

Psychological First Aid: A Consensus-Derived, Empirically Supported, Competency-Based Training Model

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Surges in demand for professional mental health services occasioned by disasters represent a major public health challenge. To build response capacity, numerous psychological first aid (PFA) training models for professional and lay audiences have been developed that, although often concurring on broad intervention aims, have not systematically addressed pedagogical elements necessary for optimal learning or teaching. We describe a competency-based model of PFA training developed under the auspices of the Centers for Disease Control and Prevention and the Association of Schools of Public Health. We explain the approach used for developing and refining the competency set and summarize the observable knowledge, skills, and attitudes underlying the 6 core competency domains. We discuss the strategies for model dissemination, validation, and adoption in professional and lay communities. (*Am J Public Health*. 2014;104:621–628. doi:10.2105/AJPH.2013.301219)

The beginning of the 21st century has seen considerable attention devoted to improving emergency response capabilities at the national, state, and local levels of the US public health emergency preparedness system. A daunting challenge has been planning for the disproportionately high volume of psychological (vs physical) casualties that attend natural, technological, and intentional hazards.^{1–7} Evidence suggests that many disaster survivors fail to receive the care they need⁸ and that care deprivation under such circumstances is associated with mental health morbidity and increased rates of suicide.^{9,10} The difficulty of managing disaster-occasioned surges of demand for mental and behavioral health services is further compounded by the shortage of able and willing responders.^{11–14}

An increasingly popular idea for enhancing surge capacity during disaster scenarios is to develop cadres of potential responders trained in mental and behavioral health management, including psychological first aid (PFA).^{15–19} The American Red Cross²⁰ and the World Health Organization²¹ provide PFA training programs, and the National Child Traumatic Stress Network and National Center for PTSD (posttraumatic stress disorder) distribute PFA field

operations manuals for both general audiences and specific fields. Specialized PFA curricula have been developed for people working with the homeless,²² those working in nursing homes,²³ Medical Reserve Corps volunteers,²⁴ faith and lay community leaders,^{15,16,25,26} and public health workers.²⁷

Despite the virtual cottage industry of PFA training activities and previous efforts to identify core competencies^{16,26–28} and trauma intervention principles,²⁹ current PFA training programs have significant shortcomings, including variability of content, format, and emphasis (with little motivation for standardization); learning objectives and outcomes defined in nonobservable constructs that preclude meaningful measurement; little external accountability for quality; and no in-depth analysis of the pedagogical principles for optimal learning and teaching of PFA competencies. The result is a dearth of qualified PFA-trained responders available for call-up during public health emergencies^{11,13,30} and no widely accepted model for training public health workers in PFA competencies.

We describe the development of a PFA training curriculum based on sound pedagogical principles applicable to a broad range of

learners, including midtier public health professionals and lay community members. The product is a component competency set of the Public Health Preparedness and Response Core Competency Model,³¹ a proposed national standard of behaviorally based, observable skills for the workforce to prepare for and respond to all-hazards scenarios. The project was conducted as part of a larger effort by 14 Preparedness and Emergency Response Learning Centers (PERLCs) in accredited schools of public health. These centers, funded by the Centers for Disease Control and Prevention (CDC), aim to develop knowledge, skills, and attitudes (KSA) content for each of the competency statements in the model.³² The project could serve as a basis for enhancing consistency in preparedness training curricula and fulfilling mandates in the Pandemic and All-Hazards Preparedness Act 2006.³³

METHODS

Faculty representatives (the authors) from 4 PERLC-awarded schools of public health were selected to develop subcompetency statements and KSAs to foster learning of proficiencies in providing PFA and in preventing levels of secondary stress, which are subsumed under “Model Leadership Competency 1.2.” (The 3 other competency domains, each with 3 to 6 subcompetencies, are “Communicate and Manage Information,” “Plan for and Improve Practice,” and “Protect Worker Health and Safety.”) The participating institutions were as follows (listed alphabetically):

- Bloomberg School of Public Health, Johns Hopkins University;
- College of Behavioral and Community Sciences, University of South Florida;
- College of Public Health, University of Iowa; and

- College of Public Health, University of Oklahoma Health Sciences Center.

Workgroup Operations

We crafted measureable statements for core and subordinate competencies of a PFA training model by blending the following 3 strategies.

Review of primary-source research evidence. We systematically reviewed data from published^{16,26,34} and ongoing PFA training research studies conducted at 2 of the participating institutions. Supported through numerous grants, including a CDC-funded Preparedness and Emergency Response Research Center (PERRC) award, these investigations have focused on the development and validation of KSA-based PFA competencies. The studies have incorporated a mixed-methods approach to evaluation, yielding data from pre–post scores on knowledge tests and pre–post self-reports of competencies acquired in trainee cohorts, and from interviews with community and health department collaborators in Eastern and Midwestern regions of the United States. From these field studies, we developed a draft of KSA constructs underlying 6 core competency and subcompetency domains of PFA—a translational PERRC research to a PERLC training initiative of the kind intentionally designed into these CDC-funded programs.

Search of peer-reviewed literature. We conducted literature searches in the Medline, PsycINFO, Google Scholar, and Thomson Reuters (formerly ISI) Web of Knowledge databases. Additionally, we performed literature searches using the Google and Bing search engines to locate PFA field guides, training programs, presentations, and other relevant gray literature. We evaluated the information yield to determine whether the content contained basic PFA tenets and tactics, cited purportedly crucial learning domains, or referenced additional published articles in peer-reviewed journals. This phase of the operations established that available PFA approaches, though often proposing relevant strategic goals, frequently fail to articulate the tactical competencies to achieve them.

Dissemination of drafts of the competency set and model training content. Drafts of the PFA competencies, subcompetencies, training

modules, and empirically derived component KSAs underwent refinement through iterative cycles of dissemination, feedback, redesign, implementation, and redissemination. Reviewers of early versions of the PFA competencies were members of PERRC and PERLC advisory groups, which were composed of representatives from the fields of education, environmental health, health care administration, local and state government, medicine, psychology, social work, and sociology. We uploaded later versions of the competency set to an Internet share site for review and input by members of the 14 other competency development committees of the CDC and the Association of Schools of Public Health (ASPH). Members of the CDC–ASPH KSA Consultative Committee vetted the current competency set.

Pedagogical Domains

The pedagogical framework used to assimilate the results of the overlapping strategies encompasses 3 main learning domains.

Cognitive domain: mental skills (knowledge). We used *Bloom's Taxonomy*,³⁵ which includes hierarchical cognitive categories from simplest to complex (e.g., knowledge, application, evaluation). We also incorporated advances from the more recent revision by Anderson and Krathwohl³⁶ delineating the interaction of knowledge dimensions (e.g., factual, conceptual, procedural) with cognitive processes (e.g., remembering, analyzing, creating). The taxonomies developed by Bloom and successors, which classify levels of thinking with different standards for each level, are used extensively and effectively in education and training activities.³⁷

Psychomotor domain: manual or physical activities (skills). This domain addresses operational aspects of competency and includes manipulative and motor skills,^{38–40} as well as social skills involved in effective interpersonal communication.

Affective domain: feeling or emotion (attitudes). Consistent with increasing calls for greater appreciation of affective learning outcomes for sustainable higher education,⁴¹ this domain focuses on important constructs that support the learning of knowledge and skills, such as attitudes, values, and motivations.⁴²

We developed KSA-based competencies and subcompetencies consistent with the schema of

Gebbie and Gill,⁴³ affirming the importance of competency statements possessing an action verb (observable or measurable performance of a worker), content (subject matter, type of performance, specific task), and context (limitations, conditions, or work environment).

RESULTS

The resulting product is PFA Competency Set 1.0, an 18-cell matrix of consensus-based, empirically supported KSAs constituting 6 PFA competency domains:

1. initial contact, rapport building, and stabilization;
2. brief assessment and triage;
3. intervention;
4. triage;
5. referral, liaison, and advocacy; and
6. self-awareness and self-care.

Table 1 provides the behavioral descriptions of the KSA-based subcompetencies constituting each competency domain. Important considerations about each domain that are not easily conveyed in a summary table are elaborated here.

Initial Contact, Rapport Building, and Stabilization

This competency domain encompasses KSAs useful in establishing a positive interpersonal relationship, however transitory, within which subsequent essential elements of crisis intervention and PFA may be optimally provided, including initial efforts to deescalate problematic emotions and behavior. Important knowledge elements revolve around understanding relational (vs technical) factors shown to facilitate interpersonal helping—for example, the ability to communicate empathy, warmth, genuineness, and positive regard.^{44–50} These nonspecific helper attributes can enhance the provider's technical interventions.

Of special value to effective helping is the ability to listen attentively and express empathy, skills that foster a sense of safe environment and reduce the chances of drawing erroneous conclusions about the kind of help the person wants or needs. Facilitative affective subcompetencies are evidenced through overt expressions of warmth and concern for the physical and

TABLE 1—Psychological First Aid (PFA) Core Competencies and Subcompetencies

Competency Domain	Core Competencies and Subcompetencies		
	Knowledge	Skills	Attitudes
Initial contact, rapport building, and stabilization (positions provider for optimal effectiveness and efficiency with other PFA competencies)	Describes the effectiveness of relational and technical influences on counseling and behavior change.	Applies principles of active and reflective listening skills, expressing empathy, and establishing rapport.	Expresses a positive manner of relating to others by being warm and nonjudgmental, and showing respect for people and their differences (e.g., ethnic, racial, age-related, political).
Brief assessment and triage (informs acute intervention)	Defines characteristics of functional vs dysfunctional behavior.	Performs screening and assessment to distinguish between functional vs dysfunctional behavior.	Reports that the screening and assessment is useful to discern between functional and dysfunctional behavior.
Intervention (assumes prior determination of actual or probable dysfunction)	Describes the importance of mitigating acute distress and fostering adaptive functioning and coping.	Applies intervention techniques for mitigating acute distress and fostering adaptive functioning and coping.	Expresses confidence in ability to perform techniques to mitigate acute distress and foster adaptive functioning and coping.
Triage (informs postacute referral for post-PFA interventions)	Describes triage criteria using a response-based triage system (i.e., immediate or delayed).	Demonstrates ability to recognize and differentiate individuals requiring immediate care from those who need no care (or whose care is considered deferrable).	Reports confidence in triage capabilities in situations characterized by high stress and uncertainty.
Referral, liaison, and advocacy (facilitates access to continued support or care, as indicated)	Describes mechanisms of liaison and advocacy and knowledge of referral resources.	Demonstrates timeliness and persistence in referring persons requiring more intensive care to appropriate postevent care providers and programs.	Expresses confidence in ability to make referrals, and serves as a liaison and advocate.
Self-awareness and self-care (a prerequisite for caring for others)	Identifies at least 5 possible signs of personal stress, burnout, and vicarious trauma, and knows at least 5 self-care principles and practices such as proper nutrition, exercise, and sleep.	Applies appropriate techniques for maintaining awareness of possible signs of personal stress, burnout, and vicarious trauma and for using self-care principles and practices to mitigate potential adverse effects.	Acts as a composed leader during crises by monitoring and managing personal stress, burnout, and vicarious trauma, and by using self-care principles and practices to mitigate potential adverse effects.

Note. The competencies were developed under the auspices of the Centers for Disease Control and Prevention and the Association of Schools of Public Health.

emotional comfort of distressed persons, and by being nonjudgmental and sensitive to issues of privacy and confidentiality.

Brief Assessment and Triage

Brief assessment and triage, which is ideally unobtrusive and typically brief in most acute disaster contexts, is a competency domain encompassing screening and assessment activities designed to differentiate functionally discrete subsamples of PFA recipients, and to determine acute (i.e., immediate) intervention needs; it is comparable to determining the need to stanch arterial bleeding in physical first aid. Assessment entails an initial screening effort to answer questions with a presumed binary answer (yes or no); for example, “Is there a problem requiring immediate intervention?”; “Is further exploration into a person’s capacity

for adaptive mental and behavioral functioning warranted?” If the screen indicates that additional appraisal is necessary, further assessment poses dimensional questions; for example, “To what extent do factors exist in which adaptive functioning is being, or may be, compromised?” Addressed here are characteristics such as degree of psychophysiological distress, cognitive and intellectual functioning, affective and behavioral expression, and interpersonal and material resources.

Differentiating functional and dysfunctional behavior rests on a general understanding of the human stress response^{51,52} and familiarity with the notion of activities of daily living and instrumental activities of daily living^{53,54}—constructs borrowed from psychiatric recovery and rehabilitation contexts that refer to everyday maintenance activities associated with personal

hygiene, homemaking, employment, financial management, and so on. This orientation is compatible with a resilience framework rather than a pathology orientation,^{55,56} and is considered more suitable for public health workers and lay PFA providers who may not possess a thorough knowledge of psychological constructs.

Intervention

The knowledge required for appropriate immediate intervention is based on understanding principles of mitigating acute distress by fostering adaptive coping, both to ameliorate acute distress and to forestall the development of enduring mental health problems such as posttraumatic stress disorder and protracted grief or depression. Core skills subcompetencies entail the ability to apply

interventions to modify aspects of the person's cognitive, behavioral, physiological, or emotional life that may be impairing function. For example, the PFA provider might seek to reduce a person's distress by using simple distraction, guidance, and advice giving, or might perform more advanced interventions, such as cognitive reframing and psychophysiological self-regulation approaches (e.g., diaphragmatic breathing).

Facilitative attitude and affective subcompetencies are revealed in provider statements that reflect an understanding that psychological distress is normally expected under many situations and that interventions, though typically not needed, can be performed with confidence.

Triage

Triage, as used here, denotes a decision-making process by which persons experiencing distress, including adversely affected responders and caregivers, are determined to need follow-up services or resources not available in the immediate setting, including clinical treatment of an intensity available only in a formal continuum of care. This postacute intervention triage function is differentiated here from the preacute intervention assessment and triage activity of Competency Domain 2. Triage proficiency assumes knowledge of behavioral or "response-based" criteria for identifying impairments to key activities of daily living and instrumental activities of daily living, and prioritization decisions based on such knowledge. The response-based approach may be distinguished from, but may be

combined with, an experiential, or event-based, approach to triage decisions, whereby certain aspects of the survivor's experience are considered predictors of posttraumatic disorders (e.g., level of trauma exposure).⁵⁷

Operational skill in differentiating individuals requiring immediate or higher-level psychological support beyond acute crisis intervention⁵⁸ depends on recognizing and reacting to criteria indicative of the need for a higher level of care intensity (Box 1).

Referral, Liaison, and Advocacy

Referral, liaison, and advocacy competencies are the operations by which effective connection to needed resources is achieved. Minimally, liaison entails connecting a person in crisis with competent resources for continued postacute care or support, including return to one's natural familial, social, workplace, community, or spiritual support system. Advocacy involves promoting, on behalf of the person in crisis, needed support and benefits from a third-party resource. Vital to these functions is the PFA provider's knowledge of when, where, and how to effect these person-resource linkages, as well as timeliness, persistence, and proficiency in following up on persons requiring more intensive assistance from postevent care providers and programs.

Self-Awareness and Self-Care

To maintain effectiveness, PFA providers have the responsibility of avoiding problematic levels of secondary stress (also referred to as burnout, vicarious trauma, or compassion

fatigue) associated with their caregiver roles.⁵⁹ Self-care should be considered a prerequisite for caring for others. Key areas of knowledge for prospective PFA providers are the functional domains in which stress may be exhibited: (1) vegetative (e.g., problems with sleep and eating), (2) affective (e.g., anxiety and depression), (3) cognitive (e.g., inability to concentrate or focus on tasks), and (4) behavioral (e.g., interpersonal conflict, social withdrawal, and problematic use of alcohol or drugs).

Logically, important self-care techniques for mitigating potential adverse effects in these 4 spheres include adhering to healthy nutrition principles, participating in a regular exercise regimen, establishing regular sleep and rest cycles, scheduling vacations and down-time for oneself, and participating in gratifying activities such as hobbies or social events with friends and family members. Core affective or attitudinal subcompetencies will be evident when PFA responders and organizational leaders maintain their composure during crises. Crisis responders tend to appraise their professional roles and encounters as less stressful if they possess high levels of perceived self-efficacy in their roles.⁶⁰

DISCUSSION

PFA Competency Set 1.0 is the first national curriculum for PFA training linked to KSA domains of a widely accepted pedagogical model. It represents progress in responding to the increasing number of students, teachers, organizations, and regulatory agencies who expect competency-based curricula,⁶¹⁻⁶⁵ and to the specific mandate in the Pandemic and All-Hazards Preparedness Act of 2006³³ to develop a competency-based program to train public health practitioners to performance benchmarks that promote public health preparedness and response. By incorporating universally applicable conceptual elements and operational experience from field trials, the framework is proving feasible and effective for the training of lay (nonpublic health, nonprofessional) PFA providers. Moreover, the content is consistent with empirically established principles of immediate mass trauma intervention: to promote a sense of safety, calming, self- and collective efficacy, connectedness, and

Response-Based Criteria Indicative of Need for a Higher Level of Care Intensity

Criteria

- Sustained neuromuscular immobility, freezing
- Traumatic psychogenic amnesia
- Dissociation, depersonalization, derealization
- Extreme sympathetic nervous system dysfunction (e.g., panic attacks, malignant arrhythmias)
- Dysfunctional parasympathetic nervous system arousal
- Lingering or dysfunctional guilt reactions (survivor guilt, responsibility guilt)
- Giving up (e.g., helplessness, hopelessness)
- Self-destructive ideation (e.g., suicidal or homicidal ideation)
- Any persistent interference with significant activities of daily living, including occupational interference
- Any significant interference with caretaking responsibilities

hope.^{29,66} Although the approach assumes that PFA should be available to all persons who want and need its component services, with the exception of persons observed to be a danger to themselves or others, it does not assume that administrations of PFA should be mandatory for all who have experienced a disaster or other public health emergency.

An obstacle to the adoption of any new competency set (and to the efficient diffusion of evidence-based innovations in public health in general) is the near-total absence of an extant infrastructure, or system, through which the requisite efforts might be accomplished.⁶⁷ Questions inherent to this challenge include the following: To whom should the competencies be disseminated? How should (training in) the competencies be implemented, and through which organizational linkages and supports? What steps should be followed to optimize the tailoring to, and evaluation with, prospective user groups and at-risk populations (e.g., children)? What pedagogical methods and media should be employed, and how will their respective effectiveness be documented? Through which private and public health infrastructures might translational impact be validated?

Although an in-depth consideration of these questions is beyond the scope of this report, PFA Competency Set 1.0 has been disseminated to public health and lay audiences, and practical issues have begun to be addressed systematically through a 5-category logic model⁶⁸ that would appear to be a promising framework for guiding future work:

1. Review and incorporate postdissemination feedback from members of key stakeholder groups (input);
2. Implement and evaluate the competency set with specific user groups (activities);
3. Develop customized tools and resources—for example, slides, handouts, manuals, guides to support delivery to and refinement with trainee cohorts (outputs);
4. Collect data to confirm increased disaster literacy and PFA response competencies of individual trainees (outcomes); and
5. Promote model uptake, diffusion, and translation to real-world public health emergencies (impact).

Application With Residents of Lay Communities

Adhering to the steps of the logic model, PFA Competency Set 1.0 has been disseminated to, and continues to be implemented with, lay community trainees. This application with populations envisioned to be public health extenders is being administered through partnerships composed of academic health centers, local health departments, and faith-based organizations. Evidence of the effectiveness of the current competency set, or its precursors, delivered through this systems-based infrastructure has been collected in multiple geographic areas of the United States (Illinois, Iowa, and Maryland), in varied residential locales (urban, suburban, and rural), and with several ethnic-racial groups (African American, White, and Hispanic) of different faiths (Christian, Jewish, and Muslim). Across all trial cohorts, significant pre–post changes in measures of KSA-linked PFA competencies and disaster literacy have been consistently documented.^{16,26,69–71}

Along with the data supporting the feasibility and effectiveness of the model, evidence of the translational impact of the PFA training framework is also emerging as community trainees who receive certificates of course completion are being registered as a new class of deployable disaster volunteers in selected state Medical Reserve Corps. For example, the leadership of the Maryland Medical Reserve Corps, initially limiting membership to health care workers with licensure in a state-recognized profession (e.g., psychologist, physician, nurse), has been collaborating with the authors in instituting a protocol whereby the lay, PFA-trained applicants are pre-identified, qualified, and approved as paraprofessional volunteers for future activation during public health emergencies. This private–public partnership model is viewed by state and local government officials as a viable, scalable approach to behavioral health surge capacity building. Box 2 summarizes the key steps currently being used to incorporate program trainees into the Medical Reserve Corps.

Application With the Public Health Workforce

The intent is to continue to implement a participatory approach^{70–73} to engaging

diverse constituencies in the process of advancing the competency set. Although dissemination and evaluation activities are well underway with community-based cohorts, there is limited evidence to date of the utility of PFA Competency Set 1.0 with public health workers. Accordingly, this report is a distribution and call for input to the broad public health community, complementing dissemination of the set to public health leaders in selected PERLCs and their networks of practice partners.

Limitations and Strengths

The limitations of this and all consensus-derived competency sets, even when supplemented by field validation, are readily acknowledged. They include the risk of excessive focus on elements, with corresponding inattention to patterns, synthesis, and matters of the whole.⁶¹ Disproportional attention given to specific competencies also runs the risk of ignoring the importance of situational problem-solving, critical thinking, and other emergent behaviors found to be critical in individual and community crisis response. As PFA Competency Set 1.0 is considered a base framework to be tailored to each setting of application, it is anticipated that awareness of these limitations can mitigate their potential for negative influence in future settings where it may be applied.

Achieving proficiency in the competencies will require training. Although the framework establishes a sound conceptual platform of training content, it does not prescribe the processes for imparting the content to individual trainee cohorts. Would-be adopters are therefore encouraged to offset this limitation by aligning module-specific learning objectives with information gathered from needs assessments and with best teaching practices. Implementers should make full use of traditional in-person formats (using large classroom, small group, train-the-trainer, and exercise-based formats), as well as more contemporary approaches, including synchronous broadcasting, online, and video–CD formats. Ideally, delivery methods will be stratified into culturally appropriate cognitive and behavioral approaches, with knowledge (and to a lesser extent attitudinal or affective) competencies being amenable to any of these approaches and skills

Current Protocol for Registering Psychological First Aid (PFA)-Trained Prospective Responders Into the Medical Reserve Corps of the State of Maryland

Chronological Sequence of Key Activities

Pre-PFA training

- PFA training organization notifies MPVC coordinator of training date, time, and location;
- MPVC Coordinator, or designee, confirms availability and intention to attend PFA training;

PFA training day

- MPVC representative sets up computer work stations for on-line applications at training site;
- MPVC representative gives a brief (10-15 min), lunch-time presentation about MPVC to all participants;
- Following receipt of certificates of course completion, PFA trainees submit on-line MPVC applications; MPVC representative provides technical assistance, as needed;

Post-PFA training day

- MPVC implements other (non-PFA-related) criteria for approving applicants (e.g., criminal background checks, photo-ID badges);
- In the event of a public health emergency, volunteers are called up and deployed (and have the benefits of professional liability and Workers Compensation insurance coverage).

Note. The Medical Reserve Corps of the State of Maryland is known as the Maryland Professional Volunteer Corps (MPVC), Office of Preparedness and Response, Department of Health and Mental Hygiene.

training more suitably delivered in person, using interactive teaching methods.^{74,75} It should be anticipated that some audiences will prefer in-person trainings and avoid the use of online technology. Those for whom participant reach and program sustainability objectives are priorities may prefer train-the-trainer formats.

Conclusions

Notwithstanding these shortcomings, PFA Competency Set 1.0 would appear to embody multiple advances for the field of PFA training, and its development is consistent with other competency initiatives to ensure accountability in public health education and training.^{61-65,76,77} Among its strengths, this new competency set (1) is appropriate for many types of psychological crises; (2) is suitable for training both professional and lay participants; (3) is applicable to a broad range of disaster events (thereby aligning with the national “all-hazards” preparedness mandate); (4) is pedagogically sound, anchored to state-of-the-art educational principles and comprehensive learning domains; (5) is “non-denominational” in ideological orientation, eschewing parochial theories of psychopathology (in favor of more neutral and utilitarian emphases on functionality and resilience); (6) builds on, rather than replaces, the contributions of foregoing PFA developers and investigators; and (7) by employing the use of

competency verbs denoting observable behavior, facilitates objective evaluation of proficiencies. ■

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Contributors

O. L. McCabe had lead responsibility for developing the overall article, including writing the initial draft of the 18-cell, psychological first aid competency matrix, searching and reviewing the literature, writing the content for the section “Initial Contact, Rapport Building, and Stabilization,” and writing portions of the Methods and Discussion sections. G. S. Everly Jr. led the writing of the sections “Brief Assessment and Triage,” “Triage,” and “Referral, Liaison, and Advocacy.” L. M. Brown led writing of the section “Intervention” and contributed to the development of the Methods section. A. M. Wendelboe had lead responsibility for searching and reviewing the literature on behavioral health surge and psychological first aid and for writing the introduction of the article. N. H. Abd Hamid led the writing of the section “Pedagogical Domains.” V. L. Tallchief led the writing of the section “Self-Awareness and Self-Care.” J. M. Links

edited the entire manuscript and provided original, substantive contributions to the Methods, “Pedagogical Domains,” and Discussion sections.

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No protocol approval was necessary because there were no human participants involved in the project.

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