

Psychological First-Aid Training for Paraprofessionals: A Systems-Based Model for Enhancing Capacity of Rural Emergency Responses

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Abstract

Introduction: Ensuring the capacity of the public health, emergency preparedness system to respond to disaster-related need for mental health services is a challenge, particularly in rural areas in which the supply of responders with relevant expertise rarely matches the surge of demand for services.

Problem: This investigation established and evaluated a systems-based partnership model for recruiting, training, and promoting official recognition of community residents as paraprofessional members of the Maryland Medical Professional Volunteer Corps. The partners were leaders of local health departments (LHDs), faith-based organizations (FBOs), and an academic health center (AHC).

Methods: A one-group, quasi-experimental research design, using both post-test only and pre-/post-test assessments, was used to determine the *feasibility*, *effectiveness*, and *impact* of the overall program and of a one-day workshop in *Psychological First Aid (PFA) for Paraprofessionals*. The training was applied to and evaluated for 178 citizens drawn from 120 Christian parishes in four local health jurisdictions in rural Maryland.

Results: *Feasibility*—The model was demonstrated to be practicable, as measured by specific criteria to quantify partner readiness, willingness, and ability to collaborate and accomplish project aims. *Effectiveness*—The majority (93–99%) of individual participants “agreed” or “strongly agreed” that, as a result of the intervention, they understood the conceptual content of PFA and were confident about (“*perceived self-efficacy*”) using PFA techniques with prospective disaster survivors. *Impact*—Following PFA training, 56 of the 178 (31.5%) participants submitted same-day applications to be paraprofessional responders in the Volunteer Corps. The formal acceptance of citizens who typically do not possess licensure in a health profession reflects a project-engendered policy change by the Maryland Department of Health and Mental Hygiene.

Conclusions: These findings are consistent with the conclusion that it is feasible to consider LHDs, FBOs, and AHCs as partners to work effectively within the span of a six-month period to design, promote, conduct, and evaluate a model of capacity/capability building for public mental health emergency response based on a *professional “extender”* rationale. Moreover, consistently high levels of perceived self-efficacy as PFA responders can be achieved with lay members of the community who receive a specially-designed, one-day training program in crisis intervention and referral strategies for disaster survivors.

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Abbreviations:

AHC = academic health center
CDC = [US] Centers for Disease Control and Prevention
FBO = faith-based organization
HRSA = Health Resources and Services Administration
LHD = Local health department
MPT = Motivational Preparedness Training
PFA = Psychological first aid

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Introduction

The Problem: Mental/Behavioral Health Surge

Psychological casualties greatly outnumber physical injuries following disasters and other large-scale public health emergencies. This observation is long-standing and consistent across both intentionally-provoked^{1–6} and naturally-occurring incidents.^{7–9} Compounding this public health challenge is the vulnerability of many persons within sub-groups of the general population who are at greater risk for developing acute and chronic trauma-related problems. At-risk groups include populations living in rural areas, particularly minorities and persons of low socioeconomic status whose stress-susceptibility often is accentuated by chronic medical problems, severe mental illness, and substance use.^{10–13}

Shortage of Professional Behavioral Health Responders—Mitigating the impact of disasters on vulnerable groups is problematic, especially in light of: (1) the inadequate supply of mental health professionals with disaster-response expertise; (2) recent evidence that many healthcare professionals are reluctant to report to work,¹⁴ and (3) the fragmentation of and poor coordination among entities in the public health emergency preparedness system whose roles are vital if the service-provider supply/demand problem is to be solved.

Toward a Systems-Based Solution

It is difficult to conceive of a solution to the above issues that does not involve the establishment of a corps of professional disaster response “extenders”. Ideally, cadres of paraprofessionals, i.e., lay members of the community without advanced degrees and licensure as mental health professionals, would be prepared as prospective disaster responders through a collaborative effort among entities whose missions relate to promoting the safety and well-being of the community. The premise of this study is that an arrangement between leaders in health jurisdictions, faith-based communities, and academic and/or health centers potentially would provide an effective structure for planning, implementing, and evaluating a *paraprofessional extender model* for enhancing the capacity and capability of rural communities to respond to the psychological needs of disaster survivors.

Local Health Departments and the Community—Ensuring the well-being of citizens in the aftermath of catastrophic events is a formidable challenge for local health departments (LHDs) and public health officials. Although LHDs often are in ongoing, informal contact with a wide variety of community groups, rarely are such relationships formally organized to ensure efficient and effective emergency responses. While many states in the US have and continue to build relationships with community organizations, public health resources in rural communities throughout the US remain hard-pressed to meet the challenge of increased demand surge for psychosocial services in the absence of a supply of qualified providers. This includes the state of Maryland, where this project was conducted. Innovative, collaborative arrangements involving LHDs must be established that effectively offset the inherent difficulty of coordinating care for disaster survivors who, by virtue of their geographic, ethnic, financial, physical, age-related, or psychiatric characteristics, are destined to be disproportionately affected by catastrophic events.

Faith-Based Organizations—Traditionally, faith-based organizations (FBOs) have served communities admirably during and following disasters by making material resources available (e.g.,

food, clothing, shelter, equipment, supplies), relief personnel and by providing human services such as general fellowship, prayer leadership, and death notification.^{15,16} However, FBOs rarely are incorporated into the *formal* preparedness planning and response operations of government,¹⁷ nor has their potential been recognized fully as a vital, indigenous, frontline resource for trauma-specific psychological interventions.

Academic Health Centers—Although faith communities are a potentially valuable resource for enhancing capacity and capability for responses to behavioral health surge, their full potential to enhance the disaster response system is likely to remain unrealized without formal training in relevant crisis intervention competencies. Such a training role is well-suited for qualified faculty of academic health centers (AHCs) functioning within the framework of a formal government-faith-academic partnership, a structure that would appear to be beneficial at three levels: (1) as a means of ensuring qualified paraprofessional responders; (2) as a useful linkage for subsequent call-up/deployment; and (3) as an enduring, post-project LHD/FBO mechanism for leveraging continued preparedness planning initiatives and bi-directional learning opportunities.

Johns Hopkins Collaborative Preparedness Initiatives

Pilot Projects

The current study builds on an evidence-base and preparedness collaborations between FBOs and Johns Hopkins that have been established in prior studies.^{18–20} These projects sought to develop, characterize, and assess the potential effectiveness of a systems-based partnership model to enhance the capacity to prepare for, respond to, and recover from the psychological sequelae of public health emergencies in urban and suburban communities. Most recently, the model has incorporated the leadership of LHDs in four rural counties of Maryland as collaborators. The full approach involves the sequential provision of two preparedness interventions to members of participating faith communities, as follows:

1. *Motivational Preparedness Training (in Psychological First Aid)*—The first intervention, designated *Motivational Preparedness Training* (MPT), was a specialized form of training in psychological first aid (PFA) that was co-hosted by the LHDs and AHC (Johns Hopkins) partners, with faculty from the latter conducting the training. Ongoing efforts to develop and refine the Johns Hopkins MPT/PFA model are consistent with, and complementary to, the development of disaster mental health core competencies for the public health preparedness and response workforce being conducted under the aegis of a Cooperative Agreement between the Association of Schools of Public Health and the [US] Centers for Disease Control and Prevention (CDC).²¹

The MPT/PFA intervention is hypothesized to serve multiple purposes. First, it is intended to impart relevant knowledge, skills, and attitudes to lay persons so that, collectively, they constitute a prospective new class of paraprofessional responders for inclusion in the Maryland Medical Professional Volunteer Corps administered by the Office of Preparedness and Response of the Maryland Department of Health and Mental Hygiene. Second, while labeled somewhat differently, the content of the John Hopkins paraprofessional PFA training model is concordant with

the five principles of immediate and mid-term mass-trauma intervention that have been empirically-derived by expert consensus: (1) self- and community efficacy; (2) a sense of safety; (3) calming; (4) connectedness; (5) and hope.²² Third, the MPT/PFA training event offers a forum for participating leaders of LHDs and FBOs to become acquainted with each other and to begin developing a partnership mind set. Fourth, by educating faith members in core disaster concepts and training them in PFA principles and procedures, MPT/PFA appears to motivate trainees to participate in subsequent, joint disaster preparedness planning activities with their LHD representatives. To avoid confusion, the MPT/PFA intervention shall be referenced as PFA in the remainder of the report.

2. *Guided Preparedness Planning*—Capitalizing on participants' raised awareness of the need for emergency preparedness by the PFA training experience, the second intervention, designated *Guided Preparedness Planning*, provides members of the community with the training and technical assistance developing community mental health disaster plans, further advancing the capacity and capabilities of participating faith communities' to respond during disasters. Only the results of the PFA intervention are reported here.

Aims of the Project

The project addressed questions in three domains of inquiry, *feasibility, effectiveness, and impact* of the model:

1. *Feasibility of the Tri-Partite Collaborative Model*—The first aim was to determine if the basic, three-entity collaboration idea was workable, i.e., would already-burdened and often under-resourced people from three disparate cultures in the public health system prove ready, willing, and able to come together and work on a common-cause project?
2. *Effectiveness of the PFA Intervention*—Assuming an affirmative response to the above question, the second aim was to assess the effectiveness of PFA in enhancing: (a) psychological first aid knowledge and skills in lay members of the community; and (b) willingness of participants to become formal disaster responders (assuming the state of Maryland would accept trainees into the Medical Professional Volunteer Corps); and
3. *Translational Impact of Model/Intervention*—The third aim was to determine if the PFA intervention, delivered within the framework of the academic/government/faith partnership model, would result in a change in prevailing (pre-study) government policy/practice of accepting into the Volunteer Corps.

Methods

Recruitment of Participants

Organizational Participants (Project Partners):

1. *Academic Health Center*—The academic partners were faculty members and administrators of multiple offices, departments, and centers within the Johns Hopkins Bloomberg School of Public Health, the Johns Hopkins School of Medicine, and the Johns Hopkins Hospital and Health System, who had been collaborating in the previously-described pilot projects.
2. *Local Health Department*—Government partners were Emergency Planners or Preparedness Coordinators of

four local health departments in the mid- and eastern shore region of Maryland, one of whom (CP) served as the liaison between AHC and LHD representatives. The latter were introduced to the project opportunity by CP via a conference call.

3. *Faith-Based Organizations*—Clergy and lay leaders of Christian parishes in the same local health jurisdictions ("counties") were recruited by each LHD-partner using various outreach methods such as telephone calls, e-mail, presentations at FBO meetings, and networking that built upon pre-existing LHD/FBO relationships. A *Partnership Steering Committee* was the primary vehicle through which AHC/LHD representatives participated in project planning, implementation, and evaluation activities; and
4. *Individual Participants (PFA Trainees)*—Prospective trainees were recruited by FBOs and LHDs using a range of approaches including newspaper ads, announcements at Sunday worship services, brochure mailings, and person-to-person networking. Eligible participants were adult residents of the four identified counties.

PFA Intervention Sessions

Six PFA sessions were provided to different individual participants between 24 June 2008 and 14 July 2008. Training sessions were conducted using a professional continuing education one-day format. The PFA trainers were two licensed, doctoral-level psychologists who possessed extensive experience as disaster responders and as disaster mental health trainers. Training sessions involved a combination of didactic and experiential teaching methods. The former depended heavily on a Microsoft PowerPoint-based 2003, [Microsoft, Inc., Redmond, Washington] lecture, and the latter entailed group exercises, role playing, and discussions to encourage active involvement and to promote the development of new skills and abilities. The PFA training curriculum was derived from an integration of the PFA model originally developed for health professionals at the Johns Hopkins Center for Public Health Preparedness²³ and the PFA model for paraprofessional trainees created by the Johns Hopkins Department of Psychiatry through previously-mentioned projects.^{18–20} These base curricula were customized to focus on rural populations, including the provision of special-needs information on children, the elderly, and persons with physical or psychiatric disabilities. Session content was organized into four modules, listed here in the order presented): (1) Introduction to Disasters and Behavioral Health Surge; (2) The Johns Hopkins Reflective Listening, Assessment, Prioritization, Intervention, and Disposition (RAPID) Model of Psychological First Aid; (3) Special Needs of Vulnerable Populations; and (4) Self Care and Practical Resources for the Caregiver.

Data Collection and Measures

Feasibility of Model—Model feasibility was operationalized using a recently-developed conceptual framework of "Ready, Willing, and Able" (RWA).²⁴ The specific questions and operational criteria for the three constructs in the order they evolved and were assessed were:

1. *Willingness of LHDs to Respond to the AHC-Initiated Project Concept:*
Question—Will LHD leaders agree in concept and be motivated to participate in the project?

Hypothesis/Criteria—The majority (>50%) of the LHDs approached will provide verbal agreement to participate in the study and subsequently sign a “Letter of Collaborative Intent”.

2. *Readiness of LHDs and FBOs to Respond to the AHC-Initiated Project Concept and Obligations:*
Questions—If prospective partners indicate that they are inclined and favorably disposed to collaborate in the proposed project as hypothesized above, will they, individually and collectively, deploy the necessary human effort and material resources to support and sustain regular, timely participation in project planning and implementation activities? *Hypothesis/Criteria*—Participants will attend, in person or by teleconferencing, a minimum of 80% of all monthly *Partnership Steering Committee* meetings hosted by the AHC and LHD partners on an alternating monthly schedule; and
3. *Ability to Respond to Project Concept:*
Question—If LHD and FBO leadership agree in concept and deploy the resources required to support the pursuit of project objectives as described above, will they be able to perform the necessary behaviors to ensure the success of the project? *Hypothesis/Criteria*—Local health departments will promote the program to FBOs effectively, and FBOs will promote the program to community members effectively, as measured by a minimum of 20 persons attending each PFA workshop in all participating counties.

Effectiveness of the PFA Intervention:

Psychological First Aid Knowledge, Skills, and Attitudes

At the end of each training session, participants completed an evaluation process where they were asked to report the extent to which they agreed with statements related to module-specific learning objectives. The evaluation included items under three domains: (1) acquisition of disaster mental health concepts (knowledge); (2) reported confidence (perceived self-efficacy) in executing PFA strategies and techniques (abilities, skills), and (3) willingness to be a disaster volunteer first-responder (attitudes, motivation). The items were worded in a manner that sought to measure (retrospectively) perceptions of pre/post training changes. For example: “Compared to what I knew before today’s training, I am much more confident in my ability to differentiate severe from normal reactions to stress”. Participants responded using a 5-point Likert-scale (‘Strongly Disagree’ to ‘Strongly Agree’). Core study questions, hypotheses, and criteria for hypothesis confirmation were as follows:

1. *Knowledge and Skills:*
Question—Can knowledge and skills supportive of being an effective disaster responder/PFA provider be imparted effectively to lay members of the community?
Hypothesis/Criterion—The majority of participants will endorse component-items measuring PFA-related knowledge and skills with “Agree” or “Strongly Agree” responses.
2. *Attitudes and Beliefs:*
Question—Will participants’ have, and functionally demonstrate, a favorable attitude toward serving in the capacity of responder/PFA provider in real life emergency scenarios?

Hypothesis/Criteria—If given an opportunity by MD-DHMH, a minimum of one-quarter of the trainees will complete and submit applications to serve as members of the MPVC

Translational Impact of Model/Intervention—A key aim of the project was to assess the project’s translational impact.

Question—Is the model/intervention capable of effecting change in government policy or practice? No hypothesis was offered for this outcome construct. Rather, the investigators hoped the goodwill created by the collaboration, along with observing the quality of the training, would result in a reconsideration of the policy to exclude paraprofessional responders.

Criterion—State government acceptance of project-prepared, PFA-trained participants [for the first time] as bona fide members of the Medical Professional Volunteer Corps.

Data Processing

Simple frequency counts (e.g., number of meetings attended by organizational partners, number of participants completing volunteer corps applications) and descriptive statistics were used as metrics to characterize outcomes on key dependent/criterion variables. The number of Likert-item endorsements of “Agree or Strongly Agree” were aggregated from each participant’s PFA evaluation forms and summarized as percentages of total possible endorsements of all participants. Only fully-completed and legible forms were used in the data analysis (explaining the discrepancy between the 238 registered participants and the 178 respondents used in the statistical processing).

Results

Model Feasibility

Willingness of LHD Leaders to Respond to Project Concept—Five LHDs were formally approached to participate in the partnership. Four (80%) LHD leaders provided the AHC investigators with affirmative verbal responses about project participation during a conference call, and all four submitted signed *Letters of Collaborative Intent*.

Readiness of LHD to Respond to Project Responsibilities—Once the project began, LHD representatives or designees attended 100% of the meetings of the *Partnership Steering Committee*.

Ability of LHD and FBOs to Respond to their Recruitment Responsibilities—The LHD and FBO partners successfully carried out project planning and implementation activities, including the key task of ensuring an adequate volume of community residents to participate in PFA training workshops.

The LHD partners were able to recruit 120 FBOs to collaborate in the project (Table 1). In turn, FBO clergy and lay leaders were responsible for enlisting 238 community residents as formal participant-trainees in the six PFA workshops. The average number who attended a training was 40 participants.

Participant demographics are listed in Table 2, indicating that the typical enrollee was a Caucasian female in her mid-50s. However, one of every four trainees was of African-American race/ethnicity. Fourteen trainees were mono-lingual Hispanic participants. Real-time translation of the training into Spanish using electronic transmission/reception equipment was provided to those participants.

Category of Participant	County A	County B		County C		County D	Totals
		PFA Training #1	PFA Training #2	PFA Training #1	PFA Training #2		
Individuals	25	27	28	63	71	24	238
Organizations	14	13	26	26	30	11	120

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Table 1—Training workshops for psychological first aid (PFA): Summary of participating individuals and faith organizations, by county

Characteristics	Metrics
Race	
Caucasian	65.7%
African-American	25%
Hispanic	6%
Other Race	1%
Bi-racial	2%
Age (years)	
Average (mean)	56.5
Gender	
Female	71%
Male	29%

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Table 2—Demographic characteristics of participants (n = 239)

Intervention Effectiveness

Knowledge: Participant Understanding of Disaster Mental Health Concepts—Essentially all participants indicated that they “Agreed” or “Strongly Agreed” that the training objectives relating to knowledge-acquisition of the principles and practices of disaster mental health, PFA, at-risk populations, and self care were met (Table 3).

Skills (Beliefs about): Participant Self-Efficacy as a PFA Provider—A compelling question is whether training sessions of such relative brevity can enhance a participant’s perceived *self-efficacy* in providing the component-activities of PFA effectively in “real world” disaster settings. The data summarized in Table 4 indicate consistently high (96–98%) levels of participant agreement across all workshops that their perceived *self-efficacy* for applying the techniques of PFA was improved. The lowest relative level of expressed technical *self-efficacy* was associated with recognizing and referring to appropriate resources, disaster survivors whose pre-morbid condition and/or magnitude of traumatic reaction occasioned the risk for suicide.

Concepts Addressed in Training	%*
Mental health surge	97
Signs and symptoms of stress	98
Special needs of at-risk groups	98
Precursors/predictors of PTSD	97
Principles of psychological first aid	97
Harmful behaviors in crisis work	97
Principles of self-care	99

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Table 3—Understanding concepts in disaster mental health (PTSD = post-traumatic stress disorder)

*Data reflect the percentage of participants who indicated that they “Agreed” or “Strongly Agreed” that the training objectives were met in the content areas identified.

Attitudes: Willingness to Respond as a PFA Provider—Immediately following the workshops, 56 (31.5%) of the 178 trainees submitted same-day applications to be members of a paraprofessional category of volunteers in the Medical Professional Volunteer Corps, to be called up by the state of Maryland to provide PFA interventions and general pastoral care relevant to disaster responses or recovery (Table 5).

Impact

State Government Policy Change—As a result of the project, the Maryland Department of Health and Mental Hygiene, which historically had accepted into the Medical Professional Volunteer Corps only board-licensed healthcare professionals, approved the 56 project-trained applicants as members of a new paraprofessional class of disaster mental health responders.

Discussion

This project was a response to recent calls to conduct public health emergency preparedness research,^{25–27} and is consistent with the general need for systematic investigations in the new field of *public health systems research*. Investigations of *systems* and their interacting constituents have not evolved to the point in which scientific rigor similar to clinical trials can be assured. Therefore, caution must be used in drawing conclusions.

Techniques Addressed in Training	%*
Reflective listening	97
Assessment/Prioritization	98
Intervention	98
Disposition/Referral	96
Addressing special needs	95
Suicidality: Recognition/Referral	93

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Table 4—Understanding techniques of psychological first aid

*Data reflect the percentage of participants who indicated that they “Agreed” or “Strongly Agreed” that the training objectives were met in the content areas identified.

Model Feasibility

The fact that four of the five LHDs approached about study participation agreed to, and were judged to have met, the responsibilities of the partnership, would seem to signal the positive potential of similar systems-based collaborations. Even the one LHD leader who declined study participation because of competing obligations, as a gesture of support for the project, made her facilities available for meetings of the *Partnership Steering Committee*. Although the collective effort of the local government partners was sufficient to accomplish the aims of the project, it is noted that there was considerable variability in LHD success in recruiting FBO participation. The differentiating factor seemed to be the extent to which prior informal relationships with the faith community already had been established. A systematic study of the barriers to and facilitators of LHD/FBO collaboration would seem a key focus for future research if this partnership model were expanded successfully.

Intervention Effectiveness

Rather than a true experimental design, a pre-experimental design was used in the study. The use of a concurrent control group to which PFA trainees randomly were assigned would have optimized internal validity and permitted greater confidence in inferences about intervention effectiveness. The investigators are encouraged by the findings, however, not only because of their direction, breadth, and magnitude, but also because they were generated within the framework of a (post-test only) design that acknowledged experts in these matters have described as appropriate and valuable when certain criteria are met, as they were in the project, namely, when “...multiple outcome variables are measured at posttest; contextual knowledge is rich, even if impressionistic; and, intelligent presumptions can be made about what this group would have been like”²⁸ According to the same source, additional scientific value is conferred to such studies when the design is made “...more complex by adding respondents’ posttest recollections of how they were at the pretest....”²⁸

Notwithstanding the above points, *history* and *maturation* often are rival causal explanations attending some post-test only designs.²⁹ *History*, or the possibility that *external* change-producing events other than the intervention could have occurred during the conduct of the training, is problematic when a long

Post-Training Applications to State Professional Volunteer Corps	Number
PFA trainees (Total)	178
PFA trainees submitting applications	56*
Percent applying/total trainees	31.5%

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Table 5—Trainee willingness to respond

*Number of applications submitted *immediately following* training sessions; data on number of deferred presentations not available.

period of time has elapsed between the pre- and post-assessments. Given the same-day assessment points in the present study, history does not seem a highly plausible explanation of observed results. *Maturation*, or the possibility that systematic *internal* (biological, psychological, etc) changes in trainees, (e.g., growing older, wiser, etc.) with the passage of time, independent of external events, can confound uncontrolled studies, but given the seven-hour length of the intervention, it seems unlikely that maturational variables influenced outcome data.

Ideally, an evaluation of a PFA training intervention would involve an *in vivo* assessment of competencies with disaster survivors or with other individuals experiencing acute crises, but the obstacles to realizing that aspiration are substantial. As a proxy for real-world competency assessment, the perceived *self-efficacy* construct used in the study has a long and laudable record as a strong mediating predictive variable for actual performance, particularly when *affirmation-of-capability* is combined with an assessment of *strength-of-belief*, as opposed to the less predictive potency of the more idiomatic term, *confidence*, when allowed to remain semantically non-specific relative to the extent or level of anticipated attainment.³⁰

Translational Impact

Maryland state’s policy change to accept lay members into its professional volunteer corps means that Workers’ Compensation and general liability coverage will be provided to the new Corps members when they are called upon to respond to a gubernatorially declared disaster. This policy change acknowledges the significant resource the faith/lay community can be in time of disaster, with its capabilities presumably enhanced by the training received through this project. Registering the volunteers provides the state with the ability to deploy the participants in an expeditious manner and better ensures an organized callout reflective of support needs, rather than the alternative of sometimes-problematic spontaneous responses.

Overall Multi-Level Significance

By bringing together key actors in the public health emergency preparedness system and jointly executing a program that empowers citizens to meet community emergency behavioral health needs without the widespread availability of professional disaster expertise, the investigators believe they have begun to establish a base of evidence for an approach that could have considerable public health significance. Considering that the results reported here are for PFA only versus results for PFA and the other one-day training and subsequent technical assistance workshops in community disaster

preparedness planning (see “*Guided Preparedness Planning*”), the significance is likely to be enhanced with the full, two-intervention program.

Presumably, if taken to scale, the approach embodies an innovative model of capacity building at multiple levels of societal impact, including neighborhoods, communities, townships, counties, and the state. Specifically, as a function of a project administered *ex novo* over a summer season: (1) *neighborhoods and communities* in each of the participating counties now have access to individuals trained in disaster mental health competencies who can directly provide and perpetuate training in emergency mental health services to the community; (2) *clergy and lay leaders of faith organizations* report benefiting from the opportunity to acquire specialized knowledge and skills for application not only in disasters, but also for use in their regular pastoral crisis intervention work with victims of everyday “mini-disasters”, (and their relationships with county health departments are strengthened, presumably resulting in increased trust); (3) *rural hospitals and other clinical facilities* potentially have, in the form of the increased congregational crisis-intervention capacity and more knowledgeable referral capabilities, a diversion mechanism for those persons—psychologically affected but physically uninjured—who otherwise, likely would consume resources needed for genuine medical emergencies; and (4) *county and state governments* now have their have their continuum of disaster workforce assets enhanced with an important new category of grassroots responders.

Conclusions

The project supports a systems-based partnership approach to enhancing capacity and capability of public health emergency

planning, where an academic health center facilitated alliances between local health jurisdictions and faith communities. Its outcomes were paraprofessionals ready, willing, and able to provide services to meet mental health surge in a culturally appropriate manner; policy change at the state level to recognize and protect the paraprofessionals; and enhanced community capacity to detect, respond, mitigate, and potentially prevent the mental health consequences of disaster.

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