

A mental health training program for community members following a natural disaster

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This study reports data on a disaster mental health training program to enhance the capacity of lay people from disaster-affected communities, to provide assistance to others following a bushfire disaster. Local facilitators conducted training sessions which were actively promoted within communities. Participants were asked to complete an anonymous pre- and post-training survey to obtain data on the impact and quality of the training program. Responses from 462 (80%) of 577 people who attended 39 sessions showed substantial and significant increases in key competencies including confidence in their abilities to detect difficulties coping in others and to provide assistance. The quality of the program and materials were rated highly. The findings of the evaluation provide support for the program as a beneficial, acceptable and feasible community-level intervention following disaster.

Fire and other natural disasters are known to have a significant impact on the mental health and wellbeing of community members,¹ and can precipitate greater cohesion but also conflict in the wider community.² Mental health is a key public health issue in disaster recovery that needs to be addressed as part of a wider community development approach to assist affected communities.^{3,4}

Following a disaster, the majority of people will not require specialist mental health services and can be expected to recover with reliance on personal resilience, family and community supports, and local assistance programs.⁵ Community members are a vital source of practical, emotional and social support to ameliorate the mental health effects of natural disasters.⁶ Both individual and community-level interventions can be guided by the following empirically supported principles: safety, calming, self- and community efficacy, connectedness and hope.⁷ More specifically, these interventions can draw on Psychological First Aid (PFA) which emphasizes listening (not encouraging disclosure as occurs in psychological debriefing), mobilising social support, addressing immediate needs and identifying individuals who may require more intensive support.⁴

Most disaster mental health training programs have been for practitioners rather than community members, and few of these have reported evaluation findings.⁸ One program for community members that has been published is Project CREST which was developed to address community mental health needs following the 1993 floods that affected St Louis, Missouri.⁹ In that study, mental health professionals trained more than 2800 community members in supportive listening, disaster coping, and referral skills during a 3-h training session. In rural and remote New South Wales, Australia, the Rural Adversity Mental Health

Program (RAMHP) operated from 2007 to 2010 to address drought-related mental health needs.¹⁰ In addition to community events and a free telephone support line, more than 3,000 people received mental health literacy training using the Mental Health First Aid program which has shown positive effects on knowledge, attitudes and confidence to assist others in non-disaster settings.¹¹ A limitation of the reports on these community-level mental health training programs following disaster is that they did not report data on the potential benefits for program participants or the quality of the program.

In February 2009, bushfires in the state of Victoria were one of the most lethal and damaging natural disasters in Australia's history, resulting in the death of 173 people and widespread destruction. To improve the knowledge and skills of community members to provide assistance to others who were having difficulties coping following this disaster, the Community Support Training Program (CSTP) was developed, implemented and evaluated as part of the government-led psychosocial recovery plan.

Design and Development

The program was funded by the Australian Government Department of Health and Aging, and developed and implemented by trauma, disaster and health promotion experts from the Australian Centre for Posttraumatic Mental Health (ACPMH), the Mater Hospital Brisbane and *beyondblue* as part of the Victorian Government's Bushfire Psychosocial Recovery Plan.¹² Further information about the program is available online.¹³

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Key activities of the program included:

- Formation of expert advisory and reference groups comprised of key government and non-government stakeholders to provide oversight and advice on the development and implementation of the program, including integration with other initiatives and existing resources.
- Extensive consultation with disaster recovery experts and key personnel from government and non-government organizations to assist with developing the program.

The target audience was lay people from the general community including people with a high community profile such as those working in disaster support and recovery roles, and members of local sporting and community organizations.

The learning objectives for participants were:

- To improve their knowledge of different psychological responses, common mental health problems, and individual, family and community-level reactions following disaster.
- To increase confidence in their abilities to detect clues that someone may be having difficulties coping, to ask questions and listen to that person, and to provide support to them.
- To improve their knowledge of how and when to refer people to professional support and of local services and supports.

The face-to-face training sessions were educational and provided an opportunity for discussion, reflection, and skill development. The sessions followed a structured session plan with scheduled group exercises and facilitated discussion. Versions of the program that were available were of 90, 120 and 180 min duration. The structure and duration of the program was designed to best meet the needs of community members, many of whom were dealing with demanding practical issues. Following the training, participants were supported via newsletters and emails for a further three to six months to reinforce key competencies and information about available services.

The program materials developed included:

- A Facilitator manual which included advice on preparing to run a session and engaging with local communities, session plans and schedules, and sample responses to frequently asked questions.
- A Participant manual which included useful information on disaster recovery and mental health supports.
- Participant handouts to provide advice on recovery from disaster.
- Audiovisual materials, including PowerPoint slides and a DVD of interviews with survivors of previous bushfires.
- Posters and other promotional materials.
- A webpage with training session dates and resources.

Delivery

Interested individuals registered for a session by contacting the local host. The promotion of the program within disaster-affected communities relied upon a community development approach that included proactive and sensitive engagement and collaboration with key community agencies such as local recovery committees, primary health services and community and sporting clubs.

Nine facilitators were recruited and formally trained and accredited in a single day to prepare them to run the training sessions. Facilitator prerequisites were a tertiary mental health qualification; two years minimum experience as a mental health practitioner; and previous experience of facilitating training sessions in community settings.

Prior to each training session, the project manager, facilitator and local host held a teleconference to brief the facilitator on local issues and the planned session. A meal was often provided to create an opportunity for community members to meet others in an informal way. Following each training session, the project manager contacted the facilitator to review proceedings and offer support and advice. Facilitators' experiences of running the sessions were shared via a monthly facilitator newsletter.

Participants learnt about common psychological and relationship problems (including risk and protective factors) following disaster, with the aim of reducing stigma and improving understanding and empathy for others in the community. In order to develop greater confidence and better skills to listen to and assist others, the program encouraged participants to consider and rehearse what they would say and do when approaching someone. The focus for participants was on assisting others, including active listening and encouraging them to seek professional help if necessary, rather than becoming experts in mental health diagnosis or treatment. Some simple tips discussed with participants to help them initiate and manage a conversation with another person included:

- Start with practical questions such as *"How is the clean-up coming along?"*
- Try to normalize the person's distress to encourage them to talk, for example you could say *"A lot of people have been having difficulties coping lately. How are you managing?"*
- Choose a time to talk when you are less likely to be interrupted and when you are available to spend some time with the person.
- There is no "right thing" to say, but try not to talk too much about yourself or use 'conversation stoppers' such as *"You should think yourself lucky, it could have been worse"*.
- If you identify that the person needs extra help, such as showing signs of a mental health problem, then the priority is to refer them to local services for assistance.

Participants were given the opportunity to rehearse "opening lines" when approaching someone, and were encouraged to incorporate these simple tips when initiating conversations with fellow community members.

Evaluation

To evaluate the effectiveness of the program, participants were asked to complete an anonymous survey to obtain pre- and post-training self-report ratings by participants on key competencies tied to the learning objectives of the training session, and post-training ratings on the quality of the session and materials. Ratings of key competencies were provided on a four-point scale: 1 = very little or none, 2 = a little, 3 = quite a bit and 4 = a great deal. Paired samples t-tests were conducted to compare pre- and

Table 1. Pre- and post-training ratings by participants on key competencies

Item	n	Pre-training	Post-training	t-test	p	Cohen's <i>d</i>
		Mean (SD)	Mean (SD)			
1. Knowledge of different psychological responses that people may have	459	2.58(0.70)	3.02(0.61)	t(457) = -14.17	< 0.001	0.67
2. Knowledge of common mental health problems	460	2.52(0.69)	3.02(0.58)	t(458) = -16.49	< 0.001	0.75
3. Knowledge of reactions that may be anticipated from the community, families, and individuals	459	2.55(0.72)	3.06(0.61)	t(457) = -15.14	< 0.001	0.72
4. Confidence in ability to detect clues that someone may be having difficulties coping	458	2.56(0.71)	3.05(0.61)	t(456) = -15.29	< 0.001	0.66
5. Confidence in ability to ask questions and listen to someone who may be having difficulties coping	456	2.64(0.79)	3.09(0.65)	t(454) = -13.60	< 0.001	0.55
6. Confidence in ability to provide support to people having difficulties coping	459	2.55(0.77)	3.06(0.63)	t(457) = -15.27	< 0.001	0.67
7. Understanding of how and when to refer people	454	2.50(0.82)	3.05(0.65)	t(452) = -15.40	< 0.001	0.67
8. Knowledge of services and supports available	462	2.48(0.84)	3.02(0.66)	t(459) = -14.74	< 0.001	0.62

Note: n may be less than 462 for some items due to missing data. SD, Standard Deviation; Scores for items 1 to 8 ranged from 1 (very little or none) to 4 (a great deal).

post-training participant ratings, and Cohen's *d* was calculated as a measure of the standardized difference between rating means at the two time-points.

In total, 51 training sessions were attended by 909 community members from April 2009 to December 2010. Surveys were completed by 462 (80.1%) of 577 eligible people who attended one of 39 sessions run between August 2009 and October 2010. The mean age of participants was 48.1 y (SD = 12.9) and the majority (60.4%) were women. Thirty-three (84.6%) of the training sessions delivered were of 180 min duration.

Comparisons between community members' pre- and post-training ratings showed substantial and significant increases in knowledge of post-disaster reactions and mental health problems; confidence in abilities to detect difficulties coping in others and to provide assistance; and knowledge of available services and supports and how and when to refer someone (see Table 1). Cohen's *d* values ranged from 0.55 to 0.75 which are indicative of moderate to large effect sizes. The similarity of scores for all items at both respective time-points may be indicative of response bias, such as the general tendency to avoid extreme response options. In addition, a typical pre-training mean score of 2.5 on a four-point scale may have inadvertently led to a ceiling effect on the post-training ratings.

The large majority of community members who attended the program rated the quality of the program and materials highly, with at least 98% indicating that they agreed or strongly agreed with the following: the session was interesting, the information was clearly provided, the discussion was useful, there was enough time for questions, the participant manual was user-friendly and a willingness to recommend the program to others.

The study findings provide support for the Community Support Training Program as a beneficial, acceptable and feasible community-level intervention as part of a coordinated and early mental health response to communities affected by the 2009

Victorian bushfires. Reports from community members indicated that the program increased key competencies to help them recognize when others may be having difficulties coping and to provide them with care and assistance. In addition, the quality of the program was rated very highly by the large number of people who attended local training sessions in the aftermath of a natural disaster. The acceptability of the program is further supported by the finding that almost all participants reported that they would recommend the program to others.

A limitation of the study is the lack of follow-up data to determine whether or not the training resulted in sustained improvement of participants' competencies, and whether or not the training program resulted in participants providing more or improved assistance to others at risk of mental health problems. To address this limitation, we are seeking to undertake a more extensive evaluation of the program that incorporates more direct assessment of community members' competencies and helping behaviors at follow-up.¹⁴ Ideally, more sophisticated testing of the effectiveness of the training program would include a control or comparison group using an experimental research design.

There are a number of strengths of the program and its evaluation. First, the program demonstrated that there are excellent opportunities for governments to partner with non-government agencies and local communities on disaster mental health training programs for community members. Second, the delivery of the program used a community development approach that relied upon collaboration with existing community networks and recovery systems in order to facilitate delivery of the program by local trainers. This type of approach is consistent with wider efforts to protect and develop the adaptive capacities of disaster-affected communities.⁶ Third, quality assurance measures for this program included governance arrangements to ensure coordination and integration with other disaster recovery initiatives and existing resources; design of the training sessions and

materials by an expert group comprised of trauma, disaster and health promotion experts; and recruitment of trainers who met minimum prerequisite mental health and training qualifications. Fourth, the program met minimum standards of disaster mental health training programs by making explicit the objectives, target audience, training topic and focus, means of delivery, measurable outcomes, and evaluation procedures.⁸ Finally, the study used quantitative measures of participants' competencies to make comparisons between the pre-and post-training time-points.

Since the implementation of the program as part of the psychosocial response to the 2009 Victorian bushfires, the program has been modified for use in the aftermath of other types of natural disaster, and has subsequently been delivered in several other disaster-affected regions across Australia with an expanded pool of facilitators. This provides an important opportunity to further evaluate the effectiveness of the program.

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Disclosure of Potential Conflicts of Interest

No potential conflicts of interest were disclosed.

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Human Participant Protection

We did not seek an ethics committee to review the program evaluation because the data collected were for quality assurance purposes only and posed no risks and minimal burden on participants.¹⁵