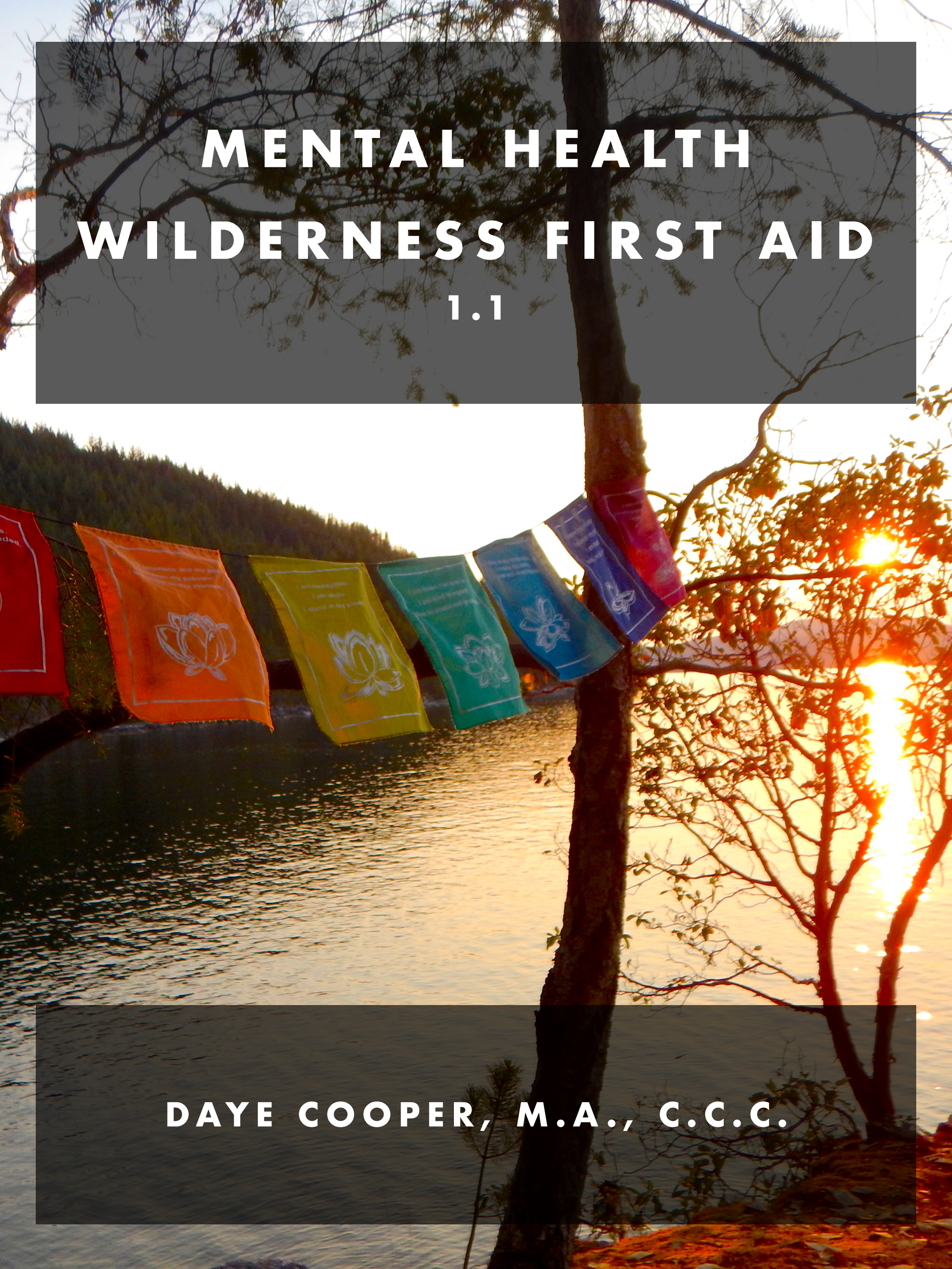

MENTAL HEALTH WILDERNESS FIRST AID

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TITLE PAGE

Mental Health Wilderness First Aid (v) 1.1

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Mental Health Wilderness First Aid

www.mentalhealthwildernessfirstaid.ca

This book is not intended as a substitute for professional diagnosis, advice, or treatment from a mental health professional or physician. The reader should consult a mental health professional or physician in matters relating to mental or physical health and particularly with respect to any symptoms that may require diagnosis or medical attention.

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PREFACE

IT CAN BE HARD TO KNOW WHAT TO SAY

In the fall of 2016, with my close friend and colleague Alex Champoux, I took my Wilderness First Aid (WFA) certification for the sixth time. As some readers will know, recerting your WFA is a rite of passage that most wilderness professionals undertake every three years. The atmosphere, while industrious, is lively. For three to five days a small cohort of outdoor enthusiasts runs around the forest in medical moulage, taking symptom inventories and improvising bone splints and stretchers out of rain jackets, socks, duct tape, juvenile alders and cut-up pant legs. It is an opportunity to refresh skills, share stories, and network in the industry.

2016 had been a big year. At the time, I had been averaging 110-140 field days per year as a professional kayaking, canoeing, and hiking guide in Coast Salish, Kwa'kwa'ka'wakw, and Nuu-chah-nulth territories on the west coast of British Columbia. I was freshly into my fourth decade, new to the Executive Director role at the Sea Kayak Guides Alliance of B.C., and transitioning out of a significant relationship. Alex's and my dear friend and tripping buddy, Randy, had died by suicide that June. As Randy previously had, I was volunteering evenings on a mental health crisis line. And to top it off, I was entering my second year as a Counselling Psychology graduate student at the University of Victoria.

I remember reviewing the topic list at that WFA recert: *Advanced Wilderness First Aid*. Traumatic injuries: concussions, unstable spines, fractures, small wound care. Illnesses: diabetes, appendicitis, angina, Rocky Mountain Spotted Fever. The field manual summarized "Psychological Conditions" on a single row — reading, in part: "Suicide attempt in the field: critical evacuation."

This prioritization on physical conditions was not uncommon for first aid courses of any type. But in the world I inhabited and was just beginning to *see*, health transcended mere biological functionality. Trauma may include witnessing a vehicle accident from afar. Illnesses include depression and anxiety. I reflected on my actual first aid experience: in twelve years as a guide, I had handed out a box worth of band-aids and blister tape, but had evacuated only seven people: two with open wounds requiring stitches, one with second-degree burns, one with a radial fracture, and three for "acute abdomen".

By comparison, on average I had supported someone with mental health symptoms — anxiety, grief, self-harm, trauma, depression or suicidal ideation — *every trip*. More of the "stomachaches" experienced by my clients seemed to be psychogenic in origin compared to those attributable to appendicitis or gastrointestinal bugs. In 2016 alone I had performed multiple suicide risk assessments in the field, evacuated a client for severe depression, supported one youth who was self-injuring and another with chronic panic and anxiety. I had personally been struggling on the trail with PTSD flashbacks from my own unresolved trauma. Throughout it all, Randy was on my mind. Yet even as a graduate counselling student, the tools I possessed to respond to mental health were scattered and inconsistent.

Some time after our recert, Alex and I talked over a post-hike beer at the Howe Sound Brew Pub. When we had met in 2010 as students at Strathcona Park Lodge's COLT program, I was initially irked by Alex, a smart-mouthed climber with an impulsive streak. In 2010, my uncle had just died by suicide, and while Randy had been a support for me in Vancouver, the COLT program was more isolating. I was finding myself in the mountains struggling to breathe on a glacier, or waking up from nightmares in a panic, gasping for breath and clawing at my bivy. With no one to talk to in my hyperaroused state, some unrelated comments from Alex during group discussions had landed poorly. It was only after Alex expressed his own vulnerability the night before an alpine ascent on the Augerpoint traverse that we became friends — and then fast mutual supports.

Now, years later, we reflected on our journeys and our own mental health struggles and triumphs, both in and out of the wilderness. Randy would have been thirty-seven, we reflected, and he had been a champion of mental health and inclusivity issues as well as a beloved hiking and paddling companion. The isolation he must have experienced at the end of his life was a mystery to us. Randy's infectious joy, deep appreciation for Chinese philosophy and phenomenal ability to hold space for people who were in despair were memories that continued to inform the person and the professional I was becoming. Randy "walked in both worlds", mental health and wilderness; he would have "gotten" this. *Why hasn't anyone come up with any psychological Wilderness First Aid training?* Alex and I mused.

Mental health scenarios were difficult, even for people who worked in the field. “It can be hard to know what to say,” we agreed.

Helping people know what to say became my Master’s project. Beginning with anxiety, I created a wilderness first aid training program based on peer-reviewed research, the Mental Health Commission of Canada’s guidelines, the work that I was doing in two clinical internships, and consultations with other professionals in the field. By 2019 I had expanded the program to include depression, suicidal ideation, self-harm, psychosis, grief, and trauma. I was running Mental Health Wilderness First Aid training for guides, universities, Search and Rescue members, and staff trainings. This book is a direct result of the evolution of that training, and is intended to serve as a course manual as well as a standalone text for anyone building mental health support skills in the backcountry.

Dedicated to Randy, who continues to walk with me, in two worlds.

Randy at Elfin Lakes, 2009: Photo by author.

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ACKNOWLEDGEMENTS

Photo courtesy Heather More

So many people walk with me creating Mental Health Wilderness First Aid and this manual.

Dr. Tim Black, my supervisor at the University of Victoria, provided invaluable support at the nascence of the project, including vocalizing the belief that I was developing a unique and invaluable contribution to the communities in which I "walked in both worlds". Kate Hives, Peter Carson, Jack Rosen, and Lisa Denholm saw the value in this program right away, attending early presentations and providing wonderful feedback. Michael "Doc" Crawford, Slipstream Wilderness First Aid owner and instructor, did the same and has been a particularly valuable resource and sounding board from our first coffeeshop meeting when this was still a dream, to ongoing curriculum development consultations. Jessica Cumming did a phenomenal job proofreading my citations, Eric Kingsley my technical sections and Aaron Banfield my prose. Errors remain my own. I did not take all of their advice.

My amazing wilderness colleagues at the Sea Kayak Guides Alliance of BC, Salt Spring Island Search and Rescue, and outdoor education organizations including Strathcona Park Lodge, Island Escapades, the YMCA-YWCA Camp Thunderbird, West Point Grey Academy, and Outward Bound Canada have each been a fantastic and joy-full part of my professional guiding career. And my clinical teams at the Ministry of Children and Family Development and Nuu-chah-nulth Tribal Council have provided feedback and learning environments in which I have been challenged enough to grow in to a skilled clinician. My colleague Kaitlyn Lauzon has been a particularly wonderful source of professional feedback as well as of suggestions for pop-culture references to illustrate clinical concepts.

Alex Champoux, Jeremy Addleman, Tara Souch, Kevin Hawker, Khoi Chau, Leo Duncan, Brian Huang, Dr. Heather More, and Dr. David Mulder all shared meaningful conversations with me in developing material and practicing concepts, both in and out of the field. Randy has also been part of this friend group; he does indeed continue to "follow me" in to the mountains, and he totally would have gotten this. Innumerable clients and students heard about this topic or took a course and encountered their own vulnerabilities, and shared their stories. I am grateful to each of them for working so hard to educate me about mental wellness.

Finally, thanks to my Dad, who tells me I can do anything; my Mom, who started me kayaking; my godfamily, who always believed I could write; and my sister, who encourages my self-care.

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INTRODUCTION

IT CAN BE HARD TO KNOW WHAT TO SAY

While traditional first aid focuses on physical health, mental wellness challenges are just as frequent in the wilderness as cuts and broken bones. Developed by clinical counsellors and wilderness professionals, Mental Health Wilderness First Aid is an interactive, empowering, evidence-based program that trains students to recognize, assess, and intervene in a range of mental health conditions including anxiety, trauma, depression, grief, psychosis, self-injury, and suicidal ideation.

The course is designed for those having a personal or professional, but not specifically therapeutic, duty to care for others in wilderness settings. Objectives of the mental health first aider include holding space, assessing and supporting in the moment, and connecting to professional resources outside of the field. The material will also be of value to anyone who may encounter mental health challenges in rural or urban settings; in recreational, personal, or Good Samaritan contexts.

This book is a direct adaptation of the training program, which has been in operation since 2018. It can be hard to know what to say. We're changing that.

PUTTING THE “WILDERNESS" IN MENTAL HEALTH FIRST AID

Photo courtesy Alex Champoux

Urban-oriented first aid courses in Canada provide a solid orientation to assessing, stabilizing, and supporting clients with emergency conditions. Modern medical resources such as sterile dressings, spine boards, automatic external defibrillators and aspirin are generally assumed to be available. A first aider is encouraged in most cases to follow their assessment and treatment interventions with a referral to “emergency services” — highly-trained paramedics and medical doctors who can take over patient care within minutes. Particularly in a country where health care is a shared social resource, there may be a tendency to take for granted the availability of simple life-saving tools.

For wilderness venturers, on the other hand, every ounce of equipment may be carefully considered, and the most highly skilled medical professional available for hours or days is likely the trip leader. Those who live or work in remote communities — perhaps a two-hour drive, bush plane flight, or water taxi away from the nearest medical clinic (and that’s if the weather holds) — may be reliant on the collaborative experience and training held between themselves and a few dozen other villagers to respond to critical incidents. In wild places with few human-generated resources, isolation makes a virtue of self-reliance.

- **Communication:** In areas with no cell phone reception, communication may be limited to a handheld VHF radio, an inReach on which one text may be squeezed out every few minutes, or a sat phone requiring just the right combination of satellites to pass overhead for a $2/minute call. Some expeditions may be completely self-reliant, depending solely on the group for support or evacuation.

- **Plan**: Once a call is made, what are the next steps? Are you evacuating this client? Asking for a professional assessment (over the sat phone)? Just as in physical health first aid, it helps to have a good idea of what your plan is, what resources you need, and / or where an evacuation should be to, before you make that call.
- **Evacuation logistics**: Rural and wilderness evacuations are not casual endeavours and carry risk, not only to the client but also to the group and the rescuer. Helicopter rescue in high-angle terrain? Five group members carrying a makeshift stretcher through the night? Water taxi out through high seas? This necessitates more nuanced assessment than the conservative "always call an ambulance" policy of which urban environments have the luxury. Evacuations also take *time*. What can be done to support a client in the hours or days while an evacuation is underway?
- **Impact on others:** The presence of other group members on a remote expedition adds complexity to a mental health scenario. Group members may be influenced or triggered by witnessing a client's mental health or behaviour; for instance, self-harm practice and suicidal ideation may take on a "contagious" quality in vulnerable groups. Understanding how "mirror neurons" operate in our brains (see "Neurology") can help provide some context to this phenomenon, and why providing a grounded, nonanxious presence is fundamental to all mental health interventions.

WHOM THIS BOOK IS FOR

Those who live, work, and play in remote communities or wilderness areas face a special set of circumstances that can make assessment, intervention, and resources require a different set of skills than in an urban environment. As of 2020, tree planters, wilderness guides, Canadian Armed Forces members, Search and Rescue volunteers, postsecondary students, other remote area professionals, and rural community members have all benefitted from Mental Health Wilderness First Aid training.

Photos by author

The information and protocols in MHWFA are developed for the following contexts:

- Those who want to **be able to support others in a personal or professional capacity** (e.g. supporting a student in a classroom, the subject of a search and rescue mission, a client on a backpacking trip, or a personal friend or family member);
- In **backcountry or wilderness areas**, where considerations may include exposure to the elements and/or lack of access to prompt outside professional assistance;
- Who work or operate in a **non-mental-health-specialized role.**

  Someone in a "mental health specialized role" is actively *expecting* to frequently support those experiencing mental health challenges requiring specialized knowledge, in a designated or long-term capacity. For instance, while a remote-area "counsellor" or "grief & loss support worker" may certainly benefit from a MHWFA program, they should have additional training and experience in mental health assessment and support to fully engage their specialized professional role.

  However, remote area teachers, labourers, nurses, and other community members are "non-mental-health-specialized" roles that will nevertheless inevitably encounter mental health situations in the course of their work and lives. MHWFA training is designed to assist them to be able to respond and provide effective mental health first aid.

  Similarly, wilderness guides who are leading recreational, outdoor education, or leadership programs will benefit from MHWFA. However, the facilitators of "Bonnie's Bereavement Backpacking Bushwhacks" or "Terry's Trauma-Survivor Treks" should have more professional training and experience in mental health and trauma-informed practice than a single weekend course can provide.

This book and scenarios are primarily written to an imagined audience of wilderness venturers, but may be easily adapted for those living or working in remote-area communities with varying infrastructure.

WHAT THIS BOOK IS NOT

- **Very long.** A lifetime can be devoted to developing mental health support skills. At the same time, simply holding space, and providing simple interventions can make an enormous difference to someone's well-being. *First* aid is an initial step in what may be a client's longer journey. Be gentle with the text, the course, and with yourself.
- **Therapy**. Just as providing physical health first aid is not the same as being a doctor, providing mental health first aid is not the same as being a counsellor. **The objectives of a mental health first aid provider are not to solve underlying problems or dig in to childhood traumas, but rather simply to hold space, assess and support in the field, and connect to professional resources.**
- **Substance use and addictions.** Although these are critical topics, and common challenges for people that are often co-occuring with other mental health conditions, the scope of providing supportive first aid for substance use and addictions is considerable, and not covered by this program at this time. One lifesaving training to strongly consider in this realm is basic naloxone training (https://towardtheheart.com/naloxone-training).
- **Medical first aid.** Many of the conditions discussed in this text (see "Differential Diagnoses") require knowledge of medical first aid in order to assess potential physiological conditions such as heart attack, brain injury, and poisoning. Take a medical Wilderness First Aid course from a reputable organization like Slipstream (www.wildernessfirstaid.ca).

Photo by author

REDUCING STIGMA

Photo by author

While awareness of mental health is growing, social stigma continues to significantly impact the ways that people ask for help, admit they are struggling, receive information and offer support.[1] Ideas for reducing mental health stigma on expedition:

- Talk about it! If you are running a program, make a feelings reflection a regular part of the morning or evening check-in. Set an example by sharing your own feelings, a moment during the day when you felt vulnerable, or a healthy coping strategy you used in a difficult moment.
- Demystify — for yourself — the idea of *providing* mental health support. While professional mental health clinicians are a positive resource, research indicates that in most cases, the presence of an empathic, caring individual is usually more important than *what* specifically is said. *We* are the primary mental health supporters for the person in the moment - especially in wilderness settings. Develop confidence that your empathic, caring presence is a meaningful support to the person you are with. Take the time. Hold the space. Don't rush it.
- Invite alternatives for the casual use of mental health terms like "OCD", "PTSD", "retard", "triggered", "kill myself" etc.
- Where reasonable, look for creative ways to include and integrate participation of people with a range of mental wellness states in wilderness activities.
- Consider mentioning your own mental health journey in an brief, sincere, non-specific manner. Share "**headlines, not details**"; remember, when you're in a guiding role, "it's not about you." A casual "my therapist suggested that I start doing yoga," or "I do 5-4-3-2-1 for myself all the time when I feel anxious" is sufficient to help to normalize and personalize mental health dialogue.
- Recognize that sometimes, humour or flippancy is a client's way of engaging with a topic that actually carries weight for them. You might respond with an invitation to dig further. "I noticed you joke about having anxiety a lot. Is anxiety something that comes up for you sometimes?"

[1] Canadian Medical Association, 2008

TRAUMA-INFORMED PRACTICE

Trauma-informed practice includes simply being aware of the possibility of trauma in people's pasts, how trauma can influence behaviour, and strategies you can adapt to proactively support healing.

As a professional, you can build your trauma-informed practice by being aware of:

- The capacity of individuals to heal and express resilience through traumatic experiences. In other words, seeing people's strengths, not just their struggles!
- How some behaviours, which may be easy to dismiss as "troublemaking", "unfocused", "problematic," etc may actually be a product of trauma. Spaciness, irritability, trouble focusing, low motivation or social awkwardness are common examples. Rather than framing a perspective in your mind of "*What's wrong with you?*" consider conceptualizing instead, "*What happened to you?*"
- Certain behaviours, words, or situations that can be overwhelming or genuinely triggering for individuals who have been exposed to traumatic events. This includes jokes about sexual assault, or unwanted physical contact (e.g. hugs or physical games), or other situations. A trauma-informed approach puts limits on sensitive subjects (e.g. "hey guys, that's really not an appropriate thing to joke about") and supports being able to easily say "yes" or "no" to physical contact. ("Can I give you a hug?").
- Provide **choice, voice, and control** during crisis intervention. See "lizard brain interventions" for some examples of utilizing consent-based interventions.
- Break complex tasks down to assist with overwhelming feelings. See "baby step ladder" for some examples of this.

Photo by author

CONFIDENTIALITY

Confidentiality — respecting privacy — is a cornerstone of mental health and first aid practice. When we are supporting someone in the field, we may assure them that the information they share with us is confidential - we will not share it publicly.

Limits to confidentiality include:

- Harm to self (*e.g.* an active plan to die by suicide),
- Harm to others (*e.g.* an active plan to assault or kill someone else),
- A child in need of protection (from physical or emotional abuse, or neglect).

Tip: Confidentiality

It's good to clarify expectations about what is private and what is not with someone you are supporting. You can do this individually, or say it to the whole group at the start of a trip.

"I just want you to know that I won't share the things you tell me with other people unless you say it's okay. I'll talk to Tammy and Jeff about it later, because they are my co-guides, and we want to make sure we're doing everything we can to support you. The times I would have to tell someone else are if there's significant danger, like if someone's at risk of hurting themselves or someone else, or if a child needs protecting. Then it's my job to get help to keep people safe. Does that make sense?"

Information in these categories is not confidential, and as a care provider, **there is a legal requirement for you to report this information**. Call 911, or in the case of a child in need of protection, call the Ministry of Children and Family Development at 1-800-663-9122.

It is, however, possible for our real-life experiences and learning opportunities to be shared while still maintaining confidentiality. The principle for sharing your own experiences is **"speak as though, if the person about whom you are talking were in the room listening to you, they would not be 100% sure it is them you are describing."** Consider the following:

- Do not include identifying details of the people involved. This of course means no names (or clear pseudonyms), job titles (*e.g.* "a janitor at Thrifty's"), hometowns, what trip they were on, or other specific descriptions (*e.g.* "an Indo-Canadian family from Salmon Arm with a mom, dad, 17-year-old son and 11-year-old daughter"). Leave this kind of information out, or actively change it.
- Other details that are nonessential to the core of the situation should also be changed, including, potentially: the client's gender, age, kind of trip, location, etc. A 22-year-old with anxiety on your canoe journey last week is just effectively described as a 29-year-old on your base camp trip in 2015. The core lesson is the same.

Each of the examples and scenarios in this manual is drawn from my seventeen years of experience on personal and professional wilderness expeditions. Some situations are based on real incidents that have had multiple identifying details changed, while others are amalgamations of characters or real events.

PRE-TRIP SCREENING

The pre-trip medical form is an excellent opportunity to exchange information about mental health with your clients. This is a two-way exchange: while clients are disclosing information about their mental health experiences, the course provider or guide is communicating that they are oriented to mental health issues, and is setting the stage for future genuine connection and conversations.

Far too often, however, this opportunity is squandered as pre-trip forms focus on physical health issues while neglecting to open a dialogue on other kinds of wellness. Some pre-trip prompts to keep in mind:

- **Mental health conditions**. You know those boxes you check to indicate if you have diabetes, back problems, or a heart condition? If you're committed to checkboxes, consider including the mental health conditions in this book on the list. Anxiety, trauma, panic, grief, depression, psychosis, self-harm, and suicidal ideation are all key for an expedition guide to know about.
  Provide blank space for additional information for whichever boxes are checked. Particularly with potentially consequential conditions such as panic attacks, self-harm, and psychosis, it is critical to know the person's history: How long has this been happening? What does it look like? How long does it last? What are the strategies when it happens? What happens next (e.g. doctor visit, stay home and rest, or nothing?).
- **Specific fears** (phobias), such as a fear of heights, water, snakes, enclosed spaces, or "other" (leave a blank space for them to write in other specific fears).
- **Suicidal ideation** (thoughts of suicide) - if a "yes", this should be followed up with as much detail as you would solicit information about an allergy. Has this person attempted suicide in the past? How long ago? What happened? What have they done to heal since? What supports are in their life? What, if anything, do they need on this trip for support? See "Suicidal Ideation" for more.
- **Medication** is already a section on your trip's med form (or else, it sure ought to be). Some considerations with mental health medication (get this information from your client and/or from a medical resource like the Compendium of Pharmaceuticals and Specialties):[2]
  - How long have they been on this medication? Has the medication or dosage recently changed? In general, you want psychoactive medications to be stable - avoid experimenting with new dosages in wilderness settings. Particularly to be discouraged or disallowed for safety reasons are "medication vacations" - when a client decides to suddenly stop taking a medication during your trip just to "see how it goes".
  - Is their medication being monitored? Are meds taken "as needed", or on a schedule?.
  - What happens in case of overdose (particularly if they have a history of suicidal ideation)?
  - What happens in case they miss a dose (particularly if they have a history of psychosis, panic, self-injury, or mood disorders)?
- Have they been under the care of a **mental health professional** in the past 12 months?

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[2] Canadian Pharmacists Association, 2015

- Is there a history of **recent or unresolved trauma**, loss, or particular stress? You do not need to require details *of the trauma itself.* (You are not their therapist, and disclosing details to a stranger on a form can be re-traumatizing). However, knowing that there *has* been a trauma can support a wilderness guide's ability to be sensitive in this area, particularly if triggers are known.
- What are their **triggers** for mental health challenges (particularly trauma, anxiety, and self-harm?)
    - What triggers can you anticipate may come up in the wilderness?
    - How can you minimize triggers or support their plan for how to respond to them?
- What are the client's existing **coping strategies and strengths?** Consider putting just as much attention here as on any of their struggles. It goes a long way to acknowledge people for their strengths and healing. This furthermore reinforces in the client's mind their own capacity to respond positively to any challenges in the wilderness, as well as providing the guide with the opportunity to actively support a client's established coping strategies in the wilderness.

It should absolutely go without saying that information shared on a medical form is confidential. No one else on the trip gets to know about a client's physical or mental health history unless the client chooses to disclose it.

Based on their form responses, you may decide to initiate a pre-trip conversation with the client about the trip and their capacities at this time. Mental health is a spectrum, and most mental health issues can be accommodated on trip. Three thoughts for this process:

1) As mentioned above, frame a conversation around their strengths, supports, and coping strategies, rather than exclusively on their struggles. How can you work together to support their having a great experience?
2) If it emerges that you cannot accommodate the client's participation on the trip at this time:
    - Consider framing your decision in terms of temporality (not the right fit now, but may be in the future) and safety.
    - Avoid inadvertently shaming the client - particularly, be aware and honour that they have been vulnerable in disclosing their mental health experiences with you. How you respond to them now will influence how they talk about mental health in future.
    - Consider offering the opportunity for them to join this or another trip if they develop additional healing or coping strategies in an area where they are struggling, and/or if a counsellor or other professional attests to their preparedness.
3) When you can reasonably adapt a trip to support someone with a disclosed mental health concern attending, please promote accessibility within our industry by doing so.
    - The more we build a culture of reasonable accommodation and support, the more willing clients will be in the long run to talk openly about their mental health.
    - Spending time in nature has clinically-supported positive mental health impacts for almost every mental health condition.

POST-EVACUATION GROUP DEBRIEF

The unfortunate occurs: you opt to remove a client from your expedition for mental health reasons. Once the evacuation is complete and the client is supported externally, the business of getting back to the expedition is at hand. Some principles to keep in mind:

- Group energy is sensitive to disruption, whether that is experienced as grief, concern, or relief. A group debrief is appropriate to acknowledge this and the new group configuration.
- Be aware that it is probable that others in the group have experience with similar mental health issues in the past. Frame the discussion around support and safety, and vocalize hope that the person who left can participate in future. This is a time, especially if other group members are relatively young, when they will be 1) forming their own framework about how to think and talk about mental health issues, and 2) learning, through observation, how *you* deal with and think about mental health issues. They will be attentive to your words, and it will inform how they approach you with future concerns.
- Confidentiality and respect for the evacuated client must be maintained. However, facts that all group members are already privy to should be acknowledged openly.

> *"As you've all been aware, Jamie has been having a hard time the last few days, and last night she shared some things that made us concerned for her safety. We helped her get home so she can be better supported right now, and we hope that she can come out on a trip next summer …"*

- Allow the opportunity for group members to share. It is inappropriate to discuss the client's specific disclosures, speculate about their motives, or engage in unnecessary gossip. However, you can invite group members to share their own personal feelings or respectful reflections.
- Invite group members to express a word of support or a wish for the departed person. One meaningful way that I've done this is to have everyone write a note to the departed group member, and then burn the paper in the evening campfire, with the thought that the smoke symbolically carries the message to them.
- A brief shared physical or bonding activity following the debrief (for instance, a group game like "human knot" or frisbee) is a good way to solidify and step in to the new chapter of group identity.

Photo by author

SELF-CARE AND SELF-AWARENESS

It is normal and expected that first aiders supporting mental health may encounter personal triggers, both in their work and throughout this text. You may find yourself reflecting on a situation you or a client were in, thinking of a friend or family member who died by suicide, or experiencing guilt or shame from a time when you feel like you did the wrong thing or didn't do enough. This can be difficult work.

Additionally, those who frequently provide support for others during difficult times may experience **vicarious trauma** - where the care provider experiences personal trauma symptoms as a result of hearing about a client's experiences - or **compassion fatigue -** burnout from continually providing care.

Your well-being — as a first aider, care provider, and human being — is of fundamental importance and directly impacts your ability to support others. Take a moment now to identify the ways that you care for yourself. Include at least one boundary you can set, two people you can talk to, and three coping skills you can practice if you feel yourself becoming emotionally activated during this program. See the Appendixes in the back of this book for a nice template for this exercise, as well as some additional professional supports.

Create a culture of self-care, where you both model and actively encourage others to take deliberate time for wellness. Ideas for promoting self-care on expedition:

- Talk about it! Frontload a trip with a discussion of what self-care includes - hydration, bathroom, stretching, awareness of feelings, healthy coping skills. Follow up with specific "self-care breaks" through the trip.
- Include the concept of "self-care" in your evening debrief. Ask people for a "five-finger check-in" - holding up one to five fingers to rate their self-care throughout the day. Or, break it down and get a five-finger rating in *each* self-care category. Get people to identify where they need to do a little more self-care and when they will do it.
- Don't underestimate the value of adding additional beauty and nurturance to expeditions. Take a moment to arrange a few beachcombed treasures, a tealight, or a handful of sustainably-harvested flora to an evening's dinner plank. Make time for the whole group to engage in a little morning yoga, or afternoon "nature art" (see: cognitive interventions). Or, set out an

Photo courtesy Alex Champoux

expedition “hand care kit” with nail clippers and coconut oil. As we shall see, it needn’t take much to have a meaningful impact on the parasympathetic nervous systems of an entire group.

- Also consider that, as my supervisor declared at a recent training, “self care isn’t just about going for walks and taking bubble baths.” To be effective supporters, we also have to *do our own work* — identifying the areas where *we* struggle with interpersonal interactions, with our own history, our family, our triggers and traumas — and then not only naming it but doing the hard work to heal and change. True, holistic self-care includes holding ourselves accountable to our personal growth - and the more we do, the better we can be there for others.

Finally, take “flower blossom breaks”. When reading through heavy course material or supporting someone through trauma or grief, take time throughout the work to “step out of it” for a moment. Take a deep breath, look around, notice something beautiful. Perhaps invite your client to notice it, too. Soak in the beauty. And then return to the work.

Photo by author

WHAT IS MENTAL HEALTH?

Daye Cooper, *Feeling Again* (2017), acrylic on canvas.

"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."
- World Health Organization

"Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community."
- World Health Organization