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COMMENTARY

A COVID-19 Call to Action: Psychological First Aid Training for Medical Professionals and Trainees

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Ever since COVID-19 began to spread in early 2020 with its medical, psychosocial, and economic ramifications, it has posed an ominous threat to global mental health [1]. During the peak of the pandemic, one-third of the world's population, approximately 2.6 billion people, were required to live under quarantines [2].These isolating conditions have exacerbated dangerous social situations; as such, domestic abuse hotlines and suicide hotlines have become more utilized [2]. Internationally, racism and xenophobia have intensified towards people of Asian ethnicity since COVID-19 was first reported in China [2]. Economically, industries have struggled to remain afloat; the World Bank, Reuters, and the World Resources Institute estimate approximately 100 million people internationally will lose their jobs and income [2]. By 2029, the economic downturn alone will likely result in 75,000 more Americans dying from substance abuse and suicide [3]. Indeed, the COVID-19 pandemic, fear for one's life, mass isolation, financial distress, increased racism, and overall uncertainty of the future synergistically combine to create an intensely toxic milieu which is extremely conducive to the development and exacerbation of psychiatric disorders. In March 2020, about one-third of American adults experienced sufficient distress from the pandemic to worsen their mental health; by July 2020, the number had risen to over half of American adults [3]. Within about 1 year, the amount of Americans experiencing anxiety symptoms and depressive symptoms tripled and quadrupled, respectively [4]. Of the adults experiencing mental health impairment during the pandemic, more than one-third had sleeping concerns, around one-third had eating concerns, over one-tenth had increased alcohol intake or recreational drug use, and one-tenth experienced suicidal ideation in 1 month [3]. In the USA, firearm and alcohol commerce has skyrocketed [2]. Populations especially susceptible to mental health distress from the pandemic include essential workers, young adults, minority populations, unpaid caregivers, patients previously diagnosed with psychiatric illness, and those diagnosed with COVID-19 and medically vulnerable to COVID-19 [4, 5]. Healthcare professionals are also extremely vulnerable to mental health worsening, as the pandemic has been compounded by the scarcity of life-saving resources, the excessive working hours, the emotional toll of limited knowledge in caring for extremely ill patients, isolation from loved ones for their safety and health, and the high risk and fear of contracting COVID-19 [5].

Incorporating Psychological First Aid into the COVID-19 Emergency Medical Response

The World Health Organization (WHO) and the United Nations (UN) recognize worsening mental health in the setting of COVID-19 as a global concern [3, 6]. Thus, the WHO and the UN are both recommending reducing barriers to mental healthcare access through the integration of mental healthcare into emergency COVID-19 medical relief efforts and the advancement of telepsychiatry techniques [3, 6]. These necessary recommendations would be best fulfilled by providing further training in triage mental healthcare referred to as Psychological First Aid (PFA), also known as Mental Health First Aid, to a large group of pandemic first responders: medical professionals, such as physicians.

For medical emergencies, particularly cardiopulmonary emergencies, Basic Life Support (BLS) training and certification prepares the trainee to perform life-saving cardiopulmonary resuscitation techniques in the event of life-threatening cardiopulmonary emergencies. Analogously, for psychiatric

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emergencies, PFA is an available and crucial intervention for (1) immediately recognizing potentially life-altering or life-threatening psychiatric crises or psychiatric ramifications of crises, (2) safely and effectively triaging the patients in the short-term, and (3) connecting the patients to longer-term professional mental health resources [7, 8].

While BLS's building blocks include training providers to become comfortable with correctly performing chest compressions and providing airway and respiratory support, PFA's five tenets include supporting "a sense of safety, calming, self-efficacy, connectedness (to resources and other impacted survivors), and hope" [8]. Notably, PFA helps with longitudinal post-traumatic recovery, regardless of whether the PFA-provider is a mental healthcare professional [9]. Furthermore, just as BLS requires the provider to have adequate physical health to endure high-intensity physical exertion, one crucial aspect of PFA is Psychological PPE, recognized as implementing personal, interpersonal, and systemic measures, such as guided mindfulness activities and support groups, to care for and protect the PFA-provider's own mental health [8, 10]. With these PFA principles, the PFA-provider's mission is to "mitigate acute distress and instill hope" [11].

The steps of PFA can be remembered with the mnemonic *ALGEE* [7]. ALGEE reminds the PFA-provider to first privately "Approach" the patient who may be having a mental health emergency, "Assess" the patient's safety, "Assist" the patient within the current potentially dangerous emergency environment, "Listen non-judgmentally" to the patient's experiences and concerns, "Give support and information" for the patient, and lastly "Encourage" that the patient follow-up with a professional mental healthcare provider, and "Encourage" other means of mental health support services [7]. Concomitantly, the PFA-provider should be cognizant and sensitive to the patients' boundaries and comfort with the intervention and the provider [10]. The WHO has published an intensive manual for providing PFA in multiple languages [10, 12]. Additionally, there are many different organizations that provide PFA training and certification through different means, ranging from solo training to group training, in-person training to online training, and free training to training requiring monetary payment. Most of the trainings take a total of 6 hours and are interactive, simulating situations during which PFA would be helpful (Table 1).

One significant barrier to the provision of PFA includes the stigma associated with mental healthcare, making it more difficult for the medical community to embrace PFA and for patients to accept PFA. Furthermore, the success of PFA is also limited in that PFA is mostly a form of triage and the final ALGEE ("Encourage") relies upon referring the patient to longitudinal mental healthcare resources [7]. Access to follow-up and further longitudinal care unfortunately has obstacles, including difficulty in finding an affordable mental healthcare provider who accepts the patient's insurance and can accommodate new patients when the mental healthcare system is already overwhelmed by increased patient demand. Furthermore, the scarcity of mental healthcare providers in certain geographical regions, such as rural regions, can further exacerbate these hurdles to connecting the patient to long-term mental healthcare after PFA has been initiated. Notably, the expansion in creative techniques of providing mental healthcare, including telepsychiatry, is helpful in mitigating these challenges to implementing PFA effectively.

Although the effectiveness of PFA may be constrained in that it is short-term, not necessarily provided by mental healthcare professionals, and often requires proper follow-up with mental healthcare professionals, PFA remains very worthwhile [10]. Indeed, the randomized control trial for PFA delivered via the Johns Hopkins RAPID-PFA model with group counseling techniques was effective in lowering anxiety and negative emotions, as well as increasing positive mood [11]. In a trial of RAPID-PFA training, it was found that PFA leads to increased trainee education, readiness, and self-assurance for recognizing the need for PFA and triaging mental healthcare emergencies [13]. Per a systematic review of control trials and randomized control trials, PFA leads its trainees to have a better understanding of mental health and proper mental health support [14].

When nursing students were trained in PFA, it was found that they had increased confidence in both their ability to provide care for patients with psychiatric illness and their overall opinion of being readily equipped for the crisis at hand [15]. Public health researchers have encouraged expanding PFA training to nursing schools and to the general public lay-people of university students so that they may recognize and care for their own mental health and that of their peers [16, 17]. In PFA-trained pharmacy students, there was less stigmatization of psychiatric illness, better recognition of patients in need of mental healthcare, and more self-assurance in their ability to care for patients requiring mental healthcare [18]. Even though PFA-providers may not be mental healthcare professionals, PFA still advances mental healthcare knowledge and ameliorates shame and stigma associated with psychiatric illness. Thus, allowing for solely mental healthcare professionals to deliver basic emergency psychiatric care creates another hurdle to access. Just as many lay-people and non-medical professionals are BLS certified, many lay-people and non-mental healthcare professionals should be PFA certified to lessen obstacles to mental healthcare access [7, 19–21].

PFA is encouraged both domestically and internationally by the WHO, the UN, the American Red Cross, and the American Psychological Association, especially in light of the very current COVID-19 and mental health pandemics [10, 12]. Notably, in honor of World Suicide Prevention Day and in recognition of the pandemic's negative impact on mental health, Director of the National Institutes of Health Dr. Francis Collins facilitated a lecture, "Psychological Aspects of Pandemic and Human

Table 1 Situations during which psychological first aid (PFA) may be applied

ALGEE mnemonic	Example 1: Patient experiencing a panic attack in the setting of unprotected exposure to an infectious case of COVID-19	Example 2: Acute suicidality with a plan in the setting of the death of a loved one from COVID-19
Approach	- Don personal protective equipment to protect oneself from exposure to COVID-19. Ask for permission to speak with the patient and carefully approach	- Ask for permission to speak with the patient and carefully approach
Assess and assist	- Discern if the PFA-provider is in a physically safe situation, and whether or not another PFA-provider's presence may be helpful for ensuring safety - Evaluate the patient's safety and health	- Discern if the PFA-provider is in a physically safe situation, and whether or not another PFA-provider's presence may be helpful for ensuring safety - If weaponry is involved and/or present (i.e., knives, firearms, etc.), call the police for security, and ensure safety of PFA-provider - Evaluate the patient's physical safety - Inquire about if the patient has suicidal/homicidal thoughts and/or plans - Assess if the patient is responding to internal stimuli (visual/auditory hallucinations) - Monitor level of patient agitation
Listen non-judgmentally	- Listen quietly and utilize validation and reflective listening techniques as appropriate	- Listen quietly and utilize validation and reflective listening techniques as appropriate
Give support and information	- If the patient is well-appearing, escort the patient to COVID-19 testing and/or home quarantine, in accordance with most updated guidelines. If the patient is ill-appearing, escort to the emergency room - Provide information on available and easily accessible mental health resources for the patient, such as crisis hotlines and clinics for longitudinal mental healthcare services - For this patient, it may also be helpful to provide information on COVID-19 medical professional resources, such as COVID-19 hotlines	- Emergently ensure monitored transportation with escort to the emergency room, as well as confirmation of arrival at the emergency room - Recommend psychiatry consult with inpatient psychiatry admission to hospital if suicidal/homicidal thoughts and/or plans persist - Provide information on available and easily accessible mental health resources for the patient, such as suicide hotlines and clinics for longitudinal mental healthcare services - For this patient, it may also be helpful to provide information on COVID-19 medical professional resources, such as COVID-19 hotlines
Encourage	- Encourage the patient to utilize the information to connect with various mental healthcare resources and professionals. Depending on the patient's previous experience with mental healthcare providers, recommend first-time appointment or reconnecting with mental healthcare provider - For this patient, it may also be helpful for the patient to connect with and utilize their social support system of family and/or friends	- Encourage the patient to utilize the information to connect with various mental healthcare resources and professionals. Depending on the patient's previous experience with mental healthcare providers, recommend *urgent* first-time appointment or *urgently* reconnecting with mental healthcare provider - For this patient, it may also be helpful for the patient to connect with and utilize their social support system of family and/or friends

Resilience," during which renowned disaster psychiatry expert Dr. George Everly recommended Psychological First Aid and Psychological PPE [22].

Before the COVID-19 pandemic, physicians have been required to have psychiatric training during medical school and have had the opportunity to become mental healthcare providers via psychiatry residency training. Even if medical students decide to pursue other specialties rather than psychiatry, medical students still regularly utilize skills from the psychiatric training in their future careers. Indeed, frequently medical students and physicians care for patients in harrowing medical and psychosocial circumstances which may induce mental health symptoms and trauma. Medical professionals often care for patients undergoing psychiatric crises in the medical settings of the emergency room, primary care offices, surgical suites, and hospitals. One-eighth of all emergency medicine patients in 2007 had psychiatric and substance

use disorder emergencies, and the number of emergency room visits for psychiatric emergencies has only been increasing since then [23]. Correspondingly, the majority of emergency medicine resident physicians would prefer to have increased psychiatric emergency training, particularly for pediatric, pregnant, elderly, and acutely suicidal patients [23]. Indeed, the majority of internal medicine, obstetrics-gynecology, pediatrics, and family medicine residency programs teach basic psychiatry, yet the majority of these programs' residents would still prefer more psychiatric training [24]. With increased psychiatric training, there has been a correlation with increased resident "satisfaction" [24]. Thus, medical professionals are no strangers to emergencies, whether the emergencies are medical, surgical, or psychiatric.

A Call to Action for Incorporating PFA into the Mandatory Medical School Curriculum

All physicians are societally expected to be well-prepared for critically ill patients and medical emergencies, including the COVID-19 pandemic. Per the Liaison Committee on Medical Education, medical students must be appropriately trained for such medical and surgical emergencies [25–27]. Thus, the National Fourth Year Medical Student Emergency Medicine Curriculum Guide Task Force standardizes recommendations for medical students' emergency medicine training [27]. It is expected, if not mandatory, that medical schools teach BLS and that physicians be BLS certified; medical students are also trained in airway management, cervical spine safety, and wound care [26, 28].

PFA is a necessary triage strategy for mental health trauma and psychiatric emergencies [7, 8]. Yet, unlike BLS, PFA training is less commonly encouraged, as it is neither expected nor mandatory of physicians or medical students [28]. In the pandemic with the consequent psychosocial disarray, it is imperative to institute PFA training, along with BLS training, as mandatory within the medical school curriculum. Although COVID-19 vaccines are available, the psychiatric impact of the COVID-19 pandemic will have echoing longitudinal ramifications [3]. Indeed, there is no better time to remove barriers to mental healthcare support by training more people, including medical students, in PFA.

Among medical students in the UK, online PFA training enhanced the quality of psychiatric care, understanding of psychiatry, self-assurance in providing psychiatric care, and utilization of PFA skills [7]. Furthermore, in May 2020, amidst the COVID-19 crisis and global economic recession, the Australian Government dedicated $690,000 to online PFA training for all medical students through the Medical Deans Australia and New Zealand [29]. The program, Mental Health First Aid (MHFA) Australia, consists of interactive, online case studies to learn recognition, short-term management, and connection to long-term professional care for psychiatric illness [29].

PFA may be incorporated into medical school orientation, between transitioning from lecture-based didactics to clerkship-based learning, with BLS training, or during the required psychiatry rotation. Incorporating PFA training into the psychiatry clerkship would be an excellent way to standardize the psychiatry curriculum across medical schools; enhancing the psychiatry curriculum can also improve medical student perspectives on psychiatry [30]. The potential barriers to incorporating PFA into the medical school curriculum include the scarcity of time within the curriculum, the lack of professionals equipped to train participants in PFA, the concern for monetary costs, and the stigma surrounding mental health that still permeates society, including the medical profession. However, the flexibility afforded by the variety of organizations offering different PFA training programs, ranging from in-person to online, individual to group, and free to fee-based, is very helpful for medical schools in navigating these hurdles.

Ultimately, it is most urgent that medical schools incorporate PFA into the mandatory curriculum, especially given the frequency that medical professionals respond to psychiatric emergencies, the desire for increased psychiatric training, the COVID-19 pandemic and resulting mental health consequences, and recommendations for integrating mental healthcare and PFA into the pandemic medical response. Including PFA as a mandatory aspect of the medical school curriculum can help ensure that medical students and physicians of the next era are psychosocially conscious and adept at recognizing and addressing all forms of emergencies that physicians must manage—medical, surgical, and psychiatric.

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Declarations

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References

1. Srivastava N, Baxi P, Ratho RK, Saxena SK. Global trends in epidemiology of coronavirus disease 2019 (COVID-19). In: Coronavirus Disease 2019 (COVID-19) 2020 (pp. 9-21). Springer, Singapore. 2020.
2. Hiscott J, Alexandridi M, Muscolini M, Tassone E, Palermo E, Soultsioti M, Zevini A. The global impact of the coronavirus pandemic. Cytokine Growth Factor Rev. 2020;53:1–9.
3. Panchal N, Kamal R, Cox C, Garfield R. The implications of COVID-19 for mental health and substance use. KFF. 2021 [cited

2021May5]. Available from: https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/. Accessed 5 May 2021.
4. Czeisler MÉ, Lane RI, Petrosky E, Wiley JF, Christensen A, Njai R, Weaver MD, Robbins R, Facer-Childs ER, Barger LK, Czeisler CA, Howard ME, Rajaratnam SMW. Mental health, substance use, and suicidal ideation during the COVID-19 pandemic—United States, June 24–30, 2020. Morb Mortal Wkly Rep. 2020;69(32):1049–57.
5. Pfefferbaum B, North CS. Mental health and the COVID-19 pandemic. N Engl J Med. 2020;383(6):510–2.
6. North CS, Pfefferbaum B. Mental health response to community disasters: a systematic review. JAMA. 2013;310(5):507–18.
7. Davies EB, Beever E, Glazebrook C. A pilot randomised controlled study of the mental health first aid eLearning course with UK medical students. BMC Med Educ. 2018;18(1):1–2.
8. Wade D, Howard A, Fletcher S, Cooper J, Forbes D. Early response to psychological trauma: what GPs can do. Aust Fam Physician. 2013;42(9):610–4.
9. Minihan E, Gavin B, Kelly BD, McNicholas F. COVID-19, mental health and psychological first aid. Ir J Psychol Med. 2020;37(4):259–63.
10. Gray M, Monti K, Katz C, Klipstein K, Lim S. A "Mental Health PPE" model of proactive mental health support for frontline health care workers during the COVID-19 pandemic. Psychiatry Res. 2021;299:113878.
11. Despeaux KE, Lating JM, Everly GS Jr, Sherman MF, Kirkhart MW. A randomized controlled trial assessing the efficacy of group psychological first aid. J Nerv Ment Dis. 2019;207(8):626–32.
12. World Health Organization, War Trauma Foundation & World Vision International. Psychological first aid: guide for field workers. World Health Organization. 2011.
13. Everly GS Jr, Barnett DJ, Links JM. The Johns Hopkins model of psychological first aid (RAPID—PFA): curriculum development and content validation. Int J Emerg Mental Health. 2012;14(2):95–103.
14. Morgan AJ, Ross A, Reavley NJ. Systematic review and meta-analysis of mental health first aid training: effects on knowledge, stigma, and helping behaviour. PLoS One. 2018;13(5):e0197102.
15. Kılıç N, Şimşek N. The effects of psychological first aid training on disaster preparedness perception and self-efficacy. Nurse Educ Today. 2019;83:104203.
16. Crawford G, Burns S. Confidence and motivation to help those with a mental health problem: experiences from a study of nursing students completing mental health first aid (MHFA) training. BMC Med Educ. 2020;20(1):69.
17. Crawford G, Burns SK, Chih HJ, Hunt K, Tilley PM, Hallett J, et al.. Mental health first aid training for nursing students: a protocol for a pragmatic randomised controlled trial in a large university. BMC Psychiatry. 2015;15(1):1–8.
18. O'Reilly CL, Bell JS, Kelly PJ, Chen TF. Impact of mental health first aid training on pharmacy students' knowledge, attitudes and self-reported behaviour: a controlled trial. Aust N Z J Psychiatry. 2011;45(7):549–57.
19. Parker CL, Barnett DJ, Everly GS Jr, Links JM. Expanding disaster mental health response: a conceptual training framework for public health professionals. Int J Emerg Mental Health. 2006;8(2):101–9.
20. Everly GS Jr, McCabe OL, Semon NL, Thompson CB, Links JM. The development of a model of psychological first aid for non–mental health trained public health personnel: the Johns Hopkins RAPID-PFA. J Public Health Manag Pract. 2014;20:S24–9.
21. Everly GS Jr, Barnett DJ, Sperry NL, Links JM. The use of psychological first aid (PFA) training among nurses to enhance population resiliency. Int J Emerg Mental Health. 2010;12(1):21–31.
22. Garnett C. Mental health a concern: JHU's Everly prescribes 'psychological first aid' during pandemic. NIH Record. 2020;72(24)
23. Pickett J, Haas MR, Fix ML, Tabatabai RR, Carrick A, Robertson J, et al.. Training in the management of psychobehavioral conditions: a needs assessment survey of emergency medicine residents. AEM Educ Train. 2019;3(4):365–74.
24. Leigh H, Stewart D, Mallios R. Mental health and psychiatry training in primary care residency programs: part II. What skills and diagnoses are taught, how adequate, and what affects training directors' satisfaction? Gen Hosp Psychiatry. 2006;28(3):195–204.
25. Burdick WP, Jouriles NJ, D'Onofrio G, Kass LE, Mahoney JF, Restifo KM. Emergency medicine in undergraduate education. SAEM Education Committee, Undergraduate Subcommittee, Society for Academic Emergency Medicine. Acad Emerg Med. 1998;5(11):1105–10. https://doi.org/10.1111/j.1553-2712.1998.tb02671.x.
26. Wald DA, Lin M, Manthey DE, Rogers RL, Zun LS, Christopher T. Emergency medicine in the medical school curriculum. Acad Emerg Med. 2010;17:S26–30.
27. Manthey DE, Coates WC, Ander DS, Ankel FK, Blumstein H, Christopher TA, Courtney JM, Hamilton GC, Kaiyala EK, Rodgers K, Schneir AB, Thomas SH, Task Force on National Fourth Year Medical Student Emergency Medicine Curriculum Guide. Report of the task force on national fourth year medical student emergency medicine curriculum guide. Ann Emerg Med. 2006;47(3):e1–7.
28. McCoy CE, Rahman A, Rendon JC, Anderson CL, Langdorf MI, Lotfipour S, et al.. Randomized controlled trial of simulation vs. standard training for teaching medical students high-quality cardiopulmonary resuscitation. West J Emerg Med. 2019;20(1):15.
29. Australian Government Department of Health. Mental health first aid training for medical students [Internet]. Australian Government Department of Health; 2020 [cited 2021May5]. Available from: https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/mental-health-first-aid-training-for-medical-students. Accessed 5 May 2021.
30. de Cates AN, de Cates P, Singh SP, Marwaha S. Can curriculum design influence medical students' attitudes to psychiatry? A comparison of two different approaches. Med Teach. 2019;41(8):939–48.