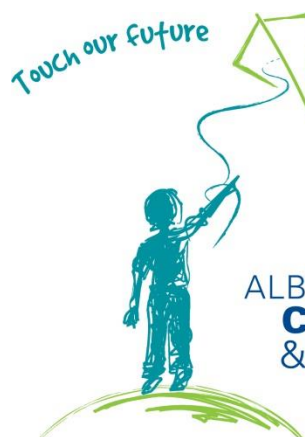# Implementation of Skills for Psychological Recovery in Alberta Post-flood: A Developmental Evaluation
Final Report

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Executive Summary

Skills for Psychological Recovery (SPR) is a disaster-related psychosocial support (DR-PSS) that was implemented following the 2013 Southern Alberta flood. In spring 2014, Alberta's Ministry of Health funded a two year Developmental Evaluation. The purpose of the evaluation was to:

1. Document how SPR has been implemented in Southern Alberta (including any adaptations that were made for this context)
2. Identify the infrastructure, capacities and resources required for SPR to be effectively implemented and sustained across the province
3. Assess whether SPR should be scaled up and implemented as part of a broader approach to psychosocial support in Alberta

Integral to achieving these goals was a study of the bigger picture of DR-PSS and an understanding of where SPR fit within the broader range of supports required to promote recovery and resilience after a disaster.

Methods

Multiple methods were used for this evaluation, including: interviews with Alberta practitioners who were trained in SPR (n=42), interviews with key informants from other jurisdictions that have implemented SPR (n=15), facilitation of a team of representatives from various organizations involved in implementing SPR (referred to as the SPR Development Team), evaluation of SPR in a non-disaster context, and a review of the literature related to SPR and disaster-related psycho-social supports more generally. Reports were generated for all of these evaluation activities, and the high level findings from each are integrated into this summary report.

Key Insights related to DR-PSS and SPR

The following insights represent a synthesis of overall findings from the developmental evaluation related to DR-PSS and SPR. Detailed description of the findings related to each of these insights will be discussed in further detail in later sections. Key insights identified through the developmental evaluation include:

- **Psychosocial supports are an integral aspect of the overall disaster effort.** A continuum of individual and community supports is required to effectively respond to, and address, the psychosocial impacts of disaster.

- **SPR is one component of a broader approach to DR-PSS**; one that includes not only clinical interventions, but also capacity- and resilience-building interventions for both individuals and communities.

- **SPR is a low-intensity, skills-based psychosocial support designed to promote adaptive coping in disaster-affected individuals who are experiencing mild to moderate distress**. The intervention has been used in a number of countries throughout the world, including the US, Australia and Japan.

- **SPR is based on considerable research about the kinds of mental health issues that are most likely to occur post-disaster, and the types of strategies that are most effective in preventing these problems.** Evaluations from other jurisdictions show that practitioners feel SPR has been helpful in their work with people post-disaster. Practitioners in Alberta have offered similar feedback.

- SPR was implemented in Southern Alberta after the 2013 flood, and has continued to gain momentum since that time. **About 280 Alberta practitioners have now been trained in SPR, and a number of resources have been developed to support implementation**.

- **Alberta is the first jurisdiction to have piloted the use of SPR in non-disaster contexts**, and practitioners here (and elsewhere) feel that SPR has relevance for everyday coping and resilience. By integrating SPR into everyday practice, practitioners can maintain the capacity to deliver the intervention between disasters.

- **By integrating SPR into everyday practice, practitioners can maintain the capacity to deliver the intervention between disasters.**

- Because **SPR has the potential to promote individual and community resilience in both disaster *and* non-disaster contexts,** an investment in this approach is an investment in the overall wellbeing of Albertans.

- **Given the complexity of communities, disasters, and comprehensive approaches to DR-PSS, it is crucial to embed a solid approach to ongoing learning and adaptation into this work.** SPR requires ongoing learning and evaluation to better understand how people integrate it into their lives and whether they find the intervention helpful. Collective and participatory approaches to learning and development may be particularly valuable (e.g., participatory action research, developmental evaluation and community-academic partnerships).

- **Sustained system and organizational supports are needed.** In order to scale SPR provincially, leadership and collaboration will be required within larger systems, including governmental ministries, provincial and municipal emergency management agencies, and various portfolios within Alberta Health Services. In time of disaster, DR-PSS (including SPR) are more effectively mobilized when a provincial post-disaster psychosocial framework is well established and sustained in non-disaster contexts.

Findings

How has SPR been implemented in Alberta?

In November 2013 and January 2014, Alberta Health Services (AHS) facilitated SPR training sessions with over 100 practitioners from Calgary and the surrounding area. As of spring 2016, about 280 Albertans

have been trained in SPR. Interviews with some of the trainees suggested that most (70%) had used or were using SPR in the year following the flood, and almost all found the intervention to be helpful. A key barrier to using SPR was citizen engagement (i.e., practitioners experienced challenges engaging people who might benefit from the intervention). Requests for ongoing coaching, mentoring and support were common.

Many (65.5%) of the interviewees who were implementing SPR said that they were using the intervention not only with flood-affected people, but also with others who were experiencing other forms of stress or trauma unrelated to the flood (e.g., domestic violence, job loss, marriage breakdown). This finding suggests that many feel the value of this intervention goes beyond disaster recovery; a hypothesis that was tested to some extent by members of the Development Team. Alberta agencies have piloted the use of SPR in several non-disaster settings, including a homeless shelter and four social housing sites.

Since the initial training sessions, AHS has continued to promote SPR as a key component of a stepped care approach to disaster psychosocial recovery, and has worked with organizations such as the Canadian Red Cross, Samaritan's Purse, Hull Services, and Carya in Southern Alberta to build greater capacity to deliver disaster-related psychosocial supports in the province. This has included the development of a number of SPR-related resources and supports.

What is required to optimize the effectiveness and sustainability of SPR?
A number of factors were identified that can help to optimize the effectiveness and sustainability of SPR in Alberta. These include:

- **A system-wide continuum of support:** Most DR-PSS emphasize clinical or treatment-based interventions. SPR is not a clinical intervention; it is essentially "facilitated self-help." A philosophical shift is therefore required to embrace a broader approach to psychosocial recovery and wellbeing.

- **Effective engagement strategies:** The literature suggests that few people seek out formal counseling or psychosocial supports after a disaster, and partially because mental health interventions tend to be stigmatized. Therefore, practitioners need to be supported to know how best to engage citizens in SPR.

- **Opportunities to practice SPR between disasters:** As with any skill or competency, the capacity to implement SPR can only be maintained through practice (i.e., use it or lose it). Use of SPR in non-disaster contexts provides an opportunity to embed the intervention into everyday practice and maintain skills between disasters.

- **Ongoing coaching, mentoring and support:** Findings from both the literature and practitioner interviews clearly point to the need for ongoing mentoring, training, case-conferencing and supervision in order to support effective implementation.

- **Achieving a balance between fidelity with flexibility:** SPR is designed to be flexibly deployed to meet the specific needs and goals of each individual. This level of flexibility is one of the strengths of the intervention, but it must be balanced with fidelity to the underlying principles and functional elements of SPR.

- **Effective system and organizational supports:** The leadership and collaboration that has been evident in Southern Alberta has sparked considerable momentum around SPR and has helped to enhance stakeholders' understanding of how best to implement this intervention. In order to scale SPR to the rest of the province, this type of leadership and collaboration will be required within larger systems, including governmental ministries (e.g., Health, Education, Municipal Affairs, Human Services), provincial and municipal emergency management agencies (e.g., Alberta Emergency Management Agency), and various portfolios within AHS. For effective provincial implementation, DR-PSS (including SPR) will also need to be adequately resourced and supported, provincial and regional oversight, as well as ongoing training and support.

Who should deliver SPR?
The SPR manual states that "SPR is designed for delivery by mental health and other health workers who provide ongoing support and assistance to affected children, families, and adults as part of an organized disaster response effort" (Berkowitz et al., 2010, p. 10); however, some of the developers of SPR suggested that other professionals (e.g., social workers) could effectively deliver the intervention. At least two of the developers are open to exploring delivery of SPR by paraprofessionals and lay persons. Because people who have had no prior involvement with a mental health professional are unlikely to seek out support from a clinical professional after a disaster, it may be important to find ways to deliver community-based supports via a *range* of professionals (e.g., community workers), paraprofessionals (e.g., faith leaders) and lay persons (e.g., volunteers).

Should SPR be implemented as part of the post-disaster psychosocial response in Alberta?
There are several reasons that SPR should comprise a component of the province's disaster-related psychosocial response, including the following:
- SPR is based on substantial research and evaluative evidence related to psychosocial supports and demonstrates that these types of principles and techniques are effective in reducing risk and promoting resilience following trauma.

- Evaluations show that SPR is considered effective by practitioners in jurisdictions in the US and Australia who say that SPR has been helpful in their work with people post-disaster. Alberta practitioners echo these reports, saying that the skills are helpful and the intervention provides structure that helps them to feel more confident in their post-disaster work.

- Low-intensity supports like SPR are increasingly being included in DR-PPS frameworks internationally (e.g., by the World Health Organization), and SPR has been implemented in jurisdictions throughout the world, including Australia, Hong Kong, Japan, Poland, Singapore, Ukraine and the United States.

- There is considerable momentum around SPR in Southern Alberta.

- SPR has the potential to impact outcomes beyond the disaster context (i.e., the skills that are required for adaptive coping after a disaster are the same skills that are needed for resilience generally).

Conclusions

An effective DR-PSS approach requires a coordinated, cross-sectoral, cross-ministerial collaborative strategy which includes SPR. For future provincial implementation of a Provincial DR-PSS response one option is creation of an Inter-Sectoral DR-PSS Network supported by a Network Administration Organization.

Introduction

In June 2013, Alberta experienced the worst flood in its history. Triggered by high water levels and heavy rainfalls, the flood affected residents across Southern Alberta, including the communities of Black Diamond, Calgary, Canmore, Crowsnest, Exshaw, High River, Lethbridge, Siksika and Turner Valley. Over 100,000 people were evacuated, approximately 2,700 people were displaced from their homes, and many schools and business were closed. The floods resulted in five deaths. In total, 31 communities were directly affected by the flood, and damage costs were estimated at over $5 billion (MNP, 2015).

The psychosocial impacts to citizens in Southern Alberta after the flood were "severe" (MNP, 2015, p. 31), highlighting the need for effective provision of disaster-related psychosocial supports (DR-PSS). Following the flood, Alberta's Ministry of Health provided funding to Alberta Health Services (AHS) to implement *Skills for Psychological Recovery* (SPR), an evidence-informed intervention designed to foster short- and long-term adaptive coping in disaster survivors who are experiencing mild to moderate distress (Berkowitz et al., 2010). SPR is based on a large body of research that suggests that skills-based approaches are more effective than narrative therapy or supportive counseling in post-trauma situations (Watson, 2016). Five skills comprise the basis of the intervention: problem-solving, positive activities, managing reactions, helpful thinking, and building healthy social connections (Berkowitz et al., 2010).

> Psychosocial wellbeing pertains to the intersection between the psychological (the inner mind, recognition of one's own strengths and values), the social (social connections and support of the individual and community), the environment in which one lives (cultural norms and social expectations) and the social determinants of health. Psychosocial wellbeing is dynamic and contextually determined.

In spring 2014, the Alberta Centre for Child, Family and Community Research (the Centre) supported a Developmental Evaluation (DE) of SPR implementation in Alberta. Funded by the Ministry of Health, the purpose of the evaluation was to:

1. Document how SPR has been implemented in Southern Alberta (including any adaptations that were made for this context).
2. Identify the infrastructure, capacities and resources required for SPR to be effectively implemented and sustained across the province.
3. Assess whether SPR should be scaled up and implemented as part of a broader approach to psychosocial support in Alberta.

Integral to achieving these goals was a study of the 'bigger picture' of DR-PSS. This provided a foundation for understanding SPR within the larger context of DR-PSS supports, and was critical to determining whether and how SPR should be scaled across Alberta.

Over the course of the evaluation (May 2014 to May 2016), multiple methods were employed to document implementation of SPR in Southern Alberta, determine its appropriateness for the Alberta context, and work with stakeholders to develop an understanding of the conditions required to scale this approach across the province in an effective and sustainable way. Methods included:

- Interviews with Alberta practitioners (n=42) who were trained in SPR
- An environmental scan, which included a review of grey literature and interviews with key informants from other jurisdictions (n=15)
- Facilitation of a team of representatives from various organizations involved in implementing SPR (referred to as the SPR Development Team)
- Review of the literature related to SPR and disaster-related psycho-social supports[1]

The data generated by the evaluation led to a shift in the collective understanding of SPR. While the approach was originally designed to prevent the development of psychopathology after a disaster, the skills that comprise the intervention are also conducive to the promotion of positive mental health and resilience (i.e., self-empowerment/self-efficacy, and an increased ability to cope with adversity). As such, the range of outcomes that might be associated with SPR could be expanded beyond prevention of pathology to the promotion of psychosocial well-being and enhanced capacity for resilience. With this understanding, the focus of was expanded in the second year to include an evaluation of implementation of SPR in non-disaster contexts.

> This report is intended to offer a high-level overview of the findings emerging from all of these evaluation activities and briefly answer key evaluation questions that were developed at the outset of this project. The report concludes with recommendations and options for scaling SPR across Alberta as part of a broader approach to DR-PSS.

Methods

This section briefly outlines key methods used over the course of this two-year evaluation. For more detailed methodology, please refer to the Methods sections within each of the reports that were generated for this initiative.

Evaluation Approach

DE was the approach taken for this evaluation. DE is appropriate in situations that are marked by social complexity, emergence and high levels of adaptation. In contrast to traditional forms of evaluation, DE situates the evaluator within the development team to support evidence-informed decision-making and course-correction throughout the initiative (Quinn Patton, 2011).

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[1] Detailed reports outlining findings from each of these evaluation activities were produced, and can be accessed from The Alberta Centre for Child, Family and Community Research.

The approach was deemed the most suitable evaluation method in this situation for several reasons:

1. SPR was being implemented by a range of practitioners in diverse settings, with varying organizational support. Therefore, the situation was not stable enough to conduct an impact evaluation.
2. While the content that comprises SPR is based on a large body of research, little is known about how best to implement it (i.e., the best way to deliver the content and help citizens to develop the skills that comprise SPR). Thus there is some need for further testing and development related to the implementation of SPR.
3. SPR was developed in the US and had not been implemented in Canada prior to 2013. The Centre was aware that the approach might need to be adapted to fit the Alberta context and align with the larger psychosocial strategy in this province.
4. The literature suggests that changing practice requires far more than training – it involves attending to a range of individual, organizational and systemic factors and conditions (Fixsen et al., 2005). Thus, the evaluation needed to extend beyond training to encompass a complex range of factors that potentially influence implementation.

Given all of these considerations, the evaluation design was necessarily emergent in nature. However, it was guided by a comprehensive Learning Framework (Appendix A), which outlined key evaluation questions and potential methods for data collection.

SPR Development Team

A key methodology for this evaluation has been to work closely with a Development Team comprised of representatives who have experience with SPR and are actively seeking to advance its implementation in Alberta (Appendix B). Initiated in December 2014, the purpose of the Development Team was to explore, test and refine ways of supporting effective implementation of SPR implementation in Alberta.

The group met thirteen times over the course of the evaluation, convening about every two months. The purpose of the meetings was to share ways that SPR was being implemented in Southern Alberta, to enhance existing efforts to build practitioner capacity for implementing SPR and to support further development (e.g., the group hosted an SPR Refresher). In addition to minutes from the meetings, a report was produced in September 2015 outlining key lessons learned and developments emerging from the work with the Development Team.

Other Evaluation Methods

In addition to ongoing work with the Development Team, a number of other methods were used over the course of this evaluation, including the following:

- **Trainee Interviews:** Telephone interviews were conducted in June/July 2014 with 42 practitioners who were trained in Calgary in November 2013 and January 2014. The purpose of the interviews was: 1) to understand whether and how trainees were implementing the approach both generally and with people affected by the 2013 flood in Southern Alberta; and 2) to identify opportunities for optimizing the SPR Training Program and other supports to enable

effective use of the SPR skills by practitioners in their work with disaster survivors.

- **Environmental Scan:** An environmental scan was conducted, with a goal of maximizing learning from research and experience in other jurisdictions. The scan included:
    - Interviews with key informants (n=15) who were doing research in the field of post-disaster psychosocial support and/or working in the field.
    - Review of relevant gray literature, resulting in a review of 35 documents.
    - A search of the peer-reviewed literature was conducted to identify published literature related to the provision of disaster-related psychosocial supports. A total of 3944 articles were identified; these were then narrowed down to 198 full text journal articles and book chapters, of which 119 were identified as relevant to the review. A critical appraisal of these articles yielded key themes pertaining to what is known to date about SPR and the broader context of post-disaster psychosocial support within which SPR is situated.

- **Evaluation of SPR in a non-disaster context:** An evaluation of Hull Services' implementation of SPR within four social housing sites (collectively referred to as "Patch") was conducted to explore: 1) the use of SPR in this context; 2) the effectiveness of the adaptation; 3) perceived benefits and challenges; and 4) suggestions for improvements. The evaluation included interviews with Patch staff (n=9) and management (n=2) and a client satisfaction survey

Key Findings

Key findings are summarized below according to the broad evaluation questions that were posed at the start of this developmental evaluation and agreed to by the Advisory Committee. These include the following:

1. What is known about the 'big picture' of DR-PSS?
2. Where does SPR fit within this broader framework of supports?
3. What is known about the effectiveness of SPR from research and practice?
4. How is SPR being implemented in Alberta?
5. What is required to optimize the effectiveness and sustainability of SPR in Alberta?
6. Who should deliver SPR?
7. Should SPR be implemented as part of the post-disaster PSS response in Alberta?

What is known about the 'big picture' of DR-PSS?

The review of the literature surfaced a number of overarching principles to guide humanitarian and psychosocial response to disaster. One theme emerged consistently, and can be considered a superordinate principle: Psychosocial supports need to be an integral aspect of the overall disaster effort (NATO, 2008; Ursano

> Psychosocial supports need to be an integral aspect of the overall disaster effort.
>
> *NATO, 2008; Ursano et al., 2007*

et al., 2007). Psychosocial supports are not merely an 'add on' or something that is 'nice to do' if there is time. Rather, they are an integral aspect of the overall disaster effort.

In addition to this overarching principle, a number of principles for DR-PSS emerged to outline the 'what' (the focus or content of psychosocial support) and the 'how' (guiding principles of DR-PSS). (Please see Appendix C for a more detailed description of each).

Focus of DR-PSS
- Promote a sense of safety
- Promote calming
- Promote a sense of self- and community- efficacy
- Promote hope
- Promote connectedness
- Allow for grieving and mourning in culturally meaningful ways
- Re-establish a sense of place
- Re-establish connections with cultural practices and lessons learned from ancestors
  (Hobfoll et al., 2007; Miller 2016, 2012)

Guiding principles of DR-PSS
- Human rights and equity
- Do no harm
- Person and community centered
- Build on strengths and capabilities
- Support participation, collaboration and integration
- Focus on performance, learning and transparency
- Provide multi-layered, contextual embedded supports
  (Inter-Agency Standing Committee, 2007; Sphere Project, 2011)

The literature review and environmental scan also highlighted a diverse mix of paradigms, guidelines, frameworks, models and practical approaches for DR-PSS, including national- and state-level frameworks, comprehensive guidelines and frameworks, and guidelines for working with specific populations (e.g., children, youth, seniors), settings (e.g., schools, workplaces, seniors' housing), types of disasters, and individual psychopathologies. One of the most comprehensive and consistently cited frameworks for DR-PSS was developed by the Inter-Agency Standing Committee (IASC) of the United Nations. The 2007 IASC *Guidelines on Mental Health and Psychosocial Support in Emergency Settings* include background information about disasters, guiding principles for DR-PSS, and specific guidance for mental health and psychosocial support (e.g., coordination, assessment, monitoring and evaluation; community mobilization and support; health services). The IASC *Guidelines* also provide a matrix to guide delivery of DR-PSS, including:
- Considerations for emergency preparedness;
- Minimum actions to be taken in early stages of an emergency; and
- Comprehensive responses for recovery and rehabilitation.

The matrix is intended to guide coordination and collaboration across sectors.

One of the earliest observations in the literature review and in conversations with key informants was the presence of two distinct yet complementary paradigms for DR-PSS – disaster mental health (DMH) and psychosocial capacity building and resilience (PSCBR). Both aim to promote psychosocial wellbeing; however, they differ in terms of *how* DR-PSS is conceived and provided (Table 1 below offers an overview of each approach).

DMH is a longstanding approach to DR-PSS that emerged from crisis intervention. The approach is based on an understanding of the psychological responses of individuals to trauma (Miller, 2012), and focuses on preventing, identifying and treating psychopathology (particularly PTSD) arising from exposure to trauma and disaster. Cognitive behavioural approaches currently form the foundation of DMH, and services are delivered by trained professionals (e.g., psychologists, social workers, nurses, and psychiatrists).

> "How psychosocial responses are managed may define the extent and effectiveness of communities' recovery. The evidence indicates that the way in which people's psychosocial responses to disasters are managed may be the defining factor in the ability of communities to recover."
>
> *(NATO, 2008, pg. 1)*

In contrast, PSCBR is "culturally grounded, empowerment-based and resiliency-oriented" (Miller, 2012, pg. 216). The primary focus is on social groups and communities, although individuals are also included. PSCBR emphasizes building on existing strengths and assets and working in ways that are collaborative, participatory and empowering. There is an emphasis on re-building or strengthening collective capacity through the empowerment of local people who know their community, their culture, and one another. Multi-sectoral, multi-pronged approaches are also a hallmark of PSCBR, as is an emphasis on human rights, equity, social justice and cultural responsiveness (Miller, 2012). PSCBR is ideally facilitated by local community members with support, as required, by helping professionals who act primarily as consultants in creating the processes and conditions that allow people and the community to self-heal.

Table 1.   Comparison of underlying assumptions: DMH and PSCBR paradigms

	DMH	PSCBR
Overarching Goal	Promote psychosocial wellbeing via prevention and treatment of pathology. Success criteria: decrease in incidence and prevalence; "healthier" behaviours; effective treatment of mental health problems and illnesses.	Promote psychosocial wellbeing via mental health promotion, capacity building and fostering resilience. Success criteria: enhanced psychosocial wellbeing; improved social networks; improved capacity and resilience.
Paradigm	Emphasis on psychological, emotional and biophysical reactions to disaster.	Major focus is on empowerment, strength and resiliency and the

	Major focus is on psychological responses and the prevention and treatment of pathology.	notion that communities have the capacity to heal themselves and the greatest resources for recovery are community members.
Intended Population	Individuals, primarily, although impact on families, groups and communities is recognized.	Social groups and communities, primarily, but also individuals and families.
Nature of Approach	▪ Major focus is on adverse effects of disaster on individuals and the need for crisis intervention and counseling. ▪ Recognition of individual strengths and importance of normalizing reactions to trauma. ▪ Psychological first aid initially, then talk therapy - cognitive behavioural approaches viewed as most efficacious. ▪ Tends to be more prescriptive in nature.	▪ Emphasis is placed on collective capacity and resilience within the community and how to strengthen and reconstruct it after disaster. ▪ Processes aimed at fostering self-empowerment of local people who know their own culture, community and one another. ▪ Local participation in planning and decision making. ▪ Multi-sectoral, multi-pronged approaches. ▪ Tends to be more organic in nature, responsive to community-determined priorities. ▪ Concern with human rights, equity and cultural responsiveness.
Provider	Trained professionals – psychologists, psychiatrists, counselors, social workers.	Ideally local community members with support as required from trained professionals who act as consultants in creating the processes and conditions that allow people and the community to self-heal.

Source: Adapted from Miller (2012, pg. 10-18); Saul & Bava (2008)

Ensuring a Continuum of Supports

Approaches to DR-PSS have tended to focus on helping individuals cope more effectively with distress and/or preventing or treating psychopathology. While this has been and will continue to be a fundamental component of DR-PSS, the literature review revealed that community-focused approaches are also needed.

Community-focused means that the emphasis is on the supporting and strengthening the entire community (e.g., rebuilding the community's social fabric; strengthening capacity to work more effectively together toward greater resilience and faster recovery). Community-focused approaches are important because:
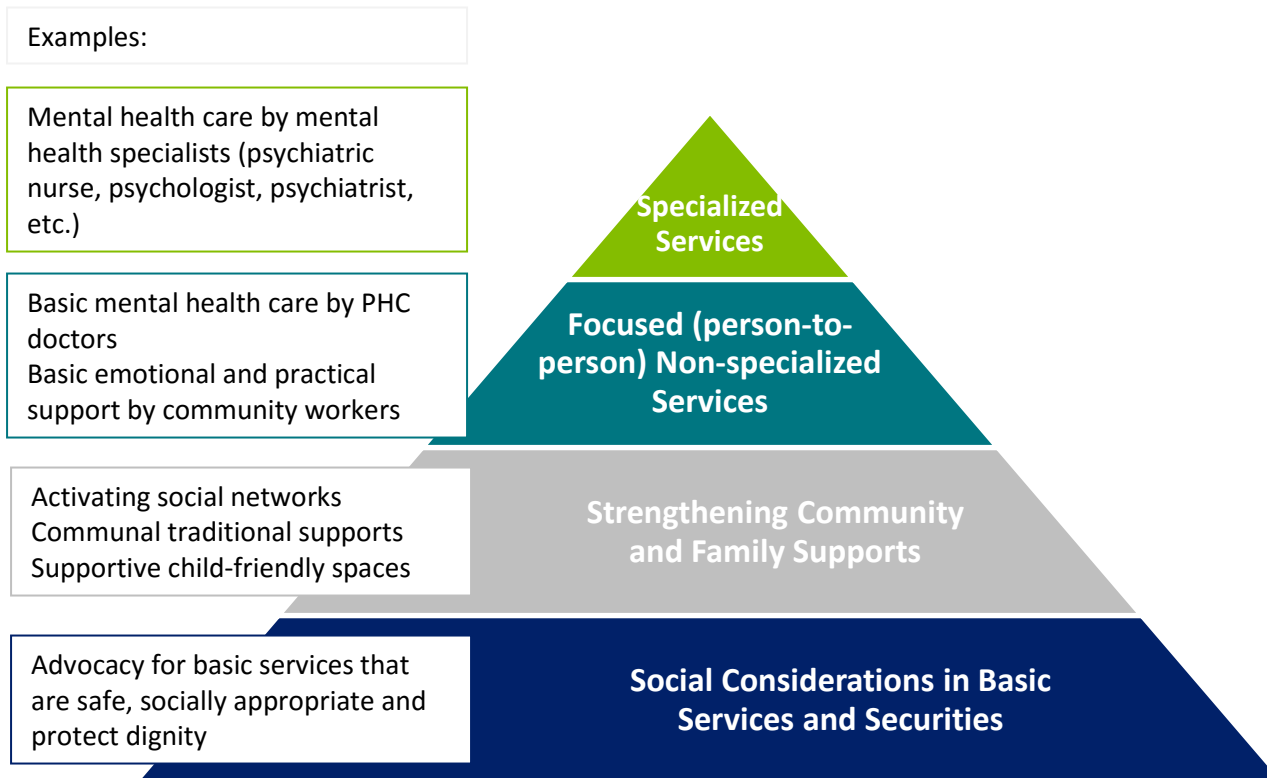
- **Disasters disrupt the cultural and social fabric that binds people together and provides the social support and connectedness that is vital to psychosocial wellbeing** (Saul, 2014; Plough et al., 2013; Bonnano et al., 2010; Rowlands, 2013; Miller, 2012; NATO, 2008; Gordon 2004a; 2004b). At a time when people most need social connections and community resources, these may no longer be accessible. A community-focused approach helps mend the fabric by ensuring there are mechanisms and places for people to gather, to play, to make sense of things, to mourn and grieve, and to rebuild the community.

> "Erosion of the fabric of relationships within the community is widespread after disaster and emergencies shatter the sense of continuity of life, community, culture and relationships that are, themselves, resources for recovery. Therefore this impact on quality of life must be addressed by understanding and supporting community processes."
>
> *(Rowlands 2013 pg. 25)*

- **Maximizing the community's participation in its own recovery keeps the community intact, connects people together and promotes a sense of efficacy and empowerment.** The community is enabled to take charge of recovery and rebuilding, ensuring local priorities are addressed in a manner appropriate to community members. This process of agentic participation strengthens capacity to enhance community wellbeing and to mitigate the impact of future adversity – that is, it builds resilience[2].

- **Community-focused interventions work on the broad community environment and thus impact multiple factors.** In this way, community-focused psychosocial capacity and resilience building can positively impact other community challenges (e.g., poverty, food security) beyond preparedness for, response to, and recovery from disaster.

- **Community-focused approaches are important for preventing or attenuating rifts that may develop over time in communities due to real or perceived disparities in the recovery process** (Gordon, 2004a, 2004b). Vigilance in identifying potential rifts and intervening early can prevent deterioration of social connections and subsequent degradation in the quality of community life.

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[2] An in-depth review of the community resilience literature was beyond the scope of the literature review, but a high level scan was conducted. The common denominator amongst various community resilience models is the notion of a community's successful adaptation to and recovery from adversity (Pfefferbaum et al., 2013) that results in the achievement of community goals and positive outcomes such as increased resources, competence and connectedness (Landau & Saul, 2004), population wellbeing (Chandra et al., 2011; Norris et al., 2008[2]), restored community functioning, socio-economic vitality (Hawe, 2009) and the ability to mitigate against future adversity (Pfefferbaum et al., 2007). Thus, resilience is about the potential to grow from crisis and reach a higher level of functioning (Brown & Kulig, 1996/7).

Thus, a continuum of supports is required to effectively respond to and address the psychosocial impacts of disaster. The IASC framework depicts this continuum as a pyramid (Figure 1 below), emphasizing that "a layered system of complementary supports that meets the needs of different groups" is needed, and "all layers of the pyramid are important and should ideally be implemented concurrently" (IASC, 2007 p. 11).

Examples:

Mental health care by mental health specialists (psychiatric nurse, psychologist, psychiatrist, etc.)

Basic mental health care by PHC doctors
Basic emotional and practical support by community workers

Activating social networks
Communal traditional supports
Supportive child-friendly spaces

Advocacy for basic services that are safe, socially appropriate and protect dignity

Specialized Services

Focused (person-to-person) Non-specialized Services

Strengthening Community and Family Supports

Social Considerations in Basic Services and Securities

(Source: IASC, 2010, pg. 3)

Figure 1: IASC Intervention Pyramid

Drawing on the literature and key information interviews, several characteristics of a comprehensive approach to DR-PSS were identified (Figure 2 below). These include the following:

- Recognition that everything done in a disaster can impact the psychosocial wellbeing of individuals, families and communities. As such, DR-PSS needs to be integrated into the overarching disaster effort.
- DR-PSS needs to be considered across the entire trajectory of a disaster – including planning, preparation, mitigation, response, short-, medium-, and long-term recovery and community re-development.
- Both DMH and PSCBR are needed. There will always be a proportion of the population that will require individual supports and specialized care, and this cannot be neglected. However, capacity and resilience building efforts that focus on whole communities are also essential.
- Given the breadth of resources and services in a community that can support psychosocial wellbeing, and the diversity of groups and populations within a community, a multi-disciplinary

and multi-sectoral approach is ideal. DR-PSS expands from supports traditionally provided by psychologists, social workers, nurses and others to numerous other sectors (e.g., community development, education, local businesses, NGOS, arts and culture, sports and recreation, pastoral and spiritual supports, economic development, civic and municipal affairs).

▪ The engagement of multiple sectors and disciplines at various levels requires significant efforts to integrate and coordinate services and supports.

▪ Given the complexity of communities, disasters, and comprehensive approaches to DR-PSS, it is crucial to embed a solid approach to ongoing learning and adaptation that can be used both to guide efforts as they are being implemented, but also to capture lessons learned for exploration and use in the future. Collective and participatory approaches to learning and development – such as participatory action research, developmental evaluation and community-academic partnerships may be particularly valuable. There is still much to learn about SPR, including how people integrate the skills into their lives, and whether they find the intervention helpful.
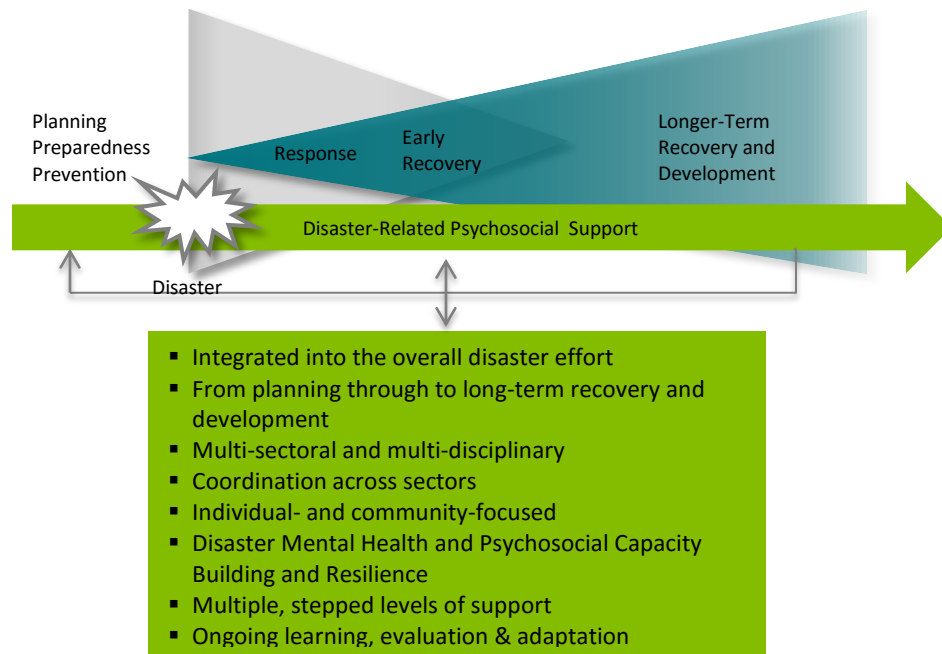
Figure 2: A Comprehensive Approach to Disaster-Related Psychosocial Support

Where Does SPR Fit Within this Broader Framework of Supports?

SPR is a modular "skills-training intervention" designed to "accelerate recovery and increase self-efficacy" in people experiencing mild to moderate distress following a disaster (Berkowitz et al., 2010, p. 7). Preventative in nature, SPR has been used to support post-disaster psychosocial recovery in several other jurisdictions, including the United States, Australia, Japan, Hong Kong, Singapore, Poland and the Ukraine. SPR involves the "brief application" of five core skills:

1. **Problem Solving:** A method to define a problem and goal, brainstorm a number of ways to solve it, evaluate those ways, then try out the solution that seems most likely to help.

2. **Positive Activities:** A way to improve mood and functioning by identifying and engaging in positive and pleasurable activities.
3. **Managing Reactions:** Skills to cope with and reduce distressing physical and emotional reactions to upsetting situations.
4. **Helpful Thinking:** Steps to identify upsetting thoughts and to counter these thoughts with less upsetting ones.
5. **Rebuilding Health Social Connections:** A way to rebuild positive relationships and community supports.

(Excerpt from: Berkowitz et al., 2010, pp. 8-9)

The intervention is intended to be flexibly deployed, based on the needs, goals and priorities of the clients. These are determined through an *Information Gathering and Prioritizing* exercise. In addition to helping identify the survivor's "most pressing needs and concerns" and "plan SPR intervention strategies," the exercise helps practitioners to determine whether "there is a need for an immediate referral" (Berkowitz et al., 2010, pp. 8-9).

SPR is an individual intervention (although it has been used with groups). As such, SPR fits within the Focused Person-to-Person Supports level of the IASC pyramid, as illustrated in the diagram below.

IASC Intervention Pyramid
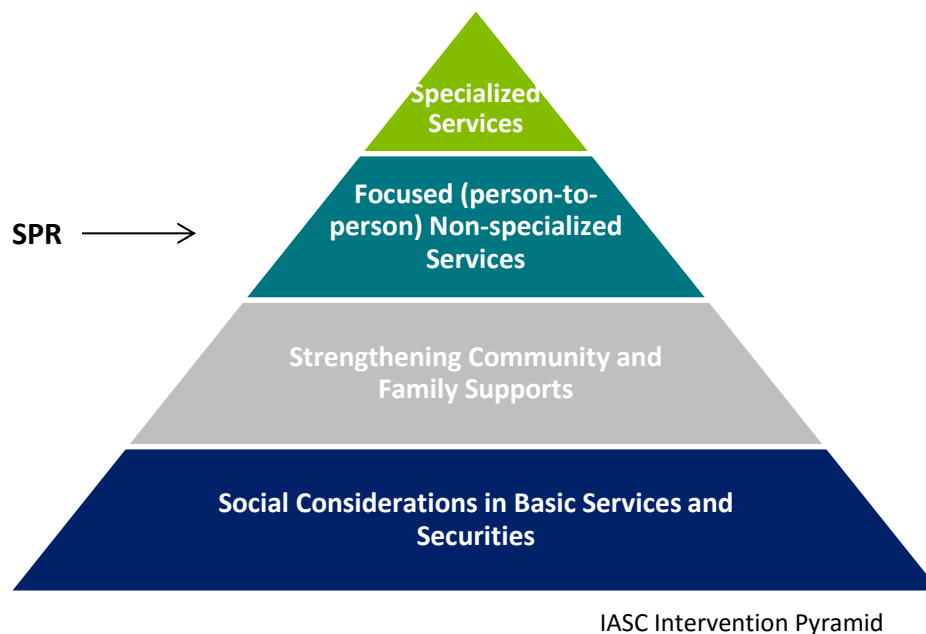
The level of individualized supports can be further broken down further in a stepped care approach (Appendix D), with supports that range from general information for everyone to treatment for a small percentage of people who have or are likely to develop PTSD. Increasingly, international organizations such as the World Health Organization (WHO) are moving towards a stepped-care approach. This is based on the understanding that, while very few people will need clinical interventions, many will benefit from interventions like SPR (which can promote positive mental health, and help to prevent serious mental health issues from developing thereby reducing the number of citizens who may

ultimately require treatment). The WHO refers to interventions like SPR as "low intensity psychological interventions" (WHO, 2014). Low intensity psychological interventions are "modified, evidence-based psychological treatments, such as:

- Brief, basic, paraprofessional-delivered versions of existing evidence-based psychological treatments (e.g., basic versions of cognitive-behavioural therapy, interpersonal therapy).
- Self-help materials drawing from evidence-based psychological treatment principles, in the form of:
    - Self-help books,
    - Self-help audiobooks or video books, and
    - Online self-help programs.
- Guided self-help in the form of individual or group programs guiding clients in the use of above mentioned self-help materials." (WHO, 2014)

The inclusion of low-intensity psychological interventions such as SPR in numerous frameworks internationally speaks to the importance of this type of approach as an essential component of disaster-related psychosocial support. While other supports are clearly needed to ensure that the full range of individual and community needs are met, interventions like SPR are a key element in the continuum of supports.

In terms of the paradigm in which SPR fits (i.e., DMH or PSCBR), there are differing views: some people view SPR from a DMH perspective, emphasizing that it is a preventive intervention delivered primarily by mental health professionals. Many others conceive of SPR as an individual PSCBR approach because it supports the cultivation of skills that help people to adapt effectively to distress and become more resilient. They also tend to feel that SPR can be facilitated by a diversity of individuals (including paraprofessionals and lay people), with mental health professionals providing supervision and support.

What is known about the Effectiveness of SPR from Research and Practice?

SPR is based on considerable research about the kinds of mental health issues that are most likely to occur post-disaster, and the types of strategies that are most effective in preventing these problems. To that extent, SPR is an evidence-informed approach. However, while the research confirms the theoretical underpinnings of the intervention, its effectiveness has not yet been rigorously tested (i.e., no experimental design research studies have been conducted to date). This is not unique to SPR: no other low- to medium-intensity post-disaster psychosocial support has been subjected to this type of evaluation either (North & Pfefferbaum, 2013). The lack of research on the impact of these types of interventions is not surprising given the challenges associated with conducting rigorously designed clinical trials in mental health – challenges that are compounded in a post-disaster environment where chaos is often the norm.[3]

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[3] A group of international researchers is currently working to address this gap in knowledge. Led by David Forbes and Richard Bryant in Australia, the group is designing a study to test the effectiveness of a low- to medium-intensity post-disaster psychosocial intervention. As the authors of the study point out, "the challenge will be to achieve a balance between a workable clinical model on the one hand, and a model that is amenable to controlled research on the other…" (Phoenix Australia, Centre for Posttraumatic Mental Health, 2015).

While the effectiveness of SPR has not been rigourously tested, the intervention is increasingly being viewed as a promising practice by people working in the field of disaster psychosocial support. For example, SPR has been used in Australia since the 2009 bushfires disaster (Forbes, et al., 2010; Reifels, et al., 2013). SPR has also been implemented in United States following several disasters, including Hurricane Katrina (2005), the BP Oil Spill (2010), and the Joplin tornado (2011), as well as in Japan after the 2011 earthquake and tsunami (Cross Hansel et al., 2011; Sundgaard Riise et al., 2009; Uchida et al., 2014). As noted previously, SPR has also been introduced in Hong Kong, Singapore, Poland and the Ukraine.

Despite the lack of research evidence to date, a number of evaluations of SPR have been conducted. These evaluations suggest that people who have been trained in SPR and have experience using it with people in post-disaster settings find it a useful intervention (Reifels et al., 2013; Forbes et al., 2010; Cross Hansel et al., 2009; Sundgaard Riise et al., 2009). For example:

- Counselors working in bushfire-affected areas in Australia reported that SPR provides a helpful and coherent framework to guide their work, and said that their clients found the SPR skills useful (Reifels et al., 2013; Forbes et al., 2010; State of Victoria, 2009; Cross Hansel et al., 2009; Sundgaard Riise et al., 2009).
- Specialized crisis counsellors using SPR in Louisiana after Hurricane Katrina felt that their clients developed increased skills for recovery, particularly in the areas of problem-solving, relaxing, positive activity scheduling, and managing upsetting reactions (Cross Hansel et al., 2009). Key informants with experience using SPR in a variety of situations corroborated these findings, saying that they found SPR to be very useful in their work; they also noted that clients said that these were skills they would use for the rest of their lives.

Alberta practitioners have offered similar views. In interviews with trainees in 2014, almost all of the respondents who were using SPR in their work with clients felt that SPR had benefited the people with whom they worked.[4] Alberta informants identified the following features of SPR as being beneficial:

- Simplicity of the approach,
- The structure it provides,
- The focus on skill development, and
- The intervention's potential to help people move forward and see things in a different way.

How is SPR being implemented in Alberta?
In the months following the flood, AHS drew on Alberta Health funding to train practitioners in SPR and support implementation in flood-affected areas. Basic SPR training was offered to over 100 practitioners in both November 2013 and January 2014, and a train-the-trainer workshop was also offered in early

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[4] Note: Very few of the people interviewed seemed to have asked clients directly about the benefits, so their responses were based on their own observations in their work with clients. (Only one person who chose to comment on this question was equivocal, noting that she hadn't seen a sufficient number of clients to make a determination about the benefits).

2014. Of the people who were trained in SPR and interviewed for this evaluation (n=42), almost 70% (n=29) said that they were using or had used SPR in their practice. Participants who were not using SPR (n=13) offered the following reasons:

- SPR is not appropriate for the population served (e.g., people in acute crisis requiring urgent care; clients with long-standing and complex mental health issues or illnesses that require advanced supports) (n=5).
- Interviewee is not seeing clients affected by the flood (n=4).
- Interviewee is not providing direct service to clients (e.g., is in a management or other kind of role) (n= 4).

The 29 people who indicated that they were using SPR in their practice could be classified into three groups:

- SPR-Centric Practice (n=~10): Using SPR as prescribed with some adaptations.
- Mix and Match Practice (n=~12): Using SPR in combination with other approaches.
- Casual Users (n=~7): Limited and ambiguous use of SPR.

Many (65.5%) of the interviewees who were implementing SPR said that they were using the intervention not only with flood-affected people, but also with others who were experiencing some form of stress or trauma unrelated to the flood. This finding suggested that many felt that SPR has value beyond disaster recovery; a hypothesis that was tested to some extent by members of the Development Team (discussed further, below).

Interviewees reported that citizen engagement was the most significant barrier to implementing SPR. Many said that they were eager to use the intervention, but they were having trouble identifying and engaging citizens who had been impacted by the flood.

When interviewees were asked for their opinions about why this population was so difficult to engage, they suggested a number of possible factors, including:

- **Stigma:** Mental health services are often stigmatized, and people with no history of mental illness may be unlikely to seek professional help.
- **Culture of Self-Reliance:** The culture of self-reliance and pragmatism that is associated with Alberta might further exacerbate the sense of stigma associated with psychosocial supports.
- **Lack of Effective Engagement Strategies:** Interviewees said that a more strategic approach to identifying the most appropriate types of people to train in SPR may be required, as people with mild to moderate distress are unlikely to seek out mental health professionals and formalized supports.
- **Timing:** A few interviewees felt that people may not have come forward because of the timing with which disaster-related psychosocial supports were introduced. (SPR training wasn't offered until November 2013, five months after the flood – and the Community Development Outreach Team was only established in January 2014).

Other barriers to implementation included limited time to review the SPR concepts and materials; limited time to implement SPR in unstructured environments where interactions are informal; limited fit of SPR for some types of clients (e.g., those with language or cognitive challenges); and lack of supervisory or organizational support for using SPR.

Asked what would help to enhance implementation of SPR, interviewees suggested the following:
- **Training and Coaching Supports**, including booster sessions, a formal network or Community of Practice, webinars, and coaching/mentoring supports;
- **Resources**, including printable materials, an SPR 'Cheat Sheet,' websites (one for professionals and one for the public), and online tools and supports; and
- **Content Enhancement**, including an enhanced version for use with clients who have pre-existing mental health issues; generic versions of the worksheets (i.e., not disaster-specific); engagement strategies; tips for using SPR with groups.

Since the initial trainings, AHS has continued to promote SPR as a key component of a stepped care approach to disaster psychosocial recovery, and has worked with organizations such as the Canadian Red Cross, Samaritan's Purse, Hull Services, and Carya in Southern Alberta to build greater capacity to deliver disaster-related psychosocial supports in the province. This has included the development of a number of SPR-related resources and supports:
- A Library Toolkit (a 90 page, hyperlinked PDF that allows for quick and easy access to any of the SPR worksheets. The Toolkit organizes the worksheets by audience, context and SPR skill);
- SPR Reference Guide for Practitioners;
- SPR lanyard cards;
- An infographic; and
- Generic, non-disaster worksheets.

AHS and other community partners have also continued to provide SPR training and support, providing a Refresher Session in Calgary in April 2015, basic training in High River (June 2015 and May 2016), basic training and train-the-trainer workshops in Edmonton (October 2015), as well as a number of smaller training sessions in Calgary and area throughout 2015. In total, approximately 280 Alberta practitioners having been trained in SPR, including 57 people who have completed the SPR train-the-trainer workshop.[5]

In addition to the use of SPR with flood-affected people, intervention has been piloted in Calgary non-disaster contexts, including four social housing sites (Hull Services) and a homeless shelter (AHS) (this is discussed further in the section that follows). Non-disaster training was also delivered to workers in two Calgary communities (Bowness and Forest Lawn), as well as Team Leaders from youth-serving organizations in Calgary.

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[5] SPR training was also offered in two other provinces over the course of the evaluation: Winnipeg, Manitoba (2014) and Vancouver, BC (March 2016).

Use of SPR in non-disaster contexts
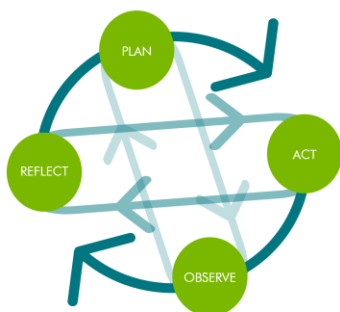
One of the most significant contributions that Alberta has made to SPR is to pilot its implementation in non-disaster contexts and develop tools and training protocols to support this approach. Findings from both the trainee interviews and the Development Team highlighted the potential usefulness of SPR in non-disaster contexts. Stakeholders in both groups felt that the five SPR skills have utility for managing the stress and trauma associated with everyday life, and that using SPR outside of a disaster context is a potentially useful strategy for building and sustaining capacity to use SPR in case of a disaster. Key informants from other jurisdictions also said that they see the value of SPR for non-disaster contexts; however, to this point, no one else has moved the practice forward in this way.

One organization, Hull Services, decided to pilot implementation of SPR in one of its community-based programs, *Patch*. The Patch program "works collaboratively with Calgary Housing Company and other community service providers to offer a broad range of services to families who live within four specific low-income housing complexes in southeast and southwest Calgary…".[6] The decision was made to provide evaluation support to the project as part of this Developmental Evaluation, as this provided an important opportunity to test the utility of using SPR in these types of situations.

Everyone interviewed as part of the Patch Evaluation felt that the SPR skills had applicability, not only for the people with whom they work (many Patch residents have been exposed to multiple kinds of trauma, abuse and stresses in their lives), but for themselves as well. Patch leadership expressed that SPR matched their existing approach; it provided a formal framework and language for an approach already being used by Patch. They also said that the SPR framework provided an opportunity to focus on capacity-building or coaching model (*"I will work with you to teach you some skills that I find helpful in my own life"*).

The introduction of SPR required a shift in practice for some Patch staff. The shift to a client-centered approach recognizes people's strengths and capabilities and teaches them skills to manage the stresses and challenges in their lives within both disaster and non-disaster contexts. This is why training alone is insufficient; a shift of this nature requires ongoing mentoring, coaching, and organizational support.

Other challenges identified through the Patch evaluation included:
- Issues associated with integrating a formal/structured intervention within a fairly informal/unstructured environment (i.e., Staff generally see residents only in passing or in crisis situations; they do not meet with them for counselling sessions.)

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[6] Retrieved Jan 29, 2016 from: http://www.hullservices.ca/services/patch

- An initial perception and/or understanding of SPR as a counseling intervention, as opposed to "facilitated self-help."[7]

Despite these initial challenges, Patch management continues to see great value in integrating SPR into service delivery, and strengthening the capacity of their staff to implement a *"skills for everyday life"* approach with the people they serve.

In addition to Hull Services, two other organizations have begun implementing SPR in non-disaster contexts. These include the following:

- AHS, Addiction and Mental Health, Calgary Zone has used SPR to structure a weekly skills group at a homeless shelter in Calgary. Client and staff feedback to this point has been very positive.
- Carya, a family-serving organization in Calgary, is now using SPR as a framework for their work in two communities where a high percentage of families have complex needs and/or are exposed to ongoing trauma.

What is required to optimize the effectiveness and sustainability of SPR?

Through the various evaluation activities undertaken over the course of this evaluation, a number of factors have been identified that could help to optimize the effectiveness and sustainability of SPR in Alberta. These include:

- A system-wide philosophical shift
- Effective engagement strategies
- Opportunities to practice SPR between disasters
- Ongoing coaching, mentoring and support
- Achieving a balance between fidelity and flexibility
- Effective system and organizational supports

Each of these factors is briefly outlined below.

A system-wide philosophical shift

Development Team members who have implemented SPR in a variety of contexts emphasize that the effective use of SPR requires a philosophical shift on at least three levels:

1. **From an over-emphasis on clinical or treatment-based supports to an approach that includes broader approaches to psychosocial recovery and well-being.** While treatment-based supports are a critical component within the continuum of psychosocial supports, as discussed previously - research shows that most people who survive a disaster do not require clinical interventions (Bonanno, et al., 2010; Bonnano, 2005). Despite this, funders and service providers often focus on clinical supports at the expense of broader supports that promote adaptation, healing, wellness, coping skills, self-efficacy and competence. This underscores the importance of reorienting professional helpers away from concentrating solely on psychopathology to

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[7] This phrase was used to describe the approach by one of the SPR developers, Patricia Watson, at an SPR Development Team meeting in Calgary in 2015.

understanding healthy human development in the context of adversity.

2. **From a focus on counselling interventions to 'facilitated self-help.'** SPR is not a professional counselling model and is not based on narrative approaches to therapy: it is skill based. As such, it is a capacity building approach, one that recognizes people's strengths and teaches them skills to manage the stresses and challenges in their lives.

3. **From an over-emphasis on individualized supports to one that recognizes a spectrum of supports.** As discussed earlier in this report, the research literature clearly positions approaches such as SPR within a continuum of supports, which range from individual to community supports.

All of this suggests that integrating SPR into practice requires far more than a two-day training session. System and organizational level supports to facilitate these philosophical shifts are necessary. These might take the form of supportive policies, mandates, investments, and practitioner supports (coaching, supervision, training, case conferencing, communities of practice, etc.). This is described in more depth in sections following.

Effective engagement strategies

Citizen engagement was identified as a key barrier in interviews conducted with Alberta-based SPR trainees in 2014; practitioners struggled to implement SPR because citizens were not coming forward or responding to outreach efforts. The literature suggests that this problem is not specific to SPR or even to disaster situations. Few people seek out formal counselling or psychosocial supports (Norris & Rosen, 2009), and mental health interventions tend to be stigmatized.

> "We talk about [SPR] as a set of skills that everyone benefits from. We tell them: 'These skills may just be review; however, when we are under stress, we forget and we need some cues on how to cope and manage effectively.'"
>
> *Development Team Member*

This has significant implications for SPR. No matter how effective the intervention might be, its promise will never be realized unless we begin to understand how to engage citizens in accessing this type of support; this points to a need to integrate engagement strategies into SPR training and support.

The Development Team has worked to develop and test a range of strategies to address this issue, starting with how to introduce or frame SPR. They note that it is helpful to present SPR in ways that normalize the approach and do not trigger associations with clinical interventions. They do this by:

- Avoiding the use of the term "Skills for Psychological Recovery".
- Framing the skills as self-help skills, coping skills, skills to build self-efficacy, and/or skills for wellbeing. Notably, interviews with key informants from other jurisdictions suggested that they took a similar approach, describing SPR as a process for building capacity for hope and resilience, helping people to help themselves, and exercises that help you to create more options for yourself.

- Encouraging practitioners to use SPR in their personal lives so that they are able to speak to the efficacy of the skills from personal experience (e.g., "I recently learned these skills and have tried them out on myself and found them very helpful").
- Framing SPR as something that everyone can use (not just people in distress or people with 'issues').

Another key factor that facilitates engagement is existing relationships. Development Team members pointed out that it is much easier to introduce SPR to people with whom they have (or their organization has) an existing relationship; an observation supported by the evaluation of the Patch program. For this reason, the issue of engaging citizens is closely tied to the issue of who should be delivering SPR. Professionals and others who are engaged in community might be more effective at introducing SPR because of existing and ongoing community relationships.

Opportunities to practice SPR between disasters

Many of the practitioners who contributed to this evaluation noted that, like anything, the capacity to implement SPR can only be maintained through practice: "Use it or lose it." Given the episodic nature of disasters, this can be challenging; consequently, practitioners have often forgotten what they learned by the time another

> "You have to embed [SPR] in communities so it stays active and alive."
>
> *Development Team Member*

disaster strikes. Furthermore the lists of those who have been trained are quickly outdated – so activating a network of supports shortly after a crisis becomes problematic. Thus, it is critical for this approach to be continually embedded in communities, so that the capacities and relationships required for an effective, cohesive response are actively maintained.

For this reason, members of the Development Team began piloting the use of SPR in non-disaster situations, including Patch at Hull Services, as previously described. When asked about the key differences between implementing SPR in disaster and non-disaster contexts, Development Team members offered the following insights:
- Interventions in non-disaster contexts are not bound in the same way. One representative pointed out that "you naturally have more containment with a disaster" (i.e., it provides a focus) whereas "it's a can of worms outside of that – when you start looking at everyday life." For this reason, practitioners need to have the capacity to set boundaries and establish a focus.
- Using SPR in non-disaster contexts provides a way of ensuring that the skills, capacities, relationships and supports that are needed to support recovery are developed in *advance* of the disaster (as one Development Team member pointed out "Just-in-Time training is actually Just-Too-*Late* Training"), and that proficiency is sustained – and *increased* – between disasters. Moreover, this type of approach might help to build resilience among individuals and groups so that they are better equipped to manage adversity in the future.

Ongoing coaching, mentoring and support

As previously noted, while the two-day basic training workshop provides a good foundation, it is far from sufficient to support effective integration of SPR into practice. Alberta informants emphasize that ongoing coaching, support and opportunities for practice are required to ensure that practitioners do not revert to old patterns of talk therapy and 'doing for'. This finding is also consistent with the literature and key informant interviews, both of which highlight the need for ongoing mentoring, training, case-conferencing and supervision in order to support effective implementation (Sundgaard Riise et al., 2009).

To support staff in implementing SPR after the flood and in non-disaster contexts, one of the agencies represented on the SPR Development Team (Hull Services) developed a number of supports that may serve as a model for other organizations. These include the following:

- **Development of a strategic plan for implementing SPR:** Managers have developed an implementation plan, so that SPR becomes supported and embedded at all levels of the Patch program, from management to frontline.
- **Integration of SPR into supervision:** Staff meet with their supervisors for a one-on-one consultation at least once a month, and SPR is a standing agenda item for those meetings. Workers have an opportunity to case-conference at these meetings and to talk about questions related to SPR.
- **Coaching:** Supervisors are onsite, so that there are opportunities for in-the-moment support, observations, teaching, and reviewing of the constructs.
- **Integration of SPR at monthly staff meetings:** In addition to these supports, team members from various sites come together once a month for a meeting. SPR is discussed at each of the meetings, and staff are invited to bring forward their ideas for using SPR and/or situations in which use has been challenging.
- **Staggered training, with opportunities for practice between sessions:** One of the key changes that Hull made to the training protocol for SPR in their High River implementation was to introduce the skills in weekly two-hour sessions (one skill per week) rather than in a two-day workshop. This approach offered participants an opportunity to try out the skill in the intervening week – a process that they felt was more effective than role-play alone. Participants were then able to bring their experiences back to the group, where trainers could build on their insights and help to address any challenges they might have experienced. This approach also enhances accountability as trainees are expected to practice the skill and report back.[8]

Achieving a balance between fidelity and flexibility

SPR is delivered in a variety of settings, to diverse populations across a range of contexts by a variety of practitioners. Given this degree of heterogeneity, standardization is simply not practical; nor is it ideal. Modular in form, the intervention is designed to be customized to the needs and goals of each

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[8] At Patch, Hull's trainers tested a modified approach to the two-day training, where the two training days are spaced one month apart. Similar to the weekly sessions, this approach offers an opportunity for trainees to practice what they have learned and bring their experiences back to the next session.

individual. Thus, SPR is designed for pragmatic rather than standardized implementation.[9] For these reasons, SPR must be implemented with a degree of flexibility. While the flexibility of the intervention is considered by many to be one of its key strengths, it creates some challenges in terms of understanding fidelity, and some people worry that the intervention could be in jeopardy of being 'watered down' and/or rendered ineffectual.

This tension between fidelity and flexibility was a key theme throughout the evaluation. It seems that this tension may be paramount to ensuring that SPR is delivered in ways that are context sensitive and client-centered. That is, what may be important is fidelity to the underlying principles and functional elements of SPR, rather than to the form or way it is delivered. Some of the developers of SPR that we spoke with identified the functional elements as the three to four steps within each of the skills. Thus, practitioners might be encouraged to balance fidelity with flexibility by adhering to the steps within each of the skills, but use their own discretion to determine the best way to deliver the intervention. It is important to note, however, that these steps have not been tested to determine whether they indeed comprise the functional elements of SPR; that is, whether those steps are required to produce the intended outcome. Other factors, such as the amount of time people have to practice the skills may also be important. As experience with using SPR in a variety of contexts continues to grow, understanding about what constitutes fidelity to SPR will also increase.

Effective system-level and organizational supports
In Alberta, significant levels of leadership and collaboration exist at the organizational level. Organizations as diverse as Alberta Health Services, the Canadian Red Cross, Carya, and Hull Services have worked together to deliver SPR training, develop resources, and identify innovative ways to embed SPR in community practice. These efforts are critical to the development of a supportive infrastructure to implement SPR across Alberta. Such infrastructure helps to ensure that, when disaster strikes, the competencies, relationships and mutual understanding required to collaborate and effectively deliver psychosocial supports will already be well established.

While this kind of organizational cooperation and capacity building is necessary, it is not sufficient. Development Team members say that, to effectively support the use of SPR province-wide, the same type of leadership and collaboration must be demonstrated by the larger systems, including governmental ministries (e.g., Health, Education, Municipal Affairs, Human Services), provincial and municipal emergency management agencies (e.g., Alberta Emergency Management Agency), and various portfolios within AHS.

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[9] Interestingly, few of the practitioners involved in this evaluation (e.g., SPR trainees who were interviewed, Patch staff, Development Team members) said that they implemented SPR in precisely the way that the manual specifies. Many pointed out that SPR is a structured intervention that is, as the manual says, "best provided in a private, quiet place that allows for at least 45 minutes of uninterrupted time" (Berkowitz et al., 2010, p. 10); however, in disaster contexts, encounters with clients are likely to be brief, informal, and episodic. Forty-five minutes is standard in a counselling setting, but extremely challenging in the types of environments in which many of the participants are working. Furthermore, an intervention that relies heavily on printed handouts and worksheets is difficult to implement outside of an office setting.

They also pointed out that DR-PSS (including SPR) must be effectively resourced and supported. This involves designated funds for:

- Training,
- Ongoing mentoring, supervision and support,
- Ongoing learning and improvement,
- Ongoing collaboration,
- Development of standards and credentialing,[10] and
- Provincial and regional oversight.

Effective and sustained implementation of SPR and other psychosocial interventions is unlikely to be achieved through the type of start-and-stop funding typically associated with disasters. Furthermore, with episodic funding, Alberta runs the risk of losing existing capacities and relationships. Sustained, operational funding would help to maintain the gains that have been made since the 2013 flood and ensure greater quality, consistency and accountability in the delivery of SPR and other psychosocial supports across the province.

Who Should Deliver SPR?

Throughout the evaluation, the question of who should deliver SPR remained central. It is clear that SPR need not only be delivered by mental health professionals as it is "not meant to be [a] formal mental health treatment; it is rather meant to be a secondary prevention model" (Berkowitz et al., 2010, p. 9). However, the range of people outside of the mental health professions that might be trained to deliver SPR is still being debated by many.

The SPR manual states that "SPR is designed for delivery by mental health and other health workers who provide ongoing support and assistance to affected children, families, and adults as part of an organized disaster response effort" (Berkowitz et al., 2010, p. 10); however, some of the developers of SPR suggested that the modifier 'health' (as in health workers) could certainly be expanded to other kinds of workers (e.g., social workers) and at least two of the developers are open to exploring delivery of SPR by paraprofessionals and lay persons.

As is known from both the literature and practice, citizens who have had no involvement with a mental health professional prior to a disaster are unlikely to seek out support from a clinical professional, and are far more likely to approach those community facilitators and leaders with whom they have an existing relationship (Rowlands, 2013). This points to the need to find ways to deliver community-based supports via a range of professionals (e.g., family doctors, nurse practitioners, other community workers) and lay people (e.g., informal community leaders, volunteers). Trusted community members are ideally situated to see and respond to people who may be experiencing more than mild levels of

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[10] Mechanisms and processes need to be developed to ensure consistency, quality control and accountability across a range of training environments. This may include the development of standards and credentialing. Alberta is already leading the way on developing a set of standards for SPR. One example is AHS's efforts to make Psychological First Aid (PFA training) a prerequisite for SPR. This is challenging because there is no body within Alberta with the authority to monitor and enforce these standards.

distress because they have direct knowledge of the community (e.g., They likely know who is most vulnerable and how they can be reached; how the community typically responds to adversity; where people tend to gather; what resources are available and how to access them, etc.). This approach also helps local communities build their own capacity to support community members and frees up mental health professionals to provide supervision and more complex supports to people affected by the disaster. This is particularly important for working with vulnerable groups within the community and in rural and remote communities where professional supports are scarce.

The move towards a more community-based model of psychosocial supports is consistent with international trends (e.g., WHO, 2014). It is also consistent with findings from key informant interviews conducted with representatives who are using SPR in other jurisdictions who said that, ideally, SPR should be delivered by a mix of mental health professionals and paraprofessionals. They described various ways this 'mix' could be constructed, but generally agreed that mental health professionals could be used to mentor, supervise and support paraprofessionals, and pointed out that this approach optimizes the use of mental health professionals as a scarce resource.

Development Team members who have begun testing this approach state that some additional training and support may be required to ensure quality and effectiveness. Specifically, content related to relational practice, setting boundaries, and knowing when and how to refer, needs to be integrated into the training of paraprofessionals and lay people. Effective and sustained supervisory support is also required.

Should SPR be implemented as part of the Post-disaster Psychosocial Response in Alberta?

This evaluation was designed, in part, to assess whether SPR should be scaled provincially and implemented as part of the post-disaster psychosocial response in Alberta. Findings from the full range of activities undertaken for this evaluation suggest that SPR should comprise a component of the province's disaster-related psychosocial response. Findings that seem to provide a rationale for this type of approach include the following:

1. **SPR is Evidence- Informed:** SPR content is based on a considerable body of evidence that demonstrates that these types of principles and techniques are effective in reducing risk and promoting resilience following trauma (Berkowitz et al., 2010, p. 7). Granted, the effectiveness of SPR has not been rigorously tested. However, the same is true for all other low- to medium-intensity psychosocial disaster-related interventions. That is, no other type of intervention of this sort has been subjected to randomized controlled trials or quasi-experimental studies.

2. **SPR is Considered Effective by Practitioners:**
   While evidence of effectiveness has not been established in this way, evaluations show that SPR is considered effective by practitioners in jurisdictions in the United States and Australia,

   > "SPR is absolutely [beneficial] – directly or indirectly if you empower the service providers to feel more competent and confident in providing supports to people who are traumatized…"
   >
   > *Practitioner*

30

who say that SPR has been helpful in their work with people post-disaster. Alberta practitioners echo these reports, saying that the skills are helpful and the intervention provides structure that helps them to feel more confident in their post-disaster work.

3. **SPR and SPR-like Interventions are Increasingly Being Included in DR-PSS Frameworks Internationally:** Increasingly, international organizations such as the WHO are moving towards a stepped-care approach, and promoting evidence-informed facilitated self-help interventions like SPR as a key element of that approach (WHO, 2014, p. 4). SPR is specifically identified in the psychosocial response framework that was developed in Australia after the 2009 bush fires, and continues to comprise a key element of disaster recovery in that country.

4. **SPR is Increasingly Being Implemented in Other Jurisdictions:** Training for SPR has been delivered in such diverse places as Poland, the Ukraine, the US, Japan, Australia, Hong Kong and Singapore. This creates the potential for increased mutuality in DR-PSS approaches to disaster, and offers opportunities for shared learning and exploration related to SPR. With the advantage of distributed intelligence, approaches to implementing SPR will continue to develop in increasingly effective ways. Jurisdictions within Canada are also showing interest in SPR, including BC, a province that provided DR-PSS support during the 2013 flood. Given that neighbouring provinces often provide aid during a disaster, common approaches to psychosocial supports would be helpful.

> "If we leave residents in a community with more skills around resiliency and we're giving them tools not only to deal with the past flood, we're giving them tools that they can then apply to future difficulties and struggles and I think that strengthens not only the individual, but the whole community".
>
> *Practitioner*

5. **There is Organizational Momentum in Southern Alberta:** As discussed, a number of organizations in Calgary and area have been implementing SPR, with some integrating it into their everyday practice.

6. **SPR Shows Relevance for Non-Disaster Contexts:** SPR has the potential to impact outcomes beyond the disaster context; the skills that are required for adaptive coping after a disaster are the same skills that are needed for resilience generally. Therefore, an investment in this approach contributes to preparedness for disasters, and is an investment in the overall wellbeing of Albertans.

Conclusion: Considerations for SPR Implementation

The findings of this DE suggest that there are a number of good reasons to support implementation of SPR across Alberta as one component of a broader psychosocial response to disaster. A number of considerations and opportunities exist to support effective and sustainable implementation.

1. SPR is a low-intensity, skills-based psychosocial support designed to promote adaptive coping in disaster-affected individuals who are experiencing mild to moderate distress. Alberta is the first jurisdiction to have piloted the use of SPR in non-disaster contexts, and practitioners here (and elsewhere) feel that SPR has relevance for everyday coping and resilience. By integrating SPR into everyday practice, practitioners can maintain the capacity to deliver the intervention between disasters.

2. SPR (and DR-PSS more generally) has considerable momentum among providers in Southern Alberta and is being integrated into community-based programs by some providers. A number of resources have already been developed to support implementation of SPR in both disaster and non-disaster contexts in Alberta. Over 280 practitioners have already been trained in SPR in Alberta, including 57 SPR Trainers. The knowledge, capacities and relationships that have been developed as part of this developmental evaluation among key stakeholders provides a solid foundation on which to develop a comprehensive DR-PSS framework.

3. Both research and experience suggest that a common approach to psychosocial interventions is critical given the nature of disasters (i.e., disaster contexts are fairly chaotic, and aid is provided by a range of players, many of whom are not local). A formalized DR-PSS framework facilitates effective practice and decision-making related to psychosocial supports, and the effective integration of SPR into a broader spectrum of supports. At this point Alberta does not have a provincial post-disaster psychosocial framework to guide a common provincial approach. The detailed environmental scan that was undertaken for this evaluation offers a robust platform on which to build a framework.

4. Integrated policy and practice frameworks are the foundation for a coordinated response to disaster. Effective and consistent implementation requires well-defined system and organizational supports which include: people with the required competencies; access to ongoing coaching and supervision; adequate resources; collaborative leadership; coordinated communication; established relationships; and, mutual understanding.

5. DR-PSS interventions are not generally amenable to RCT-type evaluation methodologies, and disaster situations make it difficult to get feedback from people who have been served by psychosocial interventions. Thus, alternate approaches and other credible forms of evidence are required to support ongoing learning and adaptation, enhance existing ways of providing disaster-related psychosocial support, and develop new ones. As Schorr and Farrow (2011) note, "Our commitment to ensuring that practice policies and strategies…will be evidence-based or evidence-informed must not diminish. But our definition of what counts as credible evidence…should be expanded to allow for continuing improvement and innovation."

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Appendices

Appendix A: SPR Developmental Evaluation Learning Framework

Overarching Evaluation Question:

Can SPR be an effective component of a psychosocial recovery plan, as part of a broader Alberta disaster response plan? If yes, under what circumstances, how and why?

Category	Sub-Category	Evaluation Question	Potential Method(s)
SPR Training Program Focus	Context/History	How and why was SPR developed? (Who was it developed for?)	Key Informant interviews (Patricia & Joe), Literature Review
		What are the key elements of SPR?	Document review (manual); literature review
		How and why was SPR selected in Alberta?	Key informant interviews; document review (meeting minutes)
		What evidence exists to support the effectiveness of SPR; and what are the contributing factors to effectiveness?	Literature review
	SPR Training & Support	How was the training delivered? (Includes how the workshops were marketed; how participants were recruited and prepped; how content was delivered, etc.)	Key informant interviews
		Who was trained, and what populations do they serve?	Program data
		Was the right audience targeted? (Who are the most appropriate people to be delivering these supports?)	Key informant interviews; Literature review
		How effective was the training? (Was it clear? helpful? sufficient? appropriately paced? etc. Were there sufficient supports in terms of funding, personnel, time, organizational supports, etc.?)	Trainee interviews, post-workshop evaluations
		What follow-up supports (if any) were offered?	Key informant interviews; documentation
		Was the training protocol modified for Alberta? If yes,	Key informant interviews; documentation

	how?	
	What (if any) improvements could be made to the way the training was delivered?	Key informant interviews; trainee interviews
SPR Content	Were trainees satisfied with the content? (Did they consider the content useful? Accurate? Appropriate? At the right level given their expertise? Etc.)	Trainee interviews; survey
	How was the content adapted for the Alberta context?	Key informant interviews; documentation
	Is the content appropriate for use with FNMI populations? If yes, what adaptations would be required?	Key informant interviews; FMNI trainee interviews
	Is the content appropriate for use with other populations (e.g., people from a variety of ethno-cultural backgrounds; the homeless) and sub-populations (e.g., seniors, children, homeless populations, rural etc.)? If yes, what adaptations would be required?	Key informant interviews; literature review
	What (if any) improvements could be made to SPR content?	Key informant interviews, trainee interviews, survey
Uptake and Delivery	Did trainees understand and accept the SRP approach?	Trainee interviews, survey
	To what extent (if any) are trainees integrating SPR into their practice? Why? (i.e., what reasons do they give for integrating it or not integrating it?)	Trainee interviews, survey
	How are trainees integrating SPR into their practice?	Trainee interviews, survey
	Are trainees seeing service users for more than one session? (How many on average?) What strategies are they using to encourage multiple sessions?	Trainee interviews, survey

	Did trainees 'train' other service providers in SPR?	Trainee interviews, survey
	What additional supports (if any) would help to increase uptake and/or fidelity?	Trainee interviews, survey
Fidelity	What type/level of fidelity is needed for SPR to be effective?	Key informant interviews (Joe, Patricia); literature review
	What type/level of fidelity is being achieved amongst those who were trained in Alberta?	Trainee interviews, survey
Impact	What is the perceived impact of SPR? On trainees? On individuals affected by the flood?	Trainee interviews, survey, survey, interviews with clients (?)
	To what extent, and how, has the SPR Training Program strengthened the capacity of trainees and their organizations to provide psychosocial supports to southern Alberta flood survivors? To respond to people affected by potential future disasters?	Key informant interviews; trainee interviews;
	Has there been effective "psychological recovery" services and support for people who were affected by the flood?	Key informant interviews; client interviews and/or citizen interviews?
Reach	Who is receiving SPR supports and how are they accessing them? (Client profile to get at the question of whether populations who are not at risk are receiving these supports)	Interviews, survey, document review (review orgs that were trained and identify client base associated with them)
	Are there any key target populations that are not receiving these supports?	
Conditions for effectiveness	What conditions are needed to ensure the effectiveness and sustainability of SPR? (e.g., What is required in terms of provincial/system/organizational	Key informant interviews; Literature review; Survey, Program data?

		leadership, buy-in, capacity or support? What is needed in terms of ongoing training, coaching, technical assistance, etc.? What supports are required to ensure that people who have received the intervention are able to maintain these skills?)	
		Is there any regional variation in terms of the conditions required?	Key informant interviews; survey, Program data?
SPR Training Program within the Context of the Southern Alberta Flood Disaster Response & Recovery	Psychosocial Supports	What other key psychosocial supports were implemented in response to the 2013 flood? (How and by whom)	Key informant interviews; document review; stakeholder mapping
	Coordination of Psychosocial Supports	How have groups worked to coordinate efforts in this area, and how effective have those efforts been?	Key informant interviews; document review; stakeholder mapping
		How could coordination have been improved? [or is it how could coordination be improved?]	Key informant interviews
		What lessons learned about coordination of services could be used in other disaster situations in Calgary area and the province as a whole?	Key informant interviews
	Local capacity to provide coordinated psychosocial supports in disaster response and recovery	What are the key domains and elements of capacity to provide coordinated psychosocial supports in disaster response/recovery (e.g., will/commitment/values, leadership, resources, networks, programs, systems, capacities, structures, processes, etc.) in southern Alberta?	Observation, key informant interviews, literature review
		How can capacity to provide coordinated psychosocial supports in disaster	Observation, key informant interviews, literature review

		response/recovery be enhanced in southern Alberta?	
	Perceived Effectiveness	What psychosocial supports were considered helpful? By service providers? By citizens? (Why?)	Interviews with citizens and service providers; document review
		What supports were considered unhelpful or ineffective? (Why?)	Interviews with citizens and service providers; document review
	Perceived Needs	What psychosocial supports might have been helpful had they been available? By service providers? By citizens? (Why?)	Interviews with citizens and service providers; document review
SPR Training Program within the Context of Developing a Provincial Disaster Response Plan	Key elements	What are the key elements of psychosocial support in disaster response plans? Which of these elements can SRP address?	Literature review (academic and grey); Review of disaster response plans in Australia and the US; Key informant interviews
		What are the key elements in the Alberta Psycho-social response plan? (How do these compare to those identified in the literature?)	
	Provincial Capacity to provide coordinated psychosocial supports in disaster response and recovery	How does SPR fit into a broader disaster response plan in Alberta?	Key informant interviews; document review
		What are the key domains and elements of capacity to provide coordinated psychosocial supports in disaster response/recovery (e.g., will/commitment/values, leadership, resources, networks, programs, systems, capacities, structures, processes, etc.) at a provincial level?	Key informant interviews, literature review
		How can capacity to provide coordinated psychosocial supports in disaster response/recovery be enhanced in Alberta?	Key informant interviews; comparative analysis of stakeholder mapping vs. identified elements

Appendix B: SPR Developmental Team Membership

Shelley Fahlman, *Alberta Health Services Provincial Addiction and Mental Health*

Judi Frank, *Disaster Management, Canadian Red Cross*

Kelly Fredell, *Hull Services*

Deb Gray, *Alberta Health Services, Provincial Addiction and Mental Health*

Catharine McFee, *Alberta Health Services, Provincial Addiction and Mental Health*

Tessa McGarrigle, *Hull Services*

Tavia Nazarko, *Alberta Health Services, Community Disaster Outreach Team/Police and Crisis Team*

Sonja Ruthe, *Canadian Red Cross*

Jolene Seib, *Alberta Health Services, Provincial Addiction and Mental Health*

Gail Smilie, *Carya*

Patricia Watson, *U.S. Department of Veterans Affairs: National Centre for PTSD*

Appendix C: Synthesis of Overarching Principles for DR-PPS

Superordinate principle: Psychosocial wellbeing and the provision of psychosocial supports need to be an integral aspect of the overall disaster effort (NATO, 2008; Ursano et al., 2007).

Principles underlying the focus or content of psychosocial support **(Hobfoll et al., 2007) with additions from Miller (2016; 2012)**	
Promote a sense of safety	This includes bringing people to safe place, reminding people and communities of their relative safety, and assisting them to develop adaptive coping strategies.
Promote calming	This includes providing clear and accurate information about the status of the disaster, normal post-disaster reactions and signs of more severe dysfunction, and working with individuals and communities on anxiety management and increasing involvement in uplifting activities.
Promote a sense of self- & community-efficacy	This includes promoting activities that are conceptualized and implemented by the community, fostering competent communities, and individual and group cognitive behavioural therapy.
Promote hope	This includes practical support to help people to rebuild their lives and their communities, to share and make meaning of their experiences, and to build on strengths that they have as individuals and communities.
Promote connectedness	This includes keeping people together (in case of evacuation) or reconnecting them, identifying and supporting people likely to be more socially isolated, and increasing the quantity, quality and frequency of supportive interactions between trauma survivors and their social supports.

Additions to Hobfoll et al. provided by Miller (2012, pg. 161)	
Allow for grieving and mourning in culturally meaningful ways	People need space and opportunity to grieve and mourn as individuals, families, and communities in their own culturally specific and meaningful fashion.
Re-establish a sense of place	Loss of communities, neighbourhoods, public spaces, businesses and homes can lead to loss of attachment to one's community. Re-establishing sense of place is essential and contributes to the foundation of feeling safe, secure, socially connected and living a meaningful life.
Re-establish connections with cultural practices and lessons learned from ancestors	Disasters can disrupt or disconnect people from their cultural and historical past, as well as routines and social practices that are an important source of meaning. It often takes a connection with the past to make sense of the present and envision the future.

Principles underlying psychosocial support
(Inter-Agency Standing Committee, 2007; Sphere Project, 2011)

Human rights & equity	Humanitarian actors should promote the human rights of all affected persons, and aim to maximize fairness in the availability and accessibility of mental health and psychosocial supports among affected populations.
Do no harm	Extra care should be taken to do no harm, given that there is a history of some humanitarian aid and mental health and psychosocial support causing unintentional harm.
Person & community centered	Psychosocial supports services should always have the expressed needs of people and communities front and centre, and work with communities to design services that will meet these needs in a way that will be sustainable.
Building on strengths & capabilities	Individuals', families' and communities' strengths & capabilities are recognized, built on, and enhanced in the design and delivery of all psychosocial support initiatives.
Participation, collaboration & integration	Individuals, families and communities actively participate in the design and implementation of a range of integrated psychosocial supports that will work for them. Note that collaborative design in an ongoing process, as needs will evolve over time. Working together over time maximizes efficiency, coverage and effectiveness.
Performance, learning & transparency	Appropriate management and supervisory support is provided to enable aid workers to perform optimally, delivering effective services with humanity and respect. There is a commitment to assessing the performance of agencies, using what is learned to improve performance and open communication of this with stakeholders.
Multi-layered, contextual embedded supports	A key to organizing psychosocial support is to develop a layered system of complementary supports, sensitive to context that will meet the different and evolving needs.

Appendix D: Stepped Care Approach

- Everyone affected by a disaster or emergency will need information in the immediate hours, days, and weeks after an event.

- Many people will need Psychological First Aid (PFA) in the hours, days, and weeks after an event.

- Some people will have stress and difficulties that continue in the weeks or months after an event. This doesn't mean they have a mental health problem. For most people action–oriented support such as Skills for Psychological Recovery (SPR) may be all the help they need to recover.

- A few people will need professional mental health treatment for problems such as, Post-Traumatic Stress Disorder (PTSD). Usually only a small percentage of people fall into this category after a disaster or emergency.

Source: Alberta Health Services. (2014). Skills for Psychological Recovery (SPR) Reference Guide for SPR Providers