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Original Article

# Assessment of Need and Readiness for a Post-Disaster Psychological First Aid Course in Barbados

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**Abstract** *This study was conducted to assess the readiness and need of community personnel to be trained to deliver psychological first aid (PFA). The assessment of readiness qualitatively measured knowledge of PFA, engagement in health-related matters, available resources, and community engagement. Need for training was determined by the frequency of responses to disaster scenarios and the level of self-efficacy during the response. The survey was constructed in REDCap and disseminated to leaders and members of faith-based organizations, educational institutions, healthcare facilities and district emergency offices. Data was collected during November and December 2021, and summary statistics were performed within REDCap. The review of the collected data revealed most respondents had never heard of PFA; however, they intuitively performed key elements of PFA such as listening and assessing need. The majority engaged in health-related matters by either hosting or attending health seminars. Some respondents had training or experience in responding to natural disasters, and could access physical resources (e.g., safe counseling spaces). Participants reported positive relationships with surrounding communities, describing them as respectful and cooperative. There were frequent opportunities to respond to emergencies (e.g., hurricanes and domestic violence), however, the majority did not feel fully prepared to do so. Over 90% agreed they would attend a PFA course. This study demonstrated the need and readiness for community members to be trained to administer PFA. Additionally, responses highlighted untapped potential within the community and a need to harness these resources for rapid mobilization for disaster response.*

**Keywords:** Psychological First Aid, Psychosocial Support, Stress First Aid, Community Resilience, PFA training.

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# INTRODUCTION

Small Island Developing States (SIDS) generally share a common set of vulnerabilities that are barriers to sustainable development. Structural factors, including size, remoteness, limited resources, lacking economies of scale, and elevated and increasing climate and natural disaster risks, are threats to individual and community health (Sachs et al., 2021). The Caribbean is particularly vulnerable to natural hazards (e.g., hurricanes, earthquakes, volcanic eruptions), and vulnerability is increasing due to global climate change (Pan American Health Organization, 2012; Thomas et al., 2020). There is recognition that comprehensive, multidisciplinary efforts are needed to develop and implement measures for climate mitigation and adaptation in the health sector (Drewry & Oura, 2022).

Both acute and creeping climate threats impact mental health in SIDS (Kelman et al., 2021). In the Caribbean, mental health professionals have begun to grapple with the implications of climate vulnerabilities in clinical, research, and policy arenas (Campbell & Greaves, 2022). The COVID-19 pandemic has further contributed to negative social, economic, and health outcomes in SIDS. Associated threats to mental health have been documented in the Caribbean (Garcia-Cerde et al., 2021; King & Devonish, 2021; Seon et al., 2023). The threats that climate and related events pose to mental health, and the downstream barriers to broader socioeconomic recovery, are likely to persist and require sustained efforts to promote resilience in the Caribbean (Cortés et al., 2020; World Health Organization, 2019). In this briefly elaborated context, efforts to support mental health are both intrinsically worthwhile to mitigate individual distress experienced by Caribbean people and an integrated component of broader resilience for the Caribbean region.

Almost all people affected by a disaster will experience psychological distress, but the scope and intensity of psychological disturbance is influenced by internal and external factors: type of disaster/emergency, availability of community support, physical health status, coping techniques, cultural background, and mental health history (Pan American Health Organization, 2012). Some people are more vulnerable in emergency/disaster situations and therefore will require additional psychosocial support (Pan American Health Organization, 2012; World Health Organization, 2019).

First responders and key community members can play a crucial role in identifying, reassuring, and referring, if needed, people experiencing psychological distress. Training key personnel and community members in basic mental health skills is therefore an important component of recovery and resilience (Clements & Casani, 2016). The Inter-Agency Standing Committee (IASC) has developed comprehensive guidelines for mental health and

psychosocial support that can be implemented by a broad range of essential workers in emergency settings (Inter-Agency Standing Committee, 2007).

Psychological first aid (PFA), which provides focused, non-specialized support for persons who may benefit from intervention beyond basic services and security, is a key element of these guidelines (Wang et al., 2021). PFA is an evidence-informed intervention that departs from problematic psychological debriefing models to provide a humane, supportive framework with the dual purpose of (1) helping a person in distress to feel calmer and be able to cope and (2) referring distressed individuals for additional support based on their needs. In SIDS, where specialized mental health services are often limited, the role of emergency responders, essential workers, and community members in psychosocial intervention is especially important.

Research on the effectiveness of training in PFA models is expanding, and there is growing evidence supporting application of PFA curricula (Wang et al., 2021). Three prominent PFA models employed in research and practice in emergency and disaster settings include: The National Child Traumatic Stress Network Psychological First Aid Field Operations Guide, the Johns Hopkins Guide to Psychological First Aid and World Health Organization (WHO) Psychological First Aid (American Psychological Association, 2006; Everly & Lating, 2017; World Health Organization, 2011). Of these three leading models, the WHO framework is the most international in scope and intent, with contributions from sixty international peer reviewers and endorsements from dozens of humanitarian relief organizations. Further, the WHO model was intentionally designed for use in resource-limited settings, particularly low-to-middle-income countries (LMICs). The WHO PFA protocol has undergone several adaptations including the development of The Pan American Health Organization (PAHO) course, "Psychological First Aid in Disaster Management in Caribbean Settings," which contains regionally and culturally relevant language, content, and illustrations. In this paper, we describe the readiness and training needs of individuals and organizations in Barbados for the PAHO PFA course.

# METHODS

This study was approved by The University of the West Indies/Ministry of Health and Wellness of Barbados Institutional Review Board.

### Participants

Participants were chosen by convenience sampling from among leaders and members of first responder and community groups in Barbados, namely faith-based organizations (FBOs), schools, healthcare workers (HCWs) and district emergency organizations (DEOs).

### Data collection

There were two versions of the survey instrument: one for leaders of community and faith-based organizations and the second for individual participants. Both the organizational survey and the individual survey were divided into two sections: (1) assessment of readiness which was guided by the Consolidated Framework for Implementation Research (CFIR) and comprised a composite of (a) knowledge of PFA (b) engagement in health-related matters (c) resources, and (d) community engagement; and (2) assessment of need which examined the frequency with which organizations or individuals responded to disaster situations and how equipped the felt during the response (CFIR, 2019).

Information regarding the study was disseminated via online flyers and invitational emails to addresses provided by key contacts. The survey was configured in the REDCap data collection and management system hosted at The George Alleyne Chronic Disease Research Centre (GA-CDRC), and a link to the online survey was embedded within the flier and emails. Data was collected between the months of November and December 2021. Summary statistics were calculated using REDCap.

## RESULTS

There were 368 unique record entries. Ninety-seven percent (344) respondents completed the consent page and were directed to their choice of organizational or individual questionnaire; 88% were completed by individuals and 12% by representatives of organizations. Survey findings are summarized in Table 1.

### Organizational leader survey

The 40 organization records comprised leaders from: Education (55%), faith-based organizations (FBOs) (23%), non-governmental organizations (NGOs) (14%), healthcare workers (HCWs) (5%) and Guides and Scouts (5%). When sub-stratified by religion, FBO respondents comprised 80% from Christian and 20% from Muslim communities. Age group ranges were collected for organizational respondents as follows: 19-34, 35-44, 45-54, 55-64, >65. The majority (60%) of respondents were between 35 and 64 years, and 76% were female.

*Assessment of readiness*

(1) Knowledge of PFA

Seventy-six percent of organization leaders reported they had never heard of PFA; however, when probed regarding the principles of PFA, the majority agreed they could identify people in distress (90%), were good

listeners (90%), were comfortable assessing and prioritizing the health and social needs of people (71%) and could identify the mental health services in their vicinity (70%). All respondents (100%) reported that people generally felt safe around them.

(2) Leadership engagement in health-related matters

Eighty-one percent of organization leaders noted that their organizations provided education on health-related topics in the last year (or the year prior to COVID), including diabetes (35%), hypertension (24%), cancer (24%), and mental health (77%). Forty percent of organizations had a designated health education officer, 75% of whom possessed health qualifications including doctors and community nurses. Ten percent of organizations had a budget set aside for training in health-related matters. Should the opportunity arise to attend a PFA training course, 100% of leaders reported that they would do so and 95% said they would encourage members / staff of their organization to attend.

(3) Resources

*Human Resources:* There was a wide range of number of members per organization (<50 to >300) and ages (<25 to >75 years). Ninety percent of organizations comprised more females than males; 66% included members who had experience in health, social work, or counseling; and 35% had members with specific training in disaster or mental health crisis response from various institutions. including tertiary-level institutions and the Red Cross. In addition, 40% had members with previous experience in responding to disaster situations with FBOs, Red Cross, or District Emergency Organisations (DEOs).

*Physical resources:* Ninety-five percent of organizations indicated they could provide a safe space for counseling.

*Relationship with the health sector*: 56% of the organizations were engaging or had engaged in collaborations with the health sector.

(4) Community engagement

Forty-one percent of leaders indicated that <25% of their members were from the community or neighboring communities where the organization was situated. They described their organization's relationship with their community variously as respectful ("trust and understanding" (61%)), cooperative ("I am fine working with them" (44%)), integrated ("I am fully involved (28%)), mutually tolerant ("we agree to disagree" (22%)), and indifferent ("neither here nor there" (6%)). No respondents indicated that their organization's relationship with the community was characterized by animosity ("I can't stand them" (0%)). Organizations either provided or facilitated social programs for the community such as support groups

(39%), cooking classes (8%), reading/ study groups (15%), singing/music classes/dance groups (8%), youth groups (31%) and feeding assistance programs (62%).

*Assessment of need*

One third of organizations reported that they frequently have opportunities to provide psychological support in a wide range of situations, with the most common scenarios being hurricanes (47%), domestic violence (40%), medical emergencies (33%), and sexual assault/violence (33%). However, no participants thought they were fully prepared. Just over half thought they were either very or moderately prepared.

**Individual member survey**

The 301 respondents included members of organizations in the following categories: education (51.9%), HCWs (23.8%), FBOs (13.4%), NGOs (2.2%), DEOs (2.2%), Guides and Scouts (0.4%), and armed/uniformed services not affiliated with any of the preceding groups (0.9%). When sub-stratified by religion, FBO members were 96.8% Christian and 3.2% Muslim. Age group ranges were collected for individual respondents as follows: 19-34, 35-44, 45-54, 55-64, >65. There was a relatively even distribution (30%) among the 19-34, 35-44, and 45-54 age groups, with fewer respondents in the 55-64 and over 65 age groups. Eighty-four percent of respondents were female.

*Assessment of readiness*

(1) Knowledge of PFA
(participants used three point Likert scale: 'Agree/Neutral/Disagree')
Seventy percent of individuals reported they had never heard of PFA; however, when probed regarding the principles of PFA, the majority agreed they could identify people in distress (70%), were good listeners (80%), were comfortable assessing and prioritizing the health and social needs of people (69%), and that people generally felt safe around them (91%). Less than half (48%) could identify the mental health services in their vicinity.

(2) Personal engagement in health-related matters
(three-point Likert scale 'Agree/Neutral/Disagree')
Fifty-six percent of individuals attended training on health-related matters in the last year (or the year prior to COVID), topics included diabetes (34%), hypertension (30%), cancer (21%), and mental health (72%). Should the opportunity arise to attend a PFA training course, 96% of individuals reported that they would attend.

(3) Personal resources
(three-point Likert scale 'Agree/Neutral/Disagree')
51% of individuals had experience in health, social work, or counseling, and 35% had specific training in disaster or mental health crises from various institutions, including tertiary level institutions and the Red Cross. Three (5.2%) had completed the PAHO PFA course. Nineteen percent had previous experience in responding to disaster situations with FBOs, the Red Cross, and DEOs.

(4) Community engagement
(descriptive multiple-choice responses)
The relationship between the individual and the community was described as respectful (41%), cooperative (56%), integrated (17%), mutually tolerant (8%), indifferent (7%). No respondents indicated their relationship with the community was characterized by animosity.

*Assessment of need*

Participants responded using a six-point Likert scale, 'Very frequently, frequently, occasionally, rarely, very rarely, never'.
A quarter of individuals reported that they frequently have opportunity to provide psychological support in a wide range of situations, the more common ones being medical emergencies (35%), domestic violence (31%) and sexual assault/violence (26%). One third indicated they were moderately prepared to provide psychological support to those in need. Ninety percent were interested in attending a two-day training course in PFA.

**Table 1**

***Summary of Survey Findings***

| | n (%) | |
|---|---|---|
| | Organization 40 (12) | Individual 301 (88) |
| **Organization represented** | | |
| FBO | 5 (22.7) | 31 (13) |
| HCW | 1 (4.5) | 55 (24) |
| Education | 12 (54.5) | 120 (52) |
| NGO | 3 (13.6) | 5 (2) |
| Guides and Scouts | 1 (4.5) | 1 (0.4) |
| Armed/uniformed forces not belonging to any of the above | -- | 2 (0.9) |
| District emergency organization | -- | 5 (2.2) |
| Other | -- | 12 (5.2) |
| **Assessment of readiness** | | |
| Knowledge of PFA | | |
| • never heard of PFA | 16 (76) | 156 (70) |
| • could identify people in distress | 19 (90) | 160 (69) |
| • good listeners | 19 (90) | 185 (80) |
| • comfortable assessing & prioritizing health & social needs | 15 (71) | 157 (69) |
| • People generally felt safe around them | 21 (100) | 210 (91) |

| | | |
|---|---|---|
| • identify the mental health services in their vicinity | 14 (70) | 112 (49) |
| Leadership / personal engagement in health | | |
| • taught / attended health-related topics in the last year | 17 (81) | 125 (55) |
| • have a health education officer | 8 (40) | -- |
| • has a budget for training in health-related matters | 2 (10) | -- |
| • would you attend a PFA training course | 21 (100) | 221 (96) |
| • would encourage members to attend a PFA course | 20 (95) | -- |
| Resources | | |
| *Human / personal resources*: | | |
| • (members with) experience in health/social work/ counseling | 16 (76) | 90 (51) |
| • (members with) training in disaster or mental health crisis | 7 (35) | 60 (34) |
| • (members with) experience in responding to disasters | 8 (40) | 41 (18) |
| *Physical resources:* | | |
| • safe space for counseling | 19 (95) | -- |
| *Relationship with health sector (past or current)* | 10 (56) | -- |
| Community engagement | | -- |
| • % members from the community | | |
| o <25% | 7 (41) | |
| o 25-50% | 2 (12) | |
| o 51-75% | 1 (6) | |
| o >75% | 3 (18) | |
| • Relationship with community | | |
| o respectful | 11 (61) | 90 (41) |
| o cooperative | 8 (44) | 123 (56) |
| o integrated | 5 (28) | 36 (17) |
| o mutual tolerance | 4 (22) | 18 (8) |
| o indifference | 1 (6) | 6 (7) |
| o animosity | 0 (0) | 0 (0) |
| • provide/facilitate social programs for the community | | |
| o support groups | 5 (39) | -- |
| o Cooking classes | 1 (8) | |
| o Reading / study groups | 2 (15) | |
| o Singing/music classes/dance groups | 1 (8) | |
| o Youth groups | 4 (31) | |
| o Feeding / assistance program | 8 (62) | |
| o Other | 3 (23) | |
| **Assessment of need** | | |
| Opportunity to provide psychological support to people in crisis | | |
| • Very Frequently | 4 (22) | 14 (6) |
| • Frequently | 2 (11) | 48 (21) |
| • Occasionally | 2 (11) | 84 (37) |
| • Rarely | 3 (17) | 38 (17) |
| • Very Rarely | 3 (17) | 24 (10) |
| • Never | 4 (22) | 22 (10) |
| Situations include | | |
| • Hurricanes | 7 (47) | 45 (23) |
| • Volcanic activity | 3 (20) | 8 (4) |
| • Medical emergencies | 5 (33) | 68 (35) |
| • Violent crime | 4 (27) | 15 (8) |
| • Domestic Violence | 6 (40) | 59 (31) |
| • Sexual Assault/Violence | 5 (33) | 51 (26) |
| • Fire | 3 (20) | 8 (4) |
| • Grief and loss | 8 (53) | 143 (74) |
| • Military deployment | 0 (0) | 4 (2) |
| • Support for first responders | 1 (7) | 8 (4) |
| • Other | 2 (13) | 28 (15) |
| Preparedness to provide psychological support | | |
| • Extremely | 0 (0) | 19 (8) |
| • Very | 3 (16) | 54 (24) |
| • Moderately | 7 (37) | 76 (33) |
| • Slightly | 7 (37) | 64 (28) |
| • Not at all | 2 (11) | 17 (7) |

## DISCUSSION

Although the PAHO PFA course for the Caribbean was launched several years ago, the majority of respondents, including HCWs and DEOs, reported that they had never heard of PFA. Currently, the course is offered as a self-paced, online learning resource. Although asynchronous virtual learning may increase accessibility and convenience, the modality has downsides, including risks that potential participants remain unaware of the site; that taking extended time to complete the course may negatively affect consolidation of knowledge; and that opportunities for live practice are not provided. Therefore, the online course may benefit from active recruitment of participants from key populations and inclusion of a live companion learning activity facilitated by mental health professionals. Another finding of the current study is that, although many participants were unaware of the term "PFA," the majority practiced core elements of PFA (active listening and providing a safe space for persons in distress). This underscores the necessity of bringing structure to the tacit knowledge and skills that reside in the community. This survey also demonstrated that a significant proportion of organizations and individuals were ready to offer PFA based on their previous training and the physical resources available; however, the majority did not feel ready to offer PFA. This points to deficits in self-efficacy and, again, highlights the untapped potential within the community.

Although previous studies have shown that PFA training improves learning (knowledge, skills), behavior (self-efficacy, resilience), practice, and satisfaction in a cross-section of participants, including HCWs, first responders, and community personnel, few studies have investigated the need for such an intervention (Everly et al., 2014; Kılıç & Şimşek, 2019; Wang et al., 2021).

With need and readiness established in our population, the next step is implementation of the course. Cultural adaptation has been shown to facilitate successful implementation (Castro et al., 2004). Although the PAHO PFA has been adapted to the Caribbean, further tweaking to improve fit to the Barbadian context can be made. Adaptations can be made to both context (e.g., having a facilitator-run course instead of the self-paced models) and content (e.g., including disaster scenario role plays). Future work should consider integrating PFA with other post-disaster guidelines as a means of creating a comprehensive course for community personnel whereby they can be trained in multiple areas to leverage assets in resource-limited regions.

A wide cross-section of community organizations and individual members in Barbados have expressed need and readiness to be trained to offer PFA. The community contains untapped potential which can be formalized into a register of resources which can be mobilized in response to natural disasters

and emergencies. Community-based PFA training is an important component of building capacity for comprehensive disaster response.

## LIMITATIONS

This study relied on convenience sampling for participant recruitment. This method of sampling was selected given the need for cost effectiveness and time efficiency. It also allowed for engagement of known key community groups and stakeholders. Invitations for survey participation were sent to leaders and members of healthcare organizations, first responder groups and community groups.

While convenience sampling is a commonly used method in qualitative research, with clear advantages in the context of the objectives of this study, it may increase the probability of bias. A more even distribution of individual participants and organizations would have improved the sample diversity of the study.

The representation of participants from faith-based organizations (FBOs) revealed the majority of participants were from Christian (80%) and Muslim (20%) organizations. While Barbados is considered a predominantly Christian society, and Christian and Muslim organizations comprise a significant majority, the researchers would have failed to capture data from the other, less represented Faith Based groups on the island.

Another potential limitation may be related to the descriptive design of the research. The surveys provided invaluable insight into the needs and readiness for PFA training among participants. The results also provide a useful platform upon which to base implementation of PFA training and build further research. However, the findings provide a brief appraisal of the needs and readiness of participants and organizations that may not be generalizable to groups not captured in this study.

## IMPLICATIONS FOR CULTURAL PSYCHIATRY AND GLOBAL MENTAL HEALTH

Psychological First Aid (PFA) has been recommended and endorsed by many international bodies, including the Inter Agency Standing Committee (IASC) and the World Health Organization (WHO), as a humane supportive framework for assisting fellow human beings after crisis events. There are many iterations of PFA in various jurisdictions, with a culturally adapted Caribbean version of PFA available as a virtual self-paced course offered by PAHO.

Barbados is a small island developing state in the Caribbean facing increasing natural disasters as a result of the climate crisis. In this context, building capacity for mental health and psychosocial support systems, of which PFA is a key component, is a crucial part of disaster preparedness and response. Prior to the efforts described in this paper, no established, in-person, culturally adapted PFA training was available in Barbados. Further, knowledge pertaining to the needs and readiness of key community groups to be trained in and provide PFA was lacking.

The present findings therefore serve to inform cultural adaptation and implementation of culturally responsive PFA to best suit the needs of Barbadian society. The knowledge gained through this study is an initial step toward further research supporting development and implementation of evidence-based mental health and psychosocial supports as Barbados confronts increasing vulnerability to climate threat.

## AUTHOR CONTRIBUTIONS

K.K.D. Conceptualization; Methodology; Investigation- data collection; Writing - Original Draft; Writing-Review & Editing; Resources- study & reference materials; Funding acquisition.

M.H.C. Conceptualization; Methodology; Investigation - data collection; Resources-Study and Reference Materials; Writing-Original Draft; Writing-Review & Editing.

M.K.E. Conceptualization; Methodology; Investigation - data collection; Writing- Review & Editing.

H.H. Conceptualization; Methodology; Investigation - data collection; Writing-Review & Editing, Project Administration.

K.F-S. Conceptualization; Methodology; Investigation - data collection; Writing - Review & Editing.

K.R.Q. Conceptualization; Methodology; Investigation - data collection; Analysis, Writing-Original Draft; Writing-Review & Editing, Project Administration.

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## CONFLICT OF INTERESTS

M.H.C. is a member of the Editorial Board for WCPRR.

K.K.D receives payment from the Ministry of Health and Wellness, Barbados for continued implementation of PFA training.

There are no other conflicts of interest to declare.

## DATA AVAILABILITY

The data from the current manuscript are not publicly available but are available from the corresponding author on reasonable request.

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