Investigating best practice in Mental Health First Aid and Psychological First Aid training for front-line emergency services volunteers

Empowering volunteers through education, opportunity and support

Executive Summary

When emergencies, crises and disasters happen in our communities we want to reach out to those affected. But how do we know what to say or do to support those who are very distressed?

The purpose of my research was to gain a greater understanding of current, global best practice in Mental Health First Aid and Psychological First Aid training for front-line emergency services volunteers.

Research was based on advice from experts, interviews with (volunteer and medically trained) practitioners, academics, researchers, trainers, managers, administrators, policy makers, clinicians in the field and observations from training courses.

The following was evident:
- The role of volunteers in emergency response is vital
- There is more interest than ever before on adequately training volunteers for what they may face
- There are many volunteer agencies that have elements of training or resources in their current programs, but no one emergency service organisation seems to have an all encompassing training model that leads the way globally.
- Ambulance Victoria offers a good base-line for mental health training. CERT volunteers as well as the communities they serve would benefit from increased MHFA and PFA content in training.

There is no reason that Victoria should not be a world leader in Mental Health First Aid and Psychological First Aid training for front-line emergency services volunteers. In order to achieve this, the following short term recommendations were made-

- Consistently integrate VACU resources and systems into CERT training
- Review CVE module annually
- Consider additional information on LMS
- Include Mental Health scenarios on scenario days
- Provide MHFA and PFA training opportunities at CERT conferences
- Recognise MHFA & PFA training in ATP points system
- Work collaboratively with other agencies to share knowledge and resources
- Consider a modification to the current model of volunteer training to enable additional, non-compulsory content.

I hope findings from this research will:
- Better inform training regimes for Ambulance Victoria and any other agencies that ask volunteers to respond to traumatic situations in routine call-outs.
- Increase community capacity and resilience
- Inspire emergency services agencies to strive to achieve best practice in MHFA and PFA training for volunteers.

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Acknowledgements

Definitions and abbreviations

Term	Use for the purpose of this report
Affected people	Used in this report in the broadest possible sense – not only referring to survivors, but anyone impacted or affected by an emergency/traumatic event.
Agencies	Used in this report to describe organisations, including government departments, response and relief organisations and not for profit organisations involved in responding to or recovering from an emergency.
ATP	Approval to Practice
AV	Ambulance Victoria
CERT (Community Emergency Response Team)	CERTs consist of ambulance volunteers who function as 'first responders' within communities where the nearest ambulance branch is at a distance. Whenever they are dispatched to a job, an ambulance is also dispatched. CERTs provide basic emergency care until the ambulance arrives. CERTs are located throughout Victoria and play a valuable role in providing emergency, pre-hospital care, especially in communities where the number of ambulance cases each year is limited and a local ambulance station can't be provided.
CISM	Critical Incident Stress Management
CVE	Continual Vocational Education (annual training regime provided to CERTs). Encompasses a range of physical first aid topics along with a topic called 'The Mental Health Patient'
Emergency	Used in this report interchangeably with traumatic event.
Emergency Services Workers	Encompass staff and volunteers from response agencies, government agencies and not for profit organisations.
ESF	Emergency Services Foundation
IASC	Inter Agency Standing Committee
Mental Health First Aid (MHFA)	First aid provided to a person developing a mental health problem or in a mental health crisis until appropriate professional treatment is received or until the crisis resolves.
Psychological First Aid (PFA)	Basic support immediately following a traumatic event, disaster or emergency, such as comfort, information, connectedness, self-efficacy, help, hope and immediate practical and emotional assistance.
PTSD	Post traumatic stress disorder
RPL	Recognition of prior learning
SAMHSA	Substance Abuse and Mental Health Services America
VACU	Victorian Ambulance Counselling Unit

Scholarship Research Report

Introduction

Purpose

The purpose of this paper is to:

- Define PFA and MHFA
- Investigate the relevance of MHFA and PFA in front line emergency services volunteer training
- Investigate current practices in MHFA and PFA training for volunteers in AV
- Compare Australian and American (and other international best-practice examples) MHFA and PFA training opportunities.
- Look at trends within other Australia organisations/agencies training front line volunteers
  in MHFA and/or PFA.
- Make recommendations around improvements for Ambulance Victoria's volunteer training regime.
- Increase mental health literacy
- Inform and contribute to the body of knowledge existing in this area of study.

Scope & Bounds

My scholarship encompassed 3 distinct activities – overseas travel, CISM conference attendance and completion of a Youth Mental Health First Aid course.

My travel was conducted between September and October 2011 and focussed on identifying best practice in Mental Health First Aid and Psychological First Aid training for front-line emergency services volunteers. See Appendix 1 for a list of places visited, people interviewed and courses attended.

The focus in this report is on emergency services volunteers. This covers a broad range of organisations with a variety of 'core business''. As a CERT volunteer, there is a definite focus on health sector first responders, like those in Ambulance Victoria. Findings may, however also be useful: across other volunteer organisations; health sector agencies; emergency services; other people experiencing traumatic situations or lengthy delays before professional assistance arrives and; those others at greater risk when underlying mental health issues are not recognised

Living in and having visited developed countries as part of the scholarship, meant that this research focused on the systems, training and organisations in developed countries. Whilst some of the information may be useful for those volunteering in third world nations, it must be acknowledged that there are further complexities that may need to be considered with these countries, people and places.

The CERT model also operates largely in rural and remote areas. Whilst much of this information is useful in an urban context, the focus is largely on rural areas/communities where response times are much longer, access to health services more difficult and the likelihood of facing natural disasters higher.

This report does not contain a formal literature review, but it does draw upon current literature.

It is not intended to serve as a comparison to work that already exists in Australia, but rather, a reflection of my experiences overseas and the conclusions I came to as a result of these experiences.

Background

3.2 million Australians (20% of the population) have a diagnosed mental illness in any given year. It constitutes the leading cause (24%) of disability burden in Australia (www.mhfa.com.au) in the 15-24 year age bracket and ranks in the top three amongst adults (along with cancer and cardiovascular disease).

The general population is becoming more aware of mental health issues. Organisations such as Beyond Blue run highly effective education campaigns, the media are covering it more often, improving the process of destigmatisation and awareness was raised on a large scale when the topic was high on the agenda in the 2010 Federal election.

Everyday around the world people are exposed to distressing events. People are affected and impacted in different ways and can experience a wide range of reactions and emotions. How someone reacts depends on the nature and severity of the event; previous experience; support mechanisms; physical and mental health; cultural background and age.

As trauma, emergencies and disasters occur more frequently and at greater intensity, the spotlight is on response efforts. Flint (2006) states "In light of the rising cost of...recovery there has been an increasing amount of attention paid to making response efforts more effective and efficient" (in Sapat, 2001). This along with exposure of inadequacies of national and international responses, has led many academics, governmental and non-governmental agencies to look at community based disaster preparation and response (Flint and Brennan 2006, Schafer et al 2008, Simpson 2001, Stehr 2001, Tootle 2007). The psychological response forms an important part of this. Having a 'community based approach' means that organizations embedded in the affected area can begin the recovery process as soon as the disaster or emergency occurs (King, 2007).

Emergency Services Volunteers are responding to more call outs than ever before (often in areas where professional response times are prolonged). Despite the high likelihood of first responders coming across someone with a Mental Health issue or in distress following a traumatic event, physical first aid training typically teaches little about psychological support.

Anecdotally, first aiders feel under- equipped to support affected people. Volunteers rely largely on existing 'soft skills' learnt in the paid workplace or on 'life skills'. Despite recognising the need for MHFA and PFA training of some kind, the bulk of emergency services agencies are yet to adequately include it in their basic training.

Australian centre for Post Traumatic Mental Health recommended that all high risk industries should have a well planned, integrated and tailored mental health support program for their current employees/volunteers. Further to this, the Mental Health First Aid training program and IASC recommended that MHFA training become a prerequisite for occupations (such as emergency service personnel and first responders) involving increased contact with people having mental health problems.

With all this in mind, it seems only logical that first responders should be adequately equipped to deal with the scenarios they face whilst in uniform and when playing an all-important informal, educative role within the community.

What is Mental Health First Aid?

MHFA is first aid provided to a person developing a mental health problem or in a mental health crisis until appropriate professional treatment is received or until the crisis resolves. MHFA is not therapy, or a substitute for professional help. It does not qualify participants to be a counsellor, just as a conventional first aid course does not qualify someone to be a doctor. MHFA increases knowledge, reduces stigma, increases supportive actions, can assist in early intervention and in the on-going community support of people with mental illnesses.

MHFA is delivered in 15 countries. In Australia, MHFA is predominantly delivered via a 12-hour standard adult MHFA course (see www.mhfa.com.au for more information). Variations have been developed in recognition of language (e.g. Vietnamese) and Cultural (Aboriginal and Torres Straight Islander) special needs.

The program has solid evidence for its effectiveness from randomized, controlled trials and qualitative studies. The course teaches the symptoms, causes and evidence-based treatments for: depression, anxiety disorders, psychosis and substance use disorder. It also addresses the possible crisis situations (e.g. suicide, panic attack, psychotic states, overdose, etc.) arising from these mental health problems and steps to help.

Just as conventional first aid courses teach a series of actions under the acronym DRABC, MHFA uses the acronym ALGEE.

The standard MHFA course is aimed at adults. An increasing proportion of call outs and issues within our community involve adolescents and young adults (15-24 year olds)[1].

The Youth MHFA course teaches adults how to assist adolescents who are developing a mental illness or in a mental health crisis (including Depression, Anxiety, Eating Disorders, Psychosis and Substance misuse, Suicidal thoughts, Non-suicidal self-injury, Panic attacks, Traumatic events, severe psychotic states, Acute effects from alcohol or other drug misuse and Aggressive behaviours).

My research (and I acknowledge that it is not all encompassing), indicates there is little (if any) youth specific Mental Health or Psychological First Aid training offered to front line emergency services volunteers in Australia.

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[1] Although the scope of this research extends to include youth MHFA, it does not address all special populations. It must be acknowledged that the elderly, people with intellectual disabilities, culturally and linguistically diverse populations and others may have additional, specific needs.

What is Psychological First Aid?

Until the late 1970s, emergency management focussed largely on the rebuilding of infrastructure and physical first aid. Some years after the development of the field of research we now call 'disaster mental health' and the identification of PTSD, it was recognised that most people did not develop serious mental health issues after emergencies, and with some basic support the majority of people recovered well. This led to the development of PFA as a primary tool post- emergency.

PFA is the provision of humane, supportive, compassionate and practical help. It is the first thing to do to support someone immediately following a disaster or emergency[2] if they experience distressing reactions like confusion, shock, grief, hopelessness, helplessness, shame, anxiety and loss of confidence. PFA can be provided anywhere, so long as it is safe and confidential.

Contacts made with people in this acute phase can help reduce their initial distress and pain, provide immediate basic support and set them up to activate their own natural recovery. This is achieved by providing a combination of the following- safety, security, calm, comfort, information, connectedness, self-efficacy, help, hope and immediate practical and emotional assistance. These core components have been drawn from the literature on risk and resilience, field experience, expert consensus and key sources in disaster literature.

PFA is an intervention that has gained increasing popularity around the world over the past few years. As with many new and quickly-adopted concepts, its widespread usage also means that it has multiple definitions and ways of being delivered (e.g. Appendix 4).

Various psychological first aid training programs are offered across Australia, some provided by independent (often private) organisations selling the courses, and others run within organisations for their own staff. None of these programs are formally accredited and the content of these courses varies across organisations.

It is widely recognised both in Australia and internationally (e.g. IASC) that psychosocial support in emergencies is best delivered as a community-based activity, rather than within a medical health system. Hence, we normally see PFA delivered by first responders, and others who arrive on scene early on. The IASC noted that all front-line workers, especially health workers, should be able to provide very basic psychological first aid.

Core components of PFA

(Emergency Management Unit,
Mental Health Branch, Queensland Health)

1. **Contact and Engagement**

   Goal: To respond to contacts initiated by survivors in a non-intrusive, compassionate and helpful manner.

2. **Safety and Comfort**

   Goal: To enhance immediate and ongoing safety, and provide physical and emotional comfort.

3. **Stabilization (if needed)**

   Goal: To calm and orient emotionally overwhelmed or disoriented survivors.

4. **Information Gathering: Current Needs and Concerns**

   Goal: To identify immediate needs and concerns, gather additional information and tailor Psychological First Aid interventions.

5. **Practical Assistance**

   Goal: Offer practical help to survivors in addressing immediate needs and concerns.

6. **Connection with Social Supports**

   Goal: Help establish brief or ongoing contacts with sources of support, including family members, friends and community resources.

7. **Information on Coping**

   Goal: Provide information about stress reactions and coping to reduce distress and promote adaptive functioning.

8. **Linkage with Collaborative Services**

   Goal: To link survivors with available services needed at the time or in the future.

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[2] It can also be useful as a first response or contact for people some months down the track.

What is CISM?

CISM is another process that needs to be considered for this research.

CISM is a highly structured, professionally recognized, peer driven, short-term intervention system focusing on the immediate trauma or incident. It spans pre-incident preparedness, acute crisis through to post-crisis follow up. It is a framework by which the psychosocial aspects of crisis and disaster may be described, analysed, and responded to (Everly, 2011).

PFA vs CISM – Pros and cons

Much has been written about the strengths and weaknesses of these two approaches. A substantial review and analysis of various interventions aimed at addressing disaster related mental health needs has been published (Gard and Ruzek, 2006; NIMH, 2002; Reid et al., 2005; Weaver et al. 2000); however, consensus on best practices is lacking.

Everly (2011) states "Although research into multi-componential intervention systems is admittedly difficult, CISM has accrued sufficient empirical support as to its effectiveness and safety to warrant programmatic consideration, especially in high-risk venues such as health care, law-enforcement and post-disaster environments ".

PFA has a long history[3], and has become more popular following research showing the dangers of CISM[4]. A number of studies (e.g. Kagee, 2002) have shown that CISM has little effect, or that it actually worsens the trauma symptoms. Several meta-analyses in the medical literature (e.g. Rose et al. 2002, Harris & Stacks, 1998, Harris et. al, 2002) either find no preventative benefit of CISM, or negative impact for those debriefed (e.g. Van Emmerik et. al 2002, Carlier et. Al 2002, Rose et al. 2002).

PFA has been recommended by many international and national expert groups, including the IASC and the Sphere Project. In 2009, WHO mhGAP Guidelines Development Group evaluated the evidence for PFA and CISM. They concluded that PFA, rather than CISM should be offered to people in severe distress after being exposed to a traumatic event (WHO, 2011).

Jacobs et. al (2004), argue that CISM has beneficial effects when conducted with emergency services personnel, but does not work or does more harm than good with accident victims.

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[3] For more information see Drayer, Cameron, Woodward & Glass 1954; Raphael 1977a&b and 1986.

[4] For more information see National Institute of Mental Health 2002; Rose, Bisson & Wessley 2003; Bisson, Brayne, Ochberg & Everly 2007; Bisson & Lewis 2009.

Allen et al (2010) completed a study examining and evaluating the impact of PFA training on front line responders' confidence to provide PFA to adults and children. Respondents indicated that participation in PFA training was perceived to increase their confidence in working with both adults and children.

Gill & Gershon (2010) indicate that the quality and effectiveness of PFA programs is difficult to assess, because of the wide range of curricula and a wide spread lack of record keeping and credentialing of trainers.

While increasing attention has focussed on the need to evaluate and distribute information on available training resources (Hoffman et al., 2005; Parker et al (2006), a comprehensive resource guide on available Disaster Mental Health training programs for acute response in the community has not been published. This is important because one of the key elements of disaster preparedness and emergency response is a competent workforce capable of addressing the community's needs (including mental health) following a disaster, emergency or incident.

PFA & MHFA training for Emergency Services Volunteers

International trends

I spoke to many individuals across a range of organisations while completing background research for this report the barriers to this occurring . I found that across the globe, there is increased recognition of the need for this kind of training post September 11, the London Bombings, wars and other natural disasters which are increasing in frequency, duration and severity.

For example, I recently spent several hours discussing this topic with Uri Shacham, Director or Magen David Adom (Israel's Ambulance service) who was in Australia to share his experiences of responding to the recent bushfires in Israel. He spoke extensively of the need to adequately train volunteers in MHFA and PFA, especially when volunteers are frequently exposed to traumatic situations, disasters, war zones, etc. He also highlighted the barriers to this occurring-time, money, resources, lack of existing standardised material and adequately trained trainers.

In America, there are a number of volunteer organisations working collaboratively and on their own to provide MHFA and PFA training to volunteers. The Medical Reserve Corps (made up of local Mental Health Professionals who volunteer their time in large scale emergencies/disasters) includes Mental Health competencies as part of their basic training (see appendix 2). They are working with colleagues at the National Institute of Mental Health to better understand how Mental Health training for volunteers might impact on improved outcomes for patients (treatment, crisis prevention, preparedness, response, etc.).[5]

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[5] Cited in interview with Rob Tosatto, Director, Office of the Civilian Volunteer Medical Reserve Corps, Marylands

The CERT program is an attempt to facilitate citizen response and preparedness across the United States. Pre-disaster planning and preparedness, as embodied in the CERT program, is becoming increasingly pertinent for those interested in decreasing the immediate and long term, individual and community impacts of disasters and emergencies. Not surprisingly, the CERTs I visited faced similar barriers (around time and resources) to receiving the MHFA and PFA training they desired.

Some quality international training programs are currently being trialled for psychological first aid responders by organisations such as the Australian Centre for Posttraumatic Mental Health, Red Cross (both the ICRC and IFRC), National Child Traumatic Stress Network (US) and the World Health Organization. These programs vary widely and cannot be easily compared.

Usually, psychological first aid training follows a set of principles, but is adapted to the specific needs of the group being trained.

Some training models are being developed for delivery via the internet, for example: NCTSN (http://learn.nctsn.org/index.php) offers a six-hour psychological first aid course online.

The Psychosocial Support in Disasters portal (www.psid.org.au) provides links to further information about psychological first aid skills, competencies and training information.

In order to provide a competent workforce, the authors of these resources strongly recommend that an introduction to psychological first aid be a standard part of the training and briefing of trained responders.

These are only a few examples across a small number of organisations. From the limited background research I conducted via email with emergency services agencies in Europe, Asia and America, the following was apparent:

- There is more interest than ever before (from volunteers and organisations) in PFA and MHFA.
- There is general agreement that additional training would positively impact on outcomes for patients and communities.
- Organisations would like to work collaboratively to share information, ideas, models, outcomes, etc.
- More funding and time is required to provide the type and frequency of training required.
- Some emergency services organisations have begun producing (limited) material or training trainers to deliver MHFA and PFA.
- No single organisation has a 'best practice' model that could be transferred to other emergency services organisation

Australian Trends

Across Australia, there is a definite interest in improving outcomes for those suffering from a mental health issue or psychological distress following trauma. A simple Google search highlights the many programs and resources available (of varying quality). Here are a few examples relevant to this research paper:

- **Improved reporting systems**
  Victoria Police are trialling (for 12 months) a program (PACT – Police and Community Triage) in Division 2 (Bayside/Glen Eira/Kingston). This does not train staff to deal with people facing mental health challenges, but rather uses their reporting system to channel them towards a team of specialist psychologists and community health workers who focus on case co-ordination and follow up. None of this training extends to volunteers.

- **Working collaboratively**
  The Australian Psychological Society (APS) worked with the Australian Red Cross to produce a brief Australian PFA manual (endorsed by multiple organisations working in disaster preparedness and response throughout Australia). They also signed a Memorandum of Understanding in December last year which sees the Red Cross training APS psychologists on how to work effectively in an emergency situation. Conversely, Red Cross volunteers receive training in 'psychological first aid' for those affected by emergencies and disasters. The agreement will enable the two organisations to work together to prepare communities for disaster so that they are more resilient, do not suffer unnecessary or prolonged distress, and are able to recover more quickly. The MoU represents an historic step towards a world class disaster response in Australia. (http://www.psychology.org.au/assets/files/red-cross-psychological-first-aid-book.pdf).

- **E-Resources for remote locations**
  The Royal Flying Doctor Service created a Psychological First Aid kit CD-ROM in 1998, in response to the challenges of training people working in rural and remote locations. Currently, the content is out of date and technology has moved on significantly. Whilst it isn't available for distribution now, it was received with interest at the time by a very wide range of organisations, professional groups, volunteers and consumers. Its uptake was not systematically evaluated and therefore I can only provide anecdotal evidence of its usefulness. It is however, worth noting as a possible delivery model in conjunction with other face-to-face, future training.

- **Increased amount, quantity and variety of printed material**
  The Mental Health First Aid for South Australians booklet (2001) is a useful tool to assist in raising community confidence about how to deal with mental health problems when they arise. It focuses on building capacity for people to respond to mental health problems in the places where they live and work, in their families, their neighbourhoods, their regional communities, and their communities of interest. The booklet outlines the aims and basic principles of MHFA (a derivative of the MHFA program outlined on previous pages) and offers practical advice on common situations (e.g. the distressed person, acute anxiety, depression, the suicidal person, substance abuse, intoxicated states, confusion, overdose and acute psychosis.

- **Public education campaigns**
  A wide variety of online resources, for example those provided by Beyond Blue. Beyond Blue recently released a short e-learning Workplace Mental Health Awareness Program (www.beyondblue.org.au/index.aspx?link_id=4.1028).

In contacting Ambulance agencies in all states of Australia (via volunteer co-ordinators, education/training branches or other appropriate sections), I discovered that all showed an interest in providing volunteers with more skills in this area and are interested in the results of this report to assist in making that happen. Anecdotally, what seemed to be preventing or slowing the process (of improving training opportunities) was a lack of time (both agencies and volunteers), funding, a formal module/model and the appropriately trained personnel to deliver.

Current practice in Ambulance Victoria CERTs

Many years ago the CERT program was developed in Victoria by AV's Geoff Harvey (and supported by others) on a tiny budget. Now, it is a well developed program with ongoing funding.

As part of AV's commitment to recruit, recognise, train and reward volunteers, there is currently a focus on educational opportunities for volunteers to create future pathways/careers in associated fields. As of 2011, the CERT program is delivered as a 100-hour (approx.), Certificate II course.

Whilst AV and other agencies provide psychological first aid to volunteers via peer support officers[6], regular volunteers aren't routinely trained to deal with PFA for patients as part of their Certificate II course.

My initial research indicates that Ambulance Victoria (AV) is the only (advanced first aid) agency nationally to provide (non-compulsory) Mental Health First Aid (MHFA) training for volunteers[7].

Over the past 3 years, AV have trained a small number of volunteer and paramedic instructors to deliver the 12- hour MHFA course to CERTs and AV employees. These courses have been well received by CERTs.

Feedback from course participants has been overwhelming in support of making tailored/abridged MHFA training compulsory for all AV volunteers (preferably beginning in the first year of training). It has been of great benefit to volunteers in treating patients, but also in supporting members of their community to better access mental health treatment, services and support.

AV also includes some information on 'the mental health patient' in the 2012 Continuing Vocational Education (CVE) learners guide. This 2 hour session discusses:

- the relevant legislation associated with the mental health patient
- The mental status assessment used by paramedics
- A very brief (3 or 4 lines) description of dementia, schizophrenia, depression, bipolar disorder, anxiety, suicide
- Case study discussions & scenarios

AV's Ambulance Peer Programs and Counselling unit have been using the M.A.N.E.R.S model of Psychological First Aid to train their peer support volunteers. M.A.N.E.R.S. aims to provide early and supportive interventions to assist those exhibiting emotional distress following involvement in an accident, injury or traumatic event. It is intended that the interventions will support and enhance people's normal coping strategies and recovery processes.

Minimise exposure
Acknowledge the response and/or event
Normalise the response or reaction
Educate as required
Restore or refer
Self-care

There is an 18 minute DVD explaining the M.A.N.E.R.S model that is currently only shown to peer support officers, paramedics and paid employees.

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[6] experienced paramedics/CERT volunteers who support AV staff, volunteers and immediate family members following their involvement in a critical incident as well as other work, personal or family related matters.

[7] Although St. John Ambulance trialled 2 courses in 2011.

In the past few years, AV have released a few educational DVDs, One, 'Stress – caring for yourself, your family and colleagues' recognises that we are faced with stressful situations and need to be mindful of the impact that has on us and those around us. It mentions some of the PFA principles as it relates to the responder. Another DVD 'Witness welfare' has some relevant information for this research topic and could be a useful tool (e.g. for example scenarios) to support information on PFA training, personnel and supervision.

AV uses (Learning Management System) LMS. This enables people to access information and training without being off the roster (to date, not a lot of modules/content have been uploaded, especially in this area of research). The downside to the LMS is that not everyone has regular and reliable access to the internet/emails and it is difficult to monitor and assess learning.

Lessons learned

My travels, interviews, research and lived experiences have enabled me to devise a list of lessons learned on this topic.

Increasing the number of volunteers trained in MHFA and PFA:
- increases and improves the opportunities to support people affected by traumatic events, emergencies, etc.
- raises community awareness of what constitutes normal reactions to abnormal events.
- by screening victims in the immediate aftermath of a disaster/emergency/trauma, those in need of more specialized treatment can rapidly be referred to health professionals working with public crisis-intervention services, potentially decreasing the long term burden on the health system.
- helps victims to understand that they are not alone in their suffering and that further help and social support are available.
- increases the level of understanding people have about mental health problems by providing tools that will help individuals and communities to be more resilient.
- provides social capital that puts back into a community.
- improves support for volunteers so they feel adequately prepared for the cases they may face.

When volunteers are better equipped to deal with the situations they find themselves in and the people they treat, better outcomes are expected for all involved. These might include:

- early intervention and access to treatment for patients (reducing hospital loads and lessening burden of disease).
- faster recovery times for patients.
- greater volunteer empowerment (nothing worse than feeling like you don't know what to do!).
- reduction of risk exposure for volunteers.
- better community understanding of mental health issues.

There are many models for the delivery of MHFA and PFA. More research needs to be done on the evaluation and effectiveness of programs on offer within Australia and internationally.

It is important to regularly re-visit the training needs of volunteers as voiced by funding bodies, service delivery organisations and those delivering the services (e.g. front line personnel/first responders/volunteers).

Sharing of knowledge and resources across agencies, states and countries benefits organisations, providers and recipients.

Recommendations for AV

1. Consistently integrate VACU resources and systems into CERT training

Currently, the chain of communication between VACU and CERT volunteers is inconsistent. Linking between volunteers and VACU is currently reliant on either self referral or a 'middle man' – e.g., peer support volunteers within CERTs, Team leaders, paramedics who attend a scene, case sheets, DTMs, etc.

Opportunity exists for improved relationships between VACU and CERTs so that individuals and teams can easily and regularly access knowledge, support, information, resources and assistance. One way to achieve this is to produce a standardized package which ensures that a consistent message is being delivered across the state by trainers who introduce VACU and 1800 MANERS to CERTs.

2. Review CVE module annually

The 2012 CVE includes a 2 hours training module entitled 'The Mental Health Patient'. This should be reviewed annually to ensure content is up to date, relevant and meets the needs of volunteers. The principles of PFA along with pre-incident education (around grief and bereavement) could be included here.

Questions to ask when reviewing might include: How flexible is training? How often is it reviewed and evaluated? Who reviews it? Who is consulted when it comes to training needs? How is content decided upon? What is the legal and moral duty of organisations to adequately train volunteers? What will happen if we do nothing? What will happen if we do something and people feel supported, valued and cared for?

3. Consider additional information on LMS

An on-line module could appear on AV's LMS named 'endeAVour'. This is an opportunity to put additional information about PFA and MHFA and provide links to reliable websites. Existing resources, like the Peer Support and M.A.N.E.R.S DVDs mentioned earlier could support this.

4. Include Mental Health Scenarios and integrate PFA on scenario days

Many CERTs run scenario days (some inter-agency) whereby volunteers respond to simulated call outs. A case involving a mental health patient could be included and the principles of PFA used in traumatic physical first aid scenarios.

5. Provide training opportunities at CERT conferences

Offer full 12-hour MHFA courses in conjunction with quarterly CERT conferences. This would enable volunteers from a variety of teams to interact with each other and individuals to self-select, rather than there be a need to fulfil minimum numbers from within a single team.

Some CERT conferences may also offer condensed PFA or MHFA workshops that introduce the concepts as part of the program.

6. MHFA & PFA recognised in ATP

Approve MHFA courses as part of the new point scoring system for CERTs to gain ATP. It could fit under 'other approved professional development' options for 3 points.

7. Work collaboratively with other agencies for better results

There are lots of 'bits and pieces' (good training resources, individuals championing the cause, etc) within agencies across Australia and internationally that could be brought together in one place. This inter-agency sharing would:

- maximise exposure of CERTs to quality material and assist in broadening their knowledge and application of MHFA and PFA principles
- reduce duplication of efforts
- begin the process of developing a 'best practice' training module for emergency services volunteers

In the interest of developing a stable and competent disaster mental health workforce, the identification of minimum standards for developing and evaluating existing or future training programs is recommended. Standards should require that each training program provide objectives, target audiences, training topic and focus, means of delivery, measurable outcomes and evaluation procedures. Minimum criteria should be developed to define a training course, length, format, course materials, instructor qualifications and trainee qualifications. These competencies should be relevant to the needs of staff involved and community requirements considered.

8. Consider a modified model of training

As of 2011, the CERT program is delivered as a 100-hour (approx.), Certificate II course. It covers physical first aid, but no PFA or MHFA. Certificate II has been great for those wanting a career path in an associated area because in many cases it provides RPL.

For those merely interested in serving their community (or for other non-vocationally oriented reasons), 100 hours is too great a time commitment and has resulted in some attrition from induction courses.

This opens the doors for the development of a modified model whereby those wanting to complete a full Certificate II can. Those who want a less time consuming option, could complete something similar to a level 3 (advanced first aid) certificate (20+ hours). The two levels of responders could then buddy up together on call outs.

Those completing advanced first aid could have the option of completing the additional 12-hour course (and other non-compulsory modules) in their first 12 months of service.

This model may result in greater retention as well as provide for further response options in rural communities where for example, about a quarter of CFA members hold first aid certificates and potentially could be called upon to assist.

Conclusion

This research highlights the many challenges and opportunities both within Australia and internationally when it comes to training front line emergency services volunteers in MHFA and PFA.

The need for PFA and MHFA seems clear, as evidenced by the endorsements of the World Health Organization, Red Cross, the United States Institute of Medicine, the American Psychiatric Association, the National Volunteer Organizations Active in Disaster and many others.

Regardless of the type of disaster, emergency or trauma facing rural communities, building local capacity prior to an event is key, both to the effectiveness of the response and to the ability to bounce back after traumatic events. The *National Mental Health Strategy* along with Everly (2001) support the notion that mental health is a community issue, best approached with a partnership between community, providers, consumers and carers working towards mental health promotion, early intervention, treatment services and rehabilitation. Everly (2011) states that 'the most effective utilization of psychological and behavioural resources would seem to call for training first responders...and any other individuals who can provide a calming and reassuring outreach and presence".

Where there is local capacity, groups like CERT can flourish and provide critical emergency response skills. Such efforts could have a dramatic effect in vulnerable rural communities by developing a sense of community among residents while addressing specific disaster/risk mitigation, preparedness, response, and recovery capabilities.

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Appendices

Appendix 1- Program of activities

Date	Place	Organisation	People met & rationale
29/9/11 – 2/10/11	Fly Melb-Syd-LA-Washington	Travel, Research Prep Rest Day	
3/10/11	Rockville	Montgomery CERT Team Leader - Anne Culver	Various - Attended Committee meeting and dinner Program educates people about disaster preparedness for hazards that may impact their area and trains them in basic disaster response skills. CERT members can assist following an event when professional responders are not immediately available to help and are encouraged to support emergency response agencies by taking a more active role in emergency preparedness projects in their community
		Montgomery County Fire and Rescue	Greg St. James - Emergency Medical Technician to help behavioural health professionals plan for and respond effectively to Mental Health and substance abuse needs following a disaster.
4/10/11	Rockville	U.S Dept of Health and Human Services	Nikki Bellamy – Public Health Advisor – Division of Traumatic Stress and Special Programs - Substance Abuse & Mental Health Services SAMHSA provides disaster technical assistance, training and consultation
		Rob Tossato, Director, Office of the Civilian Volunteer Medical Reserve Corps. Office of the Surgeon General, U.S. Dept of Health and Human Services	Citizen Corps was created to help coordinate volunteer activities that will make our communities safer, stronger, and better prepared to respond to any emergency situation. Citizen Corps is coordinated nationally by the Department of Homeland Security's Federal Emergency Management Agency. In this capacity, FEMA works closely with other federal entities, state and local governments, first responders and emergency managers, the volunteer community, and the Corporation for National & Community Service.
5/10/11	Baltimore	Rest day	
6/10/11	Baltimore	Red Cross Emergency Services	Bethany Brown The Red Cross Disaster Mental Health Services (DMHS) program has developed and evolved to assist both disaster victims and the Red Cross workers who serve them to cope with the overwhelming stresses encountered by both groups in the aftermath of disasters.
7/10/11	Sykesville	Johns Hopkins Centre for Public Health Preparedness Psychological First Aid workshop	Completed a six-hour, interactive, face-to-face training that provides public health professionals without former mental health education with the concepts and skills associated with PFA. This specialized training provides health professionals who may be asked, or might volunteer, to respond in times of emergency with perspective on injuries and trauma that are beyond those that are physical in nature. The model is readily applicable to public health settings, the workplace, the military, mass disaster venues, and even the demands of more well circumscribed critical incidents, e.g., dealing with the psychological aftermath of accidents, robberies, suicide, homicide, or community violence.

8/10/11	Baltimore	George Everly	co-founder of and Representative to the United Nations for, the International Critical Incident Stress Foundation, member of the Johns Hopkins Center for Public Health Preparedness and serves on the faculties of The Johns Hopkins University School of Medicine, The Johns Hopkins University Bloomberg School of Public Health, and Loyola College in Maryland. In addition he serves on the adjunct faculties of the Federal Emergency Management Agency, and the FBI National Academy. He is the author, co-author, or editor of 14 textbooks and over 100 professional papers, inc. Mental Health Aspects of Disasters: Public Health Preparedness and Response, Pastoral Crisis Intervention, Critical Incident Stress Management, Psychotraumatology, Critical Incident Stress Debriefing, A Clinical Guide to the Treatment of the Human Stress.
9/10/11	New York	Ground Zero	
10-11/10/11	Travel NY-Baltimore- LA-Syd-Melb		
14-15th November	Melbourne, Australia	Crisis Intervention and Management Australasia (CIMA) conference	Andrew MacLeod – Supporting Humanitarian and Emergency Services Workers. Before, During and After deployment Trevor Wilson – The impact of being first on scene Monica Kleinman - Out of the Blue: Psychological First Aid in Disaster Kokpeng Lim – Supporting our Healthcare providers John Durkin – CISM for Psychological Growth Rob Gordon – The course of personal recovery after a disaster Jan Brown – the value of support programs to staff Michael Hegenauer – Emergency staff care David Forbes – Guidelines for Peer Support Programs Alexina Baldini – Developing the Workplace capacity to respond
12-14 Feb 2012	Melbourne	Mental Health First Aid – Centre for Youth Mental Health, University of Melbourne	Claire Kelly The Youth Mental Health First Aid Course teaches adults how to assist adolescents who are developing a mental health problem or in a mental health crisis. Participants learn about adolescent development, the signs and symptoms of the common and disabling mental health problems in young people, where and how to get help when a young person is developing a mental illness, what sort of help has been shown by research to be effective, and how to provide first aid in a crisis situation. The developing mental health problems covered are: depression, anxiety, psychosis, eating disorders and substance misuse. The mental health crisis situations covered are: suicidal thoughts and behaviors, non-suicidal self-injury, panic attacks, traumatic events, acute effects of drug or alcohol use, severe psychotic states.

Appendix 2 - Ambulance Victoria's M.A.N.E.R.S model

4. Educate as required

Goal
To improve the person's immediate and short-term crisis coping

Suggestions
- Teach basic stress management and self-care when and if needed
- Do not tell the person how they are going to be affected by the event
- Provide information in response to reactions they describe
- Answer the person's questions honestly
- Remember that it is the person's issues that are important not yours
- Take action in response to the person's issues ie if they need to ask a question of their manager encourage them to do so, if they need to check that their spouse is safe assist them to make contact

5. Restore or refer

Goal
To re-establish the person's pre-incident psychological state or ensure that they are receiving professional assistance

Suggestions
Continue with follow-up contact until you are satisfied the person is okay or receiving appropriate assistance
- Satisfy yourself that the person has returned to their pre-event normal self
- If you have any concerns or doubts recommend referral to
  - Peer Support
  - Counselling Line
  - Appointment with a psychologist

6. Self care

Goal
To minimise the risk of the person providing support suffering from vicarious trauma

Suggestions
- Ensure you monitor your own welfare and take your own advice regarding self-care
- Eat, sleep and exercise in a healthy manner
- Do things you enjoy on your days off
- Spend time with people whose company you value
- Discuss with someone that you trust
- Discuss with Peer Support
- Discuss with the Duty Psychologist on the Counselling Line
- Organise an appointment with a psychologist

It is important that anyone who implements MANERS must be appropriately trained in the model. This outline does not stand alone, but is a supplement to the MANERS DVD, full set of guidelines, and the additional training provided by Peer Support and VACU.

MAS Staff Support Line
1300 762 723
RAV Staff Support Line
1800 226 617

Available for all MAS and RAV employees and their immediate family

Members of the Public should be provided with the brochure
"Dealing with Trauma & Medical Emergencies"
or referred to www.justlook.org.au for counselling services in their local area

M.A.N.E.R.S.

Model of psychological first aid

Pocket Guide

M.A.N.E.R.S. is designed for delivery by staff whose roles brings them into contact with people who have been involved in traumatic or crisis situations. When providing support your aim is to respond to the current needs and circumstances of the person. The following outline of the 6 stages of M.A.N.E.R.S. is a guide to providing appropriate support, but must not be used prescriptively. One or two stages may be applied initially and another stage or stages on subsequent contacts if or when needed. Stages are only to be applied when they are appropriate to and meet the needs of the person.

1. Minimise exposure

Goal
To reduce emotional stimulation and allow the recovery process to commence

Suggestions
- Introduce yourself with your name and describe your role
- Speak calmly and softly
- Remove the person from the event that is causing the distress
- Ensure that the person is feeling as safe as possible
- Avoid unnecessary exposure to other stressful events
- Allow the person to decide whether they look at distressing sights
- Allow the person to decide whether they listen to distressing sounds
- Allow the person to decide whether they want to speak about the distressing event
- Provide physical and emotional comfort

2. Acknowledge the event

Goal
To acknowledge that the event is more significant than normal and to build a relationship with the person to enable early recognition of any problematic issues

Suggestions
- Make sure the acknowledgement is in proportion to
  - The seriousness of the event
  - The impact of the event on the person
- When people suffer high levels of distress they frequently benefit from high levels of acknowledgement of their efforts and what they experienced
- The status, position and reputation of the person providing the acknowledgment is important
  - Managers are an important part of appropriate acknowledgement
  - Experienced employees should acknowledge junior employees
  - All employees should acknowledge each others involvement in events

- Ways in which an event can be acknowledged
  - Ask, "Are you okay?"
  - Listen to the person speak about the event (if they wish to do so)
  - Provide up-to-date information about the event
  - Conduct an operational debriefing
- Facilitate group and social support where appropriate
  - Invite all involved in the event for a coffee afterwards
  - Offer to make contact with their relatives
  - Provide time for the person to recover i.e. come out of service
  - Ensure the person is provided with a meal break
- Initiate further assistance and support based on the needs of the person
  - Notify the person's manager for contact at a later date
  - Notify Peer Support
  - Peer Support &/or Manager can visit or phone the person
  - Person can be referred to a psychologist
  - Psychologist can visit the person in the workplace at a later date

3. Normalise the experience

Goal
For the person in crisis to view their reactions as understandable given the circumstances, albeit potentially problematic and to recognize that it is the event that was abnormal not their reactions.

Suggestions
- Reassure the person that what they are experiencing is understandable and expectable
- Explain reactions if required
- Do not agree to any incorrect or abnormal perceptions expressed by the person
- Quietly and calmly state your own knowledge of the event if required
- Do not argue the point but ensure you refer the person for further assistance
- The person should feel that their reactions to the incident are normal and it is the event that is abnormal

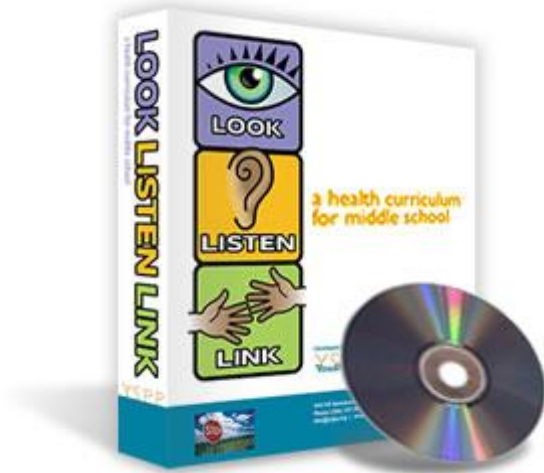# Appendix 3 – Medical Reserve Corp's Core Competencies Matrix

MRC Core Competencies Matrix

Domain #1: Health, Safety, & Personal Preparedness (continued)

Specific Competency	Knowledge		Attitude	Suggested Trainings/Tools	Assessment
Describe the impact of an event on the mental health of the MRC member and their family, team, and others.	• Identify the range of anticipated stress reactions experienced by disaster survivors, MRC members, responders, and others in the early aftermath of disaster. • Identify when, how, and where to refer disaster survivors, MRC Team members, and others for additional mental health support and care. • Identify the basic elements of Psychological First Aid and the key ways to provide emotional care and comfort to disaster survivors, MRC Members, and others in the early aftermath of disaster.	• Provide psychological first aid to disaster survivors, MRC team members, and others.	• Acknowledge that disasters and other public health emergencies are stressful events. • Acknowledge that MRC members are in a unique role to provide emotional care and comfort to disaster survivors, MRC team members and others. • Embrace the concept that providing emotional care and comfort in the early aftermath of disaster may mitigate short and long-term psychological consequences in disaster survivors, MRC team members and others.	• *Psychological First Aid: Field Operations Guide (MRC version)* www.medicalreservecorps.gov/ File/MRC_Resources/ MRC_PFA.doc • *Psychological First Aid: Helping People Cope During Disasters and Public Health Emergencies* www.centerfordisastermedicine.org/ disaster_mental_health.html • *Nebraska Psychological First Aid Curriculum* www.disastermh.nebraska.edu/ psychfirstaid.html • *Psychological First Aid: Helping Others in Times of Stress* Contact your local American Red Cross Chapter • *Introduction to Mental Health Preparedness for Local Health Department Staff and Community Volunteers* https://www.mrc.train.org/ DesktopShell.aspx?tabid=62&goto= browse&browse=subject&look for=18&clinical=both&local=all &ByCost=0	• Document participation in a Psychological First Aid training (online or classroom)

Appendix 4 – Models of PFA

WHO – look, listen, link

RAPID PFA

R eflective listening

A ssessment of needs

P rioritize attending as severe vs mild reactions

I ntervention

D isposition

SAFER-R Model of PFA (Everly, 1995; Everly & Mitchell, 1999)

S tabilization of the situation

A cknowledgement of the crisis

F acilitation and Understanding

E ncourage adaptive coping

R estoration of adaptive,

Resilient Moment Communications model (RMC) which provides information/assistance for effected individuals.

What happened?

What are the effects?

What caused the event to occur?

What is being done about it right now?

What do you need right now/What can I do for you?

Core skills (Red Cross action principles in the Australian context)

Be prepared Be prepared: know the situation, who your team members are and who is in charge; have a basic first-aid qualification.

Assess and prioritise Assess and prioritise: assess the situation and prioritise need; don't rush in.

Safety, security and shelter Safety, security and shelter: ensure people are warm, protected and have access to water or other suitable drinks etc.

Engagement: make contact, introduce yourself in a nonintrusive way, explain who you are and why you are there.

Calming and Comforting Calming and Comforting: 'be' with people, acknowledge their situation, validate their thoughts and feelings; practical strategies (breathing, grounding techniques) to calm.

Practical assistance Practical assistance: what is their most pressing concern? How can you help with this? What information is available to them?

Finding solutions Finding solutions: encouraging people to identify their needs and consider ways of meeting them, help them to do this or find information/relevant people who can assist.

Moving on to assist others Moving on to assist others: ensuring that linkages have been established for the previous person and then moving on, once again, to assess for greatest need.

Appendix 5 – Introductory letter

Hi,

I am hoping you may be able to assist me with some research I am undertaking in Mental Health and Psychological first aid training for emergency services volunteers

I am a volunteer in an Australian Community Emergency Response Team (CERT). Australian CERTs consist of volunteers (with around 100 hours of physical first aid training) who function as 'first responders' within communities where the nearest ambulance branch is some distance away. CERTs provide pre-hospital emergency care and life support until paramedics arrive. In 2009 I was part of the response team for the Black Saturday fires – Australia's worst natural disaster. I was particularly active in my home town of Kinglake, which was devastated by loss of lives and property.

I also deliver Mental Health First Aid training to other CERT volunteers in Victoria (Australia). I haven't heard of any similar programs running for emergency services volunteers, but I've seen first-hand the incredible benefits this training has had for volunteers, patients and the broader community.

I am investigating on an international level the following:
· What (if any) Mental Health and Psychological First Aid training do volunteers in the emergency services receive?
· How might Mental Health/Psychological First Aid training for volunteers impact on improved outcomes for patients (treatment, crisis prevention, preparedness, response, etc)?
· How might the community benefit from having trained volunteers respond to emergencies in their community?

Can you answer any of the above questions in relation to your agency/country?

Do you know of any International programs/conferences/research papers addressing any of the above?

Are you aware of courses, agencies or individuals who I might be able to meet up with whilst in the US?

An opportunity has arisen for me to travel to the US (Washington, Marylands. Baltimore area) to research training for volunteers in Psychological First Aid and Mental Health First Aid and share some of what we do in Australia. Does anyone have contacts that might be useful in this investigation?

If you can answer any of these questions for me, or head me in the direction of someone who could, or you know of any Mental Health training offered to your local emergency services volunteers, please let me know!

I thank you in advance for circulating this information amongst your colleagues. I am more than happy for them to contact me directly if they have any information that might assist me with my research.

Regards-

Kate Riddell