driven ORIGINAL RESEARCH

2025 RFA #2

Improving Peer Support and Personal Mental Health Skills Through Resilience First Aid (RFA) Training

Published: **April 2025**
Available Online: **driv.ai/rfa25-2**

How to cite this article: Rossouw, J.G. (2025). Improving Peer Support and Personal Mental Health Skills Through Resilience First Aid (RFA) Training. *PsyArXiv. DOI:https://doi.org/10.31234/osf.io/fm27q_v1*

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KEY TAKEAWAYS

This study presents an expanded evaluation of Resilience First Aid (RFA) as a primary prevention training program, focusing on its ability to build personal resilience and peer support capability across a broad population sample (n=769). Using a neuroscience-based framework, RFA empowers individuals to notice early warning signs of distress in others, while maintaining their own mental wellbeing. The study assesses the program's real-world impact across both live and self-paced formats, with strong implications for workplace and community mental health initiatives.

1. **Scaling Primary Prevention with Neuroscience-Informed Resilience Training** - RFA is grounded in the Predictive 6 Factor Resilience Model (PR6) and integrates the ALL Protocol – a practical conversational model for peer support. This large-scale study involved 769 participants from diverse industries, comparing outcomes between live instructor-led and self-paced training. The program's structure is designed to build sustainable peer support capacity while reducing risk across populations.

2. **Significant Increases in Resilience and Peer Support Skills** - Participants experienced a 14.5% increase in resilience and a 7.8% increase in peer support skills following RFA. Improvements were seen across all PR6 domains, with the largest gains in Reasoning (+16.7%), Vision (+16.6%), and Collaboration (+16.4%). Peer support growth was strongest in Interpersonal Skills (+11.8%) and Personal Mastery (+8.5%), reinforcing the value of RFA as both a personal and social wellbeing tool.

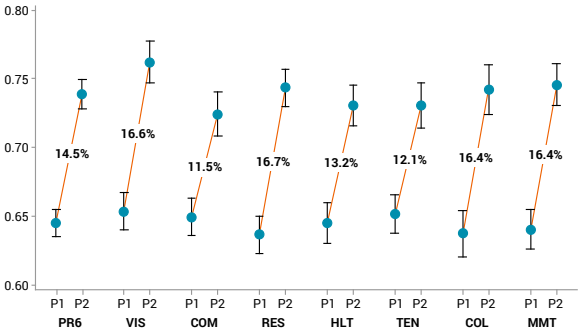
3. **Risk Reduction and Suicide Prevention Capability** - The study found a 77.7% reduction in high-risk participants (PR6 < 50%) and a 187.3% increase in those reaching high resilience levels (PR6 ≥ 85%). Notably, participants improved by 30.0% in recognising suicide warning signs, underscoring RFA's relevance to early intervention strategies. Completion rates were high across all delivery formats, particularly in mandatory self-paced settings (91.3%) without affecting impact, demonstrating strong engagement and scalability.

+14.5%
Overall resilience improvement

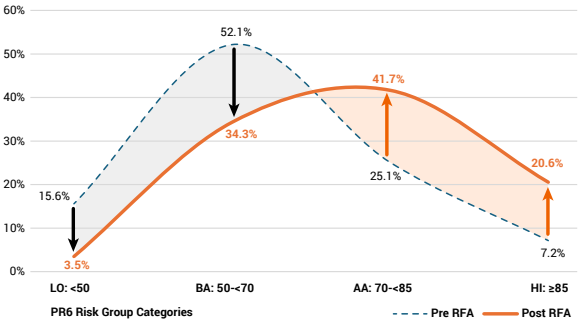
+30%
Ability to identify **suicide warning signs**

+41%
Improvement in **vulnerable** groups

Domain-level Improvement Pre & Post:



Risk Group Improvement Pre & Post:
Reduction in vulnerable participants and increase in participants with protective levels of resilience.



CONCLUSION

This study confirms Resilience First Aid as an effective, scalable intervention for improving mental health and suicide prevention capacity. By shifting individuals out of psychological risk zones and equipping them to support others effectively, RFA proves its value as a practical, neuroscience-informed approach to mental wellness. These findings support the integration of RFA into workplace wellbeing programs and broader community mental health strategies.

Explore Resilience First Aid - **driv.ai/rfa**

Crisis Support:
Australia - Lifeline: 13 11 14
United States - Lifeline: 988

Improving Peer Support and Personal Mental Health Skills Through Resilience First Aid (RFA) Training

Jurie G. Rossouw (Driven Labs - ORCID 0000-0002-3793-6561)

Abstract

Problem under investigation: Suicide rates continue to rise globally despite increased investment in reactive mental health services. This highlights the need for proactive, primary prevention approaches that build psychological resilience and peer support capabilities. This study evaluates the effectiveness of Resilience First Aid (RFA), a neuroscience-informed, strength-based training program.

Participants: The study included 769 adult participants (87% Australia, 12% USA) from diverse sectors including education, emergency services, healthcare, and government. Participants completed RFA via either live instructor-led or self-paced online formats, with both voluntary and mandatory engagement.

Method: Using a pre-post intervention design, participants completed assessments through Driven's online platform. Primary outcome measures were the Predictive 6 Factor Resilience Scale (PR6) and the Mental Health Peer Support Questionnaire (MHPSQ). Data was analyzed for overall and domain-specific changes, as well as transitions between resilience risk categories.

Findings: RFA training significantly improved resilience (+14.5%) and peer support skills (+7.8%), with industry identified gains in Emergency Services & Safety audiences (+20.3%), Financial Services (+15.6), Community & Social Work (+15.8), and Healthcare (+13.8%). The proportion of high-risk participants (PR6 < 50%) dropped by 77.7%, while those in the high-resilience group (PR6 ≥ 85%) rose by 187.3%. Suicide prevention skill improved by 30.0%. Both delivery formats were effective ($p < .001$), with no significant difference between mandatory and voluntary groups.

Conclusions and implications: RFA is an effective and scalable intervention for strengthening protective mental health factors and suicide prevention capabilities. Its flexible delivery makes it well-suited for workplace wellbeing programs and broader community implementation, contributing meaningfully to public mental health strategies.

Keywords: resilience, suicide prevention, primary prevention, mental wellness, strength-based, peer support

Introduction

The mental health landscape continues to face significant global challenges, with suicide rates persistently rising despite considerable investment in crisis intervention strategies. In the United States alone, suicide claims approximately 50,000 lives annually (CDC, 2024), while Australia has experienced an upward trend since 2004 (AIHW, 2024).

The economic cost is extensive, with suicide-related losses in the U.S. alone estimated at over US$510 billion annually (Peterson, Haileyesus, & Stone, 2024). Amid these statistics, there is growing consensus on the urgent need for primary prevention approaches to complement reactive services.

Primary prevention aims to address mental health issues before they escalate, focusing on enhancing protective factors and reducing risk factors in the general population (Sher, 2019; Xinlu, Zhongqiu, & Chaoqun, 2022). Mental health disorders are increasingly contributing to global disease burden, highlighting the importance of primary preventative interventions (Stephan, et al., 2025).

One such preventative initiative is Resilience First Aid (RFA), a strength-based training program designed to proactively build personal resilience and enhance peer support capabilities. Developed by Hello Driven, RFA integrates the Predictive 6 Factor Resilience (PR6) model (Rossouw & Rossouw, 2016) with the neuroscience-informed ALL Protocol (Appreciate, Listen, Lift) to equip individuals with the skills needed to recognize early signs of mental distress and effectively support others while safeguarding their own wellbeing (Rossouw & Ruberto, 2025). The PR6 and ALL Protocol clarifies the conceptualization of RFA as strength-based approach (Caiels, Milne, & Beadle-Brown, 2021).

The program is grounded in robust theoretical frameworks, including acceptance and commitment therapy (ACT),

motivational interviewing (MI), and cognitive behavioral therapy (CBT), and is accredited by both Suicide Prevention Australia and the American Academy for Continuing Medical Education.

Previous research has validated RFA's effectiveness in improving resilience and peer support skills. A pilot study reported significant increases in overall personal resilience (+10.2%) and peer support skills (+11.3%), with especially notable gains in interpersonal skills (+21.9%), composure (+17.2%), and tenacity (+14.7%) four weeks post-training (Rossouw & Ruberto, 2024). Additionally, participants demonstrated a 33.3% improvement in recognizing suicide warning signs, highlighting RFA's potential as a vital tool in suicide prevention.

Building on this foundation, the current study expands the scope and rigor of evaluation through a large-scale investigation involving 769 participants. It explores the impact of RFA across two delivery formats – live instructor-led and self-paced online training – while examining the development of personal resilience and peer support skills using validated psychometric instruments: the PR6 and the Mental Health Peer Support Questionnaire (MHPSQ) (Ma, Gallo, Parisi, & Joo, 2022). This study contributes to the growing body of evidence supporting RFA and seeks to provide deeper insight into its scalability, comparative format efficacy, and its role as a proactive mental health intervention.

The primary objective of this study is to evaluate the effectiveness of RFA in enhancing resilience and peer support skills across diverse participant groups and training formats. We hypothesize that participants will show statistically significant improvements in PR6 and MHPSQ scores following completion of RFA training, with some variation expected between delivery formats. Secondary analyses will explore domain-specific changes within the PR6 model, which have previously shown strong associations with mental health

TABLE 1: Participants by Country and Industry

Industry	Australia	%	USA	%	Other	%	Total	%
Community & Social Work	59	9%	-	-	-	-	**59**	**8%**
Construction & Transportation	13	2%	-	-	-	-	**13**	**2%**
Education & Training	182	27%	-	-	-	-	**182**	**24%**
Emergency Services & Safety	136	20%	-	-	-	-	**136**	**18%**
Financial Services	24	4%	-	-	-	-	**24**	**3%**
Government	53	8%	12	13%	-	-	**65**	**8%**
Healthcare	69	10%	-	-	-	-	**69**	**9%**
Other	113	17%	77	87%	13	100%	**203**	**26%**
Professional Services	18	3%	-	-	-	-	**18**	**2%**
Total	**667**	**87%**	**89**	**12%**	**13**	**2%**	**769**	**100%**

TABLE 2: Participant Characteristics

Variable	N	Mean	StDev	Min	Q1	Median	Q3	Max
PR6 Overall	**769**	**0.645**	**0.136**	**0.196**	**0.554**	**0.643**	**0.732**	**1**
VIS – Vision	769	0.654	0.191	0.000	0.477	0.596	0.723	1
COM – Composure	769	0.650	0.191	0.120	0.481	0.601	0.728	1
RES – Reasoning	769	0.637	0.190	0.000	0.521	0.651	0.769	1
HLT – Health	769	0.645	0.206	0.000	0.545	0.688	0.799	1
TEN – Tenacity	769	0.652	0.198	0.000	0.553	0.663	0.830	1
COL – Collaboration	769	0.638	0.241	0.000	0.502	0.628	0.876	1
MMT – Momentum	769	0.641	0.201	0.000	0.489	0.611	0.738	1
MHPSQ Overall	**769**	**0.758**	**0.111**	**0.458**	**0.683**	**0.758**	**0.842**	**1**
IP – Interpersonal Skills	769	0.666	0.168	0.050	0.550	0.700	0.800	1
DS – Discerning Stigma	769	0.816	0.155	0.150	0.750	0.850	0.950	1
PM – Personal Mastery	769	0.792	0.122	0.375	0.713	0.800	0.875	1

Note: PR6 = Predictive 6 Factor Resilience Scale, MHPSQ = Mental Health Peer Support Questionnaire, StDev = Standard Deviation.

TABLE 3: Country Starting Scores

	N	PR6	VIS	COM	RES	HLT	TEN	COL	MMT	MHPSQ	IP	DS	PM
Australia	667	0.642	0.65	0.645	0.63	0.645	0.646	0.637	0.639	0.755	0.66	0.816	0.791
	SD	0.134	0.189	0.187	0.19	0.205	0.197	0.24	0.199	0.112	0.164	0.158	0.124
USA	89	0.667	0.679	0.69	0.678	0.635	0.692	0.649	0.655	0.777	0.704	0.823	0.804
	SD	0.147	0.205	0.219	0.196	0.21	0.203	0.242	0.219	0.103	0.191	0.134	0.106
Other	13	0.666	0.682	0.627	0.694	0.719	0.699	0.607	0.633	0.771	0.719	0.808	0.787
	SD	0.136	0.204	0.198	0.108	0.199	0.228	0.283	0.184	0.117	0.171	0.127	0.139

Note: Mean scores on first line, standard deviation on second line. PR6 = Predictive 6 Factor Resilience Scale, VIS = Vision, COM = Composure, RES = Reasoning, HLT = Health, TEN = Tenacity, COL = Collaboration, MMT = Momentum, MHPSQ = Mental Health Peer Support Questionnaire, IP = Interpersonal Skills, DS = Discerning Stigma, PM = Personal Mastery.

outcomes (Rossouw J. G., 2024). These outcomes are of particular interest given their established links to reductions in anxiety, depression, and emotional vulnerability.

By assessing the impact of RFA on both personal and community-level protective factors, this study aims to reinforce the importance of proactive, scalable mental health training programs and offer practical recommendations for broader implementation in educational, workplace, and community settings (Benson, Leffert, Scales, & Blyth, 2012).

Method

The study investigated the effects of Resilience First Aid training on 796 participants (PR6 Overall Mean = 0.645, St-Dev = 0.136, Table 1 & 2), primarily from Australia (n = 667, PR6 Mean = 0.642, St-Dev = 0.134), and the United States (n = 89, PR6 Mean = 0.667, St-Dev = 0.147) with the remaining countries grouped as 'Other' (Table 3).

Participants were drawn from a diverse range of industries, reflecting a broad cross-section of professional sectors. The largest groups were from Education & Training (n = 191), Emergency Services & Safety (n = 143), and Healthcare (n = 74). Other industries represented included Community & Social Work (n = 65), Government (n = 65), Professional Services (n = 24), Financial Services (n = 24), Construction & Transportation (n = 14), and Technology (n = 18). An additional 151 participants identified their sector as "Other" where industry groups with less than 10 participants were grouped together (Table 1).

The industry breakdown provided a diverse and representative sample, allowing for comparisons across key sectors such as emergency services and healthcare, which are of particular interest given their exposure to high-stress environments.

Sampling Procedure

Participants were recruited via multiple channels including organizational partnerships, internal initiatives, and individual registration. Recruitment involved both voluntary and mandatory participation, particularly for self-paced training within some workplace settings. All participants completed assessments through the Driven online platform.

The study recorded a pre-assessment prior to training and a post-assessment immediately following completion.

Research Design

This study employed a pre-post intervention design. All assessments were administered online using the Driven resilience platform. The primary outcome measures were the Predictive 6 Factor Resilience Scale (PR6) and the Mental Health Peer Support Questionnaire (MHPSQ). These instruments are validated psychometric tools used to assess personal resilience and peer support competencies, respectively.

Participants completed RFA in one of two formats:

- A live format led by an instructor either in person or webinar format (LIVE),
- Or RFA was completed through self-paced format using Driven's resilience training platform to watch videos and complete online self-reflection activities (SELF).

LIVE participants complete training within a workshop setting with a certified RFA Instructor, with the pre-assessment administered prior to joining the two days of workshops, and post-assessment completed at the end of the final session.

SELF participants register for RFA on the Driven online platform, with the pre-assessment administered as part of the initial module prior to starting any training. The system progresses participants on to a series of online modules with the participant having 12 months to complete. We note that at the time of conducting this research, all unfinished participants are still within the 12 months window with time to complete. On completion of all modules, participants then complete the post-assessment.

A sub-set of the SELF group completed RFA as a mandatory requirement of their employment, enabling investigation into variation of change compared to voluntary participation.

A key objective of the RFA program is to increase participants' resilience to levels associated with enhanced mental health protection and personal development. The PR6 model categorizes resilience scores into four bands: Low (LO), Below Average (BA), Above Average (AA), and High (HI), with the High group defined by a score of 85% or above (Table 4). This 85% threshold has been identified as a critical tipping point where individuals exhibit significantly improved personality traits and substantial reductions in psychological risk factors (Rossouw J. G., 2024).

Recent research demonstrated that individuals reaching the HI grouping experienced a 2.9-fold reduction in Neuroticism, alongside 52% and 65% increases in Conscientiousness and Extraversion, respectively. Most notably, there were 5.6-fold reductions in depression, 4.2-fold reductions in anxiety, and 5.9-fold reductions in emotional vulnerability (Rossouw J. G., 2024). These findings underscore the protective value of high resilience, making upward movement across PR6 groupings a vital outcome measure for resilience interventions.

Therefore, this study evaluates the impact of RFA training on shifting participants from higher-risk categories (LO and BA) into more protective categories (AA and HI). This movement is indicative of increased psychological resilience and reduced vulnerability to mental health challenges, providing a measurable goal for primary prevention through resilience training.

Measures

The PR6 measures six domains of resilience and yields a composite score and scores for the separate resilience domains:

- **Vision** – Sense of purpose and personal goals
- **Composure** – Capacity to regulate emotions and stress
- **Reasoning** – Problem-solving, adaptability, planning, and resourcefulness
- **Tenacity** – Persistence and motivation in the face of setbacks
- **Collaboration** – Build and maintain support networks
- **Health** – Physical wellbeing including sleep, nutrition, and activity

The MHPSQ captures peer support skills across three dimensions:

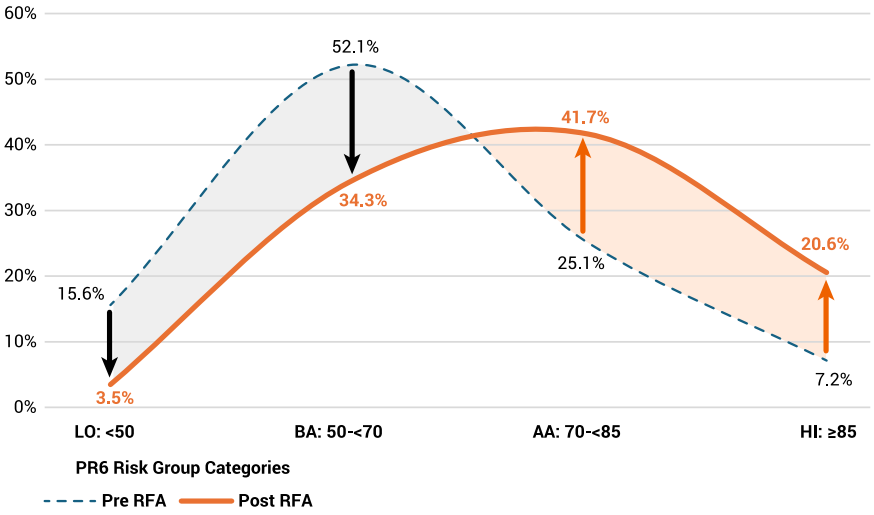
- **Interpersonal Skills** – Ability to communicate effectively and respond to others' emotional needs
- **Discerning Stigma** – Recognizing and addressing mental health stigma

TABLE 4: Overall Effects of RFA Training

	P1 - Pre-assessment		P2 - Post-assessment		
Variable	**Mean**	**StDev**	**Mean**	**StDev**	**Change**
PR6	**0.645**	**0.136**	**0.739**	**0.127**	**14.50%**
VIS	0.654	0.191	0.762	0.182	16.60%
COM	0.650	0.191	0.724	0.192	11.50%
RES	0.637	0.190	0.744	0.165	16.70%
HLT	0.645	0.206	0.730	0.177	13.20%
TEN	0.652	0.198	0.731	0.198	12.10%
COL	0.638	0.241	0.742	0.215	16.40%
MMT	0.641	0.201	0.746	0.179	16.40%
MHPSQ	**0.758**	**0.111**	**0.817**	**0.109**	**7.80%**
IP	0.666	0.168	0.745	0.171	11.80%
DS	0.816	0.155	0.847	0.156	3.80%
PM	0.792	0.122	0.860	0.109	8.50%

Note: PR6 = Predictive 6 Factor Resilience Scale, VIS = Vision, COM = Composure, RES = Reasoning, HLT = Health, TEN = Tenacity, COL = Collaboration, MMT = Momentum, MHPSQ = Mental Health Peer Support Questionnaire, IP = Interpersonal Skills, DS = Discerning Stigma, PM = Personal Mastery, StDev = Standard Deviation

FIGURE 1: Change In PR6 Risk Groups Through RFA Training



Note: Vertical axis represents percentage of participants by distribution, horizontal axis represents PR6 score grouping. Risk Group characteristics are available in Table 6. PR6 = Predictive 6 Factor Resilience Scale, LO = Low PR6 resilience group, BA = Below Average PR6 resilience group, AA = Above Average PR6 resilience group, HI = High PR6 resilience group.

- **Personal Mastery** – Confidence in one's ability to provide peer support

Both tools previously demonstrated high internal consistency in this study (PR6 α = 0.8398; MHPSQ α = 0.74) (Rossouw J. G., Rossouw, Paynter, Ward, & Khnana, 2017; Ma, Gallo, Parisi, & Joo, 2022).

Data Collection

All data were collected electronically through Driven's secure online training platform. Participants completed assessments before starting the training and immediately upon finishing the course. No paper-based data collection was used.

Sample size was determined by the natural cohort of participants who engaged with the training during the research period. No a priori power analysis was conducted. Nonetheless, the achieved sample size provides sufficient scope for meaningful analysis of training outcomes and subgroup effects across delivery formats and industry sectors.

Results

The PR6 displayed sound psychometric properties with Chronbach's alpha = 0.8165, while the MHPSQ similarly has an alpha = 0.8343.

Overall pre-assessment (P1) PR6 resilience scores were 0.645 (St-dev = 0.136) and MHPSQ scores were 0.758 (St-dev = 0.111), fitting within the standard deviation of the previous RFA pilot evaluation (Rossouw & Ruberto, 2024) (Table 4).

Improvements in personal resilience and peer support skills were observed at post-assessment (P2). PR6 resilience increased by 14.5% (0.739, St-dev = 0.127), and MHPSQ scores increased by 7.8% (0.817, St-dev = 0.109).

Among the PR6 scores, the largest improvements were observed in Reasoning (Res; +16.7%), Vision (VIS; +16.6%), and Collaboration (COL) and Momentum (MMT), both with +16.4% gains. All domains showed positive change, with Composure (COM) showing the smallest but still notable improvement (+11.5%) (Table 4).

All industry groups demonstrated positive change in resilience following the training, as measured by the PR6 assessment. The degree of improvement varied by industry. The largest gains were observed in the Emergency Services & Safety sector, which showed a 20.3% increase in PR6 scores. Financial Services (+15.6%), Community & Social Work (+15.8%), and Technology (+19.8%) also exhibited substantial improvements. The lowest change was observed in the Construction & Transportation sector, which showed an 8.2% increase (Table 5).

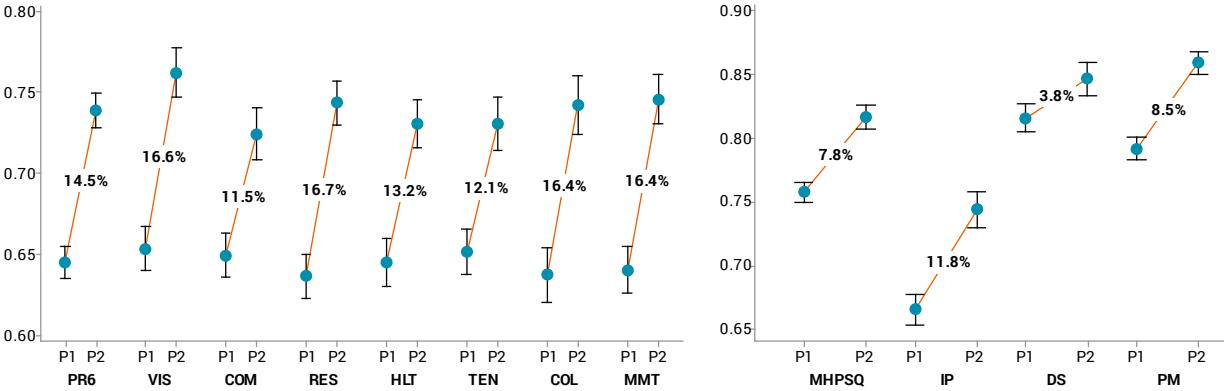
The Mental Health Peer Support Questionnaire (MHPSQ) also showed consistent improvement across all industry groups following the training. Overall, the MHPSQ mean score increased from 0.758 to 0.817, reflecting a 7.8% improvement across the full sample (Table 5).

The largest improvement was observed in the Financial Services sector (+17.1%), followed by Emergency Services & Safety (+10.8%) and Technology (+9.8%). Other sectors such as Community & Social Work (+5.0%), Education & Training

TABLE 6: Change In Risk Groups Through RFA Training

Group	Characteristics	Pre	Post	Change
LO - Low Resilience	PR6 < 50%; high risk group. Neuroticism elevated (M = 0.619), with significantly higher emotional vulnerability, anxiety, and depression. Baseline for comparison, Vulnerability M = 0.616. Depression M = 0.567, Anxiety M = 0.674	15.6%	3.5%	**-77.7%**
BA - Below Average	PR6 50% to <70%; moderate risk. Some strengths emerging, but still 2.8x higher vulnerability, 2.2x more anxiety, and 2.8x more depression than HI group. Transition group with partial protective factors developing.	52.1%	34.3%	**-34.2%**
AA - Above Average	PR6 70% to <85%; lower risk. Marked improvements: 65% higher Extraversion and 52% higher Conscientiousness vs LO group. Most mental health risk factors significantly reduced.	25.1%	41.7%	**+66.0%**
HI - High Resilience	PR6 ≥ 85%; protected group. Strongest mental health protection: lowest Neuroticism (M = 0.211), highest Conscientiousness (M = 0.846) and Extraversion (M = 0.721). 5.9x reduction in emotional vulnerability, 5.6x reduction in depression symptoms, 4.2x reduction in anxiety symptoms	7.2%	20.6%	**+187.3%**

FIGURE 2: Overall Change in PR6 and MHPSQ Scores



Note: Confidence Interval charts of pre (P1) and post (P2) assessment scores following training, indicating positive change on all domains. PR6 = Predictive 6 Factor Resilience Scale, VIS = Vision, COM = Composure, RES = Reasoning, HLT = Health, TEN = Tenacity, COL = Collaboration, MMT = Momentum, MHPSQ = Mental Health Peer Support Questionnaire, IP = Interpersonal Skills, DS = Discerning Stigma, PM = Personal Mastery, StDev = Standard Deviation

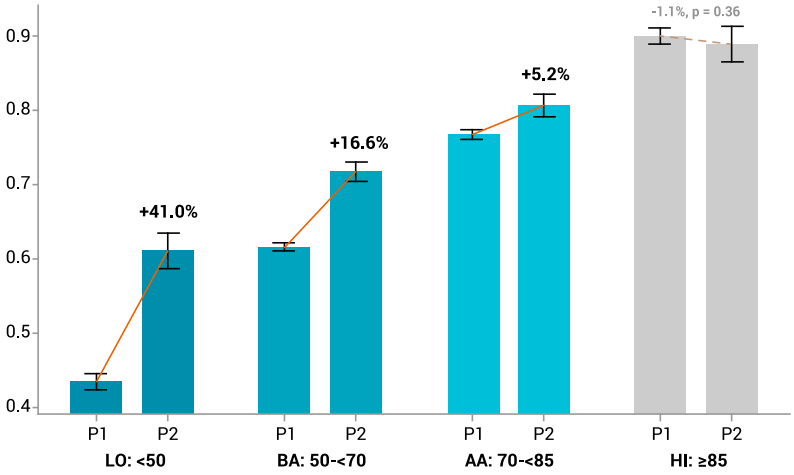
(+5.7%), and Healthcare (+5.5%) showed more modest but still positive gains.

Completion rates were highest among live training (82.1%) and self-paced mandatory participants (91.3%), with overall self-paced participants at 48.8% completion, and an overall completion rate of 70.9% across all delivery methods. The 48.8% SELF completion rate is generally higher than seen in a meta-study of digital wellness programs that found completion rates average to 43% (Cross & Alvarez-Jimenez, 2024). Self-paced participants were provided with a 12-month access window to complete the training and assessment, and further completions may still occur.

Risk Group Improvements

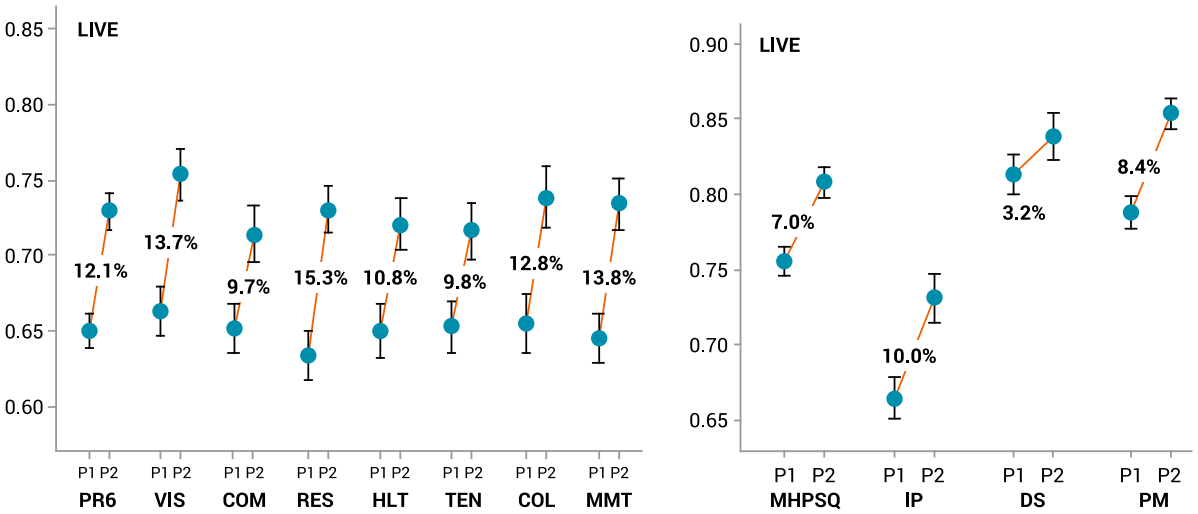
Analysis of pre- and post-training PR6 assessments revealed significant shifts in resilience distribution across the four defined categories: LO, BA, AA, and HI. Following RFA training, the proportion of

FIGURE 3: Change in PR6 Risk Starting Groups



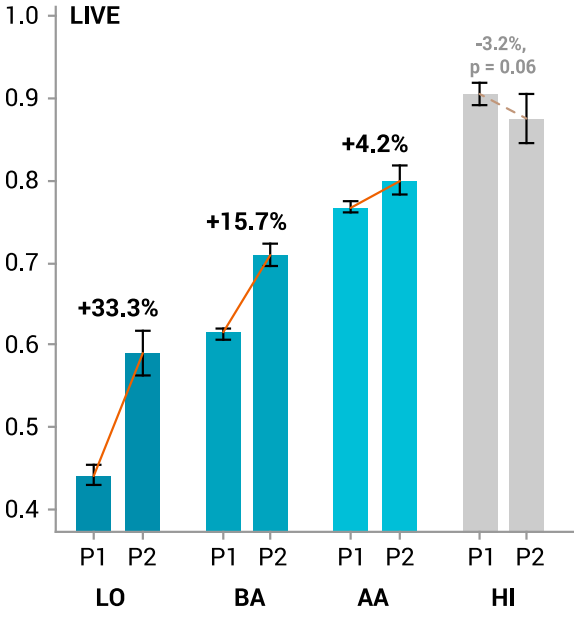
Note: Percentage change measured by risk starting group, noting strong improvements in this in higher risk groups. Solid line indicated statistically significant change. Dotted line indicates non-significant change. PR6 = Predictive 6 Factor Resilience Scale, LO = Low resilience group, BA = Below Average resilience group, AA = Above Average resilience group, HI = High resilience group

FIGURE 4: Change in PR6 and MHPSQ Scores for Live Participants



Note: Confidence Interval charts of pre (P1) and post (P2) assessment scores following Live training, indicating positive change on all domains. PR6 = Predictive 6 Factor Resilience Scale, VIS = Vision, COM = Composure, RES = Reasoning, HLT = Health, TEN = Tenacity, COL = Collaboration, MMT = Momentum, MHPSQ = Mental Health Peer Support Questionnaire, IP = Interpersonal Skills, DS = Discerning Stigma, PM = Personal Mastery, StDev = Standard Deviation

FIGURE 5: Change in PR6 Risk Starting Groups for Live Participants



Note: Percentage change measured by risk starting group, noting strong improvements in this in higher risk groups. Solid line indicated statistically significant change. Dotted line indicates non-significant change. PR6 = Predictive 6 Factor Resilience Scale, LO = Low resilience group, BA = Below Average resilience group, AA = Above Average resilience group, HI = High resilience group

participants in the LO group decreased markedly from 15.6% to 3.5%, representing a 77.7% reduction (Figure 1, Table 6). Similarly, the BA group declined from 52.1% to 34.3%, a 34.2% decrease. In contrast, the proportion of participants in the AA group rose from 25.1% to 41.7% (+66.0%), while the HI group more than doubled, increasing from 7.2% to 20.6%, a 187.3% gain.

These shifts indicate a clear upward movement in resilience capacity among participants, with a substantial number crossing the critical 85% PR6 threshold into the HI group. As defined in the PR6 Big5 study, this threshold is associated with significant protective benefits for mental health, including reduced vulnerability, anxiety, and depression, alongside improvements in Conscientiousness and Extraversion. The observed redistribution provides strong evidence that RFA training effectively moves individuals out of higher-risk categories (LO and BA) into more protective levels (AA and HI), aligning with the primary prevention objectives of the program.

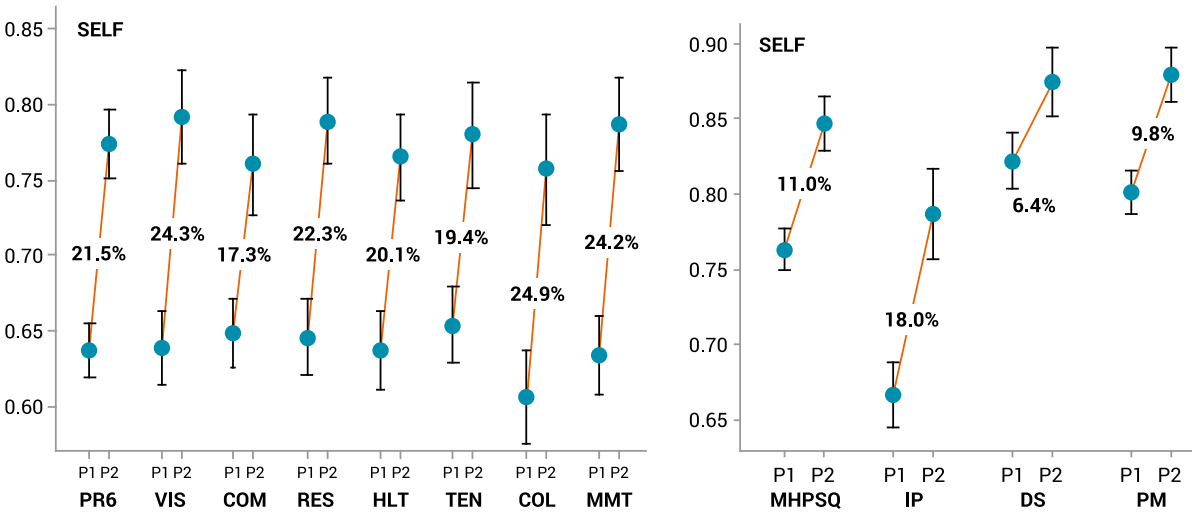
Live Training

Analysis of the 509 participants who completed RFA through the LIVE format revealed statistically and practically significant improvements in both resilience and peer support capabilities. P1 resilience scores, as measured by the PR6, averaged 0.650 and improved to 0.729 post-training – representing a 12.1% increase (Table 7). Similarly, Mental Health Peer Support Questionnaire (MHPSQ) scores rose from 0.755 to 0.808, a 7.0% improvement. These findings are visually depicted in Figure 4, which illustrates confidence intervals for all PR6 and MHPSQ domains before and after training.

All domains of resilience demonstrated gains among LIVE participants. The most substantial improvements were observed in Reasoning (RES; +15.3%), Vision (VIS; +13.7%) and Momentum (MMT; +13.8%), reflecting increased problem-solving, sense of purpose, and forward engagement with life post training. Collaboration (COL; +12.8%), and Health (HLT; +10.8%) also improved meaningfully. Although Composure (COM) demonstrated the smallest improvement (+9.7%), the change was still consistent with the upward trend across domains (Figure 4).

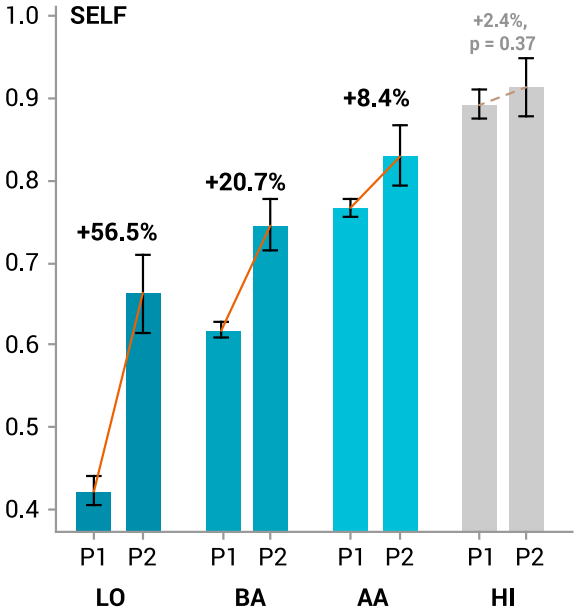
Peer support skills also advanced across all three MHPSQ subdomains. Interpersonal Skills (IP) increased by 10.0%, while Personal Mastery (PM) and Discerning Stigma (DS) improved by 8.4% and 3.2%, respectively. These enhancements support the program's emphasis on building confidence and

FIGURE 6: Change in PR6 and MHPSQ Scores for Self-paced Participants



Note: Confidence Interval charts of pre (P1) and post (P2) assessment scores following Self-Paced training, indicating positive change on all domains. PR6 = Predictive 6 Factor Resilience Scale, VIS = Vision, COM = Composure, RES = Reasoning, HLT = Health, TEN = Tenacity, COL = Collaboration, MMT = Momentum, MHPSQ = Mental Health Peer Support Questionnaire, IP = Interpersonal Skills, DS = Discerning Stigma, PM = Personal Mastery, StDev = Standard Deviation

FIGURE 7: Change in PR6 Risk Starting Groups for Self-paced Participants



Note: Percentage change measured by risk starting group, noting strong improvements in this in higher risk groups. Solid line indicated statistically significant change. Dotted line indicates non-significant change. PR6 = Predictive 6 Factor Resilience Scale, LO = Low resilience group, BA = Below Average resilience group, AA = Above Average resilience group, HI = High resilience group

competence in providing peer support, while fostering awareness of mental health stigma.

Across industries, LIVE participants experienced broad benefits, though variation in impact was evident. Financial Services reported the highest gain in MHPSQ scores (+15.9%), followed by Emergency Services & Safety (+8.3%) and Government (+7.4%). For PR6 scores, Community & Social Work (+14.7%) and Financial Services (+14.4%) showed the greatest resilience improvements, while Education & Training (+10.1%) and Government (+8.9%) observed more moderate increases (Table 7).

A key measure of effectiveness was the effect of RFA training on participants in risk categories. Figure 5 illustrates that participants in the LO group (highest mental health risk) on average increased PR6 resilience scores by 33.3%. Those in the BA group increased by an average of 15.7%, showing strong value to those with the highest risk. The AA group experienced an average of 4.2% increase in PR6 scores, while those in the HI group noted no statistically significant change.

Self-paced Training

A total of 260 participants engaged RFA training via the self-paced online format (SELF). This cohort demonstrated strong improvements in both resilience and peer support outcomes, with average PR6 scores increasing from 0.637 to 0.774, representing a 21.5% improvement. Similarly, MHPSQ scores rose from 0.763 to 0.847, reflecting an 11.0% increase (Table 8). These gains exceeded the improvements observed in the LIVE format cohort and are graphically represented in Figure 6, which shows consistent upward trends across all measured domains.

The most pronounced increases in PR6 domains for self-paced participants were found in Collaboration (COL; +24.9%), Vision (VIS; +24.3%), Reasoning (RES; +22.3%), and followed closely by Health (HLT; +20.1%) and Tenacity (TEN; +19.4%). These gains suggest substantial development in goal setting, mental flexibility, interpersonal connection, and health-related behaviors. Notably, Composure (COM) also improved considerably (+17.3%), suggesting that even in a self-directed learning environment, emotional regulation skills can be effectively enhanced.

Improvements in peer support skills were similarly strong. Interpersonal Skills (IP) improved by 18.0%, Discerning Stigma (DS) by 6.4%, and Personal Mastery (PM) by 9.8%. These results

TABLE 5: Change by Industry - All Responses

Industry	All	PR6 - P1	PR6 - P2	PR6 Δ	MHPSQ - P1	MHPSQ - P2	MHPSQ Δ
Community & Social Work	65	0.626	0.724	**15.8%**	0.783	0.822	**5.0%**
Construction & Transportation	14	0.607	0.656	**8.2%**	0.740	0.797	**7.6%**
Education & Training	191	0.671	0.748	**11.4%**	0.766	0.810	**5.7%**
Emergency Services & Safety	143	0.627	0.755	**20.3%**	0.750	0.831	**10.8%**
Financial Services	24	0.644	0.744	**15.6%**	0.675	0.790	**17.1%**
Government	65	0.643	0.720	**12.0%**	0.758	0.826	**8.9%**
Healthcare	74	0.626	0.712	**13.8%**	0.776	0.818	**5.5%**
Professional Services	24	0.679	0.771	**13.6%**	0.777	0.838	**7.8%**
Technology	18	0.614	0.736	**19.8%**	0.689	0.783	**13.6%**
Other	151	0.651	0.748	**14.9%**	0.756	0.822	**8.8%**
Total	**769**	**0.645**	**0.739**	**14.5%**	**0.758**	**0.817**	**7.8%**

Note: PR6 = Predictive 6 Factor Resilience Scale, MHPSQ = Mental Health Peer Support Questionnaire, P1 = Pre-assessment, P2 = Post-assessment, Δ indicates percentage change.

TABLE 7: Change by Industry - Live Participants

Industry	All	PR6 - P1	PR6 - P2	PR6 Δ	MHPSQ - P1	MHPSQ - P2	MHPSQ Δ
Community & Social Work	53	0.628	0.720	**14.7%**	0.786	0.822	**4.6%**
Construction & Transportation	11	0.601	0.656	**9.3%**	0.766	0.797	**4.0%**
Education & Training	152	0.669	0.737	**10.1%**	0.753	0.794	**5.5%**
Emergency Services & Safety	45	0.637	0.720	**13.0%**	0.756	0.819	**8.3%**
Financial Services	23	0.650	0.744	**14.4%**	0.682	0.790	**15.9%**
Government	41	0.661	0.720	**8.9%**	0.760	0.816	**7.4%**
Healthcare	53	0.636	0.708	**11.3%**	0.777	0.814	**4.8%**
Professional Services	14	0.686	0.745	**8.6%**	0.798	0.847	**6.1%**
Other	117	0.641	0.738	**15.1%**	0.742	0.814	**9.7%**
Total	**509**	**0.650**	**0.729**	**12.1%**	**0.755**	**0.808**	**7.0%**

Note: Live = Completion via a certified instructor, PR6 = Predictive 6 Factor Resilience Scale, MHPSQ = Mental Health Peer Support Questionnaire, P1 = Pre-assessment, P2 = Post-assessment, Δ indicates percentage change.

TABLE 8: Change by Industry - Self-paced Participants

Industry	All	PR6 - P1	PR6 - P2	PR6 Δ	MHPSQ - P1	MHPSQ - P2	MHPSQ Δ
Community & Social Work	12	0.613	0.754	**23.1%**	0.774	0.826	**6.8%**
Education & Training	39	0.678	0.813	**19.9%**	0.816	0.904	**10.7%**
Emergency Services & Safety	98	0.623	0.777	**24.7%**	0.747	0.838	**12.2%**
Government	24	0.612	0.721	**17.7%**	0.755	0.852	**12.9%**
Healthcare	21	0.599	0.731	**22.0%**	0.772	0.835	**8.1%**
Professional Services	10	0.670	0.825	**23.2%**	0.749	0.820	**9.5%**
Technology	14	0.652	0.765	**17.3%**	0.715	0.767	**7.3%**
Other	42	0.657	0.774	**17.8%**	0.770	0.866	**12.4%**
Total	**260**	**0.637**	**0.774**	**21.5%**	**0.763**	**0.847**	**11.0%**

Note: Self-paced = Completion via self-paced online learning, PR6 = Predictive 6 Factor Resilience Scale, MHPSQ = Mental Health Peer Support Questionnaire, P1 = Pre-assessment, P2 = Post-assessment, Δ indicates percentage change.

demonstrate that the self-paced format successfully develops essential peer support competencies and confidence in applying them.

A noteworthy outcome within the SELF training group was the sub-analysis of participants for whom RFA completion was mandatory. This sub-group included 23 individuals, of whom 21 completed the training, resulting in a high completion rate of 91.3%. By contrast, overall completion among the broader self-paced cohort was 48.8%, indicating that mandating participation may significantly improve engagement and course completion.

To explore whether the mandatory condition influenced outcomes, a two-sample t-test was conducted comparing changes in PR6 scores between mandatory (n = 21) and voluntary (n = 106) participants. The mean change in the mandatory group was 0.200 (StDev = 0.223), while the voluntary group had a slightly higher mean change of 0.218 (StDev = 0.262). The estimated difference in means was -0.0181 with a 95% confidence interval of (-0.1302, 0.0940). The result was not statistically significant (t = -0.33, p = 0.744, df = 31), indicating that both RFA groups achieved similar improvement irrespective of whether participation was voluntary or mandatory.

This finding is of particular importance when considering broader implementation strategies. The comparable efficacy of mandatory and voluntary completion, combined with higher completion rates among mandatory participants, supports the recommendation that RFA training may be effectively designated as a required component of workplace wellbeing programs. Such an approach could help maximize program reach and impact while preserving the training's positive outcomes.

Further, analysis of risk group transitions confirmed robust improvements for SELF participants. Participants in the LO on average increased PR6 scores by 56.5%, while those in the BA group increased by 20.7%. This represents a strong impact on those most at risk of mental illness. Participants in the AA group increased by 8.4% on average, and those in the HI group didn't experience a statistically significant change. Figure 7 illustrates this impact, particularly the pronounced upward movement from vulnerable to protective resilience levels, reinforcing the primary prevention potential of the self-paced RFA format.

Suicide Prevention

A key item within the MHPSQ that directly reflects suicide prevention capability is the reverse-scored statement: "I find it difficult to identify warning signs of suicide." In the current study, this item showed a substantial improvement of 30.0% from pre- to post-assessment, indicating a significant enhancement in participants' ability to recognize early warning signs of suicide.

This finding builds upon the 2024 pilot evaluation, which reported a 21% increase at post-assessment and a 33.33% gain at four-week follow-up (Rossouw & Ruberto, 2024). The present result not only confirms the prior trend but also affirms the effectiveness of RFA in equipping individuals with a critical suicide prevention skill

As this item most directly reflects the early intervention capacity central to primary prevention strategies, its continued improvement across studies supports RFA's value as an accredited suicide prevention training program. This outcome reinforces RFA's broader potential to reduce the incidence of suicidal ideation and promote earlier help-seeking and support within communities.

Participant Feedback

To assess the subjective experience of participants, all individuals who completed Resilience First Aid (RFA) training were invited to provide feedback on three core dimensions of the program: the overall experience, the instructor(s), and the accompanying materials. These dimensions were rated using a 5-point Likert scale ranging from 'Very Dissatisfied' to 'Very Satisfied'.

Across all respondents, the RFA program received exceptionally high satisfaction ratings: 93.2% of participants rated the program overall as 'Satisfied' or 'Very Satisfied', with instructor satisfaction rated even higher at 94.5% (Table 9). Ratings for the materials - which included the RFA manual and Responder Pack - matched the overall program rating at 93.2%.

These high approval levels were consistent across both delivery formats. The LIVE format received slightly higher scores for all three categories (Program: 93.8%, Instructor: 94.7%, Materials: 93.8%) compared to the SELF format (Program: 91.1%, Instructor: 93.5%, Materials: 91.1%), indicating consistently strong engagement and perceived value regardless of training delivery method.

TABLE 9: Satisfaction Ratings

	Program	Instructor	Materials
Overall	93.2%	94.5%	93.2%
Live	93.8%	94.7%	93.8%
Self-paced	91.1%	93.5%	91.1%

Qualitative feedback was overwhelmingly positive and offers deeper insight into participants' experiences. Several key themes emerged from the open-ended responses:

- **Relevance and Practicality:** Participants consistently highlighted the applicability of the RFA training to both personal and professional contexts. Many described the tools and frameworks - particularly the ALL Protocol and the PR6 model - as immediately usable, easy to remember, and helpful for real-world mental health support.
- **Neuroscience and Engagement:** The neuroscience component was frequently cited as a standout feature, with participants expressing appreciation for learning how brain function relates to resilience. The combination of scientific explanation with relatable visuals, such as whiteboard videos and handouts, was credited with enhancing understanding and retention.
- **Flexibility and Accessibility:** Self-paced (SELF) participants valued the ability to engage with the course at their own schedule, describing the structure as intuitive and the app interface as helpful in tracking progress. The LIVE format was praised for its interactive sessions, group discussions, and the expertise and energy of facilitators.
- **Instructional Quality:** Instructors received specific commendations for being engaging, knowledgeable, and relatable. Several facilitators were personally named and praised for their enthusiasm, storytelling, and ability to foster a safe, inclusive learning environment.
- **Behavioral Impact:** Numerous participants reported increased self-awareness and described using what they learned to support others in meaningful ways. Some noted that the training helped them better understand personal mental health challenges and provided strategies to manage stress and improve resilience.

Constructive feedback, though limited, provided valuable suggestions. A few participants noted that the course could benefit from greater interactivity in the self-paced format, shorter videos, and clearer progress indicators in the online modules. Others requested additional downloadable resources, more examples of the ALL protocol in action, and, particularly for LIVE participants, more time for reflection and discussion.

Overall, participant feedback affirms the strong reception and practical value of RFA training across formats. The high approval ratings, alongside detailed thematic commentary, support the conclusion that the program is well-designed, engaging, and effective in equipping individuals with proactive mental health skills.

Discussion

The findings of this study provide compelling evidence that RFA training meaningfully enhances both personal resilience and peer support skills across diverse populations and delivery formats. Building on earlier pilot research, this expanded evaluation with a robust sample size (n = 769) confirms RFA's scalability and effectiveness as a proactive mental health intervention.

Effectiveness Across Measures

The overall improvement in PR6 scores (+14.5%) and MHPSQ scores (+7.8%) underscores the strength-based nature of the RFA program. Notably, the domains showing the greatest improvements were Reasoning (+16.7%), Vision (+16.6%), and Collaboration (+16.4%), reflecting participants' growing capacity for adaptive thinking, goal-setting, and social

connection - all of which are core pillars of the PR6 model. Gains in these domains suggest that RFA training equips individuals not only with emotional tools but also with practical strategies for engaging with life's challenges more effectively.

Complementing the increase in personal resilience, participants also showed meaningful gains in peer support capabilities as measured by the MHPSQ. Among the three subdomains, IP showed the highest improvement (+11.8%), suggesting stronger communication and empathic engagement with others through the ALL Protocol. PM, which reflects confidence in one's ability to provide support, improved by 8.5%, indicating greater self-efficacy among participants. While DS showed a more modest gain (+3.8%), this still reflects a positive shift in participants' awareness and ability to challenge mental health stigma. These outcomes reinforce the value of RFA not only as a personal development tool but also as a catalyst for improving community-level mental health support networks.

These quantitative gains were mirrored by strong subjective feedback, with over 93% of participants expressing satisfaction with the training content, instructors, and materials. The inclusion of neuroscience, practical tools such as the ALL Protocol, and interactive learning elements were consistently praised - reinforcing the program's engagement and accessibility.

Improvements Across Risk Groups

Perhaps the most impactful outcome of this study was the marked reduction in psychological risk, as reflected in PR6 category transitions. Participants in the LO resilience group declined from 15.6% to 3.5% - a 77.7% reduction - while the HI resilience group nearly tripled from 7.2% to 20.6%. These upward shifts are of particular importance given the well-established protective mental health outcomes associated with high resilience, including significant reductions in anxiety, depression, and emotional vulnerability (Rossouw J. G., 2024).

The fact that participants from the LO and BA categories experienced the largest percentage increases in resilience (LO: +33.3% in live training; +56.5% in self-paced training) highlights RFA's value as an early intervention for those at heightened mental health risk. These improvements suggest that the program can meaningfully shift the resilience baseline in the general population - a critical requirement for effective primary prevention.

Delivery Format Differences

Both the LIVE and SELF formats yielded statistically and practically significant improvements, though the self-paced cohort demonstrated slightly higher overall gains in both resilience (+21.5%) and peer support skills (+11.0%) compared to the live cohort (+12.1% and +7.0%, respectively). This may reflect the extended engagement window in the SELF format, allowing participants to revisit content and integrate skills at their own pace.

PR6 and MHPSQ improvement on average for SELF is 77.5% and 57.1% higher than LIVE training respectively.

One consideration is the potential for selection bias in voluntary participation. Individuals who voluntarily choose to engage with training may already be more motivated or possess higher baseline capabilities, potentially reducing the observable treatment effect. However, in our study, outcomes did not differ significantly between mandatory and voluntary participants in the SELF format, suggesting comparable efficacy. Notably, mandatory participants showed much higher completion rates (91.3% vs. 48.8%), indicating a clear benefit in engagement when participation is required.

Recent experimental evidence from a large workplace mentorship study by Sandvik et al. supports these findings (Sandvik, Saouma, Seegert, & Stanton, 2021). Their field trial revealed that the greatest productivity gains were seen among individuals who were least likely to opt into voluntary programs, and that mandatory participation was essential to unlocking the full benefit of the intervention. Voluntary programs disproportionately attracted higher-performing employees with the least to gain, while lower-performing individuals - who stood to benefit most - often opted out. These findings underscore the potential for mandatory programs not only to increase completion but also to ensure that high-risk individuals receive support, ultimately maximizing program impact.

Taken together, the current study and broader evidence suggest that integrating RFA as a required component of workplace wellbeing programs may yield stronger, more equitable outcomes. By removing participation barriers and reaching those who may not otherwise seek out support, mandatory implementation can improve engagement, reduce disparities in benefit, and better realize the preventative aims of the training.

Industry Insights

All industry groups showed improvements post-training, though the magnitude of change varied. Emergency Services & Safety showed the largest resilience gains (+20.3%), which is particularly significant given the elevated baseline stress and trauma exposure in this sector. The Financial Services and Technology sectors also demonstrated notable gains across both resilience and peer support, potentially reflecting a growing demand for proactive mental health training in high-performance work environments.

Conversely, industries such as Construction & Transportation showed more modest though still meaningful gains (+8.2% PR6, +7.6% MHPSQ), which may be influenced by cultural or systemic barriers to engagement with mental health training. These disparities warrant further exploration, including tailored approaches and incorporate of lived experience to boost uptake and relevance within specific sectors.

Limitations

This study's pre-post design, while useful for measuring change, does not control for external variables that may influence results over time. Longitudinal follow-up would help determine the durability of observed gains and further validate RFA's protective impact over time, expanding on previous pilot research that showed further improvements over four weeks post training (Rossouw & Ruberto, 2024). Additionally, while completion rates for mandatory SELF participants were encouraging, the overall drop-off in the self-paced group highlights the importance of motivational support to sustain engagement or otherwise set training as a mandatory component of a workplace wellness program (Sandvik, Saouma, Seegert, & Stanton, 2021).

Implications and Future Directions

The results of this study support the conclusion that RFA training is a scalable, flexible, and effective intervention for building psychological resilience and peer support capabilities. It provides critical upstream value in mental health prevention efforts - shifting individuals into more protected resilience

bands and building a peer network better equipped to recognize and respond to early signs of distress (Kirkbride, et al., 2024).

Given the comparable efficacy of live and self-paced formats, RFA can be confidently deployed in both in-person and digital settings to meet workplace and community needs. Future research should explore long-term outcomes, the influence of specific program elements (e.g., ALL Protocol practice), and strategies for increasing engagement among lower-performing groups.

In an era where mental health systems remain overstretched and reactive, scalable primary prevention solutions like RFA represent a vital shift toward a proactive, skill-based public health approach. RFA's results in enhancing both personal and community resilience connects to recent findings on the value of enhancing collective capacity (Migliorini, Olcese, & Cardinali, 2025). The present study affirms its relevance, impact, and promise as a cornerstone of community mental health promotion.

Conclusion

This study provides strong empirical support for Resilience First Aid (RFA) as an effective, scalable, and well-received primary prevention training program that strengthens both personal resilience and peer support capabilities. Across a diverse participant base, RFA led to statistically and practically significant improvements in mental health protective factors, with especially marked gains in high-risk groups. The program was successful in shifting participants out of psychologically vulnerable categories and into more resilient, protected states, reinforcing the relevance of the PR6 model in building adaptive capacity across populations.

Crucially, peer support skills also advanced meaningfully, including a 30% improvement in noticing suicide warning signs – affirming RFA's critical role in suicide prevention. These results validate RFA's design, which integrates neuroscience-based frameworks and strength-building interventions, while offering practical and accessible tools such as the ALL Protocol.

Both live and self-paced delivery formats proved effective, allowing RFA to be implemented flexibly across workplace and community settings, with mandatory training appearing as a useful pathway to achieve strong results and high completion rates. High participant satisfaction and strong behavioral feedback further underscore the program's real-world relevance and impact.

In conclusion, RFA stands as a proactive, evidence-based approach to addressing the global mental health crisis, offering a valuable addition to workplace wellbeing strategies and public health initiatives. Its continued deployment and evaluation will be essential to building a more resilient, connected, and mentally healthy society.

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