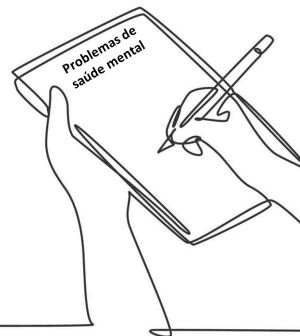
Doenças mentais

Distúrbios clinicamente
significativos que causam
disfunção

Sintomas de doença
mental que ainda não
justificam o diagnóstico de
doença

3

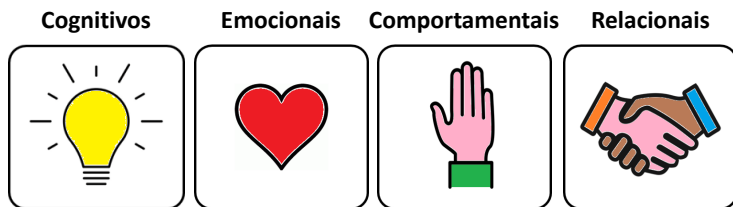
Análise do trabalho de casa



Listar problemas de
saúde mental

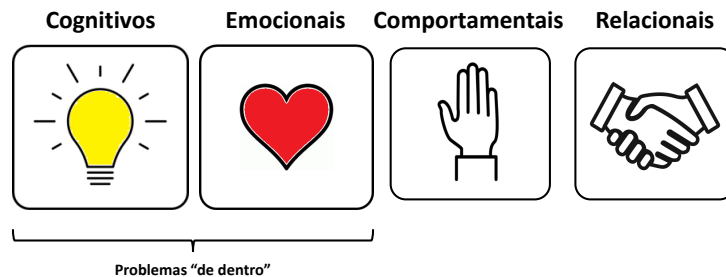
4

Que tipos de problemas de saúde mental existem?



5

Problemas que abordaremos neste módulo



6

Problemas Cognitivos



Problemas de memória

Problemas de atenção

Problemas de linguagem

Problemas de percepção

Problemas de pensamento

Problemas de autoconceito

7

Problemas de Memória



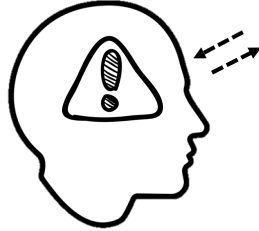
Dificuldade de **adquirir**, **armazenar** e **recuperar** informações disponíveis no cérebro (**alteração na memória**)

8

Problemas de Atenção

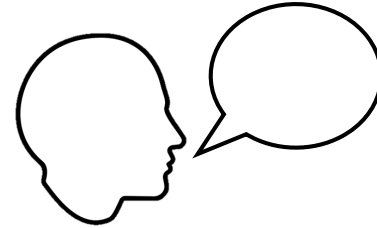
Dificuldade de **receber** e **processar** intencionalmente informação (**alteração na atenção**)

Dificuldade em **focalizar** a atividade mental para armazenar e recordar informações (**alteração na concentração**)



9

Problemas de Linguagem



Dificuldade para **expressar** palavras **oralmente** (**disfasia**)

Dificuldade na **leitura** (**dislexia**)

10

Problemas de Percepção



Percepção real de um estímulo que não existe (**alucinação**)

11

Problemas de Pensamento

Dificuldade em **processar ideias** concretas e/ou abstratas (**alteração no pensamento**)

Dificuldade em **adquirir competências** por meio do estudo, formação e experiência (**alteração na aprendizagem**)

Crenças erradas/implausíveis mantidas com **absoluta convicção**, mesmo com provas contrárias (**delírios**)

Ponderação e/ou planejamento de **suicídio** (**Ideação suicida**)



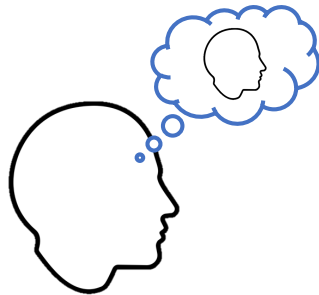
Perda progressiva de funções cognitivas (**demência**)

Alteração da memória com **desorientação** em relação à pessoa, local ou tempo (**confusão**)

Ideias, imagens ou impulsos **recorrentes**, persistentes, intrusivos e indesejados (**obsessão**)

12

Problemas de Autoconceito



Dificuldade em definir o “eu” (**identidade pessoal perturbada**)

Imagem mental negativa de si próprio (**autoimagem negativa**)

Imagem mental negativa da **aparência física** do próprio (**imagem corporal perturbada**)

Valor inapropriado que o próprio atribui a si (**autoestima baixa ou excessiva**)

13

Síntese



14

Problemas Emocionais

Existência de
emoções
negativas



Falta de emoções
positivas

15

Existência de emoções negativas



Sentimento de **antecipação** de uma **ameaça** futura (**ansiedade**)

Sentimento de **sobre-excitação** (**nervosismo**)

Sentimentos de **incerteza** (**insegurança**)

16

Existência de emoções negativas



Sentimento de exclusão e de **falta de pertença (solidão)**



Sentimento de **pena** associados a **perda** ou **morte** significativa (**luto**)

Sentimento de **falta de ânimo**:

- Pontual (**tristeza**)
- Persistente (**humor depressivo**)



17

Existência de emoções negativas



Sentimento de **dor** intensa e forte, pena e aflição com **sensação de sufoco (angústia)**

Sentimento de profunda falta de esperança e valor, sentimento de **vazio (desespero)**



Sentimento prolongado de **pena** associados a martírio e à **necessidade de tolerar condições devastadoras (sofrimento)**

18

Existência de emoções negativas



Sentimentos **contraditórios** e **opostos** perante uma pessoa ou coisa (**ambivalência**)



19

Existência de emoções negativas

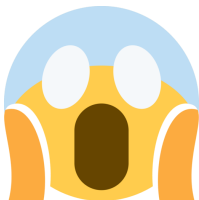


Sentimento de alegria com uma **sensação exagerada de bem-estar**, não se baseando na realidade e não sendo proporcional à situação (**euforia**)

20

Existência de emoções negativas

Sentimento de **ameaça real** ou percebida (**medo**)



21

Existência de emoções negativas

Dano mental que ocorre como resultado de um evento angustiante (por exemplo: guerra) (**trauma**)



22

Existência de emoções negativas

Sentimento de estar “**sob pressão**” (**stress**)

Sentimento de desgaste e **cansaço**, de diminuição da força (**fadiga** e **exaustão**)



23

Existência de emoções negativas

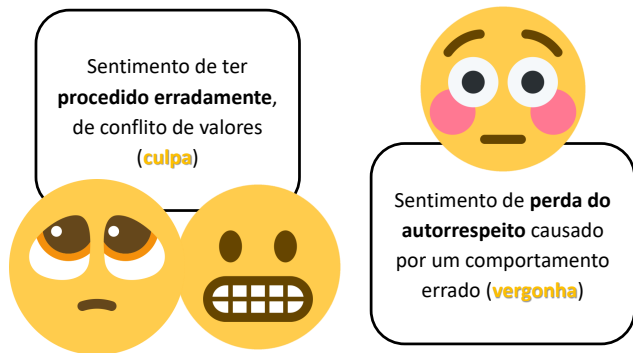
Sentimento de **ameaça**, provocado pela suspeita de que a pessoa amada **dedique o seu afeto a outrem** (**ciúme**)



Sentimento de **descontentamento por não possuir algo** (por exemplo: qualidades, objetos) que outro indivíduo tem (**inveja**)

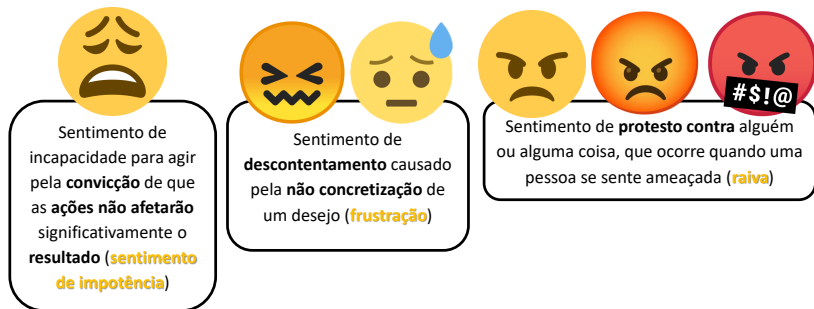
24

Existência de emoções negativas



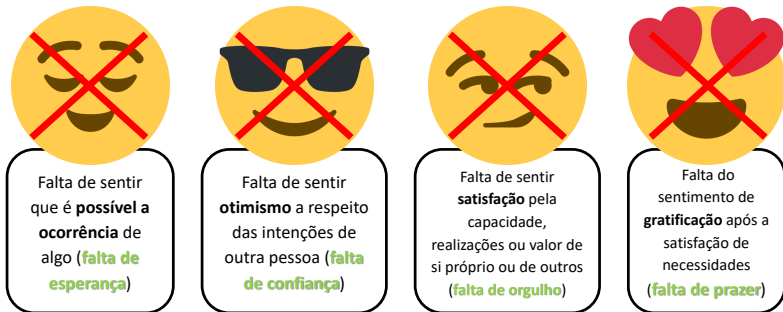
25

Existência de emoções negativas



26

Falta de emoções positivas



27

Síntese

- Os **problemas de saúde mental** são perturbações na **cognição**, nas **emoções**, nos **comportamentos** e/ou nas **relações** dos indivíduos.
- Os **problemas cognitivos** envolvem alterações da memória, atenção, linguagem, percepção, pensamento e autoconceito.
- Os **problemas emocionais** compreendem a existência de emoções negativas e a falta de emoções positivas.

28

Continuamos?



29

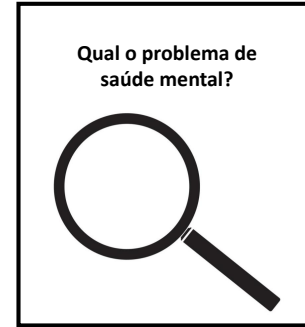
Qual o problema de saúde mental?

Caso 1: A Odete esquece-se frequentemente dos seus pertences (por exemplo, carteira, chaves de casa) e do que ia fazer (por exemplo, cozinhar).
Caso 2: A mãe da Tiago pede-lhe ajuda para tarefas. O Tiago diz ser muito distraído e que a maioria das vezes não ouve os pedidos da sua mãe.
Caso 3: A Inês não consegue manter-se focada no que a professora está a explicar na aula.
Caso 4: O Manuel está no 4º ano de escolaridade. Tem muita dificuldade na leitura, trocando frequentemente letras e sílabas nas palavras.
Caso 5: A Maria tem dificuldade em expressar oralmente as suas ideias ("faltam-me as palavras").
Caso 6: O António refere que vê monstros e que esses monstros lhe dizem que vão destruir o mundo.

- ➡ Alteração na memória
- ➡ Alteração na atenção
- ➡ Alteração na concentração
- ➡ Dislexia
- ➡ Disfasia
- ➡ Alucinação

31

Torneio



30

Qual o problema de saúde mental?

Caso 7: A Maria refere que se sente mais lenta a pensar e que, por vezes, as ideias lhe fogem.
Caso 8: O Igor tem mau aproveitamento escolar e já reprovou uma vez. Ele refere que, por mais que estude e que tenha explicações, não consegue ter bons resultados.
Caso 9: A Carolina acha que a vida não faz sentido e tem pensado em pôr fim à sua vida.
Caso 10: A Isaura está sempre a pensar que algo em sua casa está desarrumado ou sujo. Ela quase nunca sai de casa para manter tudo "na ordem".
Caso 11: O Guilherme refere que os vizinhos o perseguem, que o restaurante onde comeu o tentou envenenar e que a sua esposa lhe pôs uma bomba debaixo do carro. A polícia afirma ser um relato implausíveis, não existindo quaisquer provas.
Caso 12: As capacidades cognitivas da Augusta têm piorado de dia para dia. Atualmente, é necessária ajuda nas tarefas do dia-a-dia, até para manter a segurança da senhora.
Caso 13: O Joaquim foi internado. O hospital é um espaço novo para si e "muito atribulado". O Joaquim tem-se sentido desorientado (perde a noção de onde está, momento do dia em que se encontra, ...).

- ➡ Alteração no pensamento
- ➡ Alteração na aprendizagem
- ➡ Ideação suicida
- ➡ Obsessão
- ➡ Delírio
- ➡ Demência
- ➡ Confusão

32

Qual o problema de saúde mental?

Caso 14: A Joana acha-se má pessoa porque magoou o seu ex-namorado ao acabar com a relação.
Caso 15: O Diogo diz odiar o seu corpo por ser muito magro.
Caso 16: A Filipa acha que é “superior” aos outros, visto que a sua família é muito rica e culta.
Caso 17: O João acha que não tem valor como pessoa por ser analfabeto. Ele diz frequentemente “sou um lixo”.
Caso 18: A Helena sente-se persistentemente desconfortável com o seu género (feminino) e com o seu corpo. Sente-se “um homem num corpo de uma mulher”.



Autoimagem negativa



Imagem corporal perturbada



Autoestima excessiva



Autoestima baixa



Identidade pessoal perturbada

33

Qual o problema de saúde mental?

Caso 19: O João tem estado preocupado com a possibilidade de ser despedido, pois a sua empresa está com problemas financeiros. A caminho do emprego sente o seu coração a bater muito rápido, fica com falta de ar.
Caso 20: Durante os testes, a Mafalda fica muito inquieta, com tremores e não consegue parar de roer as unhas.
Caso 21: O Gabriel não sabe se deve seguir o seu sonho na música ou se deve ter um emprego “mais seguro” como informático.
Caso 22: A Isilda sente-se “em baixo”, porque se chateou com a melhor amiga.
Caso 23: O Carlos tem-se sentido há algum tempo infeliz com o rumo que a sua vida levou, sem vontade de sair da cama.
Caso 24: A Ana sente-se destruída depois do falecimento do seu pai.



Ansiedade



Nervosismo



Insegurança



Tristeza



Humor depressivo



Luto

34

Qual o problema de saúde mental?

Caso 25: Desde que mudou de escola, o Raúl sente que não pertence a nenhum grupo e que é excluído pelos seus colegas.
Caso 26: A Isabel tem uma grande dívida e sente-se com uma aflição imensa como se fosse sufocar. Sente pena que a sua família esteja a sofrer com os seus erros.
Caso 27: O José sente que tudo falhou na sua vida: perdeu o emprego e separou-se da sua namorada. Sente-se vazio e refere que não ter esperança num futuro melhor.
Caso 28: A Lia é refugiada. Vive em más condições (inclusive de alimentação, higiene, de habitação). Sente uma intensa e prologada pena pelas condições em que vive.



Solidão



Angústia



Desespero



Sofrimento

35

Qual o problema de saúde mental?

Caso 29: O Matias sempre teve uma boa relação familiar. Recentemente, tem alternado entre estados de imensa alegria e de estados de intensa tristeza perante a família.
Caso 30: A Sara encontra-se com um estado de alegria desmedida no emprego (canta, grita, dança) e de alguma desinibição com alguns dos seus clientes.
Caso 31: O João foi mordido por um cão, na infância. Desde então, sempre que vê um cão foge na direção contrária. Ele refere que eles podem morder.
Caso 32: A Íris sofreu de violência doméstica (física e verbal) durante o seu casamento. Atualmente, diz que não é capaz de ter uma nova relação amorosa por toda a angústia que vivenciou na relação anterior. Sente-se como “um copo partido em mil pedaços” que é difícil de “colar”.
Caso 33: O Carlos tem muitas tarefas ao seu encargo. Sente-se sempre sob tensão, como se fosse “puxado por todos os lados”.
Caso 34: A Aurora é mãe de três filhos e tem dois empregos. Sente-se com diminuição da força, cansada, desgastada.



Ambivalência



Euforia



Medo



Trauma



Stress



Fadiga e exaustão

36

Qual o problema de saúde mental?

Caso 35: O Abel sente que a sua esposa dá mais atenção ao Sr. Rui, o patrão dela. Refere que ela passa demasiado tempo com ele.
Caso 36: A Clara sente-se descontente por não ter ido para o ensino superior como a sua colega Ágata. Ela refere que a Ágata sempre foi “a protegida pelos professores”.
Caso 37: O Óscar traiu a sua esposa com outra mulher. Ele sente que agiu mal. Refere que os seus atos foram contra os valores em que acredita e que não devia ter cedido à tentação.
Caso 38: A Mariana saiu da prisão. Ela sente que não é merecedora de respeito, que é “ridícula” pelos comportamentos que teve.
Caso 39: O pai do André está internado com um prognóstico reservado. O André sente que não consegue ajudar na situação por muito que queira. Sente-se “de mãos atadas”.
Caso 40: A Julieta não conseguiu ficar apurada para os Jogos Olímpicos. Sente-se aborrecida por não ter concretizado o seu sonho.
Caso 41: O Romeu teve um acidente de automóvel, por culpa de outro condutor. O outro condutor não assumiu a responsabilidade. O Romeu diz que vai protestar até às últimas consequências. Sente que a qualquer momento lhe “pode saltar a tampa”.

- ⇒ Ciúme
- ⇒ Inveja
- ⇒ Culpa
- ⇒ Vergonha
- ⇒ Sentimento de impotência
- ⇒ Frustração
- ⇒ Raiva

37

Qual o problema de saúde mental?

Caso 42: A Matilde tem uma doença. Ela sente que nunca conseguirá ser novamente autónoma e ter uma vida minimamente normal.
Caso 43: A namorada do Hugo mentiu-lhe e por isso terminaram o relacionamento. O Hugo sente que não vai conseguir acreditar novamente numa mulher. Refere que não quer mais ser magoado.
Caso 44: A Irene não se sente satisfeita com a sua profissão e com as conquistas que conseguiu na sua empresa.
Caso 45: O Vasco sente que todos os dias são iguais e que a vida é monótona. Sente que até a comida já não tem sabor.

- ⇒ Falta de esperança
- ⇒ Falta de confiança
- ⇒ Falta de orgulho
- ⇒ Falta de prazer

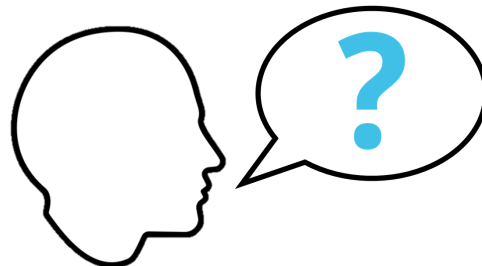
38

Síntese

- No dia-a-dia, o público em geral pode ter **contacto** com pessoas com **problemas cognitivos e emocionais**.
- Erros no reconhecimento** dos problemas de saúde mental podem ocorrer. O treino da identificação destes é fundamental.

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Dúvidas



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Referências bibliográficas

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41

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ANEXO XII

Apresentação a usar no Módulo 3 do Programa de Formação
"Empower4MentalHelp"

Programa de Formação em Primeira Ajuda em Saúde Mental: “Empower4MentalHelp”



Módulo 3: Identificação de problemas de saúde mental - um olhar para fora

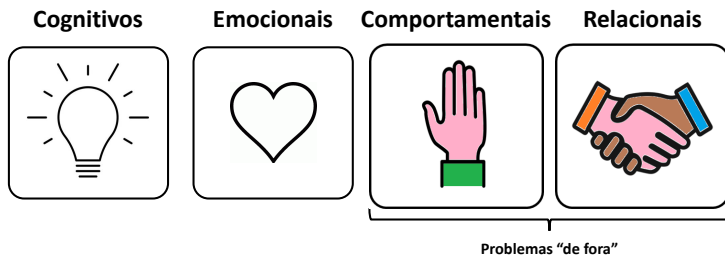
Formador:

(Especificar Nome do formador, afiliação e endereço eletrónico)

(Incluir logotipo da entidade formadora e formada)

1

Problemas que abordaremos neste módulo



3

Objetivos da sessão

Melhorar competências para identificar problemas de saúde mental

- Melhorar conhecimento sobre problemas de saúde mental (do foro comportamental e relacional) e respetivas manifestações
- Melhorar capacidade para reconhecer problemas de saúde mental (do foro comportamental e relacional)
- Melhorar atitude em relação a pessoas com problemas de saúde mental
- Melhorar conhecimento sobre as consequências dos problemas de saúde mental

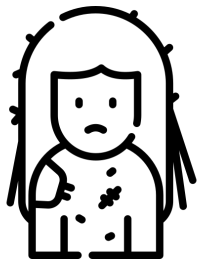
2

Problemas Comportamentais



4

Problemas de cuidado com o próprio



Falta de cuidado com o próprio, não havendo a **resposta** adequada às **necessidades do dia-a-dia** (**alteração no autocuidado**)



5

Problemas na organização de comportamentos

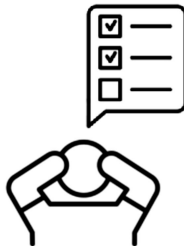


Ações desordenadas, confusas, **não adequadas ao meio envolvente** (**comportamento desorganizado**)

6

Problemas por compulsões

Atos **repetitivos** em resposta a pensamentos obsessivos (**compulsão**)



7

Problemas do comportamento alimentar



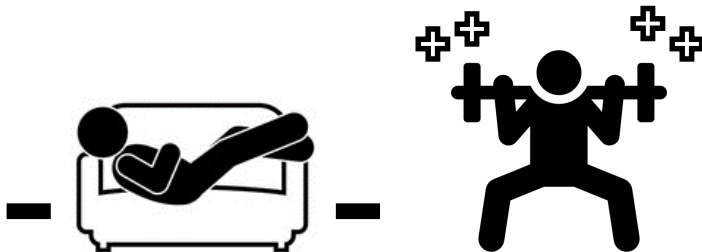
Consumo recorrente de **grandes quantidades de alimentos** com sensação de perda de controle (**comportamento alimentar compulsivo**)

Diminuição ou ausência de consumo alimentar (**anorexia**)



Episódios de grandes **excessos alimentares** seguidos de **vômito induzido**, pelo próprio indivíduo (**bulimia**).

Problemas no padrão de exercício físico



Prática **reduzida** ou **excessiva** de exercício físico (**alteração no padrão de exercício**)

9

Problemas na frequência de comportamentos



Aumento anormal **da atividade** do corpo, a dificuldade para se manter na mesma posição (**hiperatividade**)

10

Problemas de sono

Alterações no sono (período de diminuição da atividade corporal e de consciência)



Falta de sono nos períodos planejados (**insônia**)

11

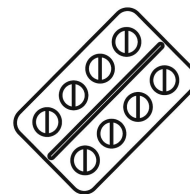
Problemas relacionados com o consumo de substâncias



Abuso de **álcool**



Abuso de **tabaco**



Abuso de **drogas**

12

Problemas com o jogo, videojogos, internet



Abuso de **jogo de apostas**



Abuso de **videojogos**



Abuso de **internet**

13

Problemas de agressividade

Comportamentos de **imposição** perante outra pessoa (**comportamento agressivo**)

Comportamentos que procuram **lesar** outra pessoa (**violência**)

14

Problemas de agressividade



Expressão **física** (inclusive sexual)



Expressão **verbal**



Expressão **simbólica**

15

Problemas de agressividade



Cara-a-cara

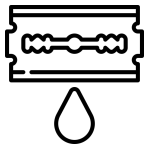


Virtual

16

Problemas de autolesão

Ações com o objetivo de o **próprio** se agredir ou **lesar** (**comportamento autodestrutivo**)



Agressão infligida pelo próprio e **não letal** (por exemplo, cortes e queimaduras) (**automutilação**)



Comportamento com o objetivo de **acabar com a própria vida** (**tentativa de suicídio**)

17

Problemas Relacionais

Problemas de
socialização



Problemas de
comunicação

19

Síntese



18

Problemas de socialização

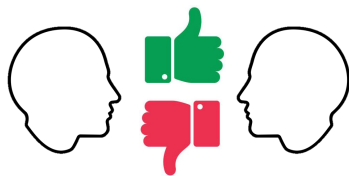
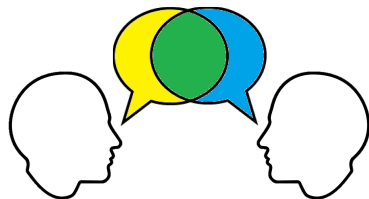
Dificuldade em **interagir** com outras pessoas e de **participar em atividades sociais** (**alteração na socialização**)

Ausência de contacto social (**isolamento social**)



20

Problemas de comunicação



Dificuldade em **dar e receber informações** utilizando comportamentos verbais e não-verbais (**alteração na comunicação**)

21

Continuamos?



23

Síntese

- Os **problemas de saúde mental** são perturbações na **cognição**, nas **emoções**, nos **comportamentos** e/ou nas **relações** dos indivíduos.
- Os **problemas comportamentais** engloba alterações no cuidado ao próprio, compulsões, alterações no padrão alimentar e de exercício físico, dependências/adições, agressividade dirigida ao próprio e a outros, alterações do sono e na organização e frequência de comportamentos.
- Os **problemas relacionais** incluem alterações na socialização e na comunicação entre indivíduos.

22

Torneio



24

Torneio

Caso 1: O Filipe tem aparecido constantemente no trabalho com a roupa suja, a cheirar mal e com barba por aparar.

➡ Alteração no autocuidado

Caso 2: A Lara tem dificuldade em fazer as atividades do dia-a-dia. Por exemplo, nas refeições deita fora a comida, no banho espalha gel de banho por toda a casa de banho.

➡ Comportamento desorganizado

Caso 3: A Leopoldina escova os dentes pelo menos 6 vezes por dia, toma pelo menos 3 banhos por dia e usa constantemente desinfetante para as mãos e superfícies. Reconhece que é exagerado. Contudo, refere que não consegue evitar porque tudo à sua volta tem bactérias.

➡ Compulsão

Caso 4: O Alexandre refere perder frequentemente o controlo a comer. Indica que comeu um bolo de 2 quilogramas ao pequeno almoço.

➡ Comportamento alimentar compulsivo

Caso 5: A Isabel refere falta de apetite, tendo “cortado” na comida. Por exemplo, ontem, comeu apenas duas maçãs durante todo o dia.

➡ Anorexia

Caso 6: Por vezes, o Sebastião come em excesso (por exemplo, três pratos de conduto). Nessas situações, ele induz o vómito, visto que não quer engordar.

➡ Bulimia

25

Torneio

Caso 7: Para ter um corpo musculado, o Miguel faz exercício físico intenso todos os dias e, por vezes, mais do que uma vez por dia. Ele tem dores musculares persistentes, fadiga persistente. Tem tido até mais lesões pelo excesso de esforço.

➡ Alteração no padrão de exercício físico

Caso 8: A Helena anda sempre de um lado para o outro, a correr, a escalar, tendo dificuldade em parar. Os pais dizem “ela anda sempre a mil”.

➡ Hiperatividade

Caso 9: A Micael tem tido pesadelos muito frequentes, acordando sobressaltada.

➡ Alteração no sono

Caso 10: O Leonel deita-se às 22h00. No entanto, só consegue adormecer pelas 3h da madrugada.

➡ Insónia

26

Torneio

Caso 11: A Cheila tem bebido pelo menos 1,5l de vinho por dia.

➡ Abuso de álcool

Caso 12: O Luís fuma dois maços de tabaco por dia.

➡ Abuso de tabaco

Caso 13: A Marina consome canábis diariamente (erva, haxixe).

➡ Abuso de drogas

Caso 14: O Francisco joga na raspadinha todos os dias e, por vezes, vai ao casino para tentar a sua sorte.

➡ Abuso de jogo de apostas

Caso 15: A Alice joga na sua consola quase todos os dias, esquecendo-se até das suas tarefas, de comer e de cuidar da sua higiene.

➡ Abuso de videojogos

Caso 16: A Genoveva está a maior parte do dia *online*. Ela está constantemente a relatar o seu dia-a-dia nas redes sociais.

➡ Abuso de internet

27

Torneio

Caso 17: O Gonçalo chateou-se com um amigo e deu um murro num vidro.

➡ Comportamento agressivo

Caso 18: A Vânia enviou várias SMS a uma colega da turma, com comentários ofensivos.

➡ Violência

Caso 19: A Filomena escreve comentários ofensivos sobre si própria no seu diário.

➡ Comportamento autodestrutivo

Caso 20: O Artur apresenta vários cortes nos punhos e pernas. Ele refere que quer materializar a dor que sente.

➡ Automutilação

Caso 21: O Joel tentou atirar-se abaixo da ponte, de modo a pôr fim à sua vida. No entanto, foi impedido pelos seus amigos.

➡ Tentativa de suicídio

28

Torneio

Caso 22: A Laurinda tem dificuldade em integrar-se num grupo. É tímida, tendo dificuldade em partilhar sobre a sua vida.

⇒ Alteração na socialização

Caso 23: Após terminar a sua relação amorosa, a Natália afastou-se dos seus amigos e familiares. Todos a fazem lembrar do seu ex-namorado.

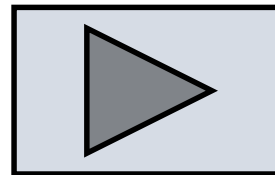
⇒ Isolamento social

Caso 24: O Pedro tem dificuldade em dizer “não” às pessoas à sua volta e de afirmar a sua opinião sobre um tema.

⇒ Alteração na comunicação

29

Experiências vivenciadas por pessoas com problemas de saúde mental



Inserir áudio ou vídeo com uma figura modelo para os participantes (por exemplo, trecho da entrevista ao António Raminhos - <https://www.youtube.com/watch?v=z7y30E0UJUQ>)

30

Estigma em saúde mental

Estigma dirigido a **pessoas com problemas de saúde mental**

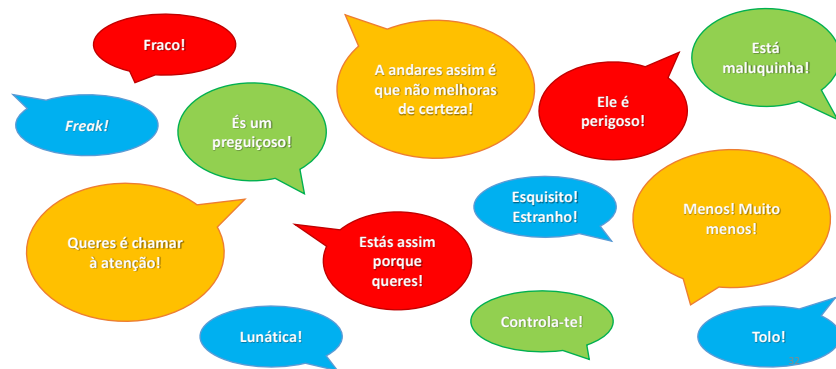
As pessoas são vistas de forma **negativa** por causa do seu problema

Por si próprias

Pela sociedade

31

Já contactaste com o estigma em saúde mental?



Consequências dos problemas de saúde mental



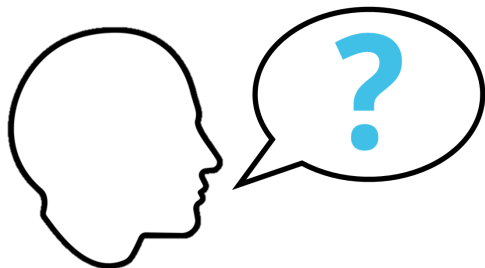
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Síntese

- No dia-a-dia, o público em geral pode ter **contacto** com pessoas com **problemas comportamentais e relacionais**.
- **Erros no reconhecimento** dos problemas de saúde mental podem ocorrer. O treino da identificação destes é fundamental.
- É importante estarmos **sensíveis** às experiências vivenciadas por pessoas com problemas de saúde mental.
- Os problemas de saúde mental têm múltiplas repercussões, representando **elevados custos económicos** para a sociedade.

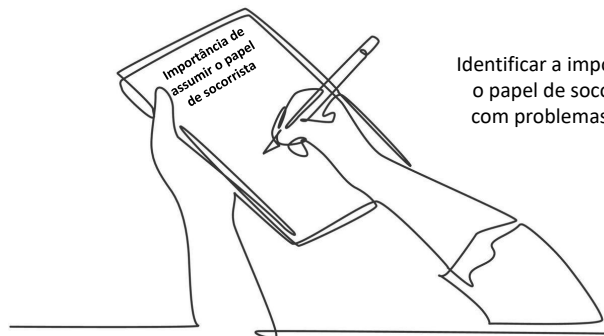
34

Dúvidas



35

Proposta de trabalho para casa



Identificar a importância de assumir o papel de socorrista de pessoas com problemas de saúde mental

36

Referências bibliográficas

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No diapositivo 21, à direita: <https://images.app.goo.gl/dZE1bsW6whfGzpFCA>

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No diapositivo 36: <https://images.app.goo.gl/LbpUr39vb2ick7me7>

ANEXO XIII

Apresentação a usar no Módulo 4 do Programa de Formação
"Empower4MentalHelp"

Programa de Formação em Primeira Ajuda em Saúde Mental: “Empower4MentalHelp”



Módulo 4: Prestação de ajuda e encaminhamento

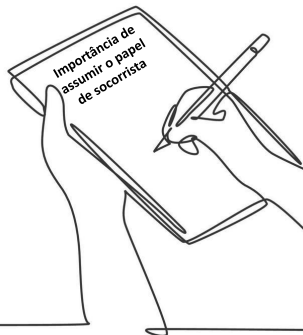
Formador:

(Especificar Nome do formador, afiliação e endereço eletrónico)

(Incluir logotipo da entidade formadora e formada)

1

Análise do trabalho para casa



Identificar a importância de assumir o papel de socorrista de pessoas com problemas de saúde mental

3

Objetivos da sessão

Melhorar competências para prestar ajuda inicial a pessoas com problema(s) de saúde mental

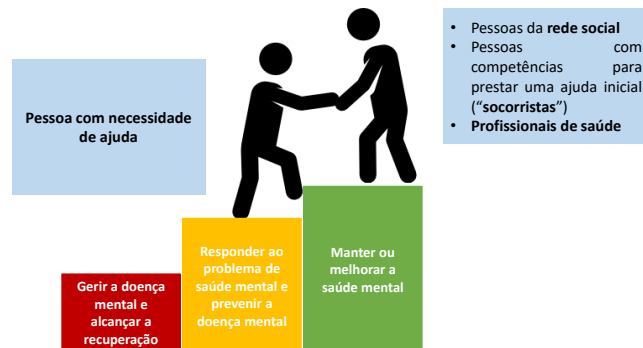
- Melhorar conhecimento sobre a necessidade de ajuda em saúde mental e sobre aspetos que facilitam e dificultam a procura de ajuda
- Melhorar conhecimento sobre a importância e o conceito de primeira ajuda em saúde mental
- Melhorar conhecimento sobre os princípios da comunicação e da relação entre pessoas
- Melhorar conhecimento sobre modos de promover o autocuidado nas pessoas com problemas de saúde mental

Melhorar competências para encaminhar pessoas com problema(s) de saúde mental

- Melhorar conhecimento sobre os recursos de ajuda em saúde mental e sobre a importância do encaminhamento

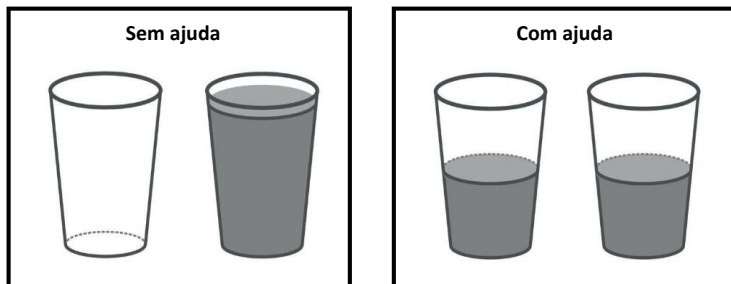
2

Necessidade de ajuda em saúde mental



4

Necessidade de ajuda em saúde mental



5

O que influencia a procura de ajuda profissional?

- Nível de literacia em saúde mental
- Falta de reconhecimento do problema de saúde
- Influência social daqueles que são próximos da pessoa que está a sofrer o problema
- Crenças acerca dos profissionais e dos tratamentos
- Disponibilidade da ajuda, acessibilidade e custos
- Experiências prévias com o problema
- Familiaridade e o estigma associado às doenças mentais
- ...

Pessoa com problema de saúde mental

influenciam

procura

Recurso de Ajuda em Saúde Mental

6

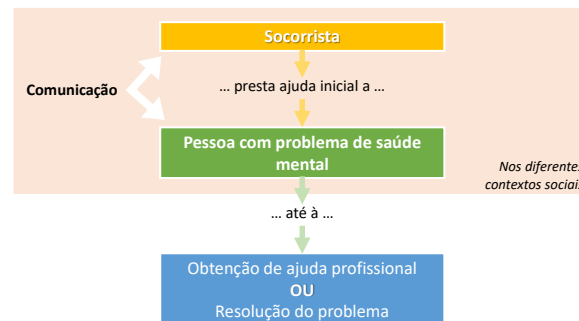
O que influencia a procura de ajuda profissional?



Há uma maior probabilidade de uma pessoa procurar ajuda se alguém lhe sugerir.

7

Vamos prestar uma primeira ajuda em saúde mental!



8

Síntese



9

Comunicação

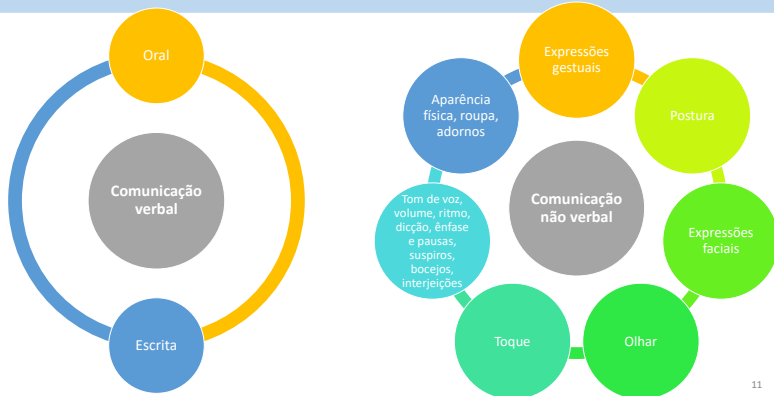


Processo dinâmico pelo qual emitimos e recebemos mensagens, compreendemos o outro e somos compreendidos

É impossível não comunicar!

10

Comunicação



11

Dicas para uma boa comunicação

- Comunique de uma forma **simples** e **sucinta**. Use preferencialmente **questões abertas**.
- Use **palavras positivas** ("Podemos falar tranquilamente sobre o que está a acontecer?") ao invés de palavras negativas ("Não faça isso!").
- Fale de modo **calmo** e **gentil**. Evite levantar o tom de voz ou falar muito rápido. Utilize uma **linguagem apropriada**, tenha cuidado com o calão.
- **Respeite o tempo** do outro para processar a informação e responder. Quando o outro estiver a falar, evite interromper. Dê também espaço ao silêncio. Utilize frases/expressões curtas ("Sim, compreendo!", "Estou a ver!") para promover o curso da conversa.

12

Dicas para uma boa comunicação

- Seja **genuíno** e **honesto** (“Nunca estive nessa situação”). Esclareça o que foi dito pela outra pessoa, quando necessário (“Não percebi o que disseste, podes explicar de novo?”). Sempre que não for entendido, repita o que disse ou use outras palavras.
- Seja **paciente** mesmo que o que ouça não seja simpático.
- Coloque de lado as suas crenças e opiniões. **Coloque-se no lugar do outro**, reflita sobre o que a outra pessoa está a vivenciar e sobre a ajuda que está a precisar. Contudo, **evite envolver-se excessivamente** na situação (por exemplo, chorar com a pessoa).

13

Dicas para uma boa comunicação

- **Evite confrontar** o outro (“Como é que nesta situação fizeste isto e naquela já agiste diferente?”, “Isso já aconteceu há tanto tempo e só agora é que andas assim?”). **Não peça justificações** (“Porquê que fizeste isso?”).
- **Não teça julgamentos negativos** à pessoa e à sua situação. **Não critique, culpabilize ou provoque** o outro. **Evite** “Tu preocupas-me”, “Não devias andar assim.”, “Menos! Muito menos!”, “Controla-te!”, “A andares assim é que não melhoras de certeza!”, “Estás assim porque queres!”, “Fracol”, “És um preguiçoso!”, “Que estúpido!”, “Ele é perigoso!”, “Tu estás a ser egoísta”, “Seu esquisito!”, “Que lunática!”, “Está maluquinho!”, “Queres é chamar à atenção”, “Não faças isso! Já disse para não fazeres isso!”).

14

Dicas para uma boa comunicação

- **Não compare a vida da pessoa** ajudada com a sua/com a de outras pessoas “Não tens motivos para estares assim”, “Aquele pessoa está pior que tu”, “Eu também já passei por isso e não estou assim”.
- **Não minimize** ou **rejeite o problema** do outro (“Isso é realmente um problema?”, “Tens uma doença da moda”, “Não pareces assim tão mal.”, “É normal andar assim de vez em quando!”, “Estás assim, mas isso passa!”, “Tens que andar com a vida para a frente!”, “Tens de ultrapassar isso!”, “Anima-te!”, “Tens de te recompor!”, “Tens de te mostrar bem!”). **Não ria ou goze** com a situação.
- **Promova a autonomia** e evite uma postura de excessiva proteção (“Eu ajudo-te!” ao invés de “Deixa estar que eu faço, tu não estás em condições!”, “Tu agora não estás capaz, eu resolvo!”).

15

Dicas para uma boa comunicação

- É fundamental que haja **congruência** entre a **comunicação verbal** e **não verbal**.
- Dê atenção à sua **linguagem corporal**.

— Evite fitar o outro “olhos nos olhos” ou nunca lhe dirigir o olhar.
— Evite uma “cara negativa” (expressão de emoções negativas, como medo, raiva).
— Evite posições defensivas como cruzar os braços, pernas e mãos.
— Evite comportamentos que expressem falta de paciência (como bater o pé, andar de um lado para o outro). Evite movimentos bruscos.
— Não invada o espaço pessoal da outra pessoa. Evite tocar numa pessoa que manifeste hostilidade, porque pode ser interpretado como ameaçador.

...

16

Como me aproximo e avalio a situação de pessoas com problemas de saúde mental?



17

Como me aproximo e avalio a situação de pessoas com problemas de saúde mental?

Estratégias	Operacionalização
Apresentar-se	Indique “Eu chamo-me (indicar primeiro nome)...”.
Aproximar-se fisicamente da pessoa, garantindo a própria segurança	Se parecer existir risco de dano, mantenha alguma distância de segurança e/ou peça para se aproximar da pessoa (“Posso juntar-me a ti para falarmos?”). Procure manter uma posição ajustada à da outra pessoa (sentar, se ela estiver sentada; de pé, se ela estiver de pé).
Explicar o objetivo da presença do socorrista	Mostre estar preocupado com a pessoa e ser capaz de ajudar (“Eu estou preocupado contigo”, “Acho que posso ajudar-te”).
Expressar disponibilidade (para ouvir, estar presente e ajudar)	Mostre-se disponível para a pessoa (“Estou disponível para te ouvir”, “Falar é dividir o problema”, “Eu realmente quero perceber o que se passa contigo”, “Eu quero ajudar-te”, “Tens o meu apoio”).
Assegurar confidencialidade	Indique que não divulgará nenhuma informação relativamente ao que for falado (“Podes falar à vontade, tudo o que falarmos ficará apenas entre nós”).
Acompanhar a pessoa para um local calmo, seguro, confortável e que permita privacidade	Considere o local e o momento certo para falarem. Decida, se possível, com a pessoa.

18

Como me aproximo e avalio a situação de pessoas com problemas de saúde mental?

Estratégias	Operacionalização
Estar presente	Não deixe a pessoa sozinha, mesmo que queira chamar ajuda.
Observar comportamento	Esteja atento à linguagem corporal da outra pessoa.
Coordenar comportamento com a pessoa ajudada	Seja previsível e consistente na interação (por exemplo, se a outra pessoa procurar abraçá-lo, abraçe; se a outra pessoa se sentar, coloque-se no mesmo nível).
Ouvir ativamente com expressão de interesse, respeito, compreensão e sem julgamento	Ouvir com atenção e dar um retorno à mensagem (“Isto deve estar a ser complicado para ti”, “Eu percebo pelo que estás a passar”, “Não estou na tua situação, mas compreendo que ...”).
Avaliar o enquadramento cultural da pessoa	Procure perceber e respeitar as crenças e os costumes da outra pessoa. Estes podem estar a influenciar a situação (por exemplo, “Na minha terra, ouvir vozes na cabeça é um dom divino”).

19

Como me aproximo e avalio a situação de pessoas com problemas de saúde mental?

Estratégias	Operacionalização
Questionar sobre a situação	Considere a disponibilidade da pessoa para falar sobre o que está a acontecer (“Queres falar sobre o que se passa?”).
Questionar sobre o problema	Foque as questões para identificar problemas cognitivos, emocionais, comportamentais e relacionais (“O que estás a pensar?”, “O que estás a sentir?”, “O que fizeste?”, “Como está a tua relação com...?”).
Questionar sobre as causas do problema	Explore o que originou o problema (“O que achas que provocou isto?”).
Questionar sobre os fatores agravantes e atenuantes do problema	Explore o que influencia o problema (“O que achas que melhora/piora o problema?”).
Questionar sobre as consequências do problema	Explore as repercussões do problema no dia-a-dia (“Que impacto é que isto tem tido na tua vida?”).

20

Como posso ajudar pessoas com problemas de saúde mental a cuidarem da sua saúde mental?

Quando têm falta de
conhecimento / capacidade



Assistir no uso de
estratégias de autoajuda

Quando têm falta de **motivação**



Incentivar o uso de
estratégias de autoajuda

21

Como posso ajudar pessoas com problemas de saúde mental a cuidarem da sua saúde mental?

Estratégias	Operacionalização
Assistir na identificação do problema de saúde mental	Pode sintetizar a situação para facilitar o reconhecimento do problema. Promova na outra pessoa a verbalização do problema ("Qual achas que é o problema?").
Informar sobre o problema de saúde mental	Por vezes, as pessoas têm dificuldade em reconhecer o seu problema. Coloque a hipótese de existir um problema ("Penso que podes ter um problema de abuso de álcool"). Não afirme com total convicção que a pessoa tem um determinado problema! Pode rotular o problema, não a pessoa ("Podes ter um problema de abuso de álcool" ao invés de "És um bêbado!").
Assistir na identificação de estratégias adaptativas	Promova a identificação de estratégias de autoajuda (O que achas que podes fazer para diminuir o problema?). Das estratégias identificadas, ajude a distinguir as adaptativas e mal-adaptativas, e destaque as potencialmente mais eficazes.

23

Como posso ajudar pessoas com problemas de saúde mental a cuidarem da sua saúde mental?



22

Como posso ajudar pessoas com problemas de saúde mental a cuidarem da sua saúde mental?

Estratégias	Operacionalização
Incentivar o uso de estratégias adaptativas	Saliente que a própria pessoa é responsável pela sua saúde mental ("Tu podes agir face a tua saúde!"). Expresse a importância do uso de estratégias adaptativas para responder ao problema de saúde mental ("Estas estratégias são fundamentais para melhorares a tua saúde mental. Avança! Usa-as!").
Incentivar o abandono de estratégias mal-adaptativas	Expresse o prejuízo das estratégias mal-adaptativas em uso ("Como disseste, essa estratégia prejudicou-te."). Encoraje a substituição ou o abandono das mesmas ("Poderias deixar de o fazer e optar por... Tu és capaz!").
Elogiar as estratégias adaptativas já em uso	Reforce todas as ações da outra pessoa que são eficazes e saudáveis ("Essa é uma excelente estratégia!").

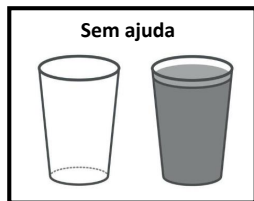
24

Síntese

- O público em geral pode precisar de ajuda em saúde mental. Múltiplas **barreiras à procura** dos recursos de ajuda devem ser consideradas.
- A prestação de **primeira ajuda em saúde mental** pode facilitar a obtenção de ajuda profissional.
- A primeira ajuda em saúde mental requer que um socorrista tenha **boas competências de comunicação**.
- Os socorristas podem usar diferentes estratégias para se **aproximarem e avaliarem a situação de um indivíduo** e para promoverem nessa pessoa o **cuidado com a própria saúde mental**.

25

Importância de encaminhar para outros recursos de ajuda



27

Continuamos?



26

Como posso encaminhar pessoas com problemas de saúde mental para outros recursos de ajuda?

Quando têm falta de
conhecimento / capacidade



**Assistir na
procura de ajudas**

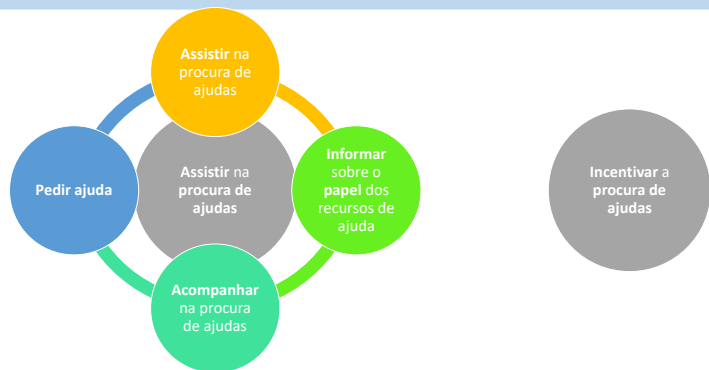
Quando têm falta de **motivação**



**Incentivar a
procura de ajudas**

28

Como posso encaminhar pessoas com problemas de saúde mental para outros recursos de ajuda?



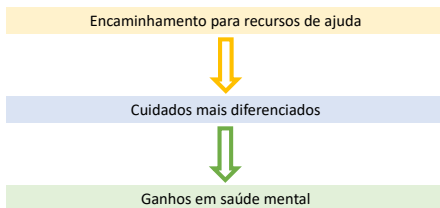
29

Como posso encaminhar pessoas com problemas de saúde mental para outros recursos de ajuda?

Estratégias	Operacionalização
Assistir na procura de ajudas	Promova a identificação de recursos de ajuda em saúde mental (Quem é que achas que te pode ajudar?). Ajude a distinguir as ajudas recomendadas e as que deve considerar com precaução. Explore com a outra pessoa as ajudas disponíveis.
Informar sobre o papel dos recursos de ajuda	Expresse que há pessoas que podem ajudar a responder ao problema, com a prestação de cuidados diferenciados ("Penso que estes profissionais podem ajudar-te a melhorar a tua saúde mental, porque fazem...").
Acompanhar na procura de ajudas	Se a outra pessoa tem dificuldade de acesso aos recursos de ajuda, podes acompanhá-la. Faça-se de convidado: "Posso acompanhar-te até ao hospital?".
Pedir ajuda	Sempre que a pessoa com o problema de saúde mental representar dano para si ou para os que a rodeiam, deve-se pedir ajuda.
Incentivar na procura de ajudas	Transmita esperança na recuperação, especificamente com ajudas adequadas e com o decorrer do tempo ("Procura ajuda! Com a ajuda de profissionais de saúde, tu vais melhorar ao longo do tempo.").

30

Recursos de ajuda em saúde mental



31

Recursos de ajuda em saúde mental

Família	Rede social	Escola	Serviços de saúde locais	Serviços de saúde à distância
- Agregado familiar - Família extensa	- Amigos - Colegas	- Pessoal docente - Não docente	- Médicos (Psiquiatras) - Psicólogos - Enfermeiros (Especialistas em Enfermagem de Saúde Mental e Psiquiátrica) - Grupos de autoajuda e ajuda mútua	- Linhas telefónicas de apoio - Terapia virtual

32

Papel da família e da rede social

- São recursos da pessoa ajudada.
- Têm potencial proximidade com a pessoa e importância para a mesma.
- Existe continuidade no contacto com a pessoa.
- Podem prestar apoio indiferenciado à pessoa.



Precaução:
Maus relacionamentos
familiares e sociais.

33

Papel da escola

- É um recurso de fácil acesso para o socorrista.
- Possui profissionais que podem prestar uma ajuda indiferenciada em saúde mental.
- Pode possuir ou articular com profissionais de saúde mental que prestam ajuda diferenciada em saúde mental.



Precaução:
Pessoa ajudada não ter
relação com a escola em
questão.

34

Papel da escola

Ajuda específica	Modo de contacto
(Indicar nome do indivíduo e profissão ou nome da equipa)	(Contacto telefónico/e-mail, ponto de encontro presencial, horário)
(Indicar nome do indivíduo e profissão ou nome da equipa)	(Contacto telefónico/e-mail, ponto de encontro presencial, horário)
...	...

35

Papel dos serviços de saúde locais

- Apresentam formação avançada em saúde geral e/ou em saúde mental.
- Apresentam proximidade geográfica do socorrista e da pessoa ajudada.
- Podem prestar uma ajuda diferenciada em resposta ao problema específico da pessoa.

Enfermeiros
Cuidam e ensinam
a cuidar-se

Psicólogos
"Personal trainers"
da mente

Médicos
Identificam a doença e
tratam (por exemplo,
com medicação)

Grupos de autoajuda
e ajuda mútua
Partilham-se os
problemas e
aprende-se com os
outros a responder

Papel dos serviços de saúde locais

Ajuda específica	Modo de contacto
(Indicar nome do indivíduo e profissão ou nome da equipa)	(Contacto telefónico/e-mail, ponto de encontro presencial, horário)
(Indicar nome do indivíduo e profissão ou nome da equipa)	(Contacto telefónico/e-mail, ponto de encontro presencial, horário)
...	...

37

Papel dos serviços de saúde à distância

- Apresentam formação avançada em saúde geral e/ou em saúde mental.
- Apresentam flexibilidade no contacto.
- Podem prestar uma ajuda diferenciada em resposta ao problema específico da pessoa.

	Ajuda específica	Modo de contacto
Linhas telefónicas de apoio	Número europeu de emergência	1. Ligar 112 (disponível 24 horas por dia) 2. Indique de forma simples e clara: • As manifestações do problema de saúde mental e a situação de risco de dano (por exemplo, tentativa de suicídio, agressão); • O número de telefone do qual está a ligar; • A localização exata e, sempre que possível, com indicação de pontos de referência; • O número, o sexo e a idade aparente da(s) pessoa(s) a necessitar de socorro; • Desligue apenas quando o operador indicar.
	 Precaução: Usar apenas se existir risco de dano para a pessoa com o problema de saúde mental e/ou para os que a rodeiam	

38

Papel dos serviços de saúde à distância

	Ajuda específica	Modo de contacto
Linhas telefónicas de apoio	SNS 24 - Serviço de aconselhamento psicológico	808 24 24 24 (24 horas por dia)
	Linha SOS Voz Amiga	213 544 545 / 912 802 669 / 963 524 660 (das 15h30 às 00h30)
	Conversa Amiga	808 237 327 / 210 027 159 (das 15h00 às 22h00)
	Telefone da Amizade	228 323 535 (das 16h00 às 23h00)
	Voz de Apoio	225 506 070 (das 21h00 às 24h00)
	Vozes Amigas de Esperança de Portugal	222 030 707 (das 16h00 às 22h00)
	Linha do Serviço de Informação às Vítimas de Violência Doméstica	800 202 148 (24 horas por dia)
	Associação Portuguesa de Apoio à Vítima (APAV) - Linha de Apoio à Vítima	116 006 (dias úteis das 8h00 às 22h00)
	Linha SOS Droga	1414 (dias úteis das 10h00 às 18h00)
	Linha SOS – Deixar de fumar	808 208 888 (dias úteis das 13h00 às 21h00)
	Linha de Apoio na Demência	963 604 626
	(Adicionar nome do recurso de ajuda)	(dias úteis das 9h30 às 13h00 e das 14h00 às 17h00)
	(Adicionar contato telefónico do recurso de ajuda)	(Adicionar contato telefónico do recurso de ajuda)

39

Papel dos serviços de saúde à distância

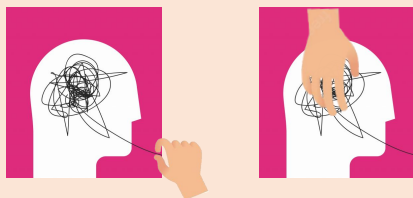
	Ajuda específica	Modo de contacto
Terapia virtual	Mindfirst	https://www.mindfirst.pt/
	Rumo	https://pt.rumo.solutions/
	(Adicionar nome do recurso de ajuda)	(Adicionar link do recurso de ajuda)
	...	...

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ALERTA!!!

Atualmente, existem muitas outras opções de ajuda.

Descubra as **diferenças** entre os dois tipos de profissionais!



Sugere-se **precaução** especial com escolha de outros recursos de ajuda!

41

Ajudar o outro e depois?



Usar estratégias adaptativas de autoajuda	Identifique e aplique as estratégias de autoajuda mais convenientes e eficazes para si.
Procurar ajuda para si próprio	Identifique e recorra a ajudas profissionais e/ou não profissionais, sempre que considere necessário melhorar a sua saúde mental ou responder a um problema de saúde mental.

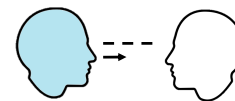
42

Síntese

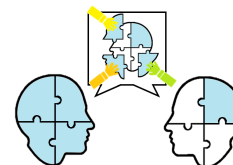


43

Plano de ação de primeira ajuda em saúde mental

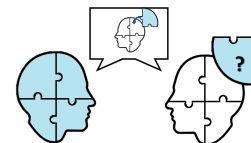


Aproximar-se da pessoa e avaliar a situação

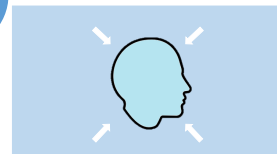


Assistir e incentivar a procura de ajudas

4As



Assistir e incentivar o uso de estratégias de autoajuda



Autocuidar

44



Mnemónica: 4As

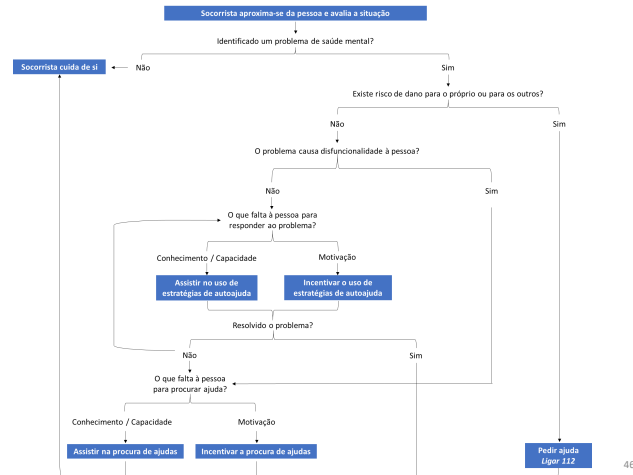
45

Síntese

- Os socorristas podem promover em pessoas com problemas de saúde mental a **procura de recursos de ajuda**.
- Ganhos em saúde mental podem ser obtidos com o **apoio da família** e da **rede social**, da **escola**, de **serviços de saúde locais** e de **serviços de saúde à distância**.
- A primeira ajuda em saúde mental é um **processo dinâmico**, com **quatro passos**: 1) aproximar-se da pessoa e avaliar a situação; 2) assistir e incentivar o uso de estratégias de autoajuda; 3) assistir e incentivar a procura de ajuda; 4) autocuidar.

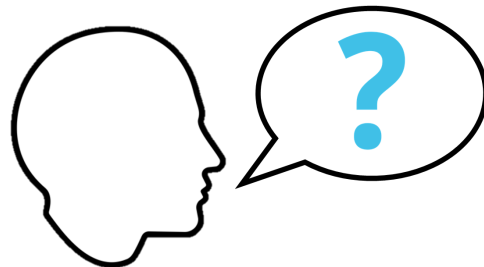
47

Operacionalização do plano de ação



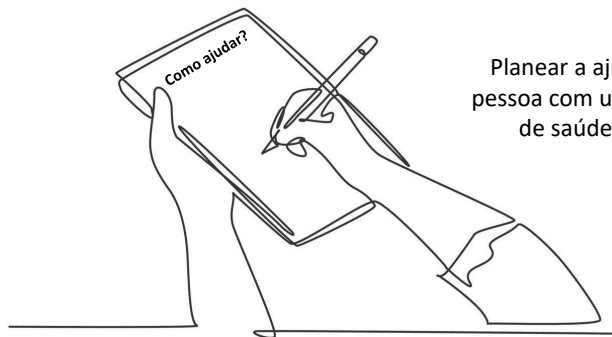
46

Dúvidas



48

Proposta de trabalho para casa



49

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50

Fontes das imagens usadas

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No diapositivo 4: <https://images.app.goo.gl/dyYFtAwjXft1clgs9>

Nos diapositivos 5 e 27: <https://images.app.goo.gl/eCxCxARuQ99YETZ4A>

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No diapositivo 41: <https://images.app.goo.gl/sADLKgagiXNQghJU9>

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No diapositivo 45: <https://images.app.goo.gl/MX3hCGj85JP14bWg7>

No diapositivo 49: <https://images.app.goo.gl/LbpUr39vb2ick7me7>

ANEXO XIV

Apresentação a usar no Módulo 5 do Programa de Formação
"Empower4MentalHelp"

Programa de Formação em Primeira Ajuda em Saúde Mental: “Empower4MentalHelp”



Módulo 5: Plano de ação

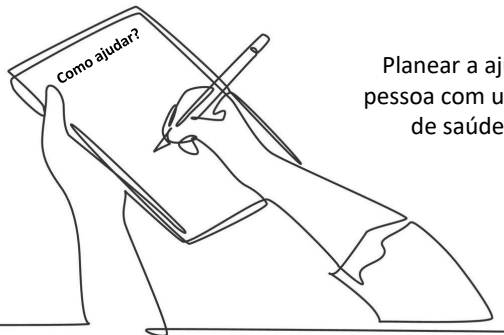
Formador:

(Especificar Nome do formador, afiliação e endereço eletrónico)

(Incluir logotipo da entidade formadora e formada)

1

Proposta de trabalho para casa



Planear a ajuda a uma
pessoa com um problema
de saúde mental

3

Objetivos da sessão

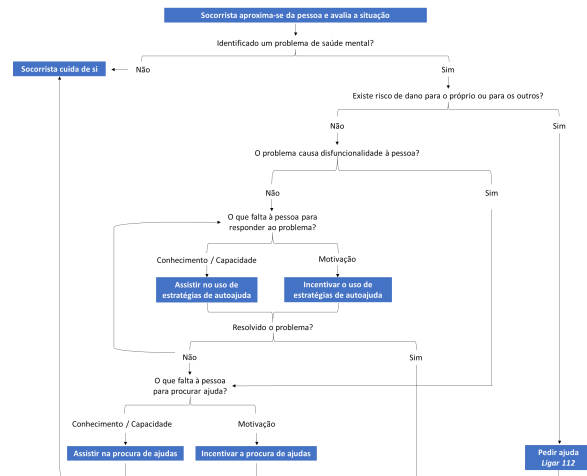
Determinar a evolução das competências para agir face pessoas com problemas de saúde mental

Melhorar competências para agir face pessoas com problemas de saúde mental

- Melhorar conhecimento sobre o plano de ação de primeira ajuda em saúde mental
- Melhorar capacidade para prestar primeira ajuda em saúde mental
- Promover a adoção do papel de socorrista em saúde mental

2

Operacionalização do plano de ação



4

EXERCÍCIO: Estudo de Caso

1. Juntem-se em grupos.
2. Cada grupo deve escolher aleatoriamente um caso para analisar.
3. Cada grupo deve indicar como se deve agir perante o caso escolhido.
4. Cada grupo deve apresentar aos restantes as suas respostas.
5. As respostas devem ser discutidas por todos.

5

Continuamos?



7

Síntese

Decidir o que fazer nem sempre é tarefa fácil!

É importante **discutirmos** com outras pessoas o que fazer e **rever** as nossas decisões, sempre que necessário.

6

EXERCÍCIO: Dramatização

1. Cada participante irá **simular** ser um **socorrista** e o dinamizador da sessão será a pessoa com um problema de saúde mental.
2. O **dinamizador** irá recriar um **caso** de uma pessoa com problema de saúde mental **à sua vontade**, tendo o participante de responder como socorrista em conformidade.
3. O **desempenho** do socorrista e da pessoa com um problema de saúde mental será **discutido** por todos.

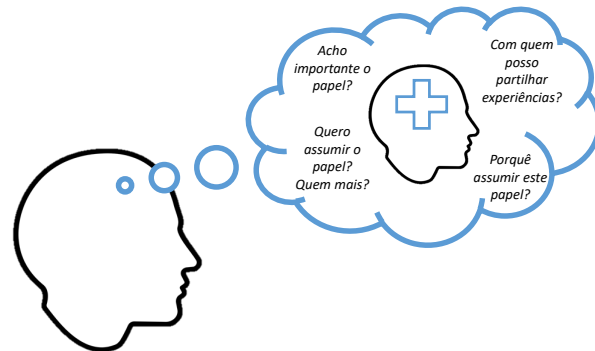
8

EXERCÍCIO: Dramatização

1. Os participantes poderão **optar por assumir o papel** de socorrista ou de pessoa com um problema de saúde mental.
2. O **participante** que assumir o papel de pessoa com problema de saúde mental pode recriar um **caso à sua vontade**. Aquele que adotar o papel de socorrista deve responder em conformidade.
3. O **desempenho** do socorrista e da pessoa com um problema de saúde mental será **discutido** por todos.

9

Futura adoção do papel de socorrista



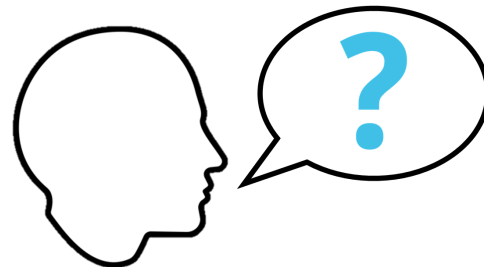
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Síntese

- A prestação de primeira ajuda em saúde mental requer o **desenvolvimento contínuo** de competências básicas.
- “**Colocarmo-nos no lugar do outro**” é fundamental para agirmos apropriadamente perante uma pessoa com problemas de saúde mental.
- A adoção do papel de socorrista revela **solidariedade** e **ética cívica**.

11

Dúvidas



12

Resultados da formação

**Print dos
instrumentos de
avaliação a
preencher**

13

Referências bibliográficas

Costa, T. F. O., Moreno Poyato, A. R., Sampaio, F. M. C., Lluch Canut, M. T., & Sequeira, C. A. C. (2023). Nurses' promotion of Mental Health First Aid Training Programmes for upper secondary students: a modified Delphi approach. *BMC Nursing*, 22(91). <https://doi.org/10.1186/s12912-023-01255-3>

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15

Certificado de Participação



Certifica-se que _____
participou no Programa de Formação em Primeira Ajuda em Saúde Mental
"Empower4MentalHelp". Ocorreu na Escola _____
entre os dias ____ de ____ de ____ e ____ de ____ de ____.
Teve uma duração total de 8 horas e 25 minutos.

_____, ____ de ____ de ____.

Pela equipa de dinamização,

14

Fontes das imagens usadas

No diapositivo 3: <https://images.app.goo.gl/LbpUr39vb2ick7me7>

ANEXO XV

Apresentação a usar na Sessão de Acompanhamento e Reforço do Programa de
Formação “Empower4MentalHelp”

Programa de Formação em Primeira Ajuda em Saúde Mental: “Empower4MentalHelp”



Sessão de Acompanhamento e Reforço

Formador:

(Especificar Nome do formador, afiliação e endereço eletrónico)

(Incluir logotipo da entidade formadora e formada)

1

Resultados da formação

**Print dos
instrumentos de
avaliação a
preencher**

3

Objetivos da sessão

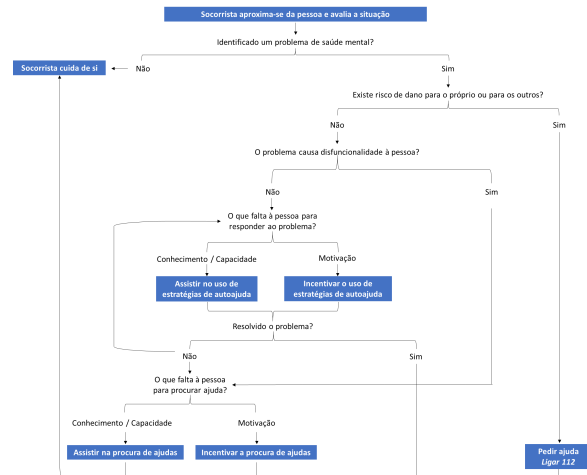
Determinar a evolução das competências para agir face pessoas com problemas de saúde mental

Melhorar competências para agir face pessoas com problemas de saúde mental

- Melhorar conhecimento sobre o plano de ação de primeira ajuda em saúde mental
- Melhorar capacidade para prestar primeira ajuda em saúde mental
- Promover a adoção do papel de socorrista em saúde mental

2

Operacionalização do plano de ação



4

EXERCÍCIO: Dramatização

1. Os participantes poderão **optar por assumir o papel** de socorrista ou de pessoa com um problema de saúde mental.
2. O **participante** que assumir o papel de pessoa com problema de saúde mental pode recriar um **caso à sua vontade**. Aquele que adotar o papel de socorrista deve responder em conformidade.
3. O **desempenho** do socorrista e da pessoa com um problema de saúde mental será **discutido** por todos.

5

Dúvidas



7

Síntese

A prestação de primeira ajuda em saúde mental requer o **desenvolvimento contínuo** de competência básicas.

6

Referências bibliográficas

- Costa, T. F. O., Moreno Poyato, A. R., Sampaio, F. M. C., Lluch Canut, M. T., & Sequeira, C. A. C. (2023). Nurses' promotion of Mental Health First Aid Training Programmes for upper secondary students: a modified Delphi approach. *BMC Nursing*, 22(91). <https://doi.org/10.1186/s12912-023-01255-3>
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- Costa, T. F. O., Sampaio, F. M. C., Sequeira, C. A. C., Lluch Canut, M. T., & Moreno Poyato, A. R. (2022). Nurses' perspective about the Mental Health First Aid Training Programmes for adolescents in upper secondary schools: A focus group study. *Journal of Psychiatric and Mental Health Nursing*, 29(5), 721-731. <https://doi.org/10.1111/jpm.12823>
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8

ANEXO XVI

Lista de Casos de Pessoas com Problemas de Saúde Mental

Problema de saúde mental	Casos de pessoas com problemas de saúde mental
1. Alteração na memória	1. A Odete esquece-se frequentemente dos seus pertences (por exemplo, carteira, chaves de casa) e do que ia fazer (por exemplo, cozinhar).
2. Alteração na atenção	2. A mãe da Tiago pede-lhe ajuda para tarefas. O Tiago diz ser muito distraído e que a maioria das vezes não ouve os pedidos da sua mãe.
3. Alteração na concentração	3. A Inês não consegue manter-se focada no que a professora está a explicar na aula.
4. Dislexia	4. O Manuel está no 4º ano de escolaridade. Tem muita dificuldade na leitura, trocando frequentemente letras e sílabas nas palavras.
5. Disfasia	5. A Maria tem dificuldade em expressar oralmente as suas ideias ("faltam-me as palavras").
6. Alucinação	6. O António refere que vê monstros e que esses monstros lhe dizem que vão destruir o mundo.
7. Alteração no pensamento	7. A Maria refere que se sente mais lenta a pensar e que, por vezes, as ideias lhe fogem.
8. Alteração na aprendizagem	8. O Igor tem mau aproveitamento escolar e já reprovou uma vez. Ele refere que, por mais que estude e que tenha explicações, não consegue ter bons resultados.
9. Ideação suicida	9. A Carolina acha que a vida não faz sentido e tem pensado em pôr fim à sua vida.
10. Obsessão	10. A Isaura está sempre a pensar que algo em sua casa está desarrumado ou sujo. Ela quase nunca sai de casa para manter tudo "na ordem".
11. Delírio	11. O Guilherme refere que os vizinhos o perseguem, que o restaurante onde comeu o tentou envenenar e que a sua esposa lhe pôs uma bomba debaixo do carro. A polícia afirma ser um relato implausíveis, não existindo quaisquer provas.
12. Demência	12. As capacidades cognitivas da Augusta têm piorado de dia para dia. Atualmente, é necessária ajuda nas tarefas do dia-a-dia, até para manter a segurança da senhora.
13. Confusão	13. O Joaquim foi internado. O hospital é um espaço novo para si e "muito atribulado". O Joaquim tem-se sentido desorientado (perde a noção de onde está, momento do dia em que se encontra, ...).
14. Autoimagem negativa	14. A Joana acha-se má pessoa porque magoou o seu ex-namorado ao acabar com a relação.
15. Imagem corporal perturbada	15. O Diogo diz odiar o seu corpo por ser muito magro.

16.Autoestima excessiva	16. A Filipa acha que é "superior" aos outros, visto que a sua família é muito rica e culta.
17.Autoestima baixa	17. O João acha que não tem valor como pessoa por ser analfabeto. Ele diz frequentemente "sou um lixo".
18.Identidade pessoal perturbada	18. A Helena sente-se persistentemente desconfortável com o seu género (feminino) e com o seu corpo. Sente-se "um homem num corpo de uma mulher".
19.Ansiedade	19. O João tem estado preocupado com a possibilidade de ser despedido, pois a sua empresa está com problemas financeiros. A caminho do emprego sente o seu coração a bater muito rápido, fica com falta de ar.
20.Nervosismo	20. Durante os testes, a Mafalda fica muito inquieta, com tremores e não consegue parar de roer as unhas.
21.Insegurança	21. O Gabriel não sabe se deve seguir o seu sonho na música ou se deve ter um emprego "mais seguro" como informático.
22.Tristeza	22. A Isilda sente-se "em baixo", porque se chateou com a melhor amiga.
23.Humor depressivo	23. O Carlos tem-se sentido há algum tempo infeliz com o rumo que a sua vida levou, sem vontade de sair da cama.
24.Luto	24. A Ana sente-se destroçada depois do falecimento do seu pai.
25.Solidão	25. Desde que mudou de escola, o Raúl sente que não pertence a nenhum grupo e que é excluído pelos seus colegas.
26.Angústia	26. A Isabel tem uma grande dívida e sente-se com uma aflição imensa como se fosse sufocar. Sente pena que a sua família esteja a sofrer com os seus erros.
27.Desespero	27. O José sente que tudo falhou na sua vida: perdeu o emprego e separou-se da sua namorada. Sente-se vazio e refere que não ter esperança num futuro melhor.
28.Sofrimento	28. A Lia é refugiada. Vive em más condições (inclusive de alimentação, higiene, de habitação). Sente uma intensa e prologada pena pelas condições em que vive.
29.Ambivalência	29. O Matias sempre teve uma boa relação familiar. Recentemente, tem alternado entre estados de imensa alegria e de estados de intensa tristeza perante a família.
30.Euforia	30. A Sara encontra-se com um estado de alegria desmedida no emprego (canta, grita, dança) e de alguma desinibição com alguns dos seus clientes.
31.Medo	31. O João foi mordido por um cão, na infância. Desde então, sempre que vê um cão foge na direção contrária. Ele refere que eles podem morder.
32.Trauma	32. A Íris sofreu de violência doméstica (física e verbal) durante o seu casamento. Atualmente, diz que não é capaz de ter uma nova relação amorosa por toda a angústia que vivenciou na relação anterior. Sente-se como "um copo partido em mil pedaços" que é difícil de "colar".

33.Stress	33. O Carlos tem muitas tarefas ao seu encargo. Sente-se sempre sob tensão, como se fosse "puxado por todos os lados".
34.Fadiga e exaustão	34. A Aurora é mãe de três filhos e tem dois empregos. Sente-se com diminuição da força, cansada, desgastada.
35.Ciúme	35. O Abel sente que a sua esposa dá mais atenção ao Sr. Rui, o patrão dela. Refere que ela passa demasiado tempo com ele.
36.Inveja	36. A Clara sente-se descontente por não ter ido para o ensino superior como a sua colega Ágata. Ela refere que a Ágata sempre foi "a protegida pelos professores".
37.Culpa	37. O Óscar traiu a sua esposa com outra mulher. Ele sente que agiu mal. Refere que os seus atos foram contra os valores em que acredita e que não devia ter cedido à tentação.
38.Vergonha	38. A Mariana saiu da prisão. Ela sente que não é merecedora de respeito, que é "ridícula" pelos comportamentos que teve.
39.Sentimento de impotência	39. O pai do André está internado com um prognóstico reservado. O André sente que não consegue ajudar na situação por muito que queira. Sente-se "de mãos atadas".
40.Frustração	40. A Julieta não conseguiu ficar apurada para os Jogos Olímpicos. Sente-se aborrecida por não ter concretizado o seu sonho.
41.Raiva	41. O Romeu teve um acidente de automóvel, por culpa de outro condutor. O outro condutor não assumiu a responsabilidade. O Romeu diz que vai protestar até às últimas consequências. Sente que a qualquer momento lhe "pode saltar a tampa".
42.Falta de esperança	42. A Matilde tem uma doença. Ela sente que nunca conseguirá ser novamente autónoma e ter uma vida minimamente normal.
43.Falta de confiança	43. A namorada do Hugo mentiu-lhe e por isso terminaram o relacionamento. O Hugo sente que não vai conseguir acreditar novamente numa mulher. Refere que não quer mais ser magoado.
44.Falta de orgulho	44. A Irene não se sente satisfeita com a sua profissão e com as conquistas que conseguiu na sua empresa.
45.Falta de prazer	45. O Vasco sente que todos os dias são iguais e que a vida é monótona. Sente que até a comida já não tem sabor.
46.Alteração no autocuidado	46. O Filipe tem aparecido constantemente no trabalho com a roupa suja, a cheirar mal e com barba por aparar.
47.Comportamento desorganizado	47. A Lara tem dificuldade em fazer as atividades do dia-a-dia. Por exemplo, nas refeições deita fora a comida, no banho espalha gel de banho por toda a casa de banho.
48.Compulsão	48. A Leopoldina escova os dentes pelo menos 6 vezes por dia, toma pelo menos 3 banhos por dia e usa constantemente desinfetante para as mãos e superfícies. Reconhece que é exagerado. Contudo, refere que não consegue evitar porque tudo à sua volta tem bactérias.

49.Comportamento alimentar compulsivo	49. O Alexandre refere perder frequentemente o controlo a comer. Indica que comeu um bolo de 2 quilogramas ao pequeno almoço.
50.Anorexia	50. A Isabel refere falta de apetite, tendo “cortado” na comida. Por exemplo, ontem, comeu apenas duas maçãs durante todo o dia.
51.Bulimia	51. Por vezes, o Sebastião come em excesso (por exemplo, três pratos de conduto). Nessas situações, ele induz o vómito, visto que não quer engordar.
52.Alteração no padrão de exercício físico	52. Para ter um corpo musculado, o Miguel faz exercício físico intenso todos os dias e, por vezes, mais do que uma vez por dia. Ele tem dores musculares persistentes, fadiga persistente. Tem tido até mais lesões pelo excesso de esforço.
53.Hiperatividade	53. A Helena anda sempre de um lado para o outro, a correr, a escalar, tendo dificuldade em parar. Os pais dizem “ela anda sempre a mil”.
54.Alteração no sono	54. A Micael tem tido pesadelos muito frequentes, acordando sobressaltada.
55.Insónia	55. O Leonel deita-se às 22h00. No entanto, só consegue adormecer pelas 3h da madrugada.
56.Abuso de álcool	56. A Cheila tem bebido pelo menos 1,5l de vinho por dia.
57.Abuso de tabaco	57. O Luís fuma dois maços de tabaco por dia.
58.Abuso de drogas	58. A Marina consome canábis diariamente (erva, haxixe).
59.Abuso de jogo de apostas	59. O Francisco joga na raspadinha todos os dias e, por vezes, vai ao casino para tentar a sua sorte.
60.Abuso de videojogos	60. A Alice joga na sua consola quase todos os dias, esquecendo-se até das suas tarefas, de comer e de cuidar da sua higiene.
61.Abuso de internet	61. A Genoveva está a maior parte do dia online. Ela está constantemente a relatar o seu dia-a-dia nas redes sociais.
62.Comportamento agressivo	62. O Gonçalo chateou-se com um amigo e deu um murro num vidro.
63.Violência	63. A Vânia enviou várias SMS a uma colega da turma, com comentários ofensivos.
64.Comportamento autodestrutivo	64. A Filomena escreve comentários ofensivos sobre si própria no seu diário.
65.Automutilação	65. O Artur apresenta vários cortes nos punhos e pernas. Ele refere que quer materializar a dor que sente.
66.Tentativa de suicídio	66. O Joel tentou atirar-se abaixo da ponte, de modo a pôr fim à sua vida. No entanto, foi impedido pelos seus amigos.
67.Alteração na socialização	67. A Laurinda tem dificuldade em integrar-se num grupo. É tímida, tendo dificuldade em partilhar sobre a sua vida.

68. Isolamento social	68. Após terminar a sua relação amorosa, a Natália afastou-se dos seus amigos e familiares. Todos a fazem lembrar do seu ex-namorado.
69. Alteração na comunicação	69. O Pedro tem dificuldade em dizer “não” às pessoas à sua volta e de afirmar a sua opinião sobre um tema.



ANEXO XVII

Certificado de Participação no Programa de Formação "Empower4MentalHelp"

Certificado de Participação



Certifica-se que _____,
participou no Programa de Formação em Primeira Ajuda em Saúde Mental
“Empower4MentalHelp”. Ocorreu na Escola _____
entre os dias ____ de _____ de ____ e ____ de _____ de ____ .
Teve uma duração total de 8 horas e 25 minutos.

_____, ____ de _____ de _____.

Pela equipa de dinamização,
