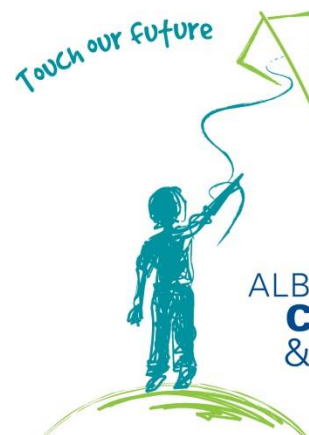


Skills for Psychological Recovery Developmental Evaluation Environmental Scan

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Key Insights: SPR and Psychosocial Supports in Disaster-Related Planning, Prevention/Mitigation, Response, Recovery and Development

The following insights represent a synthesis of overall findings from the review and scan related to DR-PSS and SPR. Detailed descriptions of the findings related to each of these insights are discussed in further detail in the literature review.

- **Psychosocial support needs to be integrated into the overall disaster effort.** Every element of a response to disaster has the potential to impact the psychosocial wellbeing of individuals, families and whole communities.
- **There is a clear need for collaboration and coordination of supports.** Multiple agencies, organizations, and government working together effectively with communities to set priorities, draw upon existing strengths and resources, and implement actions to support psychosocial wellbeing for all is a necessity.
- **Effective DR-PSS responses require equal emphasis** on individual-focused approaches (which predominate in the western world) and community interventions (which ensure those who may not access individual support receive care).
- **Integration of two complementary disaster response paradigms** (Disaster Mental Health and Psychosocial Capacity Building and Resilience) is a necessity for comprehensive disaster response.
- **The foundation of psychosocial capacity building and community resilience models is the participation of community members.** Community members assess their strengths and needs, determining priorities, and taking action to rebuild the community.
- **DR-PSS may be best envisioned as a wide constellation** of processes and supports integrated throughout disaster planning, response, recovery and rebuilding.
- **SPR is one of a number of evidence-informed, individual-focused approaches for DR-PSS.** SPR fills a unique niche in the spectrum of DR-PSS strategies; it is one of the only interventions that is suitable for helping people experiencing mild to moderate distress as a result of their disaster experience, and that can therefore support recovery from disaster.
- **SPR can be delivered by anyone** who is capable of developing trusting and respectful relationships with people experiencing distress and who is able to teach the skills in an effective manner.

Executive Summary | SPR Literature Review and Environmental Scan

The 2013 flood in southern Alberta demonstrated the crucial importance of providing psychosocial supports to citizens affected by disaster. Following the flood, Alberta's Ministry of Health supported Alberta Health Services (AHS) to implement Skills for Psychological Recovery (SPR) (Berkowitz, et al., 2010), an evidence-informed intervention to support disaster-affected people who are experiencing mild to moderate levels of distress. The focus of SPR is on building skills for short- and long-term adaptive coping. Community-based mental health and other interested service providers were trained to help individuals cope with the mental and emotional impacts of their flood experiences.

In spring 2014, the Ministry of Health funded a developmental evaluation of the SPR training program to optimize the implementation of SPR in Alberta. In support of this work, a literature review and environmental scan were conducted. The questions addressed through this review and scan were:

1. What is known about the overarching picture of Disaster-related psychosocial support (DR-PSS) within which SPR fits?
2. What is known about the implementation, effectiveness and efficacy of SPR?

Disaster-related psychosocial support is the process of *“facilitating resilience within individuals, families and communities with resilience being understood as the ability of individuals, communities, organizations or countries exposed to disasters to anticipate, reduce the impact of, cope with and recover from the effects of adversity without compromising their long-term prospects”*.

IFRC 2009, pg. 5

Methods

A search of the peer-reviewed literature was conducted to locate published literature regarding the provision of disaster-related psychosocial supports (DR-PSS). A search strategy was developed to address the two overarching questions listed above.

A total of 3,944 published materials were identified using this strategy. After a review for relevance to the questions posed, a total of 119 were identified as potentially relevant to this review; additional articles were located by reviewing reference lists of identified articles; still others were recommended to us by key informants. Overall, a total of seventy two publications were assessed as relevant and included in this review.

In order to maximize learning from research and experience in other jurisdictions, an environmental scan was also conducted to supplement the literature review. This scan included both a search for relevant gray literature (resulting in a review of thirty five documents), and interviews with fifteen key informants who are either conducting research in the field of DR-PSS and/or working in the field.

Findings

Disasters affect whole communities, not just individuals. They can injure a community's social, cultural and physical ecologies in ways that cannot be remediated by exclusively addressing the issues of individuals. The most powerful impact is disruption of the social fabric that binds people together and provides the social support and connectedness that is vital to psychosocial wellbeing.

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. DR-PSS is the process of "facilitating resilience within individuals, families and communities with resilience being understood as the ability of individuals, communities, organizations or countries exposed to disasters to anticipate, reduce the impact of, cope with and recover from the effects of adversity without compromising their long-term prospects" (International Federation of Red Cross and Red Crescent Societies 2009, pg. 5).

The broad context of DR-PSS

A number of overarching and guiding principles for humanitarian response and DR-PSS are presented in the literature. A strong guiding principle is that the consideration of psychosocial wellbeing and the provision of psychosocial supports cannot be merely an 'add on' or a 'nice to do if there is time and resources', but rather needs to be an integral aspect of the overall disaster effort and across the spectrum from community assessment, planning and prevention all the way to disaster response, recovery and community rebuilding. In addition to this guiding principle, three frequently referenced sets of overarching principles for humanitarian aid, including DR-PSS specifically, were identified.

The Sphere Project (2011) and the Inter-Agency Standing Committee (2007) prescribe how psychosocial support should be delivered (e.g., with respect for human rights and equity; to do no harm; to build on strengths and capabilities, and so on). The Hobfoll et al. (2007) principles suggest what kinds of actions will likely promote psychosocial wellbeing (i.e., promote a sense of: safety, calm, self- and collective- efficacy, connectedness and hope).

Two distinct yet complementary paradigms shape how DR-PSS is conceptualized and implemented. Miller (2012) distinguishes these as disaster mental health (DMH) and psychosocial capacity building. Others (Saul & Bava 2008; Labonte, 1993) have discussed the psychosocial capacity building paradigm to include resilience (PSSCBR). Each paradigm is grounded in a particular understanding of health, the role of helping professionals in achieving health, and the role of individuals and communities in the process. Both of these paradigms have essential roles in DR-PSS and both aim to protect and promote psychological wellbeing. Some DR-PSS models include elements of both paradigms. However, the approach taken toward psychosocial support will vary depending on which paradigm is dominant.

- DMH is rooted in biomedical and behavioural views of health, and emerged from crisis intervention, informed by trauma reactions, particularly PTSD. As such, the focus is on the

prevention of, screening for, and treatment of PTSD and other mental health problems and illnesses occurring in individuals and arising from, or exacerbated by, disaster. Trained professionals such as psychologists, psychiatrists, social workers and counselors typically provide this kind of care.

- PSSCBR is resonant with mental health promotion and aims to enhance mental wellbeing, build capacity and foster resilience. These approaches emphasize building on existing strengths and assets and working in ways that are collaborative, participatory and empowering. In the disaster context, PSSCBR approaches strongly emphasize collective capacity and how it can be strengthened and reconstructed through empowerment of local people who know their community, their culture and one another. There remains an important role for professionals; however, the role is one of working with people and communities to assess strengths and needs, set goals and implement strategies for achieving them.

Through the literature review, a typology of approaches based on two dimensions emerged. The first dimension pertains to the dominant paradigms (i.e., DMH or PSSCBR). The second dimension is the focus of support – that is, whether interventions are primarily focused on the psychosocial wellbeing of individuals, or whether the focus is on the psychosocial wellbeing of whole communities: respectively termed ‘individual-focused psychosocial supports’ and ‘community-focused psychosocial supports’. Figure 1 was developed to illustrate an understanding and organization of the various DR-PSS frameworks, guidelines and models that surfaced. The overlap and blurring between the quadrants in this typology are intentional, indicating that there are few, if any, pure models that fit only into one quadrant. The pyramid in the middle represents a number of comprehensive frameworks that integrate all four paradigms.

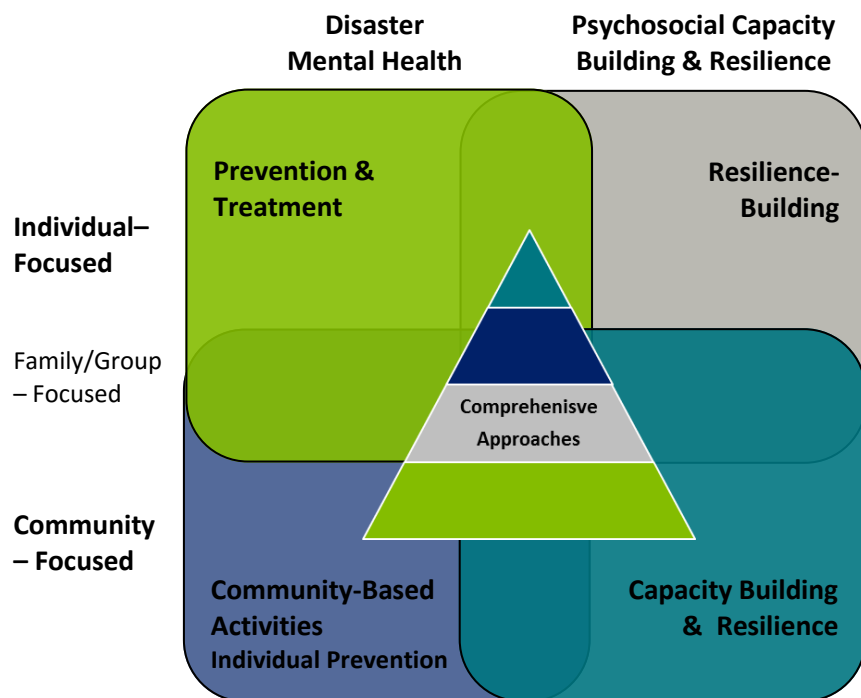


Figure 1. A simplified typology of models and frameworks for disaster-related psychosocial support

DR-PSS frameworks, guidelines and models

A wide array of DR-PSS models, frameworks, guidelines and individual programs are in existence. A number of comprehensive high level, international, national and state frameworks for DR-PSS and specific models such as SPR and psychosocial capacity building exist. In addition, some frameworks and models are intended for implementation before disaster; others for immediate disaster response; and still others, for short-, medium- and longer-term recovery and community rebuilding.

Comprehensive approaches integrate all four dimensions of this typology, illustrated in Figure 1; that is, DMH and PSSCBR, focused on individuals and on whole communities¹. These high level frameworks and guidelines are informative for organizations and governments wishing to develop a comprehensive approach for DR-PSS. They provide a “whole package” of guidance, including background information, principles for action, an overarching assessment/planning/implementation/evaluation frame and descriptions of integrated actions typically organized from broad, community-wide approaches all the way to specialized mental health services for individuals severely impacted by the disaster.

DMH- oriented models: Individual-focused

DMH guidelines or models typically outline different interventions at different points along the trajectory of a disaster and as the needs of survivors change. The goals of mid- to long-term intervention are to prevent and treat psychopathology. As such, these approaches have a crucial role in DR-PSS. One example is a set of guidelines developed by the European Network for Traumatic Stress (TENTS) (2008), *Guidelines for Psychosocial Care Following Disasters and Major Incidents*. These guidelines primarily emphasize clinical care for individuals, with recognition that such care should be provided with consideration of the individual’s family and community. Components related to actions in the first month and beyond focus on supports to individuals, including assessments and use of evidence-based treatments for mental health problems and illnesses. Community members may be consulted to ensure that programs and services are appropriate for the community.

DMH-oriented models: Community-focused

By definition, DMH models focus on care and support for individuals and do not focus on whole communities. At this time, no DMH-community focused models were found, although there is frequent mention in the DMH literature about epidemiological studies of the incidence and prevalence of psychopathology in populations and communities. Many individual-focused DMH models do, however, mention delivery of community-based activities that support individual-focused DMH (for example, talking about SPR at a community dinner), and some individual-focused DMH models speak to community actions, such as facilitation of communal healing practices (see the TENTS model).

¹ One of the most commonly cited frameworks is the Inter-Agency Standing Committee (IASC) (2007) *Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (2007) from the Inter-Agency Standing Committee (IASC). The IASC is a unique forum of key United Nations (UN) and non-UN humanitarian partners. It is the primary mechanism for interagency coordination of humanitarian assistance.

PSSCBR-oriented models: Individual-focused

Broadly defined, individual resilience is the vital sense of flexibility and the capacity to re-establish one's own balance; the essential feeling of being in control with regard to oneself and to the outside world. Individual-focused resilience models aim to help people understand their reactions are normal and to help them reassert control over their lives. The primary goal within the first month following a disaster, the response stage, is to promote safety, attend to practical needs, enhance coping, stabilize survivors and connect survivors to additional resources. In the immediate and longer term, these approaches protect and promote psychosocial wellbeing and build capacity to navigate adversity. SPR fits within this individual-focused PSSCBR or resilience paradigm.

PSSCBR-oriented models: Community-focused

PSSCBR approaches strengthen the community's social fabric, a fundamental source of psychosocial support. In addition, they address psychosocial impacts on whole communities and they strengthen the community's ability in general to protect and promote the wellbeing of its members, including a greater ability to address future adversity. Common features of these approaches include:

- A focus on the whole community and active, representative engagement of community members in assessing, planning, setting priorities, and implementing psychosocial response and recovery strategies. While outside agencies and professionals may provide supports, facilitation and processes for this work, the community determines the content and goals of such efforts. This process in and of itself builds capacity for community members and groups to work effectively together and build a more resilient community.
- These approaches are fundamentally about rebuilding the community's social fabric; implementing actions to protect and promote psychosocial wellbeing of individuals, families, groups and the community as a whole; and enhancing the adaptive capacity of the community, thus helping to mitigate the impact of future adversity.

Skills for Psychological Recovery (SPR)

SPR (Berkowitz, et al., 2010) is an evidence-informed intervention designed for delivery by practitioners of varying backgrounds and qualifications. It is:

- Based on extensive research regarding the most common emotional and behavioural reactions arising from disasters in adults and children
- Aimed at developing the briefest but most effective strategies derived from evidence-based approaches to managing these reactions
- Formatted to ensure that training and delivery is feasible in the wake of massive disasters
- Based on development of five core skills: problem solving, positive activity scheduling, managing physical and emotional reactions, helpful thinking and rebuilding social connections

SPR focuses on the support of individuals. As such, in the broad spectrum of approaches we reviewed, particularly the IASC (2007) pyramid of interventions, SPR fits in the second tier from the top (“focused person-to-person supports”). From the perspective of individual-focused stepped models of care, such as that of the Australian Psychological Society (Online), it fits in the second tier (“simple psychological strategies”). This is depicted in Figure 2. Comparison between the IASC and the APS pyramids makes it clear that while SPR is an important, if not essential, component of disaster-related psychosocial support it is only part of a comprehensive approach.

In terms of the paradigm in which SPR fits, some individuals conceive of SPR from a disaster mental health perspective, emphasizing SPR more as a preventive intervention delivered primarily by mental health professionals. Many others conceive of SPR more as a capacity and resilience-building approach because it builds skills that help people adapt effectively to distress, and in the process, become more resilient. Those who focus on SPR as a resilience approach also support SPR being facilitated by a diversity of individuals with an interest in supporting others, with mental health professional support and supervision.

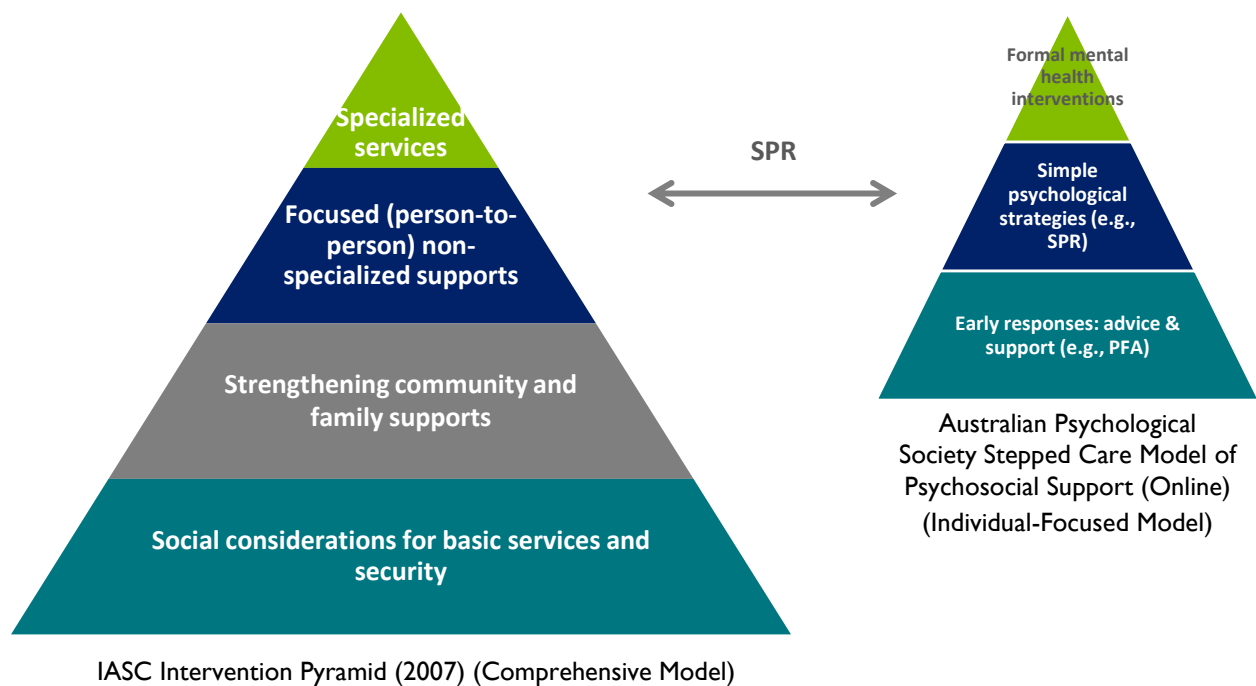


Figure 2. Where SPR fits in the overarching picture of disaster-related psychosocial supports, in comprehensive models and individual-focused models

Findings related to SPR efficacy and effectiveness, as well as a variety of factors related to SPR implementation, are summarized in Table 1 on the next page.

Table 1. Findings related to SPR

<p>What is known about the efficacy of SPR?</p>	<ul style="list-style-type: none"> ▪ SPR is evidence informed: it was developed based on what is known from research about the kind of mental health problems most likely to occur post-disaster and the kinds of strategies most effective in prevent these problems from occurring. ▪ No experimental design research has been published to date on the efficacy of SPR as an intervention for promoting psychological health and preventing mental illness in disaster survivors. There was also no research found on the efficacy of other psychosocial recovery interventions.
<p>What is known about the effectiveness of SPR based on practice?</p>	<ul style="list-style-type: none"> ▪ People who have been trained in SPR and who have experience using it in post-disaster settings find it a useful intervention; they report it is a useful and coherent framework and they report that people using SPR seem to benefit in terms of increased skills. ▪ SPR is seen as a promising practice, widely used in Australia in the bushfires disaster, in Louisiana in the hurricane disasters, after the BP oil spill, and in the Joplin, Missouri tornado.
<p>Can SPR be used with groups of people?</p>	<ul style="list-style-type: none"> ▪ SPR has been used in group and community settings. ▪ Some potential challenges are coordination of peoples' schedules (finding time to meet as a group); and some people may not be comfortable talking about their concerns with people they know.
<p>Can SPR be used outside of a disaster context?</p>	<ul style="list-style-type: none"> ▪ To date, there has been little experience with use of SPR outside a disaster context. ▪ Many key informants felt that it would make sense to use SPR beyond disaster contexts because the five skills are applicable for people experiencing other kinds of trauma and difficult life events; and this is a useful strategy for keeping skills updated.
<p>What is known about implementing SPR in a variety of contexts and with different populations?</p>	<ul style="list-style-type: none"> ▪ SPR is being used with a wide variety of populations (including children, youth, seniors, homeless populations, both rural and urban populations and people from a variety of ethno-cultural backgrounds). ▪ A key challenge is that many people won't come to an office for "counselling," meaning that SPR is best provided in the community and integrated into other activities. ▪ A lesson learned is not to introduce SPR as a "mental health" or "psychological" intervention, in part because of the stigma related to mental health; more effective terms include "helping people to help themselves" or "building capacity for hope and resilience." ▪ A promising practice is to first talk with community leaders about SPR and how it might best be introduced in the community.

<p>What is known about developing capacity for integrating SPR into practice?</p>	<ul style="list-style-type: none"> ▪ A key facilitating factor in Australia for building SPR capacity post-disaster has been cooperation between various levels of government to develop an integrated training response. ▪ Another lesson learned is that if a stepped approach to DR-PSS is implemented, it is important to optimize the targeting of training to avoid participant confusion (i.e. clearly articulate the target audience, purpose, scope and application of the training, and applicable pre-requisites.) ▪ It is important to know how to work with and lead multi-disciplinary teams that often include volunteers. ▪ Ongoing provision of support, supervision, mentoring and training is essential for building practitioner proficiency and confidence in using SPR. ▪ State-wide training via video-conferencing was used successfully in Louisiana. ▪ Training programs should take into account that service providers may be using the skills for their own recovery. ▪ The approach to building SPR capacity will necessarily be different in different contexts. ▪ Train-the-trainer approaches are being widely used to build SPR capacity. ▪ SPR needs to be simple enough that it does not require a lot of training.
<p>Who should be trained in SPR?</p>	<ul style="list-style-type: none"> ▪ All key informants said that ideally SPR trainees would include a mix of mental health professionals and paraprofessionals. The precise mix will be influenced by the context in which it will be implemented. ▪ Having the ability to work effectively with people and make a connection with them appears to matter more than professional background. ▪ It was noted that it can be more challenging to train mental health professionals in SPR as a lot of “unlearning” may be required. ▪ In Australia, different levels of training were developed to meet the needs of different groups of service providers.
<p>What is known about referring people who require more professional support?</p>	<ul style="list-style-type: none"> ▪ Knowing when to refer a person to professional mental health supports is an important aspect of SPR; however, key informants noted this can be challenging. ▪ In some cases, there simply is a dearth of mental health services, or people are unwilling or unable to access them.
<p>What does fidelity to SPR look like?</p>	<ul style="list-style-type: none"> ▪ Given the strong evidence upon which SPR is based, key informants noted that most important is “staying true” to these five skill areas, and helping people to build these skills. ▪ While the skills remain constant, contextualization and tailoring of SPR has been shown to be instrumental in successful delivery of SPR.

Considerations for Future Research and Evaluation

A consistent finding in our review of the literature was the dearth of research and evaluation regarding the effectiveness of the various approaches to DR-PSS. Psychosocial interventions such as Psychological First Aid, SPR, crisis counselling and psychoeducation have not been sufficiently evaluated to establish their benefit or harm in disaster situations. A similar state exists for PSSCBR approaches. However, on both fronts, efforts are underway to address these deficits.

A key challenge in evaluating these kinds of interventions is the chaos that accompanies disaster, combined with the complexity of communities, of collaborating across organizations, and of DR-PSS interventions. Innovative approaches are required. Consideration needs to be given to what the anticipated outcomes of DR-PSS should be. DMH approaches have dominated to date, focusing on incidence and prevalence of psychopathology. PSSCBR interventions broaden the range of expected outcomes including, for example, positive mental health, capacity and resilience. In addition, DR-PSS research and evaluation needs to place particular emphasis on understanding the dynamic and complex contexts in which DR-PSS occurs, and how this impacts implementation and outcomes of actions. Developmental evaluation and other “real time” approaches to learning and enquiry will be particularly helpful in building understanding of implementation of interventions in context.

Introduction and Background

In June 2013, southern Alberta experienced a major flood, triggered by heavy rainfalls at a time when water levels were already high. This flood affected residents across the area, including the communities of Black Diamond, Calgary, Canmore, Crowsnest, Exshaw, High River, Lethbridge, Siksika and Turner Valley. By June 21, 75,000 residents in these communities had been evacuated, and many schools and business were closed. RCMP reported four casualties from the High River area. In total, the flood directly affected thirty one communities and damage costs were estimated at between three and five billion dollars (Calgary Herald, 2013).

In the months following the flood, Alberta's Ministry of Health supported Alberta Health Services to provide practitioner training in Skills for Psychological Recovery (SPR) as one of a range of psychosocial supports for citizens who were impacted by the disaster. SPR is an evidence-informed intervention designed to foster short- and long-term adaptive coping in disaster survivors who are experiencing mild to moderate distress. The intervention is based on a substantial body of evidence that suggests that skills-based approaches are more effective than narrative therapy or supportive counseling in post-trauma situations. SPR offers simplified, brief application of five skills: problem-solving, positive activity scheduling, managing reactions, helpful thinking and building healthy social connections.²

SPR is an evidence-informed intervention designed to foster short- and long-term adaptive coping in disaster survivors who are experiencing mild to moderate distress.

At the time, it was known that SPR had been used in two other jurisdictions (United States and Australia), and that it was increasingly being recognized as a promising practice but had had limited evaluation. The Ministry of Health asked the Alberta Centre for Child, Family & Community Research to coordinate a developmental evaluation of the SPR Training Program. Developmental evaluation is appropriate where there is a need to develop innovative approaches to dealing with complex health and social issues. This evaluative approach is particularly suited to this project because both the processes and outcomes of the SPR Training Program, and other implementation strategies, may need to be redefined to ensure appropriateness within the Alberta context.

Developmental evaluation differs from traditional forms of evaluation in several ways. One of the key ways is that the role of evaluator extends well beyond data collection and analysis. The evaluator works with a development team to implement and test recommendations *as they emerge in real-time*, using data and logic to inform decision making and shape the course of development. In the developmental evaluation of SPR, an evaluation team is working with a development team to integrate the learning that emerges from the SPR Training Program Evaluation as part of an ongoing, iterative development process.

² For an overview of SPR, please see: <http://www.nctsn.org/content/skills-psychological-recovery-spr>

The purpose of this developmental evaluation, then, is supporting the identification *and* development of the various factors (infrastructure, capacities, supports, etc.) required for SPR to be successfully implemented and sustained in Alberta. Developmental evaluation involves the ongoing development of a model or initiative, so it is important to continue collecting knowledge that can inform that development. This ongoing knowledge collection comes from a variety of sources, including knowledge generated through: the ongoing evaluation of the evolving local initiative (i.e., in this case SPR in southern Alberta); and exploration of relevant research and practice in other jurisdictions.

Developmental evaluation involves the ongoing development of a model or initiative.

The literature review and environment scan reported herein was conducted with two overarching purposes: first, to inform the ongoing development of SPR in the province; second, and more broadly, to understand where SPR fits in the big picture of disaster-related psychosocial support (DR-PSS) and to inform provincial planning for DR-PSS. Consistent with a developmental evaluation approach, the intent was to increase our understanding of what works, in which contexts, how, and why. Summarized below are the keys questions that guided our work. These questions, and a number of more detailed sub-questions, were outlined in a learning framework intended to guide the developmental evaluation.

1. What is known about the overarching picture of disaster-related psychosocial support (DR-PSS), within which SPR fits?
2. SPR effectiveness: What is known from research, evaluation and current practice about whether SPR makes a difference for people post-disaster or trauma?
3. SPR implementation: What is known from evaluation and current practice about how others are implementing SPR in a variety of contexts, and what they have learned about what work in a variety of contexts?
4. SPR in context: What is known about where SPR fits in the bigger psychosocial support and capacity building picture?

Methods

Literature Review

A search of the peer-reviewed literature was conducted to locate published literature related to the provision of disaster-related psychosocial supports. A search strategy was developed to address two overarching questions: 1) *What is known about the implementation, effectiveness and efficacy of SPR;* and, 2) *What is known about the broader post-disaster psychosocial support context within which SPR is situated?* Key articles provided by members of the SPR evaluation advisory committee were used to identify key words and to test the search strategy. That is, the goal was to develop a strategy that would identify these key articles without also identifying too many “out-of-scope” articles.

The search strategy was developed and executed in MEDLINE, and then adapted as required to match the thesauri of three other databases: PubMed, PsycINFO and PILOTS (Published Literature on Traumatic Stress). The search was limited to English language literature from 1970 to 2015.

Selection and critical appraisal of the articles

A total of 3944 published materials were identified using this strategy. Given the vast number of articles, the decision was made to limit this review to articles published in the past ten years (i.e., from 2005-2015), which came to a total of 3330. Having said that, older articles that were frequently cited or that were particularly pertinent to this evaluation were identified and included by searching the reference lists of more recent articles, and through key informant interviews with researchers working in this field.

A preliminary review of titles and then abstracts from 2005 on narrowed this list down to a total of 198 articles. These 198 full text journal articles and book chapters were screened for relevance, and 119 were identified as relevant to this 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. A total of 72 articles, those of most relevance to these themes, are cited in this report. It is important to note that very few research articles discussing SPR were found, likely because SPR is a relatively new psychosocial intervention (see Figure 3).

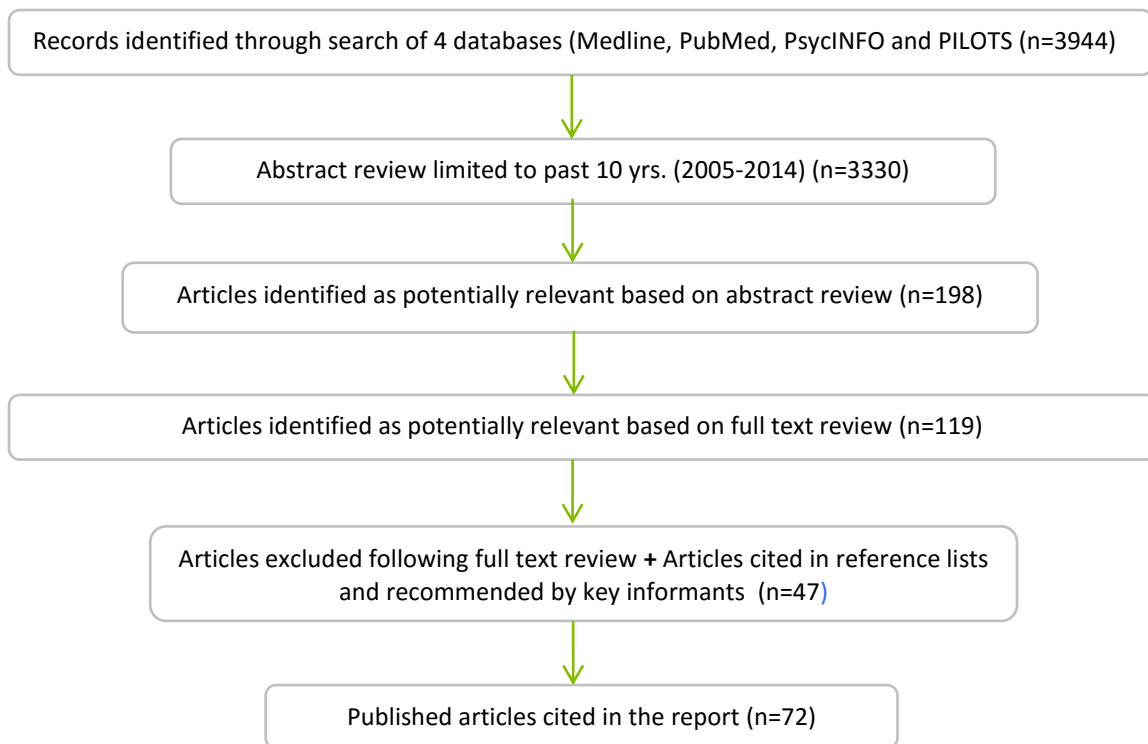


Figure 3. Literature search and screening process results

Environmental Scan

An environmental scan was also conducted to supplement the literature review, with a goal of maximizing our learning from research and experience in other jurisdictions. This scan included both a search for relevant gray literature (resulting in a review of thirty five documents) and interviews with key informants either doing research in the field of post-disaster psychosocial support and/or working in the field. Findings from the literature review, as well as discussions with members of the Alberta SPR Advisory Committee, and members of the SPR Evaluation Development Team helped to both identify key sources for gray literature, and people we should speak with. Dr. Patricia Watson, who is both a member of the Advisory Committee and the Development Team, was especially helpful here.

With respect to the key informant interviews, a total of 11 were conducted interviews with 15 key informants (see Table 2).

Table 2. Key informant interviews

Type of key informant	Number of interviewees
People using and evaluating SPR in a variety of contexts (e.g., Louisiana, post-Hurricane Katrina and post-BP oil spill; Joplin Missouri, post-tornado; Victoria Australia, post-bushfires).	4
People based in academic settings involved in the development and evaluation of SPR, and who have an interest in SPR research.	5
People writing up and interested in the broader SPR context including psycho-social and community capacity building, community resilience, and positive mental health.	3
Members of the SPR Evaluation Advisory Committee.	3
Total	15

With respect to the gray literature, in addition to materials passed along by members of our SPR evaluation advisory committee, we found a number of relevant frameworks and guidance documents through websites in those countries known to have a strong psychosocial support component to their disaster response and recovery, and key international organizations.

Strengths and Limitations

The strengths of this work are the systematic approach taken to our critical review of the peer-reviewed and gray literatures, and the number and variety of people we were able to speak with through the key informant interviews. The fifteen people we had the privilege to speak with had acquired considerable wisdom through their practical and academic experiences. The members of the advisory committee overseeing this work also brought extensive expertise. They provided a number of key references that helped to shape our search strategy, and connected us with key informants. Their review of earlier drafts of this report contributed to the development of a stronger and more useful document.

There are of course limitations to this work. This is not a traditional systematic review of the literature, but rather, a critical analysis of major streams of thought that emerged through the literature and key informant interviews. The field of disaster-related psychosocial supports is complex, involving numerous disciplines including, for example, psychiatry, psychology, social work, social psychology, community psychology, public health, population mental health, community development, disaster management and others. Each discipline has its own perspective on the nature of disaster-related psychosocial supports and how and when these are best implemented. A comprehensive review of the major streams of thought in each discipline, let alone an analysis of symmetries and contradictions, was beyond the scope of our review. Wherever possible, we have reviewed highly cited articles and resources.

Further, it is not possible to assess the extent to which the models, frameworks and guidelines presented in this report have been evaluated; and accordingly, we have not reported any evidence of their effectiveness. In general, we found that most frameworks had not been rigorously tested. We do realize that this is a daunting task given the complexity of some of the frameworks, combined with all the complexities that accompany a major disaster.

The Broad Context of Disaster-Related Psychosocial Support

In this section, we describe literature review and environmental scan findings related to the following questions set out in the learning framework for the SPR evaluation.

Overarching question: What is known about the overarching picture of disaster-related psychosocial support (DR-PSS), within which SPR fits?

Sub-questions:

- How is psychosocial support conceptualized in the literature?
- What models or approaches are described and what are their key features and components?
- Are there components of psychosocial response and recovery that address communities? If yes, how are community needs addressed?
- How are these different models likely to influence how psychosocial support is conceived and rolled out?
- What are the key domains and elements of organizational capacity to provide coordinated psychosocial supports in disaster response/recovery?

Our review of the literature and environmental scan surfaced a diverse mix of paradigms, frameworks, guidelines, models and practical approaches for disaster-related psychosocial support (DR-PSS). What follows is a high level description of these various approaches, providing a snapshot of various combinations and permutations of approaches in use or prescribed for use in disasters. We preface our discussion of these models with an overview of psychosocial wellbeing, the impact of disasters on

individual and community psychosocial wellbeing, and current conceptualizations of “disaster-related psychosocial support.” Next, we present a typology of models and frameworks for addressing DR-PSS, based on our review and analysis of the literatures and conversations with key informants. After summarizing three sets of overarching principles for humanitarian aid and DR-PSS, we present examples of frameworks/approaches identified in our typology of approaches. (Note that the question regarding the key domains of organizational capacity to provide coordinated disaster-related psychosocial supports is discussed later in the paper.)

Defining Psychosocial Wellbeing

Surprisingly few articles and documents explicitly define “psychosocial wellbeing” although what appears to be common across most of the works reviewed is an understanding that the term pertains to the intersection between psychological (the inner mind) and social (relationships with others and the environment in which one lives). While the two are seen as inseparable, we found that some models/approaches privilege the psychological aspect of this equation while others emphasize the social and community aspect. Comprehensive models attend to both dimensions.

One of the most comprehensive definitions of psychosocial wellbeing found in our review was that of the International Federation of Red Cross and Red Crescent Societies (IFRC). The IFRC (2009, pg. 27-29) describes this phenomenon as relating to three core domains: human capacity (physical and mental health, recognizing one’s own strengths and values); social ecology (social connections and support including, for example, relationships, networks and support systems of the individual and the community); and culture and values (cultural norms and behaviours that are linked to a society’s value systems, linked with individual and social expectations). Psychological wellbeing depends on the ability to draw from these core domains, yet crisis and disaster can deplete these resources. Thus, external interventions and assistance may be required to rebuild individual and community psychosocial wellbeing.

Importantly, psychosocial wellbeing is dynamic and contextually determined and as such, no “standard” definition can be applied since the term will have different meanings to different people in different contexts and cultures. Since contexts and other factors are always changing, so will the experience of psychosocial wellbeing (IFRC, 2009, pg. 28). Thus, before preparing any psychosocial response, it is important to learn what “psychosocial wellbeing” actually means for those affected by disaster. This helps to ensure that interventions are relevant to local people, not just a replication of activities that worked elsewhere (IFRC, 2009, pg. 29).

No “standard” definition can be applied to psychosocial well-being as it is contextually determined.

Finally, psychosocial wellbeing is determined to a large extent by structural, societal, cultural, political and economic factors (determinants of health) such as peace, safety, social connections and inclusion, healthy child development, affordable and adequate housing, education and literacy, food security, adequate income and working conditions, social status, gender, culture, equity and social justice (Public Health Agency of Canada, World Health Organization, 1986).

This view of psychosocial wellbeing is highly resonant with definitions of positive mental health which emphasize the presence of positive qualities such as empowerment, positive affect, happiness, life satisfaction, self-acceptance, personal growth, purpose in life, mastery and a sense of connectedness and belonging (Keyes, 2003).³ The Public Health Agency of Canada (2006), for example, defines mental health as, “the capacity of each and all of us to feel, think and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional and spiritual wellbeing that respects the importance of culture, equity, social justice, interconnections and personal dignity.”

How Disasters Impact the Psychosocial Wellbeing of Individuals

In this section we provide a brief overview of some of the key impacts of disaster on the psychosocial wellbeing of individuals. There is a vast literature in this regard and a comprehensive review was beyond the scope of our remit. Our intent here is simply to provide a foundation for description of models and approaches focused on disaster-related psychosocial supports for individuals, specifically, the kinds of issues that “disaster-related psychosocial support” is intended to address.

Disasters result in loss. People might lose, for example: their loved ones; control over their life and future; a sense of security; hope and initiative; dignity; social infrastructure and institutions; access to services; property; and, prospects of a livelihood. These significant losses can impact one’s psychological, spiritual, emotional and social wellbeing (IFRC, 2009). The nature, degree, timing and extent of reactions vary amongst individuals, as does the need for corresponding interventions (Bonanno, Brewin, Kaniasty & La Greca, 2010; IFRC, 2009).

Until recently, the bulk of published studies regarding psychosocial impacts of disaster have focused almost exclusively on individuals and their reactions to trauma, and with a strong emphasis on development of post-traumatic stress disorder (PTSD).

Recent research has shown that the typical response to trauma or disaster is resilience.

(Bonanno, 2004; 2005)

Nevertheless, recent research has shown that the typical response to trauma or disaster is resilience (Bonanno, 2004; 2005); that is, most disaster survivors do well (Ursano, et al., 2007a) and will not require the services of mental health professionals (Watson, Brymer & Bonanno, 2011). Most often, more than half of survivors experience only transient distress and maintain a stable trajectory of healthy functioning or resilience (Bonanno et al., 2010). In short, as Bonanno (2005, pg. 3) observes, “although many people are psychologically harmed by disasters, a great many people also manage to endure their

³Note that in this document, we use the term “mental health” in its positive sense. We use the term “mental illness” to mean a “recognized, medically diagnosable illness that results in significant impairment of an individual’s cognitive, affective or relational abilities” (Epp, 1988, pg. 5), and “mental health problem” as a “a disruption in the interactions between the individual, the group and the environment. [They] interfere with cognitive, affective or relational abilities but to a lesser extent than mental illness. They are more common complaints, less severe and of shorter duration than mental illness and often occur in response to life stressors” (Commonwealth Department of Health and Aged Care, 2000, pg. 5). Accordingly, “mental health promotion” means the promotion of positive mental health and resilience while “mental illness prevention” emphasizes prevention, screening/diagnosis, treatment and rehabilitation (secondary, tertiary prevention) from mental illness.]

consequences with minimal psychological cost.” Further, there are many studies indicating that struggling to recover in the aftermath of trauma often yields remarkable transformation and positive growth such as the realization of new opportunities and possibilities, deeper relationships and greater compassion for others, feeling stronger to face life challenges, reordered priorities and a fuller appreciation of life, and deepening of spirituality (Walsh, 2007; Calhoun & Tedeschi, 2006, 1999).

A significant number of survivors (up to half, depending on circumstances), however, will experience “immediate, intense reactions that decline over time,” and will exhibit a variety of reactions (Watson, Brymer & Bonnano 2011, pg. 1). As the State of Victoria, Australia (2014, pg. 6) points out:

“[Peoples’] understanding of themselves, which has serviced them in normal life, is likely to lack a detailed understanding of reactions and needs related to highly unusual and disturbing events. They will often need information, education and assistance to understand and respond appropriately to their needs.”

A smaller proportion may develop a variety of mental health problems and illnesses, including PTSD, grief, depression, anxiety, panic disorder, phobic disorder, stress-related health costs, substance abuse and suicidal ideation, and contribution to physical illness, but severe levels of these problems are usually observed only in a minority of survivors, rarely exceeding thirty percent of exposed individuals, and usually, a considerably smaller proportion (Bonanno, et al., 2010; North, 2007; Ursano et al., 2007a). To design and implement effective psychosocial support strategies then, it is important to understand some of the more common issues and problems that disaster-affected individuals might experience.

Norris et al. (2002) described six patterns of outcomes associated with disasters:

- Specific psychological problems and symptoms (e.g. PTSD, depression, anxiety, other psychiatric problems)
- Non-specific distress (e.g., elevation of stress-related psychological and psychosomatic symptoms rather than a particular problem – perceived stress or negative affect, for example)
- Health problems and concerns (e.g., somatic complaints such as sleep disruption, increased substance use, elevation of physiological markers of stress)
- Chronic problems in living (e.g., secondary stresses caused by the disaster: troubled interpersonal relationships, new family strains and conflicts, financial and occupational stress)
- Psychosocial resource loss (e.g., reductions in: social embeddedness and social support, self-efficacy, optimism and control)
- Problems specific to youth (e.g., separation anxiety, hyperactivity, minor deviance, delinquency).

Importantly, the psychosocial impacts of disaster can occur immediately, or develop later, and can last several years. Common psychosocial reactions described in the gray literature include:

Common reactions shortly after a disaster (NATO, 2008, pg. 1-50):

- Emotional reactions: shock/numbness; disorientation; confusion; fear and anxiety; helplessness and/or hopelessness; fear of recurrence; guilt; anger; anhedonia; difficulty identifying and connecting with emotions
- Cognitive reactions: impaired memory; impaired concentration; confusion or disorientation; intrusive thoughts; dissociation or denial; reduced confidence or self-esteem; hypervigilance; difficulty with planning, decision making, setting priorities and anticipating future needs
- Social reactions: regression; withdrawal; irritability; interpersonal conflict; avoidance
- Physical reactions: insomnia; hyperarousal; headaches; somatic complaints; reduced appetite; lethargy

Common reactions weeks to months after a disaster (State of Victoria, 2014, pg. 4-5):

- A wide range of emotional reactions – distress, fear, grief, sadness, anger, uncertainty and insecurity about the future; there can also be strong feelings of altruism, togetherness and concern
- There may be strong reactions to political or community events; emotions can be expressed via practical problems or other events, including blaming those providing services for things over which they have no control
- People are often overloaded or in a state of constant stress for months – health may deteriorate, accidents increase and relationships may become tense; the family may be burdened as different members deal with recovery in their own way
- The inequality of effects of the disaster can lead to community tensions, jealousy, rivalry and changes in friendship networks; misunderstanding and confusion are common and there may be doubt and skepticism about who can be trusted and accepted

Common reactions in the longer term (State of Victoria, 2014, pg. 6):

- For some people the effects become obvious after a year or more; these can include economic hardship; the effects of living under stress for a long time; poor health; depression; relationship problems; developmental, academic and behavioural problems in children; loss of leisure and recreation; loss of friendship networks; loss of a sense of direction in life; and continuing disturbing memories of the emergency
- People may feel isolated from their friends and family who do not understand the ongoing consequences of the emergency; people who find their recovery taking longer than others may feel their pre-existing networks are no longer a safe place to speak of their struggle; instead of being supportive, some relationships may become a source of rejection and further loss; the community may have also changed and no longer feels the same, which can lead to feelings of further isolation

- Conversely, people who are well supported and able to plan and manage their recovery report gaining new or increased wisdom or understanding, positive shifts in priorities for their lifestyle and value system and new or strengthened coping skills

No single dominant predictor of psychosocial outcomes following disaster exposure has been found; rather, most variables exert small to moderate effects and it is the combination of factors for risk and resilience that shapes outcomes (Bonnano, et al., 2010, pg. 1). Groups typically identified as being at higher risk for psychosocial harm (in no particular order) include:

- Injured
- Bereaved
- First responders, rescuers, staff
- Women
- Men (e.g., ex-combatants, idle men who have lost the means to take care of their families)
- Children
- Elderly people (especially those who have lost family members who were caregivers)
- Poverty or low socioeconomic status
- Ethnic minority groups, refugees, migrants
- Severe exposure to trauma, life threat
- Little previous experience relevant to coping with disaster
- Prior or current psychiatric or medical illness
- Pre-existing, severe, physical, neurological or mental disabilities or disorders
- Institutionalized
- People experiencing severe social stigma
- Post-event risk factors:
 - Lack of supportive relationships
 - Lack or loss of both practical and social resources
 - Negative coping strategies (e.g., self-blame)
 - Negative appraisals about the event in relation to one's role in the event, one's reactions and of potential future risk

Source :(Watson, et al., 2011, pg. 2; IASC, 2007, pg. 3-4; Ursano et al., 2007)

How Disasters Impact Psychosocial Wellbeing of Communities

Disasters also put neighbourhoods and whole communities at risk. They damage or destroy the social structures, dynamics and material resources that affected people need for coping and recovery – thus extending the effects beyond the individual to the social environment (IASC, 2015). “Community” can be variously understood, including people connected by the same gender or a common interest (e.g., a church congregation, a sports team), a workplace, or those who live in the same geographical area (e.g., particular rural areas or groupings of homes/farms, neighbourhoods, or cities). Our review of the literatures revealed that “community” in the disaster-related psychosocial support world typically refers to geographical communities, and that it is important to understand that such communities aren't necessarily homogeneous or harmonious (Twigg, 2007).⁴

⁴ An exception to this rule is the case in which a disaster happens to a group of people who are removed from their own communities – a plane crash, for example.

Communities are not simply collections of individuals. They are composed of unique social and cultural contexts that include past history, patterns of relationships amongst various groups, social and economic disparities, unequal power, status and social capital, cultural beliefs and practices, and sociopolitical factors. Because of this social ecology, families and groups are variously impacted by the same event. Understanding this social ecology has implications for understanding who needs help and how to respond, and who is best positioned to respond (Miller, 2012, pg. 9). In other words, with intimate knowledge of the community, vulnerable groups (those at risk for psychosocial harm) can be identified. This knowledge also enables identification and mobilization of existing strengths and assets to address individual, family and community psychosocial needs.

Disasters affect whole communities, not just individuals

Importantly, communities have their own collective dynamics and patterns of interactions within a constantly changing environment. Saul (2014, pg. 10) argues, for example, that “social phenomena are more than the summation of individual problems; they are social dynamics. As such, the community must be understood as a whole, composed of individuals and groups, bound together to respond collectively.” Disasters can injure a population’s social, cultural and physical ecologies in ways that cannot be remediated by addressing the issues of individuals. They can disrupt social networks and shared sentiments, and can cause a collapse in morale. They can lead to increases in violence, inability to react to threat and opportunity, social fragmentation, and can open up or exacerbate previously existing fault lines of racism and other forms of discrimination, social and economic inequalities and prior historical traumas. These challenges require community level action (Saul, 2014, pg. 4; Miller, 2012; Gordon 2009, 2004a,b). As Saul (2014, pg. 4) notes, “focusing exclusively on individual symptoms and psychopathology following disasters may miss some of the more troubling relational impacts and serious risks of ineffective coping.”

“Focusing exclusively on individual symptoms and psychopathology following disasters may miss some of the more troubling relational impacts and serious risks of ineffective coping.”

(Saul, 2014, pg. 4.)

Disasters disrupt the major source of psychosocial support for individuals and families: The community’s social fabric

Perhaps the most powerful, and certainly the most commonly cited, impact of disaster on communities is disruption of the 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). As Gordon (2004b, pg. 19) notes, “the unique characteristic of disasters is that they damage the community fabric.”

Saul (2014, pg. 1) describes this disruption as “collective trauma,” a “blow to the basic tissues of social life” that, over time, insidiously permeates the community:

“By collective trauma...I mean a blow to the basic tissues of social life that damages the bonds attaching people together and impairs the prevailing sense of communality. The collective trauma

works its way slowly and even insidiously into the awareness of those who suffer from it...a gradual realization that the community no longer exists as a source of support."

This disruption and collective trauma is important since the social environment is a major source of psychosocial support for community members; it is the "greatest resource for personal recovery":

"The integrity, organization and processes of the social environment comprise the greatest resource for personal recovery, mediate the impact of stress and trauma and determine the effects on health and wellbeing following disaster. The informal social system is most important in this process, but is often overwhelmed and people have to draw on their neighbourhood and the formal social systems of their community, often for the first time (Gordon, 2004a, pg. 12)."

In essence, the quality and character of a community's social environment is the ground in which individual and collective recovery is either forged or stymied (Rowlands, 2013; Gordon, 2004a, 2004b). The ability of individuals and collectives to triumph over shared adversities requires feelings of being supported, of social cohesion and cooperation and a sense of belonging to a valued group or community (Bonnano, et al., 2010). But at the time when survivors most need these important social connections and community resources, they may no longer be accessible (Rowlands, 2013; Bonnano et al., 2010). Temporary or permanent relocation disrupts neighbourhood patterns and engenders interpersonal strains and conflicts. Traditional supporters may be affected, incapacitated, or re-located; many survivors may find that their friends and neighbours have moved away, changing the social structure of the community (Bonanno et al., 2010). Over time, a decrease in social participation is commonly seen (Bonanno, et al., 2010; Norris et al., 2002).

The quality and character of a community's social environment is the ground in which individual and collective recovery is either forged or stymied.

(Rowlands, 2013; Gordon, 2004a, 2004b)

In addition to the social dynamics within the community per se, the influx of outside helpers places further strain, overwhelming local resources and threatening the function and safety of the community. Combined with the dynamics noted above, the need for social and psychological support may surpass its availability (Bonanno, et al., 2010; Norris et al., 2002). Ursano et al. (2007, pg. 5) describe this well:

"Word of disaster is disseminated quickly ... the community is soon flooded with outsiders: people offering assistance, curiosity seekers, the media. This sudden influx of strangers affects the community in many ways. The presence of large numbers of media representatives can be experienced by the community as intrusive and insensitive. Hotels have no vacancies, restaurants are crowded with unfamiliar faces and the normal routine of the community is altered...[A]t a time when, traditionally, communities turn inward to grieve and assist affected families, the normal social supports are strained and disrupted by outsiders."

Regardless of the incidence of individual pathology resulting from disaster, these events and the resulting disruption of a community’s social fabric can lead to widespread degradation of quality of life, “meaning that people are unhappy, go through the motions of life without enthusiasm, lose the heart of relationships and neglect goals that motivated them” (Gordon 2004b, pg. 10). While individuals with psychological disorders can be referred for professional care, a degraded quality of life and disrupted social fabric requires intervention at the collective environmental and social level. A community-focused approach helps to ensure there are community-mechanisms and places for people to gather; and that there are opportunities for recreation, collective sense-making and mourning and community re-building (Miller, 2012).

Gordon (2009, 2004a, 2004b) believes that if we can understand how disasters disrupt the social makeup of communities, we can find ways to prevent or mend the deterioration. Based on his experiences with numerous disasters, he outlines the process of social environment degradation following a disaster. A description of this process, and facilitative actions to thwart degradation, is presented in Appendix A. Examples of facilitative actions include providing accurate and timely information about the disaster and available resources; bringing people together to talk about their experiences; promoting community-based cultural events to represent the disaster and/or its consequences; supporting rituals, symbols and artistic forms of expression; and, promoting opportunities to people to form groups with those experiencing similar issues, and providing facilitation and resources for these groups.

In the next section, we examine various definitions of “psychosocial support” found in our review.

Defining Psychosocial Support

A sampling of definitions of “psychosocial support” found in our literature review is provided in Table 3.

Table 3. Definitions of psychosocial support found in the literature

Organization/Author	Definition of psychosocial support
Cox & Danford (2014)	<i>“The interplay between social, cognitive, emotional and spiritual needs and interventions (i.e. providing shelter has psychosocial implications; providing emotional support can include addressing functional needs). This “psychosocial” support incorporates the basic psychological, social and cultural aspects of human interactions that impact wellbeing (pg. 2).”</i>
State of Victoria, Australia (2014)	<i>“Psychosocial support can ease the emotional, spiritual, cultural, psychological and social impacts of an emergency as individuals and communities return to an effective level of functioning. Psychosocial support can range from personal support, psychological first aid, emotional and spiritual care, outreach, case support/case management, counseling, mental health services to community information sessions and community engagement (pg. 2).”</i>
International Federation of Red	<i>“Psychosocial support is generally defined as a process of facilitating resilience within individuals, families and communities with “resilience” understood as:</i>

Cross and Red Crescent Societies Psychosocial Centre (2013)	<i>the ability of individuals, communities, organizations or countries exposed to disasters and crises and underlying vulnerabilities to anticipate, reduce the impact of, cope with, and recover from the effects of adversity without compromising their long-term prospects (pg. 5)."</i>
Actions for the Rights of Children (ARC) (2009)	<i>"Psychosocial support is a continuum of care and support which influences both the individual and the social environment in which people live, and ranges from care and support offered by caregivers, family members, friends, neighbours, teachers, health workers and community members on a daily basis but also extends to care and support offered by specialised psychological and social services (pg. 10)."</i>
NATO (2008)	<i>"The adjective psychosocial refers to personal psychological development in the context of a social environment. It is a specific term that is used to describe the unique internal processes that occur within people. It is usually used in the context of psychosocial interventions which include psychoeducation, psychological therapies and or psychopharmacological treatments (pg. 7)."</i>
Prewitt-Diaz & Dayal (2008)	<i>"Psychosocial [support] addresses reactions to enormous losses, such as grief, displacement, disorientation and alienation...[It] builds on the knowledge and awareness of local needs and protective factors to provide psychological and social support to people involved in disaster situations. The aim is to enhance survivors' resilience in achieving psychological competence by empowering them to overcome grief reactions and move forward in a collaborative fashion (pg. 1)."</i>
Inter-Agency Standing Committee (IASC) (2007)	<i>"Mental health and psychosocial support (MHPSS) is a composite term ... to describe any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder (pg. 16)."</i>
New Zealand Ministry of Health (2007)	<i>Speaks to "psychosocial recovery": Recovery encompasses the psychological and social dimensions that are part of the regeneration of a community. The process of psychosocial recovery from emergencies involves easing the physical and psychological difficulties for individuals, families/whanau and communities, as well as building and bolstering social and psychological wellbeing (pg.vi). "</i>

As with definitions of psychosocial wellbeing, the common denominator amongst these definitions is the integral interconnection between psychological and social, and in some cases, cultural dimensions of human experience, whether this is at the individual, family or community level. Some definitions clearly indicate that the emphasis is on support to individuals; others have a broader perspective, including families, groups and communities, while others are somewhat obscure in this regard. Several definitions make reference to promoting wellbeing while others include the fostering of resilience within individuals and communities.

Overarching Principles for Humanitarian Response and Psychosocial Support

Our review of the literature revealed a number of overarching principles to guide the practice of humanitarian response to disaster. A strong guiding principle is that the consideration of psychosocial wellbeing and the provision of psychosocial supports cannot be merely an “add on” or a “nice ‘to do’ if there is time and resources,” but rather needs to be an integral aspect of the overall disaster effort. How things are done in the overarching effort can significantly impact mental health and psychosocial wellbeing of individuals, families and communities (State of Victoria, 2014; NATO, 2008; Ursano et al., 2007b):

“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. Information and activities that normalize reactions, protect social and community resources and signpost access to additional services are fundamental to effective psychosocial responses (NATO, 2008, pg. 1-8).”

“How the psychological response to a disaster is managed may be the defining factor in the ability of a community to recover... Interventions require rapid, effective and sustained mobilization of resources... Sustaining the social fabric of the community and facilitating recovery depend on leadership’s knowledge of a community’s resilience and vulnerabilities as well as an understanding of the distress, disorder and health risk behavioural responses to the event. A coordinated systems approach across the medical care system, public health system, and emergency response system is necessary to meet the mental health care needs of a disaster region (Ursano, et al., 2007b, pg. 3).”

In addition to this guiding principle, three sources for overarching principles relevant to disaster-related psychosocial support that were frequently referenced in the academic and gray literatures were identified. The Sphere Project (2011) and the Inter-Agency Standing Committee (2007) prescribe “how” psychosocial support should be delivered (e.g., with respect for human rights and equity; to do no harm; to build on strengths and capabilities, and so on). The Hobfoll et al. (2007) principles suggest what kinds of actions will likely promote psychosocial wellbeing (i.e., promote a sense of: safety, calm, self- and collective- efficacy, connectedness, and hope).

A synthesis of all these principles is presented in Table 4 below. More detailed information about each set of principles is provided in Appendix B.

Table 4. Overarching principles for post-disaster psychosocial support

Guiding 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 “how” of psychosocial support
(Inter-Agency Standing Committee, 2007; Sphere Project, 2011)**

Human rights and 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 and 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 and capabilities	Individuals', families' and communities' strengths and capabilities are recognized, built on, and enhanced in the design and delivery of all psychosocial support initiatives.
Participation, collaboration and 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 and 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.

**Principles underlying the “what” (the focus or content) of psychosocial support
(Hobfoll et al., 2007)**

Promote a sense of safety	This includes bringing people to a 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- and 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	This includes keeping people together (in case of evacuation) or reconnecting

connectedness 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.

Complementary Paradigms for Providing Disaster-Related Psychosocial Support

Our review of the literature revealed two distinct yet complementary paradigms that shape how disaster-related psychosocial support might be conceptualized and implemented. Miller (2012) distinguishes these as “disaster mental health” (DMH) and “psychosocial capacity building.” Based on our literature review, we add the term “resilience,” creating the term “psychosocial capacity building and resilience” (PSSCBR). Each paradigm is grounded in a particular understanding of health, the role of helping professionals in achieving health, and the role of individuals and communities in the process. These paradigms are not incommensurable; to the contrary, they both have an essential role in disaster-related psychosocial support. Our point in presenting these paradigms is that the ultimate goal in both is psychosocial wellbeing, but, depending on which paradigm is in play, *how* this is to be achieved (policies, plans, interventions, roles of helping professionals and volunteers) will be different. As such, various models and frameworks for disaster-related psychosocial support will look different depending on which paradigm is privileged. A brief description of each paradigm is presented below and summarized in Table 5.

Disaster mental health (DMH)

Disaster mental health is rooted in biomedical and behavioural (lifestyle) views of “health” (Labonte, 1993) that focus on the physiological workings of the body and personal health behaviours, with the goals of disease prevention, treatment and rehabilitation. From a biomedical perspective, “health” is defined as the absence of disease or infirmity, and physiological risk factors and processes (e.g., neurobiology, cholesterol levels) are viewed as health determinants (Labonte, 1993). Health is maintained or improved via prevention (addressing risk factors), early detection and treatment using medical interventions. From a behavioural perspective, “health” is associated with feeling good or feeling “fit” as a result of engaging in healthy behaviours. Health education, social marketing and advocacy for policies supporting healthy lifestyles and behaviours are principle strategies for improving health (Labonte, 1993). Healthcare practice grounded in biomedical and behavioural views of health tends to privilege the expertise of professionals who work in a manner that could be described as “doing to” and “doing for” people in the interest of helping them to improve their health.

Disaster mental health (DMH) emerged from crisis intervention, informed by trauma reactions, particularly PTSD (Miller, 2012). As such, the focus is on the prevention of, screening for, and treatment of PTSD and other mental health problems and illnesses. Currently, cognitive behavioural approaches form the foundation of this approach (Miller, 2012). Implicit in DMH approaches is that the target of recovery is the psychological wellbeing of *individuals*. While there may be concern for the impact of trauma on families and communities, and for improving social functioning, these are secondary to recovery of the individual (Miller, 2012). And, while interventions might be provided within a community context (for example, education about individual coping strategies provided in a group setting), the focus remains on supporting individuals to cope more effectively. While DMH professionals (typically

trained experts - social workers, psychologists, psychiatrists) emphasize “normalization” of reactions (“these are normal reactions to abnormal events”), much of the literature emphasizes the adverse consequences of disaster and the need for treatment for those who continue to experience symptoms in the months and years following the traumatic event (Miller, 2012).

Psychosocial capacity building and resilience (PSSCBR)

Psychosocial capacity building and resilience (PSSCBR) approaches are consistent with a broader view of “health” as more than the absence of disease or the presence of “healthy behaviours.” From this perspective, “mental health” is viewed as the ability of people to “feel, think and act in ways that enhance our ability to enjoy life and deal with the challenges we face” (PHAC, Online); it is determined by multiple psychological, social, economic, political and environmental factors – the social determinants of health (Labonte, 1993). Empowerment – “the capacity to define, analyze, and act upon one’s problems in life and living conditions,” joins treatment and prevention as an important goal (Labonte, 1993, pg. 8). PSSCBR is consistent with mental health promotion (MHP) - “the process of enhancing the capacity of individuals and communities to take control over their lives and improve their mental health” (Public Health Agency of Canada (PHAC), Online).

Mental health promotion aims to enhance mental health through approaches that build on existing strengths and assets, and that are collaborative, participatory and empowering.
(PHAC, Online; Jane-Llopis, et al., 2005)

MHP aims to enhance mental health through approaches that build on existing strengths and assets, and that are collaborative, participatory and empowering (PHAC, Online; Jane-Llopis, et al., 2005). This is about people and communities recognizing and fostering their own sense of personal and collective strength by determining their own destinies, and having the personal, collective and material resources and a supportive environment in which to do so. For individuals, mental health promotion involves a “personal sense of control, the feeling that one can rely on oneself or be supportive of others when facing difficult situations” (PHAC, Online). The role of outside helpers is one of “working *with*” individuals, groups and communities to strengthen their innate capacity to achieve and maintain their own health (Pollett, 2007). Finally, mental health promotion emphasizes collaborative action, multi-level and culturally tailored interventions to build capacity and resilience and to address the determinants of mental health, including equity and social justice (PHAC, Online; Keleher & Armstrong, 2006).

In the disaster context, PSSCBR approaches strongly emphasize collective capacity and resilience and how these can be strengthened and reconstructed through empowerment of local people who know their community, their culture and one another (Miller, 2012, pg. 15); it brings peoples’ strengths and sources of resilience to the fore. “People are viewed as being inherently durable and resilient and capable of recovering from disaster, often using their own or local resources” (Miller, 2012, pg. 14). Foundational to the work is reconstruction and restitution of collective life. This paradigm includes individuals but also extends to families, clans, tribes and other social groups. However, communities are often seen as the fundamental units of psychosocial rebuilding after disaster (Miller, 2012). As with most community capacity building endeavours, local engagement in and ownership of planning, decision-

making, implementing actions and identifying and leveraging existing strengths and assets are distinguishing features. The role of professionals in this paradigm differs from that of DMH in that the intent is to create empowering relationships with people. Rather than providing direct clinical service, they act more often as consultants in creating the conditions and supports that enable people to heal themselves, often using train-the-trainer models.

Table 5. Comparison of underlying assumptions: Disaster mental health and psychosocial capacity building and resilience paradigms

	<i>Disaster Mental Health</i>	<i>Psychosocial Capacity Building and Resilience (PSSCBR)</i>
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	Biomedical and behavioural view of health; assumption that there are universal biophysical reactions to trauma; emphasis on psychological, emotional and biophysical reactions to disaster. Major focus is on psychological responses – prevention and treatment of pathology	Broader, positive view of health and social determinants of health. Approach consistent with mental health promotion. Major focus is on empowerment, strength and resiliency and the 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	<ul style="list-style-type: none"> ▪ Major focus is on adverse effects of disaster on individuals and the need for crisis intervention and counseling 	<ul style="list-style-type: none"> ▪ Emphasis is placed on collective capacity and resilience within the community and how to strengthen and reconstruct it after disaster
Nature of approach	<ul style="list-style-type: none"> ▪ Recognition of individual strengths and importance of normalizing reactions to trauma ▪ Psychological first aid initially, then talk therapy - cognitive behavioural approaches 	<ul style="list-style-type: none"> ▪ 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

- viewed as most efficacious
- Tends to be more prescriptive in nature
- Mutual-aid, self-help groups
- Tends to be more organic in nature, responsive to community-determined priorities
- Wariness of iatrogenic effects of “helping”
- 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
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Source: Adapted from Miller (2012, pg. 10-18); Saul & Bava (2008); Labonte, (1993)

PSSCBR emphasizes cultural responsiveness and is sensitive to the fact that disaster impacts people and groups differently and that vulnerable groups may be at risk for greater difficulty. Human rights and equity are fundamental, given that inequities can be amplified by disaster. Finally, PSSCBR is wary of the unintended effects of well-intended actions of disaster support. While offering aid and assistance can help in the short term, this can create dependence and reliance on outside experts who will eventually leave the community (Miller, 2012).

As we reviewed the literature, we began to develop a typology of approaches, based on two dimensions. The first dimension pertains to the dominant paradigm in play (disaster mental health or psychosocial capacity building and resilience). The second dimension is the focus of support – that is, whether interventions are primarily focused on the psychosocial wellbeing of *individuals* (where the intent is to help individuals cope more effectively with distress, and/or to prevent or treat development of trauma-related distress, mental health problems or illnesses) or, whether the focus is on the psychosocial wellbeing of *whole communities* (where the emphasis is on supporting and strengthening the entire community (e.g., (re)building the community’s social fabric; strengthening capacity to work effectively together toward greater resilience and faster recovery). We call these, respectively, “individual-focused psychosocial supports” and “community-focused psychosocial supports.”

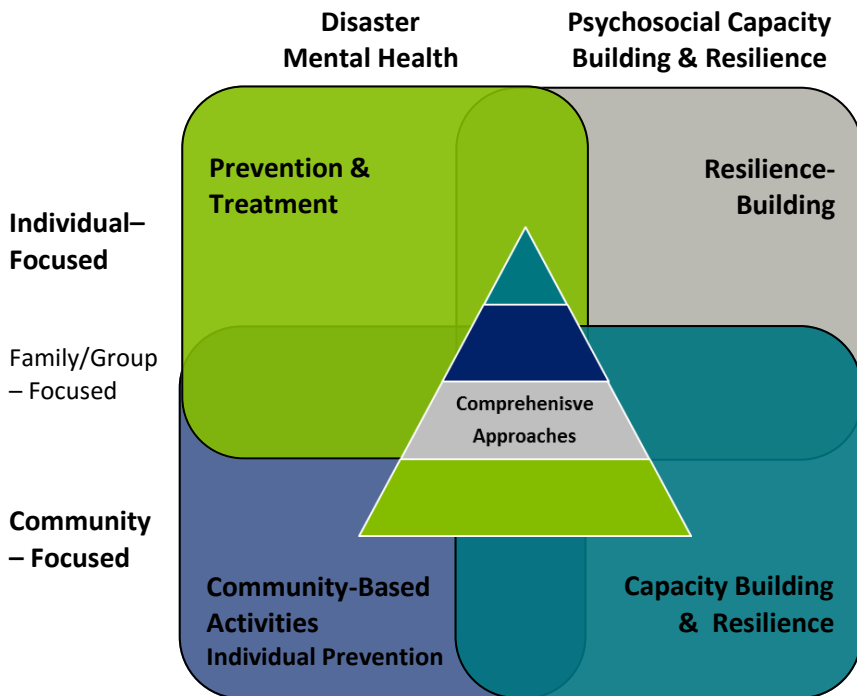


Figure 4. A simplified typology of models and frameworks for disaster-related psychosocial support

This simple typology is depicted in Figure 4 above. The left hand column represents approaches that are predominantly of a disaster mental health (DMH) nature while the right hand column represents approaches grounded primarily in psychosocial capacity building and resilience (PSSCBR). On the horizontal axes, the top row represents individual-focused approaches while the bottom row represents community-focused approaches. We have included family/group in between these levels to indicate a continuum; however, we do not describe these approaches herein. DMH in its purest form focuses on individuals (and families to some degree) and not communities. We did, however, encounter descriptions of DMH that refer to some form of community-based actions in support of individual-focused prevention and so have shaded this cell gray. The triangle in the middle of the typology represents comprehensive approaches that include elements of DMH for individuals and PSSCBR focused on individuals, families and communities.

The overlap amongst the cells indicates a degree of overlap across approaches, since few if any of the approaches we reviewed fit tidily into one particular cell of the typology. For example, some psychosocial capacity and resilience models are primarily community-focused but also support individual and family resilience. And, as noted above, some disaster mental health frameworks make mention of community activities and engagement. Further, some individual-focused models are of a “stepped care” nature and integrate both disaster mental health and resilience-building approaches. What differs with comprehensive approaches is that they integrate all four dimensions of this typology (i.e., disaster mental health and psychosocial capacity building, at both individual and community levels). As such, our typology can at best be viewed as a simplistic guide to understand and organize our

description of the various approaches to disaster-related psychosocial support that surfaced in our enquiry.

Other Considerations

A number of other characteristics of approaches identified in the literature are also salient for understanding the utility of various approaches. These include:

- Timing of implementation with respect to the disaster trajectory – While some comprehensive frameworks and guidelines organize interventions according to the trajectory of a disaster; some psychosocial support approaches are intended for particular points in the trajectory of a disaster. For example Psychological First Aid (PFA) (WHO, 2011; Brymer et al., 2006) is often cited as being most appropriately used during the immediate response to a disaster whereas Skills for Psychological Recovery (SPR) (Berkowitz, et al., 2010) is deemed more appropriate to support individual recovery in the weeks to months following the event. The Inter-Agency Standing Committee (IASC) (2007, pg. 5) guidelines are intended for implementation “as soon as possible in an emergency,” while Miller’s (2012) psychosocial capacity building approach is intended for use early in the recovery aspect of a disaster and beyond. The Community Action Resilience Toolkit (Pfefferbaum, et al., 2013) and some other community resilience models are described as best implemented before disaster occurs, or potentially in the late stages of recovery as a community begins to examine how it may prevent, mitigate or better deal with future events. Similarly, the US Institute of Medicine (2015) suggests that long term recovery and community development/healthy community strategies should be integrated.
- Nature of the disaster – The state of New South Wales in Australia, for example, produced a 260 page “Disaster Mental Health Manual” (Disaster Response & Resilience Research Group, 2012) that outlines actions in prevention, planning, response and recovery for a number of different kinds of disaster, including natural disasters, technological disasters, terrorism and disease outbreaks.
- Level of guidance – In our enquiries, we uncovered global and international frameworks alongside national, state and community level guidance documents. We also found descriptions of specific models or approaches such as Skills for Psychological Recovery and the Community Action for Resilience Toolkit.

In the following sections, we provide examples of a number of frameworks, guidelines and approaches found in the literature review and environmental scan, organized according to the typology above. We describe comprehensive frameworks and guidelines followed by a description of community-focused psychosocial capacity building and resilience models. Next, we move to individual-focused approaches including those primarily grounded in the disaster mental health paradigm, and those more oriented toward facilitating adaptive capacity and resilience.

Comprehensive Frameworks and Guidelines for Disaster-Related Psychosocial Support

Our enquiries surfaced a number of frequently cited frameworks and guidance documents that we categorized as “comprehensive frameworks and guidelines.” These are characterized by provision of:

- Background information about disasters and their impact on individuals and communities
- A set of guiding principles for disaster-related psychosocial supports
- Guidance for planning (often including community assessment), implementation, and monitoring/evaluation of psychosocial supports, often including sections on training and supporting staff and volunteers
- A comprehensive range of strategies, typically organized in the form of an intervention pyramid or stepped levels of care that encompass the spectrum of supports – from inclusion of psychosocial considerations in provision of basic supports (safety, shelter, food, healthcare) to specialized care for individuals who are severely impacted. These strategies integrate:
 - Individual-focused and community-focused supports and interventions;
 - Approaches grounded both in psychosocial capacity building/resilience and disaster mental health (typically the provision of mental health services to those experiencing severe mental health problems and illnesses)
- A description of specific actions/interventions organized according to the trajectory of a disaster (e.g., preparation, immediate response, short- term, mid-term, and longer-term recovery)

For the sake of brevity, we focus here on the Inter-Agency Standing Committee (IASC) (2007) *Guidelines on Mental Health and Psychosocial Support in Emergency Settings* as they were cited in numerous other documents. We provide detailed information about several other comprehensive models in Appendix C, including high level guidance documents from the International Federation of Red Cross and Red Crescent Societies (2009), the North Atlantic Treaty Organization (NATO, 2008), and a state level framework from Victoria, Australia (2014). While there are inevitably other such frameworks, these are the ones that surfaced most commonly in our search of the academic and gray literatures.

The Inter-Agency Standing Committee (IASC) (2007) Guidelines on Mental Health and Psychosocial Support in Emergency Settings

The IASC is an international body created by the United Nations in 1992 in response to a United Nations resolution to strengthen humanitarian assistance. Composed of UN and non-UN humanitarian partners, the IASC is the primary mechanism for inter-agency coordination of humanitarian assistance.

A challenge addressed by the IASC in 2005 was the absence of a multi-sectoral, interagency framework that could enable effective coordination, identify useful practices and also those that are potentially harmful, and that would clarify how different approaches to mental health and psychosocial support complement one another (IASC, 2007, pg. 1). To fill this gap, a multi-stakeholder taskforce, inclusive of divergent yet complementary philosophies and practices was struck in 2005 to develop guidelines for mental health and psychosocial support in emergencies. The taskforce subsequently released the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* in 2007. The Guidelines are cited in numerous frameworks and models reviewed for this document, including, for example the State of Victoria (2014); the International Federation of Red Cross and Red Crescent Societies (IFRC) (2013; 2009); Miller's (2012) psychosocial capacity building; Hawe's (2009) review of disaster response in Australia; and Actions for the Rights of Children (2009).

The Guidelines “describe an integrated framework within which divergent and complimentary approaches find a common home” (van Ommeren & Wessells, 2007, pg. 822). In this model, elements of disaster mental health and psychosocial capacity and resilience building are clearly visible. The term “mental health and psychosocial support” is used to describe “any type of local or outside support that aims to protect or promote psychosocial wellbeing or to prevent or treat mental disorders” (IASC, 2007, pg. 1). This combination of terms is intentional as the terms “mental health” and “psychosocial support,” while related and overlapping, represent different approaches in the humanitarian world, with the term “mental health” typically being used by the health sector and “psychosocial wellbeing” being used by aid agencies outside of the health sector (IASC, 2007, pg. 1; van Ommeren & Wessells, 2007). Use of the term “mental health and psychosocial support” created a bridge between the two sectors.

The IASC Guidelines emphasize mobilization of groups of disaster-affected people to organize their own supports and fully engage in the relief efforts – they are not considered passive recipients of service, but rather as agentic people with assets and resources (Rodriguez & Kohn, 2008). They also emphasize provision of support from within the community along with outside aid, and they emphasize multi-sectoral action (Rodriguez & Kohn, 2008).

Based on the principle of multi-layered supports, the Guidelines outline four levels of action, and note that, “at each layer of the intervention pyramid, key tasks are to identify, mobilize and strengthen the skills and capacities of individuals, families, communities and society” (IASC 2007, pg. 4). Figure 5 depicts the IASC Guideline pyramid of mental health and psychosocial wellbeing supports; descriptions of each layer of the pyramid are presented in Table 6.

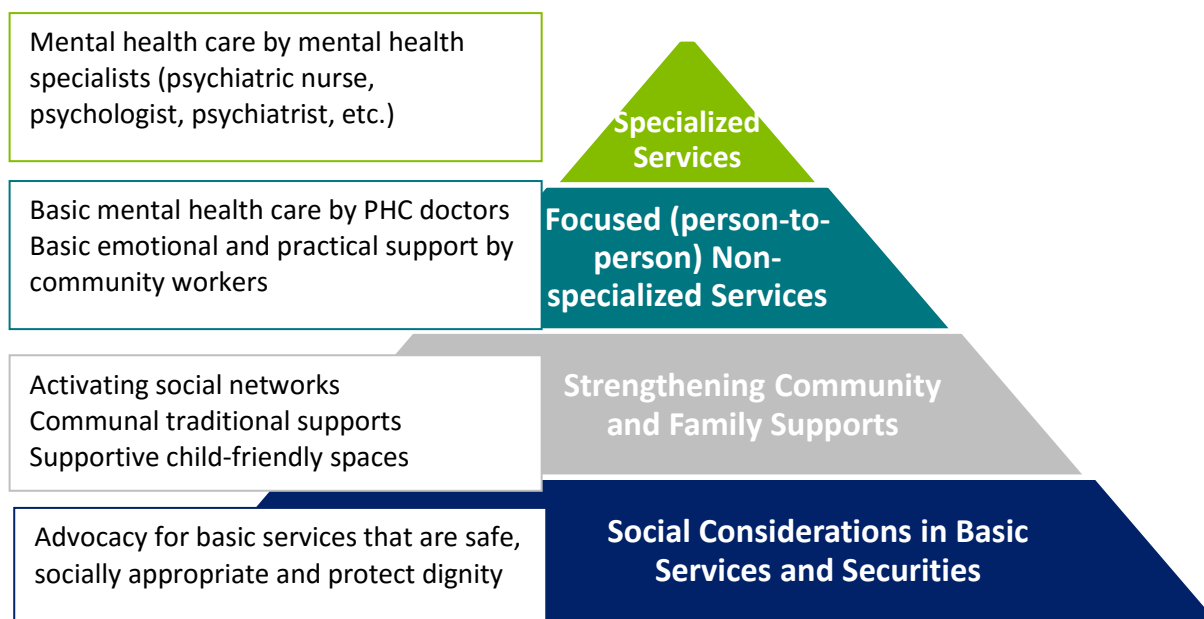


Figure 5. IASC Guidelines for Mental Health and Psychosocial Supports in Emergency Settings (Source: IASC 2010, pg. 3.)

Table 6. IASC Guidelines for Mental Health and Psychosocial Supports in Emergency Settings: Description of Multi-layered Supports in the IASC Intervention Pyramid

Bottom layer: Social considerations in basic services and security	Protection of wellbeing through the (re)-establishment of security, adequate governance and services that address basic physical needs (food, shelter, water, basic health care, control of communicable diseases). While these services are usually provided by specialists in sectors such as food, health and shelter, the role of psychosocial support workers may include: advocating that these services are put in place with responsible actors; documenting their impact on mental health and psychosocial well-being; and influencing humanitarian actors to deliver them in a way that promotes mental health and psychosocial well-being.
Second layer: Strengthening community and family supports	Emergency response for a smaller number of people who are able to maintain their mental health and psychosocial well-being if they receive help in accessing key community and family supports. Examples of activities include: family tracing and reunification, assisted mourning and communal healing ceremonies, mass communication on constructive coping methods, supportive parenting programmes, formal and non-formal educational activities, livelihood activities and the activation of social networks, such as through women’s groups and youth clubs.
Third layer: Focused (person-to-person) support	Supports necessary for the still smaller number of people who additionally require more focused individual, family or group interventions by trained and supervised workers (but who may not have had years of training in specialised care). This layer includes psychological first aid (PFA) and basic mental health care by primary health care workers.
Top layer: Specialised services	Additional support required for the small percentage of the population whose suffering, despite the supports already mentioned, is intolerable and who may have significant difficulties in basic daily functioning. This assistance should include psychological or psychiatric supports for people with severe mental disorders whenever their needs exceed the capacities of existing primary/general health services.

Source: IASC, 2007, pg. 11-13.

The IASC Guidelines also outline a set of minimum responses – that is, the first steps to occur in supporting mental health and psychosocial wellbeing during an emergency. They are presented in the form of a detailed matrix that outlines sections for various sectors at different stages of an emergency, including a set of action sheets that explain how to implement the minimum responses. A summary of IASC action sheets, demonstrating the breadth of activities conceptualized under the umbrella of mental health and psychosocial supports is included in Appendix C, along with descriptions of other comprehensive guidelines and frameworks.

Synthesis

These high level frameworks and guidelines are informative for organizations and governments wishing to develop a comprehensive approach for disaster-related psychosocial support. They provide a “whole package” of guidance, including background information, principles for action, an overarching planning/implementation/evaluation frame, and descriptions of integrated actions typically organized from broad, community-wide approaches all the way to specialized mental health services for individuals severely impacted by the disaster. In our review, we found that the IASC pyramid of interventions is most commonly cited and/or adapted. However, other frameworks/guidelines have

additional dimensions worth considering, such as NATO's (2008) stepped model of care which includes similar levels to that of the IASC and two others: strategic leadership for planning and preparation; and, developing collective and community resilience before disaster strikes (see Appendix C).

We also found that the degree to which the disaster mental health and psychosocial capacity building paradigms are emphasized within a single framework or set of guidelines varies from one framework to another. The IASC Guidelines use the terms "mental health and psychosocial support" to promote a balanced approach. The International Federation Reference Centre (IFRC) of the International Federation of Red Cross and Red Crescent Societies, for example, primarily focuses on community-based approaches to improving the psychosocial wellbeing of whole communities, meaning that the intent is to engage the community as much as possible in planning, implementing and evaluating the disaster response. The community is encouraged to take ownership and responsibility for responses to the challenges it is facing. In contrast, other guidelines are less specific regarding the purpose of participation and the degree to which communities are encouraged to be the drivers of the disaster response.

A synthesis of principles and "minimum standards" from these various frameworks and guidelines is presented in Table 7.

Table 7. Synthesis of principles and minimum standards highlighted in comprehensive frameworks

-
- Integrate psychosocial and mental healthcare response within the grand plan for preparing for and responding to disasters; appoint psychosocial and mental health advisors to commanders of responses to major incidents and disasters.
 - Be prepared in advance; be pragmatic, flexible, adaptive and scalable, recognizing the unique, complex and dynamic nature of emergencies and communities; and, be able to support the delivery of concurrent community, local, regional and state response, relief and recovery activities. Plan on providing appropriate services matched for each phase across the recovery period.
 - Protect human rights and standards throughout the entire effort; monitor, identify and respond to threats to human rights (IASC); provide supports in culturally responsive manner.
 - Fully integrate mental health and psychosocial care and establish coordination of intersectoral mental health and psychosocial support; participate in coordination of groups to learn from others and to minimize duplications and gaps in response; integrate activities and programming into existing larger systems to reduce stand-alone services, reach more people, be more sustainable, and reduce stigma.
 - Conduct assessments of mental health and psychosocial issues; make, implement and evaluate plans, adjusting as needed along the way.
 - Plan and enact a good public health risk communication and advisory strategy that involves the public and the media and which provides timely and credible information and advice. Provide information about the emergency, relief efforts and peoples' legal rights; provide access to information about positive coping methods.

- Ensure that psychosocial and mental health responses are comprehensive and stepped according to needs, are of sufficient duration, and are well coordinated
 - Promote a sense of safety, connectedness, calm, hope and efficacy at every level
 - Attend to the basic needs of the population first; early response includes practical help and pragmatic support; specific social and psychological considerations should be made in provision of basic supports (food security and nutrition, shelter and site planning, water and sanitation)
 - Reserve specialized services for those who need more care.
- Maximize the participation and empowerment of individuals, groups and communities; and identify and build on available resources and local capacities. Facilitate conditions for community mobilization, ownership and control of the emergency response; facilitate community self-help and social support; facilitate conditions for appropriate communal cultural, spiritual and religious healing practices; facilitate support for young children.
- Identify, recruit, orient and train staff and volunteers who understand local culture; organize orientation and training of psychosocial and mental health aid workers; ensure staff and volunteers are capable of working with a diversity of values and cultures.
- “Help the helpers” – ensure provision of psychosocial support for volunteers and staff engaged in the effort
- Strive to learn and improve; be open to scrutiny and external review; build monitoring and evaluation into the effort and use the results to make adjustments; stay updated on the evidence base regarding effective practices; strive to anticipate the potential consequences (benefits, harms, unintended effects) of decisions and actions; build and draw upon partnerships with academia.

Sources: State of Victoria (2014); Watson, Brymer & Bonanno (2011); IFRC (2009); NATO (2008); IASC (2007)

Psychosocial Capacity Building and Resilience Models: Community-Focused

In this section, we describe community-focused approaches that are grounded in the psychosocial capacity building and resilience paradigm. We begin with the rationale for whole of community approaches that are grounded in the PSSCBR paradigm, and then provide an overview of key characteristics of these approaches.

An important distinction to make is that we use the term “community-focused⁵” to describe interventions that support and strengthen the *community as a whole*. The hallmark of these approaches is that they strive to engage the affected community as much as possible in every aspect of the endeavour. Saul and Bava (2008, pg. 8) refer to this as “community-engaged,” meaning, “participatory processes that are designed, delivered, evaluated and sustained by and with the local people’s voice and experience.” As such, the approach is one of supporting the community to determine its own needs,

⁵ This is distinct from the commonly used term, “community-based” which implies services provided to individuals in communities. Community-focused means working in a participatory manner with an entire community to address community-identified needs and opportunities.

assess existing strengths, capacities, deficits and priorities for action, and to determine how these will be addressed. While external helpers/facilitators and content experts may provide essential information, processes and supports, the community (or a representative group of community members) takes responsibility for the focus and goals of action (Saul & Bava, 2008; Landau, 2007). (See Saul and Bava (2008) for a description and examples of community-engaged approaches.)

There are a number of reasons why community-focused or engaged interventions are important. First, maximizing the community's participation in its own recovery and managing the recovery process at the local level keeps the community intact and helps mend the community's social fabric (e.g., by ensuring there are mechanisms and places for people to gather, play, to make sense of things, to mourn and grieve and to rebuild the community).

Second, this re-connection of people also helps them find ways to work effectively together in sustainable ways, in turn promoting empowerment, a sense of self-efficacy and control. The community is thus enabled to take charge of recovery and rebuilding, ensuring that community priorities are addressed in a manner appropriate to community members (Rowlands, 2013; Aldrich, 2012; Bonnano et al., 2010; Hawe, 2009; Gordon, 2009; Saul & Bava, 2009; Landau, 2007). All of this strengthens capacity to enhance community wellbeing and to mitigate the impact of future adversity. As such, the process of agentic participation in and of itself builds community capacity and resilience.

Research by Aldrich (2012) demonstrates the power of rebuilding a community's social fabric and strengthening capacity. Aldrich studied four major disasters around the globe, including Hurricane Katrina, and concluded that, across different time periods, government capacities, levels of social development and culture, all four cases demonstrated that social resources are the engines of community recovery. Areas with more social capital made effective and efficient recoveries from crisis through coordinated efforts and cooperative activities. For example, in a study of two communities impacted by the Kobe, Japan earthquake Aldrich found that in one community with deep reservoirs of social capital, people organized themselves to combat post-earthquake fires. In another community that lacked coordination, people stood by as fires destroyed their community. Deep levels of social capital serve as informal insurance and promote mutual assistance after a disaster. By sharing tools, information, living space and other scarce resources, networks of friends and acquaintances and friends fill gaps left by external organizations. Dense and numerous social ties help survivors solve collective action problems that stymie rehabilitation. For example, in Haiti, neighbours who trusted each other set up watch committees to deter crime and looting (Aldrich, 2012).

Areas with more social capital made effective and efficient recoveries from crisis through coordinated efforts and cooperative activities.

Third, community-focused interventions work on the broad community environment and thus impact multiple factors. In this way, strengthening communities can positively impact numerous dimensions of capacity/resilience beyond preparedness for disaster (Hawe, et al., 2015; 2009). Thus, rather than having a prevention program for every problem or issue, holistic community interventions can address

multiple issues at once. Hawe, et al., (2015), for example, found that in a rural Canadian high school, a whole-school change process focused on helping students feel safe, connected and valued impacted numerous risk factors for girls, including low school engagement, drinking alcohol, unsafe sex and poor health. These findings were consistent with similar school interventions in other jurisdictions.

Finally, community-focused interventions may provide support for individuals who could benefit from individual psychosocial interventions but who choose not to access them. Experience in several Australian disasters demonstrated that individuals rarely access “labeled” mental health services – and in fact shun them in favour of opportunities to talk over their experiences in informal settings (e.g., laundromats, drop-in centres, community centres) in order to gain support from neighbours who have survived the event (Rowlands, 2013). Harvey (2007) similarly points out that most trauma survivors will not turn to psychotherapy and thus that community interventions to foster resilience and enhance resilience among untreated trauma survivors are particularly valuable.

Whole of community approaches do, however, have some drawbacks. Aside from their complexity and the challenges of authentically engaging diverse community groups, there is the potential for community action to be driven by dominant groups at the expense of those at higher risk but with less power (Norris, et al., 2002; Brown & Kulig, 1996/7). Communities are rarely homogeneous; rather, they are often fragmented, requiring an analysis and management of power dynamics that may occur between subgroups (Brown & Kulig, 1996/7). Another challenge is that few evaluations or studies of these kinds of approaches in relation to disaster-related psychosocial support have been conducted to date (Hawe, 2009), although there is growing interest and activity in this regard (see, for example, Gibbs, et al., 2013; Kulig et al., 2013; Pfefferbaum et al., 2013).

Community resilience

We discovered a proliferation of work in relation to psychosocial resilience, community resilience, and disaster resilience, particularly in more recent years. This is consistent with a recent review of the MEDLINE database for articles that discussed resilience in relation to disaster preparedness. It was found that more than 80 per cent of such articles were published after 2007 (Uscher-Pines, Chandra & Acosta, 2013).

A key observation is that in terms of disaster-related community resilience, there are two major theoretical and practical pathways (Norris, et al., 2008). The first pathway is concerned with disaster-related mental health and psychosocial and community wellbeing; the second emphasizes the management of disaster in order to reduce risks and loss and to preserve and restore essential basic structures and functions (Twigg, 2007).⁶ While the two approaches are complementary, our focus herein is on the former – those approaches concerned with the psychosocial wellbeing of communities.

⁶Much of the latter seems based on a number of national and international frameworks and policies developed in response to the increasing frequency of disasters and realization of the need to move beyond traditional emergency preparedness strategies. See, for example, the Council of Australian Governments (2011), the Sendai Framework for Disaster Reduction 2015-2030 (UNISDR, 2015) and its predecessor, the Hyogo Framework for Action (UNISDR, 2005). “Resilience” as defined in the Sendai Framework (ref, pg. 9) is “the ability of a system, community or society exposed to hazards to resist, absorb,

Within the psychosocial wellbeing pathway, there is considerable variation. These models of community resilience have emerged from numerous fields in the social sciences including community psychology, social work, sociology and public health. Numerous definitions and understandings about the nature, contributing factors, and outcomes of community resilience are described; some models are focused specifically on disaster (either prevention/mitigation, or response and recovery); others focus on general community wellbeing. Some models are intended for pre-disaster planning and preparation; others are intended for community recovery after a disaster and a recently prescribed approach is the integration of disaster recovery with healthy communities processes (see the Institute of Medicine, 2015). Some models are grounded in a “bottom up” or “grass roots” approach while others (less congruent with the PSSCBR paradigm) tend to place more emphasis on inter-agency collaboration.

In the US, a number of health and wellness-centred approaches to community resilience have recently emerged in response to the Federal Emergency Management Agency’s (FEMA) Whole Community effort and the Health and Human Services National Health Security Strategy (NHSS) (Wulff, Donato & Lurie, 2015). The NHSS “identifies community resilience as critical to national health security; i.e., ensuring that the nation is prepared for, protected from, and able to respond to and recover from incidents with potentially negative health consequences” (Chandra, et al., 2011, p. xiii).

Given the diversity of models and approaches described in the literature, a comprehensive analysis of all the various approaches is beyond the scope of this review. What we present herein is a brief overview of key ideas from commonly cited disaster-related community resilience and psychosocial capacity building publications.⁷

While community resilience is variously conceived in the literature (as a process, a set of capacities, or as an outcome), it is most commonly described as a dynamic process that continually shapes and reshapes the community (Pfefferbaum, et al., 2007). Indeed, the common denominator amongst various models and frameworks 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., 2008⁸), restored community functioning, socio-

Community resilience is commonly described as a dynamic process that continually shapes and reshapes the community.
(Pfefferbaum, et al., 2007)

accommodate to and recover from a hazard in a timely and efficient manner, including through the preservation and restoration of its essential basic structures and functions”. Contributors to resilience typically include disaster planning and assessments of risk and vulnerability, resources and community connectedness. This approach is typically described from a top-down (i.e., government led) stance, with emphasis on the responsibility of individuals, communities, businesses, governments and NGOs to prevent, prepare for, respond to and recover from disasters in order to reduce the loss of lives and the social, economic and environmental assets of communities and countries.

⁷ For those wishing further detail, a comprehensive review and discussion of community resilience in relation to disasters is presented by Norris et al. (2008).

⁸ Norris et al. (2008, pg. 127) define population wellbeing as, “high and non-disparate levels of mental and behavioral health, functioning and quality of life”.

economic vitality (Hawe, 2009) and the ability to mitigate against future adversity (Pfefferbaum et al., 2007). Thus, resilience is more than simply “bouncing back” to a previous state; it is about the potential to grow from crisis and reach a higher level of functioning (Brown & Kulig, 1996/7). Communities may be more or less resilient at any given time, and they may be resilient to one kind of trauma but not another (Brown & Kulig, 1996/7). Most important to our discussion is that community resilience and psychosocial capacity building strengthen a community’s social fabric – the fundamental source of psychosocial wellbeing; and they emphasize a community’s ability to protect and promote the wellbeing of its members.

A sampling of definitions of community resilience relevant to disaster-related psychosocial support is presented in Table 8 below.

Table 8. Definitions of community resilience

Brown & Kulig (1996/7)	<i>The ability of a community to not only deal with adversity but also to reach a higher level of functioning.</i>
Kulig, Edge, Reimer, Townshend & Lightfoot (2009)	<i>“High community resiliency is the ability of a community to deal with adversity and develop an improved level of functioning in the process. It is a process through which the community continually adjusts to the dynamic conditions they face whereby residents’ interactions as a collective unit (“getting along”) leads to a “sense of community” (community togetherness and sense of belonging), finally producing community action through visionary leadership and conflict resolution (pg. 33).”</i>
Landau and Saul (2004)	<i>“A community’s capacity, hope and faith to withstand major trauma and loss, overcome adversity, and to prevail, usually with increased resources, competence and connectedness (pg. 2).”</i>
Norris, et al., (2008)	<i>“Community resilience is a process linking a network of adaptive capacities (resources with dynamic abilities) to adaptation after a disturbance or adversity. Community adaptation is manifest in population wellness, defined as high and non-disparate levels of mental and behavioral health, functioning and quality of life. Community resilience emerges from four primary sets of adaptive capacities: economic development, social capital, information and communication, and community competence – that together provide a strategy for disaster readiness (pg. 127).”</i>
Hawe (2009)	<i>“A resilient community predicts and anticipates disasters, absorbs and recovers from the shock and improvises and innovates in its response. A resilient community comprises resilient people, but on top of that, it has a collective infrastructure and capacity for decision making and action as a collective unit, leading to the restoration of socio-economic vitality of the community (pg. 4).”</i>
Mancini & Bowen (2009)	<i>“Community resilience is the ability of communities to cope and adapt in the context of challenge and adversity in ways that promote the successful achievement of desired community results” (pg. 248).</i>

Pfefferbaum, et al. (2007)	<i>“Community resilience is grounded in the ability of community members to take meaningful, deliberate, collective action to remedy the impact of a problem, including the ability to interpret the environment, intervene, and move on. More than the ability of members to cope individually, community resilience involves interactions as a collective unit. It serves a community by fortifying it against a host of social concerns such as violence, crime, poverty as well as terrorism and other disasters...community resilience couples recovery from adversity with efforts by individuals and groups to transform their environments to mitigate future events. As such, community resilience is not simply returning to homeostasis, it entails the potential to grow from the crisis (pg. 4).”</i>
Chandra et al., (2011)	<i>“The sustained ability of a community to withstand and recover from adversity” (pg. iii)</i>
Community & Regional Resilience Institute (CARRI) (2013)	<i>“Community resilience is the capability to anticipate risk, limit impact and bounce back rapidly through survival, adaptability, evolution and growth in the face of turbulent change (pg. 10).”</i>

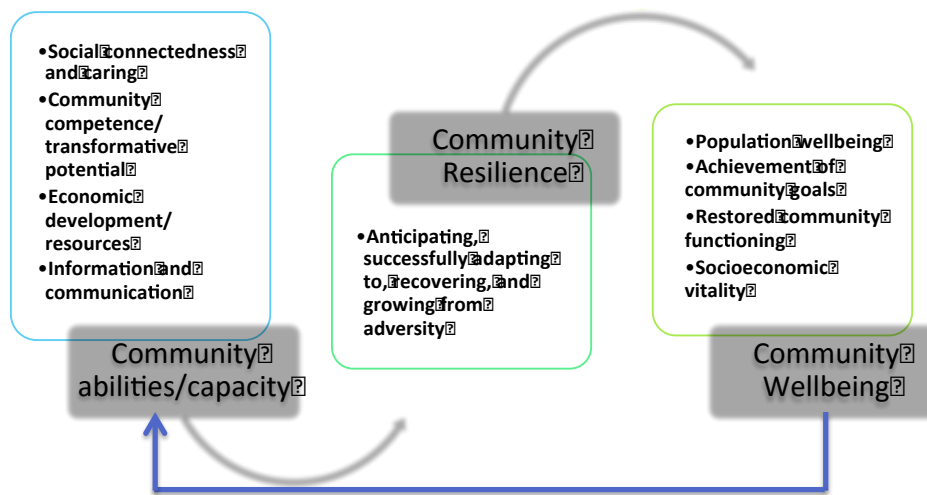
All of the definitions in Table 8 refer to capacities or abilities of a community to take adaptive action. Analysis of these articles revealed a set of capacities or abilities that are consistently identified as contributing to community resilience, and, as such, are leverage points for building or enhancing resilience.⁹ These include:

- ***Social connectedness and caring and a sense of shared responsibility*** for the welfare of the community. The foundation of community resilience is relationships amongst community members, including: social connections and social capital, social support, citizen participation, sense of community and attachment to place (O’Sullivan, et al., 2014; 2013; Aldrich, 2012; Mancini & Bowen, 2009; Norris et al., 2008; Brown & Kulig, 1996/7). A sense of shared responsibility for community wellbeing is a key driver of collective action.
- ***Community competence/transformational potential***. Community resilience requires that a community is able to work effectively together to make decisions, critically reflect and solve problems, build political partnerships and act flexibly and creatively to take advantage of opportunities to address community needs and confront situations that threaten the safety and wellbeing of community members (Mancini & Bowen, 2009; Norris et al., 2008). Community competence is rooted in empowerment and collective efficacy (Kulig, et al., 2013); it is contingent upon a learning process in the community that includes residents’ knowledge of their history, their ability to transform how they do things, and their ability to develop better and different strategies (Brown & Kulig, 1996/7).

⁹ Note that various authors identify several other capacities/abilities, but these four capacities seem to be most frequently described in the works we reviewed.

- **Economic development/resources.** This includes economic growth, resource diversity, stability of livelihoods and equitable distribution of assets and income in populations. Land and raw materials, physical capital, accessible housing, health services, schools and employment opportunities create the essential resource base of a resilient community (Norris, et al., 2008, pg. 136).
- **Information and communication.** Information enables adaptive response. People need accurate information and they need opportunities to articulate their needs, views and attitudes (Norris, et al., 2008). Information needs to come from trusted and credible sources who can clarify facts and circumstances of traumatic events, provide practical guidelines to assist in rebuilding, providing clear, consistent and accurate information and providing swift updates if there are errors in communications or changes in circumstances (Walsh, 2007). This requires systems and infrastructure for keeping the public informed (Norris et al., 2008).

A highly simplified model of community resilience is presented in Figure 6; it depicts the relationship between community capacities/abilities, community resilience and community outcomes.



A simplified model of community resilience

Figure 6. A simplified model of community resilience

Several researchers have described processes for building community resilience both before and after disasters. The general approach is very similar to community development, healthy communities, and participatory action research processes. Most models include development of a representative group of community members to guide the initiative (e.g., a community recovery committee). Depending on the circumstances the process may begin with a community visioning exercise, or it may start with an assessment of community strengths, assets, opportunities, and mapping these onto areas of need; prioritizing areas of action and developing plans; implementing actions and adjusting efforts along the way.

In the next section, we present Miller's (2012) model of psychosocial capacity building as an exemplar of PSSCBR. Additional models and approaches to PSSCBR can be found in Appendices B-D.

Psychosocial capacity building

Miller (2012, pg. 191) defines psychosocial capacity building (PSCB) as an:

"Intervention, provided by professional and nonprofessional people, both local and from the outside, that constitutes a multisystemic, culturally grounded and empowerment-and resiliency-oriented approach designed to help individuals, families, social groups and communities recover from a disaster. Psychosocial capacity building seeks to be sustainable over time and builds on the foundation of local capacities and resources."

The approach engages local people in all phases of disaster response and is predicated on the assumptions of strength and resiliency (people are viewed as being inherently durable and resilient); self-healing versus medicalization; empowerment; cultural responsiveness; mutual aid and self-help; human rights and equity (Miller, 2012).

The ultimate goal of PSCB is to rebuild a viable community, which is why we classify this as "community-focused" even though the process can build resilience in individuals and families. Objectives of PSCB include: reducing and alleviating suffering caused by a disaster; promoting community autonomy and agency; permitting space for processing, grieving and mourning; supporting meaning-making (making sense of what happened); rebuilding economic security, social networks, social capital; and promoting collective recovery; and repairing the community's torn social fabric - all of which are inextricably linked to psychological recovery.

Miller (2012, pg. 193) summarizes PSCB in this way:

"Psychosocial capacity building is based on strength and resiliency, informed by culture, focused on natural social groups (families, informal social networks) and built on the resources and local assets of local people. Moreover, [it] promotes sustainability, repairs and rebuilds social networks, and links collective economic and social recovery with individual recovery. It fosters coping, creates space for grieving, and recognizes the significance of reconstructing meaning. All of these aims are intended to reduce suffering, stimulate efficacy, reconstruct local interdependence and lead to individual and collective autonomy over time."

Miller presents an integrated model for psychosocial capacity building, conceptualized as a "wheel of recovery" (see Figure 7 below). The wheel of recovery, "diagrams a strengths-based model of recovery for communities struck by disaster, emphasizing collective capacity while also acknowledging the need to respond to stress, trauma and bereavement" (pg. 22). Surrounding the wheel are entities that can support a community struck by disaster, "offering resources and interventions in ways that respect the cultural and social integrity of the community" (pg. 23). The bottom of the circle represents community strengths and assets prior to the disaster, which can "serve as sources of wisdom and hope if this well of

the past can be uncovered from the debris of the disaster.” The horizontal band in the middle of the sphere represents reactions and dislocations caused by the disaster. Above this band are a number of post-disaster tasks and activities that contribute to individual and collective healing and recovery, incorporating ideas and interventions both from disaster mental health and psychosocial capacity building. At the top of the circle are what Miller describes as the three most important things for a community to strive for post-disaster: a sense of hope, social connectedness and meaning forged from the font of the past and the ashes of the disaster” (pg. 23).

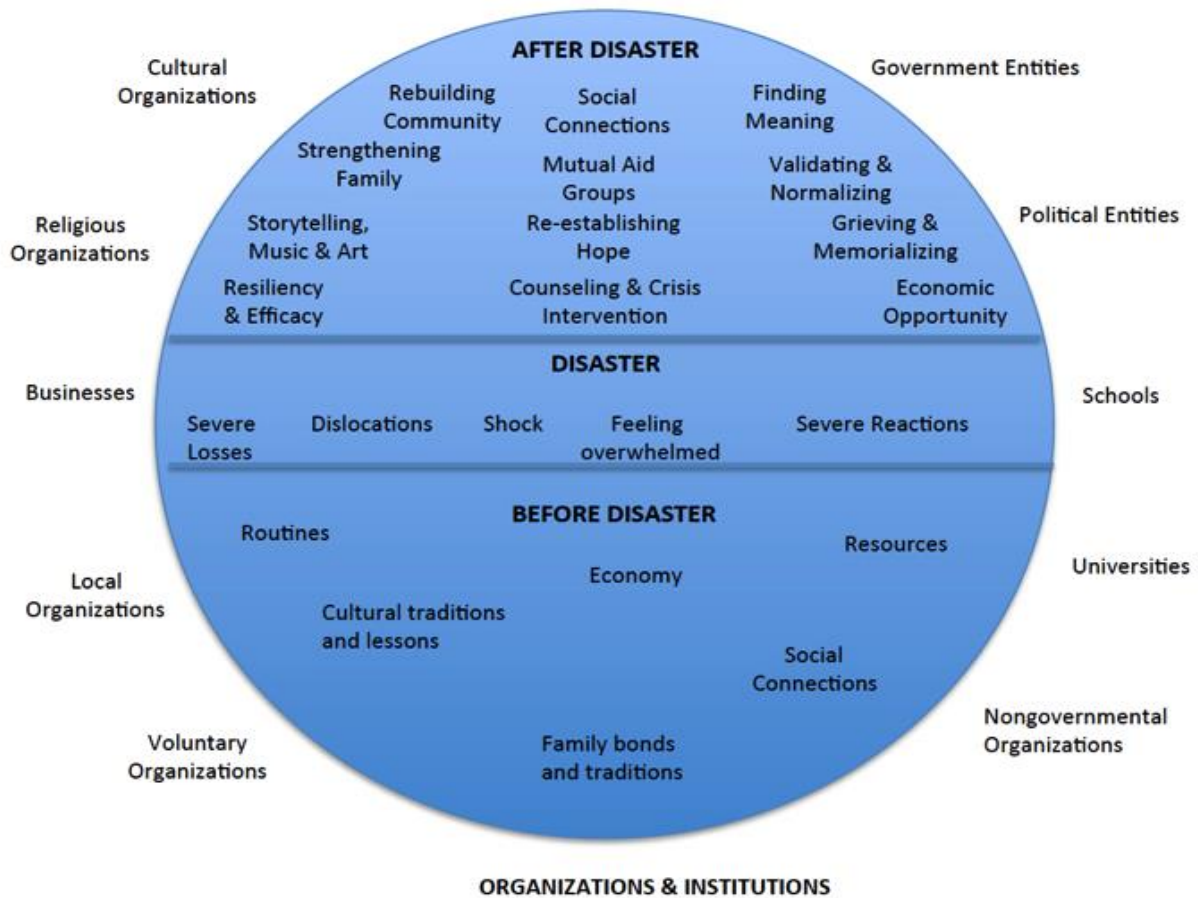


Figure 7. Miller's Wheel of Recovery (Source: Miller, 2012, pg. 22)

Miller's model brings attention to the wide array of activities falling under the umbrella of psychosocial support and capacity building (the top half of the circle) ranging from rebuilding the community to storytelling, music and art activities, to building social connections, to mutual aid, to generating economic opportunities, to grieving and memorializing, to finding meaning, to counseling and crisis intervention and so on. This broad spectrum of activities illuminates the potential helping roles to be played by numerous community groups and agencies (depicted on the outside of the circle), which in turn highlights the value of working collaboratively across these groups and organizations to provide a comprehensive web of supports.

An overview of key psychosocial capacity building processes described by Miller is presented in Table 9 below.

Table 9. Key psychosocial capacity building processes

Collaborative planning and assessment	Identification of local partners to assess the impact of the disaster, identify vulnerable groups and prioritize the most urgent needs of individuals, families and communities. The planning is multisystemic and multilevel, ranging from targeted interventions for those most in need to a broad range of population-wide capacity building efforts. Key is that affected people are integrally involved in the assessment and planning process. (Several examples are provided).
Community organizing and mobilizing	Involves actions fostering democratic, participatory activities to improve the wellbeing of a community and its residents; an emphasis on local involvement, responsibility and decision making. By emphasizing participation, community organizing shifts people from the role of victims to activists with the capacities and abilities to influence their own recoveries and futures.
Economic recovery and psychosocial healing	Connecting macro- and micro-realities (for example, developing micro-loan programs to develop entrepreneurial skills and economic resources while also providing connections to others, and linkages to resources such as information).
Social network restoration	Strategies to bring people together to (re)-establish social networks. Can be accomplished in a wide variety of ways (e.g., formal groups, informal gatherings, web-based networks).
Teaching and psychosocial education	Instruction targeted toward those directly affected by the disaster or geared toward strengthening the capacity of local people to help others, such as in a train-the-trainer model. Ideally, these activities involve collaboration between outsiders with special skills, knowledge and expertise in helping people recover with locals who have insider understanding of the community. Education encompasses numerous areas (e.g., understanding psychosocial reactions and how to start a support group, to grant writing, to economic development, to accessing resources for rebuilding).
Consultation and supervision	Acting as consultants, supervisors and trainers rather than directly intervening. The most effective approach is to partner and team with local experts.
Exit planning	Making it clear that outside helpers have a time-limited role, respecting local agency and autonomy. Having a finite time frame helps focus activities and provides an impetus for the work that needs to be done.

Source: Miller, 2012, pg. 199-210.

Miller writes extensively about the value of accomplishing much of this PCB work through groups. Numerous kinds of groups might be employed (e.g., psychoeducational groups (create space for people to process their reactions to the disaster); support groups (support for a common concern, offer mutual aid to one another); task groups (focus on accomplishing specific goals); or activity groups (socializing to express feelings and reactions and experience a sense of efficacy and empowerment). His preference for working in groups is based on the following:

- Groups create a situation in which mutual understanding, healing, mutual aid and support can occur
- There is reciprocity and equity – talking with a friend or fellow group member is egalitarian and mutual
- Groups bring multiple perspectives and create a support system that is more likely to endure than an outside supporter who will eventually leave the community
- A group can create a collective narrative about what has occurred, bringing people closer to one another through their bond of common experience
- Hearing about differences in experiences, especially strategies employed by others expands peoples’ understanding of the range of possibilities open to them
- When a group of people pool their assets and resources, they can achieve more and share the burden of responsibility
- Groups create their own energy and synergy, connecting people and creating a circuit of power that strengthens and is contagious (Miller, 2012, pg. 222-224).

It is easy to see that these group approaches have the potential to simultaneously build individual and group/community resilience, making this approach particularly valuable. However, facilitating these groups is not necessarily an easy task; it requires a sophisticated set of skills including, for example, the ability to bring people together, to create safe spaces where people feel comfortable talking and working with others, to navigate conflicts that will inevitably arise, and to stay on the path of “working with”- sustaining an environment where people realize their own power, rather than taking over and “doing for” them. This role can be especially difficult for professionals who were trained to be ‘expert providers’ of care” (Carp, 2010).

In the next section, we present some discussion about the role of helping agencies in community-focused psychosocial capacity building and resilience approaches.

Community engagement/participation and the role of helping agencies

As noted previously, true psychosocial capacity building and community resilience models place strong emphasis on the active engagement of community members in assessing the community’s strengths/assets and needs, planning, taking action, assessing progress and results, and making adjustments as needed. This is consistent with research that has demonstrated that community-led processes appear to achieve larger effects and develop more sustainable processes than externally designed interventions and that facilitated processes in communities somehow capture and strengthen natural social dynamics and guide them in ways that enhance wellbeing and minimize health and social inequities (Hawe, 2009, pg. 23). The intent, however, is not to download all responsibility for community planning, response and recovery onto the shoulders of informal groups in the community. To the contrary, PSSCBR approaches are collaborations between community residents, helping agencies, government, and other organizations (e.g., employers).

Mancini and Bowen (2009), for example, describe the synergistic relationship between informal and formal networks in a community. Informal networks are relationships amongst friends, families,

neighbourhoods and/or social groups in a community – they contribute the power of interpersonal relationships and a sense of responsibility for the community, and as such, they drive community change. Formal networks are agencies such as social services, health services, and schools that are mandated to provide services and supports. The primary role of formal networks is to support and strengthen informal networks. Formal networks are significant in driving change because of their mandate to provide services and supports, their expertise that complements the energy found in informal networks (Mancini & Bowen, 2009, pg. 253).

The nature of PSSCBR models means that the role of professional helpers and agencies is one of supporting and guiding community efforts as needed, rather than deciding what the priorities are and how they should be addressed. Landau (2007, pg. 355), the originator of the Linking Human Systems (LINC) Community Resilience model (see Appendix D) describes the role of external, professional helpers this way:

“[LINC interventions] employ existing community resources rather than installing artificial support infrastructures or imposing generic prescriptions for community health. They leave the ultimate decision-making to the people whose lives will be most affected by the changes that are instituted. As professionals, we are responsible for providing the context and skills that will allow communities to access the resilience of their ancestors and of their cultural and spiritual histories. This approach allows us to be effective interveners while not becoming embedded in communities or intruding into their privacy. As a result, the solutions that emerge are culturally appropriate and sustainable.”

A caution about “top-down” approaches (i.e., those that are *not* based on authentic community engagement) comes from the work of Aldrich (2012) who, based on his extensive study of four major disasters, including Hurricane Katrina, concluded that, “centralized plans are ambitious and flawed” (pg. 151). Aldrich is referring here to the tendency for government to view disaster as an opportunity to alter existing organizations, institute new plans, and reshape physical spaces. From his intimate study of four disasters around the globe, he observed that local entities were far more flexible and responsive than government in rebuilding healthier communities. Top down, command-control approaches, he observed, lacked popular support and almost inevitably fell apart or were contested by residents.

Aldrich’s findings indicate the need for careful deliberation about *how* community capacity building and resilience might most effectively be facilitated. They illuminate the crucial difference between “top-down”, government guided or imposed community-based models and “bottom-up” or grass roots efforts of communities where communities own and are invested in the endeavour with supports provided by professional helpers as needed. In the former, the agenda is that of government; in the latter the agenda is that of the community. As noted previously, a combination of approaches is important, as communities will have varying degrees of resources and the capacity required to effectively organize and mobilize.

A combination of approaches is important, as communities will have varying degrees of resources and the capacity required to effectively organize and mobilize.

Further, many community members will not be accustomed to participating and may need support at the outset. Agencies promoting capacity building and resilience thus need to operate in ways that are receptive to community needs, expectations and capabilities, and that can facilitate self-help (Mooney et al., 2011).

A caution to readers then, is that when reviewing potential models to adopt in the name of psychosocial capacity building and community resilience, particular attention should be paid to how community engagement and participation is conceptualized, recognizing that it is this agentic participation that fosters psychosocial support and builds community capacity and resilience. (See Cornwall (2008) for an analysis of the concept and practice of community participation.)

Synthesis: Community-focused psychosocial capacity building and resilience models

Common features of the community-focused psychosocial capacity building and resilience models that we reviewed are presented in Table 10 below.

Table 10. Community-focused psychosocial capacity building and community resilience models

- Psychosocial capacity building and community resilience approaches strengthen the community's social fabric, a fundamental source of psychosocial support. In addition, they address psychosocial impacts on whole communities and they strengthen the community's ability in general to protect and promote the wellbeing of its members, including a greater ability to address future adversity.
- There is a role for PSSCBR across the spectrum of disaster related actions in communities, including community assessment, preparedness, planning, prevention/mitigation, response to disaster, short-term recovery and longer-term recovery, community rebuilding and transformation. Several community resilience models are focused on assessing and building community resilience before disaster strikes; others are focused more on psychosocial capacity building after a disaster.
- The focus is on the whole community, and active, representative engagement of community groups in assessing, planning/preparedness, setting priorities and implementing psychosocial response and recovery strategies. The community is the predominant driver of the effort, with the support of external helpers (e.g. community facilitators) and content experts as needed. The degree to which the community drives the effort will depend on numerous factors including, for example, its capacity to do so, the nature of the disaster, and the extent to which the community is impacted. The goal, however, is to foster increased community control (empowerment) over the process of recovering from adversity. This process in and of itself builds community capacity and resilience.
- These approaches are all about enhancing the adaptive capacity of communities, meaning that the intent is to help the community to be flexible and adapt to changing circumstances and needs. One way of doing this is identifying, drawing upon and building upon existing strengths, assets and capacities.
- All of these approaches place strong emphasis on rebuilding the community's social fabric,

recognizing that this is a fundamental source of psychosocial support, wellbeing, and resilience.

- In addition to rebuilding the social fabric, PSSCBR models include a broad array of activities/supports for psychosocial support, including, for example, helping the community make sense of what has happened, recreational and expressive activities such as music, art and storytelling; mutual aid groups; family strengthening; re-establishing hope; grieving and memorializing; creating economic opportunities; and individual counseling.¹⁰
- Given the above, the strategies employed for recovery and resilience are “multi-pronged” and multi-level, meaning that multiple interventions at multiple levels within a community are necessary. This means that many helping organizations can have a role to play in supporting PSSCBR and psychosocial support in general. This, in turn requires effective collaboration and coordination of efforts to avoid unnecessary duplication of efforts and, on the other hand, avoid gaps in support.
- There is explicit recognition of equity and social justice as well as culturally sensitive and responsive approaches. Attention is paid to vulnerable groups in recognition that catastrophic events often open up underlying inequalities and trauma.

Community resilience:

- Is about a community’s successful adaptation to and recovery from adversity that results in the achievement of community goals and positive outcomes such as increased resources, competence and connectedness, population wellbeing, restored community functioning, socio-economic vitality and the ability to mitigate against future adversity; it is much more than the aggregation of resilient individuals.
- Is more than simply “bouncing back” to a previous state. Communities cannot “return to normal” as they will have changed as a result of the disaster; however, they can grow into a new equilibrium. Community resilience is about the potential to grow from crisis and reach a higher level of functioning; it involves not only recovery, but also transformation of the social and physical environment.
- Is grounded in social connectedness, caring and a felt responsibility for the wellbeing of the community, human agency, the capacity for meaningful and intentional action, and economic resources. People aren’t viewed as survivors coping with disaster, but rather as agentic beings intervening to respond, recover and grow from adversity.
- Is proactive. Once past the immediate impact of the event, the focus in building community resilience is proactive (i.e., capacity building, reducing vulnerabilities and building strengths), not reactive.
- Helps mitigate against future adversity or trauma.

¹⁰ Numerous authors speak to the importance of meaning making following community trauma. See for example, Miller (2012); Walsh (2007); Gordon, 2004b). Shattered assumptions about the world (e.g., that others can be trusted, the community is safe, there is a predictable future, God is just) can be a profound loss, challenging one’s sense of reality and the meaning of life. There is a deep need then to restore order, meaning and purpose. Meaning making includes contextualizing peoples’ distress as understandable and common amongst those who have experienced similar tragedies; and helping people gain a sense of coherence, rendering their trauma experience more comprehensible, meaningful and manageable. This, alongside the convening of community conversations and sharing experiences and having these experiences validated, is a central process in healing and recovery (Saul & Bava, 2008; Walsh, 2007).

- Benefits the community beyond preparation, mitigation, response, and recovery from disaster. It can help address other issues, such as community violence, poverty, food insecurity and so on.

Disaster Mental Health-Oriented Models: Community-Focused

By definition, DMH models focus on care and support for individuals and do not focus on whole communities. We did not come across any DMH-community focused models in our review, although there is frequent mention in the DMH literature about epidemiological studies of the incidence and prevalence of psychopathology in populations and communities. Many individual-focused DMH models do, however, mention delivery of community-based activities that support individual-focused DMH (for example, talking about SPR at a community dinner – see SPR findings below). And some individual-focused DMH models speak to community actions, such as facilitation of communal healing practices (see the TENTS model described below).

Disaster Mental Health-Oriented Models: Individual-Focused

Our literature search surfaced hundreds of articles pertaining to clinical and behavioural interventions to support people exposed to trauma and disaster. Most of this literature focuses on specific disaster-related mental health problems or illnesses, specifically, their epidemiology, neurobiology, prevention, screening, diagnosis, treatment and rehabilitation. For example, the *Textbook of Disaster Psychiatry* (Ursano, Fullerton, Weisaeth & Raphael, 2007), includes chapters about: the epidemiology of disaster mental health; neurobiology of disaster exposure: fear, anxiety, trauma and resilience; early intervention for trauma-related problems following mass trauma; acute stress disorder and post-traumatic stress disorder in the disaster environment, and so on. An extensive volume of work focuses specifically on disaster-related PTSD.

DMH guidelines typically outline different kinds of interventions at different points along the trajectory of a disaster and as the needs of survivors change (Watson et al., 2011). Community members may be consulted to ensure that programs and services are appropriate for the community. Because our focus in the literature review and environmental scan was on overarching frameworks or guidelines we did not explore the literature regarding specific DMH interventions. Instead, we surfaced and examined a handful of guidelines or approaches that are grounded predominantly in the DMH paradigm. The most commonly cited is a set of guidelines developed by the European Network for Traumatic Stress (TENTS) in which the dominant focus is on care provided to individuals. This is described below.

The European Network for Traumatic Stress (TENTS) Guidelines for Psychosocial Care Following Disasters and Major Incidents

The European Network for Traumatic Stress (TENTS) (2008) *Guidelines for Psychosocial Care Following Disasters and Major Incidents*¹¹ were developed based on a systematic review of the literature regarding

¹¹ Note: We have placed the TENTS Guidelines under the umbrella of disaster mental health because, while they do mention community-based psychosocial interventions, the dominant focus is on mental health care for individuals; there is no reference to community-focused psychosocial capacity building or resilience building, nor to community ownership of the psychosocial response. The approach is more of “doing to/for” than “doing with”.

psychosocial care following disasters and a Delphi process that involved 106 professionals and experts from twenty five different countries. The Guidelines are recommended as a “model for delivery of care in all European countries without being mandatory” (pg. 3) and are intended for implementation in communities ranging in size from 250,000 to 500,000 although they can be adapted for smaller communities.

The Guidelines are organized in six sections including: planning, preparation and management; general components; and, specific components to be included at particular phases of the response (i.e., interventions within the first week, the first month, and beyond three months).

Examples of key recommendations regarding planning, preparation and management include (TENTS, 2008, pg. 4):

- Every area should have a multi-agency psychosocial care planning group which includes mental health professionals with expertise in traumatic stress... individuals affected by disasters... should also be represented
- Every area should have guidelines on the provision of psychosocial care in emergencies (a psychosocial care plan) that are incorporated into the overall disaster/major incident plan and regularly updated
- Inter-agency cooperative planning and coordination should occur to ensure that the psychosocial care plan is effective
- Existing psychosocial services should be fully mapped and incorporated into the psychosocial care plan
- The psychosocial care plan should be tested through exercises
- Politicians/government officials should be involved in management training and exercises
- A training program should be in place in every area to ensure that individuals involved in the psychosocial care response are prepared for their roles and responsibilities
- All care providers should have undergone formal training and receive ongoing training, support and supervision
- The planning group should monitor for possible secondary traumatization and burnout symptoms among care providers, including volunteers
- Governments/authorities should provide adequate funding to maintain an appropriate psychosocial care plan that can be effectively delivered should a disaster occur

Examples of “general components of the response” include (TENTS, 2008, pg. 4-5):

- The response should promote a sense of safety, self, and community efficacy/empowerment, connectedness, calm and hope
- The human rights of individuals should be explicitly considered
- Conditions for appropriate communal, cultural, spiritual and religious healing practices should be facilitated

- Responses should provide general support, access to social support, physical support and psychological support
- Responses should involve and provide support to the family as well as the individual
- Responses should provide educational services regarding reactions to trauma and how to manage them
- Formal screening of everyone affected should not occur but helpers should be aware of the importance of identifying individuals with significant difficulties
- Provision of specific formal interventions such as a single session individual psychological debriefing for everyone affected should not occur
- Local individuals who are aware of local cultures and particular communities should be involved if not already members of the psychosocial care planning group
- General Practitioners/local doctors should be made aware of possible psychopathological sequelae
- Efforts should be made to identify the correct supportive resources (e.g., family, community, school, friends, etc.)
- Other services should be made available, for example financial assistance and legal advice
- Memorial services/ceremonies should be planned in conjunction with those affected

The focus in these 2008 Guidelines is on clinical care for individuals with recognition that such care should be provided with consideration of the individual's family and community. For example, components of the initial response emphasize provision of practical help, information, normalization of psychological reactions, the use of helplines and websites and "one-stop-shops" for assistance. Components related to actions in the first month and beyond focus entirely on supports to individuals, including assessments and use of evidence-based treatments for treatment of mental health difficulties.

The *Interventions* (TENTS, 2011) document includes a section about community-based psychosocial interventions defined as, "all activities that facilitate normalization of social, family and individual psychosocial functioning in a community affected by a disaster" (pg. 3). The target of these actions is people directly involved and their families, witnesses, and agency personnel involved in the disaster response and recovery. A range of interventions is described including material, practical and informational support, organizing memorial events, employment, facilitating mutual help and self interest groups and providing psychosocial care interventions to affected populations.

The remaining sets of interventions include: trauma-focused psychological interventions for adults with PTSD; Cognitive Behavioural Therapy for PTSD; Eye Movement Desensitization and Reprocessing; Brief Eclectic Psychotherapy; the pharmacological treatment of PTSD; and interventions among traumatized children and adolescents.

Additional guidelines oriented in DMH include: Disaster mental health recommendations developed by the US National Biodefense Science Board (2008). These are briefly described in Appendix E.

Psychosocial Capacity Building and Resilience-Oriented Models: Individual-Focused

Individual resilience is defined by the Public Health Agency of Canada (Online) as:

“[A]n integral concept in the explanation of mental health promotion. Every life is a series of ups and downs; our capacity for resilience determines whether we bounce back from our lows and learn from them in a positive way or whether we are left in a state of frustration, depression or self-destruction. Broadly defined, individual resilience is the vital sense of flexibility and the capacity to re-establish one’s own balance; the essential feeling of being in control with regard to oneself and to the outside world. The sense of being in control can be related to three fundamental concepts: a sense of being, the way we are and how we feel about ourselves; a sense of belonging, the way we relate to others and to our social, physical and cultural environments; and a sense of becoming, what we do in our lives, our aspirations and how we develop.”

In this section we describe one individual-focused resilience model of psychosocial support (J-CERT) and stepped models of care that integrate resilience and DMH approaches (we call these “hybrid approaches”): psychological first aid, and, our main topic of interest, Skills for Psychological Recovery, discussed in the next section.

The Jewish-Community Emergency Response Team (J-CERT)

Carp (2010) describes the general approach adopted by the Chicago-based Jewish-Emergency Response Team (J-CERT) in responding to over twenty incidents involving community trauma, particularly the unexpected, sometimes violent and often widely publicized deaths of children, adolescents, college-aged adults and the elderly. J-CERT has five teams of cross-trained and mostly clinically trained social work professionals. The tools and strategies used by these teams focus on resiliency rather than illness and dysfunction. Carp writes at length about the importance of re-orienting professional helpers away from concentrating on psychopathology to understanding healthy human development in the context of adversity. The latter focuses on strengths, adaptation, healing, wellness, coping skills, positive self-concept, self-efficacy and competence.

Carp (2010) emphasizes that since the “singular dynamic in traumatic events is the resulting chaos and feelings of loss of control, the primary objective of post-event interventions is to enable people to understand that their reactions are normal and to help them reassert control over their lives” (pg. 268). This is not therapy, and the participants are not clients.

The goals of J-CERT include:

1. Convey to people that their symptoms are expectable and to “normalize” the situation.
2. Help people use the strengths they and their social networks have developed to get back to their day-to-day functioning over time.
3. Enable people to understand the range of feelings and thoughts they may experience in the weeks and months following the incident.

4. Assure people that seeking professional help is okay if they feel they cannot sleep, connect and relate to others in satisfying ways, if they have flashbacks, or if they are unable to manage their lives in any way.
5. Be proactive, be respectful. Reaching out to community and institutional leadership with an offer of assistance is appropriate. While it may seem obvious, it is essential for second responders to be invited in by the leaders of the affected site.
6. Examine and analyze the impact of the incident upon the social system (institution, neighbourhood, community) and its leaders in order to utilize and bolster its strengths in the recovery phase (Carp, 2010, pg. 268).

Stepped, hybrid models of care

Stepped models of care are “individual focused” hybrid models with different tiers or levels of care. The lower levels of intervention can be conceived as primarily “resilience-building” because they help strengthen peoples’ adaptive and coping skills, while the top level of intervention – formal mental health interventions – is rooted in DMH. These stepped models of care resemble the pyramid models presented by NATO (2008) and the IASC (2007), except that they are individual-focused interventions only.

One often-cited example of a stepped model of care is the Australian Psychological Society’s¹² *Evidence-Informed Framework for Delivering Psychosocial Support and Mental Health Care Following Disasters* (Online). This is described as a “best practice framework to guide provision of support and mental healthcare to disaster affected communities” and was developed by a broad group of government and non-government stakeholders. The framework is depicted in Figure 8 and described in Table 11 below.



Figure 8. *The Australian Psychological Society’s Framework for Delivering Psychosocial Support and Mental Healthcare Following Disasters (Online).*

¹² The Australian Psychological Society has been renamed. It is now the Phoenix Australia Centre for Post-Traumatic Mental Health.

Table 11. The Australian Psychological Society’s “Evidence-Informed Framework for Delivering Psychosocial Support and Mental Health Care Following Disasters”

Level 1: Early response – advice and support	Refers to advice and simple practical and emotional support provided to affected individuals and communities in the days and weeks following a disaster. Most people will only require this level of supports. Psychological First Aid for individuals is a well-known example of this, but it can take the form of support groups, community meetings and other community development activities. This level of support can often be provided by community members with basic training to assist those experiencing distress and loss immediately following a disaster.
Level 2: Simple psychological strategies	Refers to simple, brief and practical psychological strategies that can be taught to community members with more persistent mild to moderate mental health problems. Skills for Psychological Recovery is a skills-based approach that assists individuals to better recover from the effects of disaster. This level of support can be provided by practitioners with basic counseling skills working in primary care, mental health and community-based settings.
Level 3: Formal mental health interventions	Refers to formal evidence-based psychological and pharmacological interventions for people with more persistent and severe distress, including those with diagnosable mental health conditions. A relatively small but significant number of people affected by disaster will require this level of intervention. These interventions are typically provided by mental health specialists with expertise in treating people with mental health conditions.

Source: Australian Psychological Society (Online, retrieved May 2015)

Psychological First Aid (PFA)

Watson et al. (2011) note there is little evidence for any psychological intervention within the first month following a traumatic event; rather the primary goal at this stage is to “promote safety, attend to practical needs, enhance coping, stabilize survivors and connect survivors to additional resources” (pg. 5). This is referred to as psychological first aid (PFA). The DMH literature also makes frequent reference to PFA, sometimes as a general set of principles, but we feel it is also contains elements often described in the resilience literature.

Brymer et al. (2006) and the World Health Organization (2011) have produced guidance documents for PFA. Here, we provide an overview of the approach developed by Brymer, et al. PFA is intended for use in the immediate aftermath of disasters. Basic objectives are to:

- Establish a human connection in a non-intrusive, compassionate manner
- Enhance immediate and ongoing safety, and provide physical and emotional comfort
- Calm and orient emotionally overwhelmed or distraught survivors
- Help survivors to tell you specifically what their immediate needs and concerns are, and gather additional information as appropriate

- Offer practical assistance and information to help survivors address their immediate needs and concerns
- Connect survivors as soon as possible to social support networks, including family members, friends, neighbours and community helping resources
- Support adaptive coping, acknowledge coping efforts and strengths and empower survivors; encourage adults, children and families to take an active role in their recovery
- Provide information that may help survivors cope effectively with the psychological impact of disasters
- Be clear about your availability and (when appropriate) link the survivor to another member of a disaster response team or to local recovery systems, mental health services, public-sector services, and organizations (Brymer et al., 2006, pg. 6-7).

The foundation of PFA is a set of eight core actions; these are summarized in Table 12 below.

Table 12. Psychological First Aid (PFA) Core Actions

Contact and engagement	To respond to contacts initiated by survivors, or to initiate contacts in a non-intrusive, compassionate and helpful manner
Safety and comfort	To enhance immediate and ongoing safety, and provide physical and emotional comfort
Stabilization	To calm and orient emotionally overwhelmed or disoriented survivors
Information gathering: current needs and concerns	To identify immediate needs and concerns, gather additional information and tailor PFA interventions
Practical assistance	To offer practical help to survivors in addressing immediate needs and concerns
Connection with social supports	To help establish brief or ongoing contacts with primary support persons and other sources of support, including family members, friends, and community helping resources
Information on coping	To provide information about stress reactions and coping to reduce distress and promote adaptive functioning
Linkage to collaborative services	To link survivors with available services needed at the time or in the future

Source: Brymer et al., (2006, pg. 19)

This concludes our presentation of the “big picture” of DR-PSS. In the next section we focus on findings specific to Skills for Psychological Recovery.

Skills for Psychological Recovery (SPR)

In addition to informing development of provincial planning for disaster-related psychosocial support, an equally important purpose of this literature review and environmental scan was to inform the

ongoing development of Skills for Psychological Recovery (SPR) in Alberta. Because evaluation of SPR is the primary focus of our work, we describe our “SPR learnings” in some depth. The findings are organized according to the learning foci and questions set forth in the learning framework for evaluation of SPR including: the history of SPR; SPR efficacy and effectiveness; and, SPR implementation. Importantly, we found few published research articles about SPR, likely because this is a relatively new psychosocial intervention. Much of what we learned came from the key informant interviews conducted with researchers and practitioners.

History and Description of SPR

SPR was developed in response to Hurricane Katrina under the auspices of the US National Center for PTSD (NCPTSD) and the National Child Traumatic Stress Network (NCTSN). Hurricane Katrina spurred realization of the need for a low intensity intervention to improve mental health support post-disaster (Forbes, et al., 2010; Reifels et al., 2013b; key informants). Forbes et al. (2010, pg. 1106-1107) describe SPR as being designed for practitioners of varying backgrounds and qualifications, noting that it is:

- Based on extensive research of the most common emotional and behavioural reactions arising after disasters in adults and children
- Aimed at developing the briefest but most effective strategies derived from evidence-based approaches to managing these reactions
- Formatted to ensure that training and delivery would be feasible in the wake of massive disasters.

The individuals widely recognized as working together to develop SPR are Dr. Joseph Ruzek and Dr. Patricia Watson of the United States and Dr. Richard Bryant from Australia. They sat down together and mapped out what they thought would be an evidence-informed approach to tackling the major problems people have after a disaster, considering the New Orleans context where the skill base was very low and many people needed to get trained quickly (key informants). Given this context, the overarching question that led to the development of SPR was: *“How do you develop something that’s likely to impart the most skills and is most likely to get traction with the common problems people have after a disaster?”* It would need to be flexible in its approach so that it could be adapted for use in a variety of contexts and cultures, and for use with the many different kinds of people who are affected in a disaster including, for example, children, adolescents, parents/caregivers, families, adults, first responders, disaster-relief workers (Brymer et al., 2008; Cross Hansel et al., 2011; key informants).

Research suggested that a skills-building approach would be more effective than supportive counseling, and consequently SPR was developed to embody problem- and solution-focused approaches (Brymer et al., 2008). The five core skills of SPR, and their goals are briefly described in Table 13.

Table 13: Skills for Psychological Recovery

Skill	Goal
Problem solving	To help individuals prioritize and solve problems effectively

Positive activity scheduling	To help individuals plan and engage in positive, pleasurable or meaningful activities, to improve their mood and regain their sense of control
Managing physical and emotional reactions	To enhance skills to calm upsetting physical and emotional reactions to stressful situations (including reminders), and put words to difficult experiences to better manage distress
Helpful thinking	To help individuals identify what they are saying to themselves about the disaster experience or their current situation, and to help them choose less distressing ways of thinking
Re-building healthy social connections	To increase connections to positive relationships and community supports.

Source: Berkowitz, et al., (2010); Alberta Health Services (2014)

SPR is often referred to as a low-level, or facilitated self-help, intervention designed to help survivors gain skills to reduce ongoing distress and effectively cope with post-disaster stresses and adversities (psychological, behavioural, spiritual) over differing periods of time. While many survivors will recover on their own, some will experience distressing reactions that interfere with adaptive coping. SPR is often described as being introduced in the recovery period following disaster and trauma (i.e., after the response period where Psychological First Aid (PFA) has been utilized), and/or when more intensive intervention than PFA is needed (key informants). This is well articulated in the Australian Psychological Society’s stepped care model (online); and in the recently developed Alberta Health Services stepped care model, which is an adaptation of the Australian model (AHS, online).

The Effectiveness of SPR and Other Post-Trauma Interventions

What is known about the efficacy of SPR?

So what is the efficacy of SPR as an intervention for supporting disaster survivors to better cope with the mental and emotional effects of disaster and/or to prevent them from experiencing more serious mental health problems such as post-traumatic stress disorder (PTSD), depression, anxiety and/or complicated grief? As described earlier, although SPR is evidence-informed in that it was developed based on what is known from research about the kind of mental health problems most likely to occur post-disaster, and the kinds of strategies most effective in trying to prevent these problems from occurring, there has been no experimental design research studies on SPR carried out to date.

Our review of the published literature relating to SPR and our environmental scan on the use of SPR in other jurisdictions failed to surface any research about the efficacy of SPR, nor any other psychological recovery interventions. That is, there is no clear “best practice” based on research evidence. As Reifels et al. (2013a) state, “the efficacy of low and medium intensity interventions such as PFA, SPR and crisis counseling remains unknown”. North and Pfefferbaum (2013, pg. 507) similarly conclude, based on a systematic review of mental health responses in disaster, that:

“Evidence-based treatments are available for patients with active psychiatric disorders, but psychosocial interventions such as psychological first aid, psychological debriefing, crisis

counseling and psychoeducation for individuals with distress have not been sufficiently evaluated to establish their benefit or harm in disaster settings.”

In other words, no “gold standard” interventions for disaster-related psychological recovery have been identified because existing approaches haven’t been sufficiently evaluated to determine their impact.

This is not surprising, as SPR is a relatively new intervention, developed in the past decade. In addition, a lack of research on the impact of interventions is not unique to post-disaster mental health interventions but is a general issue with respect to mental health interventions. This is in part due to the challenge of conducting rigorously designed clinical trials in mental health. This challenge is compounded in a post-disaster environment where chaos is often the norm.

To address this gap in knowledge, a multi-national trial looking at the efficacy of SPR, led by David Forbes and Richard Bryant in Australia, is in the development stage and has a good chance of being funded (key informants). Conducting experimental design research on an intervention like SPR that is preventive and mental health promoting in nature, is going to be challenging.

At this time, with respect to promising practices in disaster/emergency psychosocial support there appears to be consensus around response interventions (where PFA seems increasingly to be seen as a promising practice) than recovery interventions. This observation is based on the frequency that PFA is included in disaster psychosocial frameworks and review articles, in comparison with the frequency of SPR. SPR does seem, however, to be being increasingly viewed by people working in the field of disaster psychosocial support as a promising practice. SPR has been used in Australia since the 2009 bushfires disaster (Forbes et al., 2010; Reifels et al., 2013b), in parts of the US following Hurricane Katrina in the 2005 (Cross Hansel et al., 2011; Sundgaard Riise et al., 2009) and in Japan after the 2011 earthquake and tsunami disaster (Uchida et al., 2014).

What is known about the efficacy of other post-trauma interventions?

There is a growing body of research regarding Critical Incident Stress Debriefing (CISD), which was put into practice some time ago. CISD is a group intervention, originally developed for use with first responders, that is organized around exploring facts, thoughts and reactions to a critical event. It was widely accepted for use with primary survivors primary to 9/11. There have now been a number of studies and reviews, however, concluding that CISD cannot be endorsed for use with trauma survivors (Brymer et al., 2009; Gray & Litz, 2005; McNally et al., 2003; Van Emmerick et al., 2002).

There is also a small but growing body of evidence on post-trauma interventions more generally, and some of this research may be useful in informing the design of post-disaster interventions.

What is known about the effectiveness of SPR from practice?

Despite the lack of research evidence to date, an increasing number of evaluations of SPR are being conducted. Understandably, the primary goal of these early process evaluations has been to increase understanding of whether SPR can be used in practice in a post-disaster setting. It is important to

understand whether and how SPR can be delivered in practice before designing evaluations that assess the impact on clients. The evaluations of SPR implementation conducted to date, then, have focused primarily on the effectiveness of SPR training with respect to increasing service providers' competency and confidence in working with people post-disaster, and on their perspectives of the usefulness of SPR in the post-disaster settings within which they are working.

The main findings to date are:

1. It is possible to train a variety of different kinds of people in SPR; and,
2. 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., 2013b, Forbes et al., 2010; Cross Hansel et al., 2009; Sundgaard Riise et al., 2009).

In addition, the most commonly reported barrier to using SPR seems to be the difficulty of engaging community members who might benefit from SPR (Australian Centre for Post-Traumatic Mental Health, 2012). The skill areas that people trained in SPR in Australia following the Victoria bushfires disaster report being least confident in is managing reactions (Forbes, et al., 2010).

With respect to how useful SPR is to disaster survivors themselves, the published evaluations conducted to date in Louisiana and Australia have captured the perspectives of service providers regarding how helpful SPR has been to their clients. Counselors working in bushfire-affected areas in Australia report that SPR is a useful and coherent framework for them to use in their work with people, and that their clients found the SPR skills useful (Reifels et al., 2013b; Forbes et al., 2010; Government of Victoria, 2009; Cross Hansel et al., 2009; Sundgaard Riise et al., 2009). An evaluation of specialized crisis counseling services (SCCS)(based on SPR) in Louisiana post-Katrina, for example, found that crisis counselors believed people with whom they used SPR developed increased skills, particularly in the areas of problem-solving, relaxation, positive activity scheduling, and managing upsetting reactions (Cross Hansel et al., 2011). Data collected through these early evaluations of SPR also indicate that practitioners are using the SPR skills with clients in the wake of other traumatic events, and not just natural disasters (Reifels et al., 2013b).

Key informants with experience using SPR in a variety of jurisdictions (i.e., Louisiana post- Hurricanes Katrina and Rita and post-BP oil spill; Joplin Missouri post-tornado) corroborated and added to the published evaluation findings. That is, it was possible to train a number of people quite quickly to use SPR with disaster survivors, and they found SPR to be very useful in their work. With respect to disaster survivors' perspectives on the usefulness of SPR, they described receiving mostly anecdotal data directly from clients and citizens. Examples include:

- People said that these were skills they would use for the rest of their life (Louisiana post-hurricanes)
- Some school counselors who co-facilitated SPR workshops are still reinforcing skills with their students, as well as using the skills themselves (Louisiana – post-BP oil spill)

- An SPR trainer uses it all the time in her own psychology practice now, even with people who do not have trauma related problems (e.g., people with problems with depression and anxiety) (Australiapost-bush fires)
- An evaluator described success stories as when residents referred to the crisis counselors as their "coaches", implying that the work was being done by the disaster survivors with the support of their counselors (Louisianapost-hurricanes Katrina)
- An individual involved in rolling out SPR received a lot of positive anecdotal feedback about the value of the informal SPR they delivered through community dinners. *"People said you should not underestimate what this program did for us; allowing us to get together with our neighbours over dinner."* (Joplin, Missouri –post-tornado)
- These same individuals also organized some more formal SPR workshop, and delivered them in two formats (i.e., five weeks long with one skill per week, and ten weeks long with two weeks per skill). They measured outcomes via a client survey with four to five pre- and post-questions. The most important question, from her perspective, was: *"How confident are you that you can continue helping yourself and your family for the next storm season?"* Confidence improved through both the five and ten week sessions, but confidence improved more in the 10-week sessions. People said they had trouble coming for ten weeks, however. She noted that: *"We know the classes work, but it's very difficult to get people to attend classes."*

To conclude, it is possible to train many people quickly in SPR and SPR has been used effectively in practice by a variety of practitioners. That is, practitioners have increased confidence working with individuals post-disaster, they find SPR useful, and their perceptions are that their clients find it useful as well. Anecdotal information received directly from clients support this perception. A current gap is the collection of client experience with SPR in a systematic way, but this is seen as the next step in SPR evaluation in practice settings.

SPR Implementation

There is little information on the implementation of SPR in the published or gray literature, but a wealth of knowledge among people who are actively training people in SPR and/or using SPR in practice. The majority of the findings reported on here come from key informant interviews with people involved in rolling out SPR in a variety of jurisdictions. The learning from these individuals' experiences, and supplemented by the literature where possible, is grouped into a number of sub-sections that correspond with key implementation questions of interest to people in Alberta. These questions are:

- How can SPR be effectively implemented and sustained in a variety of contexts?
- How is capacity built for integrating SPR into practice?
- What does fidelity to SPR look like?

What is known about implementing SPR in a variety of contexts and with different populations?

The devastating effects of major natural disasters on community resources and amenities pose significant practical challenges for the implementation of psychosocial interventions in many contexts

(Reifels et al., 2013b; key informants). Challenges described include:

- Destroyed infrastructure and practical issues with conducting training in areas affected by disaster;
- Multiple recovery efforts and competing demands for action;
- A sense of information overload and diminished ability to take on new information on the part of community members; and,
- Service providers being directly or indirectly affected by the disaster themselves (Reifels et al., 2013b).

There is growing experience, however, with SPR being used by a range of providers in a variety of settings, and with different populations of people (i.e., children, youth, seniors, homeless populations, both rural and urban populations, people from a variety of ethno-cultural backgrounds). SPR was designed to be flexible so that it could be adapted to these different contexts and different cultures (Brymer, 2008; Norris & Rosen, 2009, key informants). As one key informant stated: *“SPR can be used in any culture, as this is the way it was initially developed. In its pure form, I think it can be adapted.”*

SPR is often best provided in the community and integrated into other activities such as home visits, school programs and community dinners.

A consistent but not surprising finding is that many people won't come to an office for "counseling," meaning that SPR is often best provided in the community and integrated into other activities such as home visits, school programs and community dinners. As Norris and Rosen (2009) note, most people do not view themselves as having mental health problems, and to meet their needs programs have to shift from a traditional clinic-based model of care to a proactive community-based model. It is important to note that this finding is not specific to disasters; that is, people are often reticent about seeking out mental health professionals - hence the importance of designing approaches where counselors can work with people in a variety of settings. In current practice SPR is not described as a clinical or mental health service.

In Louisiana post-Katrina, for example, they knew they had to go with a community outreach model; *“people weren't going to come to an office for counseling.”* They needed more support and resiliency building. They used a dyad model where resource liaison coordinators went door to door with crisis counselors trained in SPR. Each dyad worked together a little differently. Often both people stayed through the whole visit, one would be helping with resource needs and the counselor would be working with the client(s) on developing a skill. Most interventions began with strategies related to problem solving as this was a good way to identify/prioritize goals and empower the survivor to take an active part in his recovery plan” (Sundgaard Riise et al., 2009, pg. 44).

People using SPR in a variety of contexts often made a point of saying that SPR was never introduced to the citizens they were working with as “mental health”. Rather, key informants describe SPR in a variety of ways, including *“helping people to help themselves”* and *“building capacity for hope and resilience”*. They describe a number of ways of approaching SPR with people affected by a disaster, for example:

- Approaching people in door-to-door visits in Louisiana post-Katrina by asking, *“what is your issue today, where would you like to be, and how can I help you get there?”*
- Introducing SPR to a First Nations Community in Louisiana post-BP oil spill by describing SPR as nothing fancy, but rather something that reinforces skills that you already have but that people often lose when they are under stress. SPR provides some *“exercises that help you to create more options for yourself”*.

The need for flexibility in SPR implementation was described frequently, and there are many examples of adaptation and of integrating SPR strategies in creative ways to meet the complex needs of survivors (key informants; Hansel et al, 2011). What is quite stable across implementation experiences, however, is the consistent teaching of all five of the SPR skills, plus the information collection and assessment module. So the adaption is of the implementation format and not the essential SPR content. This is described in more depth under the section entitled: “What is fidelity to SPR?”

People implementing SPR emphasize the importance of working with communities to identify if and how SPR might be used post-disaster. One key informant stated that it is often a good idea to start by meeting with community leaders to determine what they are already doing, what their needs are, and then working with them to integrate SPR if they are interested in a way that makes sense for that particular community. Working with people in the community also ensures that some capacity remains once any outside facilitators’ work is done.

For example, in post-tornado Joplin, Missouri, outside facilitators worked with community leaders and together they held focus groups with a variety of people (e.g., hospital employees, seniors, general community). In these focus groups they discussed what might help them move on and recover, and this is where they came up with the idea of having dinners. See the vignette in Table 14 below.

Table 14: Adapting SPR for use in a community dinner setting

In Joplin, Missouri, post-tornado SPR was primarily provided through community dinners, held every second week, over two years. As noted previously, this idea came out of focus groups held with a few different groups of people. People were desperate to connect with their neighbours, as the neighbourhood was destroyed. Some of these dinners were held in temporary ‘trailer’ communities, some were held in schools (that were paid to provide and serve the food), and others were held with seniors in churches.

People ate together, and then someone trained in SPR did a brief talk on one SPR skill. They had SPR flyers on the tables, and then SPR trained facilitators at each table hosted a post-dinner table talk focusing on that skill. These dinners were a great way for people to connect with others, given that many of the places where people would usually have gotten together had been destroyed. Well over 10,000 meals were served during the course of these dinners.

In another example, in Louisiana post-BP oil spill, community leaders identified working with youth as a priority. So a plan was developed to work with middle schools to delivery SPR. See the vignette in Table 15 below.

Table 15. Adapting SPR for use in a middle school

After the Louisiana BP oil spill, the community identified middle school-aged kids as a group that would benefit from SPR. These school-based programs were often co-facilitated by a mental health professional trained in SPR and a school counselor. The kids would get together for an hour once a week, working on one skill at a time - using a mix of discussion and games/activities. Each of the SPR skills was tailored for use in a school setting. The SPR trained program facilitators brought what they knew from their therapeutic experiences to help incorporate the SPR skills into kids' daily lives. Students were given the opportunity to dictate the topics of discussion in a particular week. Using this model, with four trained SPR mental health professionals working in schools with school counselors, they were able to serve 817 kids between 2010 and 2013.

Can SPR be used with groups of people?

As has just been described, in some jurisdictions people trained in SPR are working with groups of people (e.g., in schools, through community dinners, workshops in community settings). The use of SPR in Australia appears to have been primarily done with individuals, as far as the people involved in the training know. In Australia, first responders (i.e., police and EMS) are interesting in using SPR with their personnel, but they are interested in doing SPR with groups due to the stigma around individual counseling.

The general perspective of key informants is that they could see any reason why SPR could not be used with groups, if it was felt that group work made sense in a particular context. As one key informant said: *"There's nothing contrary to group intervention in SPR. It's very context-specific. So, in non-western contexts, the low intensity interventions [such as SPR] can be done in groups, because that's the context of their culture – more collectivist societies. I mean it comes back to logistics and timetabling and can you coordinate a group to get together at the same time. I mean there are some issues there as well. But there is absolutely no reason why it can't be group work."*

Can SPR be used outside of a disaster context?

To date, there does not seem to have been much experience in other jurisdictions with using SPR outside a disaster situation, so this is an area requiring further study. Many key informants, however, believe that it makes a lot of sense. They cited two main reasons: 1) The five skills that comprise SPR are applicable to people experiencing other kinds of trauma and negative life events, and 2) SPR is a useful strategy for keeping skills up.

As one key informant said: *"The ideal scenario is that people are trained in something like SPR prior to a disaster, not afterwards. But in that case you need to have the skill maintained. So... getting people doing it; reviewing it, supervising them periodically and using it in all sort of contexts between disasters makes a lot of sense."*

Experiences using SPR in the non-disaster situations and/or in the longer term, that key informants did describe, include the following.

- A psychologist and SPR trainer in Australia, describes using SPR frequently in her own practice now, even with people who do not have trauma related problems (e.g., people with problems with depression and anxiety). She also noted that: *“If people are using it [SPR] in everyday practice, it would help them be ready for the next disaster.”*
- SPR has been integrated into a longer-term program for youth in Louisiana post-hurricane Katrina.
- In Louisiana SPR trained school counselors who co-facilitated SPR sessions in middle-schools described being thankful that they were able to now incorporate SPR into their ongoing counseling with youth. Some counselors were continuing to do this long after the formal SPR program had ended.

What is known about developing capacity for integrating SPR into practice?

There are large bodies of literature on adult pedagogy and capacity building that could be drawn upon to inform the development of capacity for integrating SPR into practice. This is beyond the scope of this literature review and environmental scan. What is briefly described here is what we learned from the published literature describing PFA and SPR training, and from conversations with key informants involved in SPR training. Generally, with respect to building capacity for psychosocial response and recovery, there is more in the literature about building capacity for PFA than SPR. Much of this does seem transferable to SPR and other low level interventions. Some preliminary highlights are summarized below:

- ***A key facilitating factor in Australia for developing capacity for post-disaster psychosocial interventions generally, and training initiatives specifically, is cooperation between various levels of governments to develop an integrated training response*** (Reifels et al., 2013b; key informants).
- ***Another lesson learned in Australia is that if a multilevel or a stepped approach to psychosocial support is being implemented, it is important to optimize the targeting of training to avoid participant confusion.*** Training information should clearly articulate the target audience, purpose, scope and application of the training – as well as any applicable prerequisites (Reifels et al., 2013b).
- ***Learning how to work with and lead multi-disciplinary teams that often include volunteers (e.g., team building, management, etc.) is an important dimension of any psychosocial support training.*** Team building and self-care are integral parts of building capacity. Supervisor training and mentoring for the team supervisors was also important. Having a more experienced supervisor co-facilitating early team supervision meetings with the team coordinator worked well (key informants; Sundgaard Riise et al., 2009).

- ***Provide ongoing support, supervision, mentoring and training support to frontline counselors is an important factor in developing confidence in using SPR and competence*** (key informants; Sundgaard Riise et al., 2009). Ensuring that counselors had lots of opportunities to suggest what topics they would like to cover in upcoming training sessions also worked well. The post-Katrina experience in Louisiana with this approach is described below:
 - *“Follow-up consultation sessions provided counselors the opportunity to present cases and receive advice from the national experts, as well as to hear about the experiences of other counselors and their feedback...Counselors who participated in the training indicated that reinforcement of the skills from training in small group supervision sessions within their teams was an important factor in developing competence in the use of these strategies.”* (Sundgaard Riise et al., 2009, pg. 44)
 - *“These training programs were very successful in developing counselor competence and confidence in applying skills-based strategies.”* (Cross Hansel et al., 2011, pg. 2; key informant interview).

- ***A training strategy that worked well in Louisiana post-Katrina was having state wide training conducted via videoconferencing*** – with local teams meeting at a community office to participate jointly in the training. It was felt to be important for all levels of staff (i.e., frontline crisis counsellors, supervisors, and managers) to be trained in SPR. Support for individual counsellors and teams were also provided upon demand, and consultation with licensed mental health professionals was available 24/7 through a staffed hotline (Sundgaard Riise et al., 2009).

- ***Disaster mental health training programs should take into account that service providers may be using the skills for their own recovery*** (i.e., that they may also have been affected personally by the emergency/disaster), and this is helpful. For example, the crisis counselors trained in SPR post-Hurricane Katrina in Louisiana talked about actively using SPR for their own recovery (key informants, Hansel et al., 2011). Training programs should also insure that self-care modules are integrated along with training in an intervention (Cross Hansel et al., 2011).

- ***The approach taken to build capacity to use SPR is going to be different in different contexts.*** In Australia, they adapted their training, developing their own version of the Field Operations Guide that had been developed in the U.S. as they found the U.S. guide to be overly complex. The content of SPR itself was cut down relative to American version. The need for adaptation was described as being an even bigger issue when you take SPR to non-western, low-middle income countries. For example in the Southeast Asia subcontinent, where they have phenomenal numbers of regular disasters, you would need to approach training people to deliver SPR very differently - given the lack of health infrastructure, the illiteracy of most of the population, and poverty. *“It is very, very important to get it down to the core elements [of SPR].”*

- ***Train-the-trainer approaches are being widely used to develop capacity for SPR. Key informants described being able to extend the reach of SPR, and subsequently work with many more people, using this approach.*** For example, in Australia the SPR training and support provided on a state wide level post-bushfires in Victoria Australia was done as a partnership between the Australian Centre for Post-traumatic Mental Health and the Australian Psychological Society. A train-the-trainer approach was used and continues to be used to facilitate SPR training, recognizing that this approach benefits from a strong focus on quality assurance and accreditation processes (i.e., through trainer selection, delivery and follow-up) (Reifels et al., 2013b). To date, forty trainers have been accredited. Their approach involved a two-day training workshop, ongoing online support, and a number of quality assurance processes. Train-the-trainer models have also been effectively used in non-western countries to increase capacity to provide a “low level” psychosocial intervention that really is very similar to SPR with respect to the core elements. Reifels et al. (2013b) confirm that developing and maintaining a pool of qualified and accredited trainers with expertise in delivering this training is important and could be supported through the development of a trainer network and/or a community of practice that includes ongoing professional development activities.
- Finally as one key informant said, ***“it’s critically important that SPR be simple enough that it does not require a lot of training...if it’s not simple then it’s not cost effective, and we can’t get learning...pretty simple things.”***

Some specific training tips, again drawing both from the literature and key informant interviews, are briefly summarized in Table 16.

Table 16: Training tips

-
- Use language appropriate for lay audiences
 - Variety is key, due to different learning styles and preferences
 - There is a desire for experiential learning (e.g., demonstrations, case discussions, role play)
 - Provide some online training options, self-paced learning modules can be helpful
 - Do some site-based learning with the teams you will be working with
 - Introduce SPR one skill at a time, followed by consultation sessions for sharing case experiences
 - Particular resources requested to support capacity development include: Referral aids (who to refer for MH professional support and how); laminated cards that summarize key steps in the intervention; and online information
-

Who should be trained in SPR?

An important consideration related to building broad-based capacity for SPR is who should be trained in SPR? An important contextual piece here is the flexibility and simplicity built into the origins of SPR, and including the recognition that SPR is more of a facilitated self-help intervention than a traditional mental health intervention. As one key informant said, the decision re who to train is often a purely pragmatic one, and resource driven; *“so, you work with what you’ve got”*. For example, when going to work with

low-middle income countries, they just do not have enough mental health workers; so you work with the women in the village, fishermen.

All the key informants we interviewed believe that ideally the individuals trained in SPR would be a mix of mental health professionals and paraprofessionals (e.g., community workers, faith leaders), at least in our western, urban contexts. Precisely what this mix would look like is described as being highly influenced by the context. For example, one key informant described a good model as having a mental health professional team leader working with four to five people who were community people or paraprofessionals. A model that seemed to work well in Louisiana post-Katrina (2007-09) was having teams of about ten people, and only the supervisor would be a masters level trained MH counselor (i.e., usually licensed psychologists or social workers). Others on the team (i.e., specialized crisis counselors) had some college, may have had some MH training and experience, and were trained in SPR.

Some referred to community people trained in SPR as “extenders”, as they were able to serve and support so many more people with SPR using this kind of a model (e.g., the use of SPR in middle-schools in Louisiana post-BP Oil Spill). Again, another reason that this mixed model works well is that once the trained MH professionals need to move on, these community members trained in SPR are there to provide ongoing support. Overall then, many key informants felt that much of the direct support of SPR did not need to be delivered by mental health professionals, and that the role of scarce mental health professionals should be more of an ongoing mentoring, support and supervision role.

Another strong theme that emerged from the key informant interviews is that ***having the ability to work with people and make a connection matters more than their professional background.*** “Give me a paraprofessional, really good with people, problem solver and there are the best people to train in SPR to work with others in their community.” And as another key informant stated: “Sometimes we think as mental health professionals we are the only ones that can do this, but often we find it difficult to take off our clinical hats. Lay people and “paraprofessionals” often bring so much common sense.” When asked directly, all the key informants with SPR experience felt that lay people could be trained in SPR.

An Australia-based psychologist who has been very involved in SPR training, for example, feels that it is a great idea to train lay people in SPR (although they are not doing that currently). She gave three reasons for this:

1. The five SPR skills are clearly articulated;
2. People would now know that there are these five great skills that will help them and their children for any crisis in their lives;
3. It is appropriate to bring SPR skills in earlier into the recovery (i.e., in the first four weeks post-disaster).

A number of key informants said that it can be more challenging to train mental health professionals in SPR, and they often need to do a lot of “unlearning.” For example, in the SPR workshops conducted with mental health professionals in Australia they focused on getting them to unlearn their ideas about

a disaster-affected person. Their experience was that some mental health professionals tended to want to do deep-therapy that would go on for some time, whereas in SPR you are meant to work with people briefly and send them back out to work on the skills. One thing Australia has done more recently is develop on-line training for people interested in working with people involved in disaster. Through these modules people learn about the disaster context, what disaster affected people are like, what they often need and how they are different from other people who might come for counseling.

In Australia different levels of training were developed to meet the needs of different groups of service providers:

- Their training and support of practitioners that would be using SPR with their clients involved a one-day training workshop; online modules provided over nine months to promote good practice and uptake; and, teleconferences and online support.
- A special half-day training program and accompanying materials were developed for family physicians, as it was recognized that they were very “time poor” and yet many people would not seek out mental health services but would turn to their family physician for some help. See Table 17 for a brief description of this program and the findings.

Table 17: Training family physicians in Australia

The Australia Centre for Post-Traumatic Mental Health (ACPMH) facilitated six general practitioner training sessions in March 2012. A total of sixty practitioners attended this training. The objectives of this program were to provide a brief overview of SPR so that physicians:

- Could learn some basic evidence-based techniques to support their patients who may be coming in with post-traumatic mental health issues
- Know where to refer their patients who might need some more structured support around SPR

The main evaluation findings were that:

- The confidence of practitioners to deliver the SPR interventions improved after attending the training, and this improvement was largely maintained two months after the training
- Most practitioners demonstrated an understanding of key aspects of the program
- During the two months following training, there was a high uptake and delivery of SPR interventions

What is known about referring people who require more professional support?

Although the development of assessment and referral processes to refer people who require more professional support is an important component of a stepped approach to psychosocial support models, key informants acknowledge that the referral piece can be challenging. It is widely recognized that people are often reluctant to access mental health support and that this is more of an issue in some

contexts than others. For example, this reluctance is described as being even more of an issue in rural and small town environments.

Also, sometimes there are no professional mental health services to access either because they just do not exist or an individual does not have the time and/or money to do so. As one key informant working with kids in middle schools said: *“Don't start asking these kinds of questions if there is nowhere to refer kids to for professional MH services.”* The experience in some settings was that even when professional mental health services were available free-of-charge, people are often still reluctant to access them. People working on the frontlines used various strategies to encourage people to go for more specialized counseling, if they thought they needed it.

In Louisiana post-Katrina, a particular strategy was developed to encourage people who were assessed as needing more specialized counseling to see mental health professionals. It was sold as positive to be eligible for this specialized service (i.e., that the individual's hurricane experience was so challenging that they warranted this service). In this case, the referral was made to the team leader who would be a master's-trained mental health professional. These services were provided at the place the client wished (i.e., their home, or coming down to the counselor's "office"). Some only wanted one to two of these visits, *the average number of visits was six.*

As another key informant noted, seeking help for mental health issues is terrible at the best of times. In Victoria, Australia they have been doing waves of epidemiological surveys in the population of people affected by the bushfires. They found that four years after the fires, the people who were suicidal, had severe PTSD, and/or other significant mental health issues, the vast majority had never seen a mental health professional. He stated:

“This is normal – you see this in every disaster. So I don't think it's a matter that people would develop a relationship and not go on and see somebody else because I think in terms of the first point of call, very often that just would be a very brief interaction – it's not a relationship to develop. It's more that if I have an existing relationship – like my local doctor I've been seeing for ten years, and I feel comfortable, that's who I'll talk with about my sleep problem... I don't want to sort of label myself as having a mental health problem and go off to see somebody.”

In his opinion, this reluctance to seek support from mental health professionals is likely worse in more rural and small town environments. *“These people are not... mental health savvy; this is not the sort of thing they do.”* This was the reason why training family physicians in SPR was felt to be an important strategy in Australia.

What does fidelity to SPR look like?

Given the strong evidence base that led to the development of the five skill areas in SPR, what is described by key informants as being important is staying true to these five skill areas, and working with people in a way that supporting them to build these five skills. It is an active skill-building model. It is expected that SPR will look different across contexts, but what will be the same are the five core skills

areas that are being developed. This means that we do not have, and likely will never have a single “gold standard” with respect to delivering or implementing SPR.

This perspective expressed by key informants, fits with the increasing recognition that thinking of “best principles” rather than decontextualized best practice makes so much more sense with community based and health promoting initiatives. So what becomes important is fidelity to core content, principles, and/or underlying theory rather than to a particular format or “*manualized version of SPR.*”

One Australian key informant stated that the greatest value is having people going away knowing that these are five pretty useful skills, and teaching these skills in a way that works for them within a particular context. It is apparently made very clear in the Australian SPR manual that SPR is flexible and meant to be delivered anywhere. For example, there is no expectation you will get people for six sessions and/or that they will go to an office for counseling.

There is interest in better evaluating fidelity to SPR principles and the core elements. Many key informants said that they were not able to evaluate the fidelity of what the counselors actually did in the field. One key informant noted that everybody is an individual re how they might take SPR and apply it in their work with clients. “*Now we can only say that someone has done the workshop, so really don’t know how well they actually work with people on SPR.*” Overall, with respect to mental health professionals using SPR, simply getting people to work with clients on these skills - rather than doing more traditional counseling –would be hugely helpful.

To conclude, as stated in a published article on an evaluation of the psychosocial support training programs in Australia: “*Findings suggest that there is great merit in tailoring and contextualizing the delivery of standard training programmes to the work settings of target audiences and particulars of the local disaster context. While fidelity of the underpinning approach would remain paramount, contextualization and tailoring proved to be key ingredients in the successful delivery of training programmes*” (Reifels et al., 2013b, pg. 255).

In the next section, we present key insights about SPR and the various models and frameworks for disaster-related psychosocial support, based on our review of the literature and environmental scan.

Key Insights: SPR and Psychosocial Supports in Disaster-Related Planning, Prevention/Mitigation, Response, Recovery and Development

Our review and analysis of the gray and academic literatures and interviews with key informants generated the following key insights regarding disaster-related psychosocial supports.

The “Big Picture” of Disaster-Related Psychosocial Support – Key Insights

Key insight 1: *Everything done in a disaster has the potential to impact the psychosocial wellbeing of individuals, families and whole communities.* As such, psychosocial support needs to be integrated into the overall disaster effort, from planning, preparation, mitigation, response, recovery and development. Leading organizations involved in the overall disaster effort require knowledge, or access to knowledge about psychosocial support such that decisions made and actions taken will support psychosocial wellbeing for individuals, families and communities.

Key insight 2: *Although DMH and PSSCBR paradigms imply different approaches to psychosocial health and wellbeing interventions, both are integral to a comprehensive approach to DR-PSS.* DMH approaches serve those disaster-affected people who develop serious mental health problems, or whose pre-existing mental health problems/illnesses are exacerbated as a result of their trauma experiences. PSSCBR approaches focus on building the psychosocial wellbeing, capacity and resilience of individuals, families, groups and whole communities. They are able to address community-wide impacts of disaster that individual-focused approaches cannot.

Key insight 3: *While integration of the DMH and PSSCBR paradigms makes sense, this can be difficult to implement on the ground,* given that these paradigms are long-standing and that entire systems are grounded in one or the other. Paradigmatic differences in terms of professional roles, including what the relationship between provider and person/community should be (expert or collaborator/facilitator), means that one sector alone likely cannot address the full spectrum of supports because they rely on different skill sets and capacities. For example, the health sector may focus on the psychological and the individual while other organizations or sectors with skills in community development/facilitation may be better equipped to work at the community level. A collaborative, intersectoral approach is a necessity.

Key insight 4. *To date, in the western world, there appears to have been more development of individual-focused approaches for disaster-related psychosocial support.* There are a number of reasons why putting an equal emphasis on community-focused interventions is important, as follows:

- First, disasters impact whole communities, disrupting the major source of psychosocial support for individuals and families: the community’s social and cultural fabric that binds people together and provides the social support and connectedness that is vital for psychosocial wellbeing.
- Second, addressing only the issues of individuals will not repair damage to a community’s social fabric. 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.
- Third, maximizing the community’s participation in its own recovery and managing the recovery process at the local level keeps the community intact, connects people together and promotes a sense of efficacy and empowerment that builds capacity for future collaborative action.
- Fourth, 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 numerous dimensions of capacity/resilience beyond preparedness for and recovery from disaster.

- Fifth, community-focused interventions may provide support for individuals who could benefit from individual psychosocial interventions but who choose not to access them.

Key insight 5. *The foundation of psychosocial capacity building and community resilience models is the participation of community members* in the processes of assessing community strengths and needs, determining priorities, and taking action to rebuild the community. Many psychosocial support models use the terms “community participation” and “community engagement,” but not all conceive of community participation in an active, agentic way. When choosing among various approaches for community-focused psychosocial support it is therefore important to critically scrutinize how community participation is conceptualized.

Key Insight 6: *There exists a wide constellation of strategies for DR-PSS.* At the time of impact, for example, psychosocial support consists of ensuring safety, promoting calm, providing accurate and timely information and managing the media, reuniting loved ones, and meeting basic needs (e.g., shelter, nutrition and health care) and psychological first aid. Further down the path, the range of strategies expands dramatically, ranging from individual counseling and treatment for mental health problems and illnesses, to psychoeducation, to helping individuals build coping skills and resilience, to yoga and relaxation classes and engagement in uplifting activities, to providing recreational activities, to creative expression (music, art, storytelling), to bringing the community together to talk about and make sense of what has happened, to mourn and/or to engage in collective rituals, to services to help people get their lives back in place (housing, employment, school), to rebuilding local economies, psychosocial capacity building and resilience and so on. The range of possibilities for protecting and promoting individual and community psychosocial wellbeing, capacity and resilience is far ranging. Given this broad constellation of possibilities, it is obvious that no single organization can do it all; there is a clear need for collaboration and coordination of supports – multiple agencies, organizations and governments working effectively together with communities to assess the situation, set priorities, draw upon existing strengths and resources, and to implement and adapt actions to support psychosocial wellbeing for all.

Key insight 7: Disaster-related psychosocial support may be best envisioned as a wide constellation of processes and supports across the trajectory of a disaster (i.e., planning/prevention/mitigation; response; recovery; and rebuilding) to prevent and treat mental health problems and illnesses, and to protect and promote the psychosocial wellbeing, capacity and resilience of individuals, families, groups and communities. It includes strategies grounded in disaster mental health and psychosocial capacity building and resilience paradigms. As such, it requires collaboration and coordination across diverse helping agencies, professional groups and government to work *with* communities as they navigate the challenges and opportunities associated with disaster and trauma.

Skills for Psychological Recovery - Key Insights and Where it Fits in the “Big Picture”

Key insight 8: *What do we know about the effectiveness of SPR and how it can be implemented?*

There is little “hard evidence” about the efficacy about SPR for preventing mental health problems and illnesses or promoting individual skill building and resilience; however, this skill-building intervention is based on solid evidence about supporting people in traumatic situations. SPR fills a unique niche in the spectrum of DR-PSS strategies; it is one of the only interventions that is suitable for helping people experiencing mild to moderate distress as a result of their disaster experience, and that can therefore support recovery from disaster. It has been used in numerous disasters and diverse contexts with diverse populations and with positive reports from practitioners who have noted SPR is a helpful framework that is easy to use. Practitioners have further reported that the people they’ve used SPR with have appeared to benefit in the form of development and use of SPR skills. Discussions with key informants regarding what constitutes fidelity to SPR have generated consistent responses: the five skill areas are based on solid evidence, and thus, “staying true” to teaching these skills and helping clients learn to use them is seen as the key aspect of fidelity. However, aside from keeping to the five skills, contextualization and tailoring of SPR is important for successful delivery of SPR.

One consistently identified barrier to the use of SPR is the reluctance of people to seek or use mental health or psychological services. Reframing SPR in alternate terms such as “helping people to help themselves” has been found to make SPR more palatable to people.

In terms of training and implementing SPR, this intervention is one of facilitated self-help; it is not therapy or treatment. As such, it can be delivered by anyone who is capable of developing trusting and respectful relationships with people experiencing distress and who is able to teach the skills in an effective manner. To date, paraprofessionals and mental health professionals are the typical trainees in SPR training programs; however, many key informants thought SPR could be implemented by lay people, with sufficient supervision and mentoring by trained professionals. Most importantly, ongoing provision of support, supervision, mentoring and training is essential for building practitioner proficiency and confidence in using SPR.

Key insight 9: *Where does SPR fit in the “big picture” of DR-PSS?* SPR focuses on the support of individuals. As such, in the broad spectrum of approaches we reviewed, particularly the IASC (2007) pyramid of interventions, SPR fits in the second tier from the top (“focused person-to-person supports”). From the perspective of individual-focused stepped models of care, such as that of the Australian Psychological Society, it fits in the second tier (“simple psychological strategies”). This is depicted in Figure 9. Comparison between the IASC and the APS pyramids makes it clear that while SPR is an important, if not essential, component of disaster-related psychosocial support it is only part of a comprehensive approach.

In terms of the paradigm in which SPR fits, we found that some people conceive of it from a disaster mental health perspective, emphasizing SPR more as a preventive intervention delivered primarily by mental health professionals. Many others conceive of SPR more as a capacity and resilience-building approach because it builds skills that help people adapt effectively to distress, and in the process, become more resilient. Those who lean more toward a resilience direction also tend to feel that SPR can

be facilitated by a diversity of individuals with an interest in supporting others, with mental health professional support and supervision.

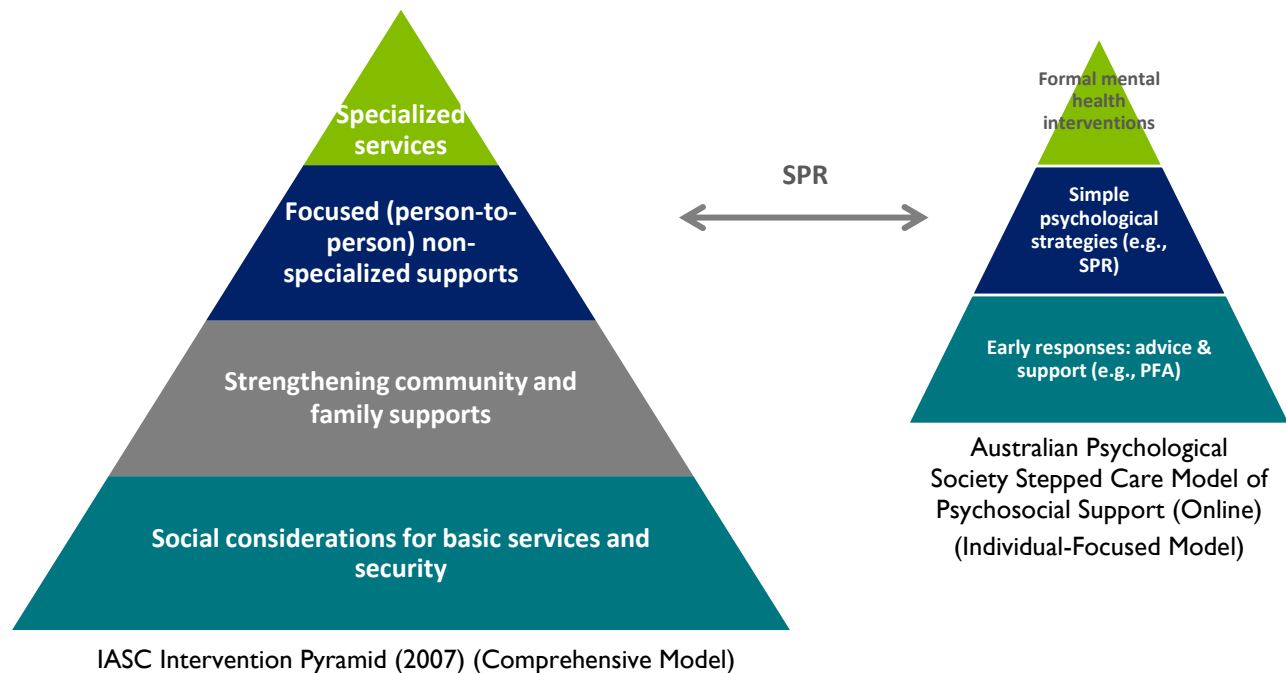


Figure 9. Where SPR fits in the overarching picture of disaster-related psychosocial supports.

In the next section we move beyond descriptions of various models and approaches and raise some considerations about what infrastructure and capacities helping organizations require in order to effectively provide disaster-related psychosocial supports.

Organizational Capacity for Effective Delivery of Disaster-Related Psychosocial Supports

The final question from our learning framework re: “the big picture” was: What capacity do caregiving and human service organizations require in order to effectively provide the spectrum of supports falling under the umbrella of psychosocial supports. While we did not encounter literature specifically in answer to this question, some facets of our review and our previous experience and research may provide a starting point for further exploration.

First, it is important to answer the question, “capacity for what?” In this case, we might be speaking about the capacity of helping organizations to effectively support individuals and communities to be prepared for, plan, mitigate, respond to, and recover from the psychosocial impacts of trauma and disasters. Or, the scope might be narrower or different. Whatever the case, it is important to be clear about what capacity is being built and for what purpose. Second, “capacity building” is often too

simplistically regarded as developing the knowledge, skills and abilities of workers; but it is much more than that. Even the most skilled and knowledgeable workers will be unsuccessful if there aren't appropriate organizational values, commitment, structures, processes and resources in place to support them.

Domains of capacity frequently included in organizational capacity models include: shared values; shared aims; shared leadership; organizational/political will and commitment to the work; mutually respectful and trusting relationships amongst stakeholders; supportive organizational structures and processes (e.g., governance structures, decision making processes, communication processes, processes for ongoing learning and improvement; flexibility; appropriate job design and so on); resources (time, money, information, technology); and skilled and knowledgeable people (Cohen, et al., 2014; Germann & Wilson, 2004).

Above all, all caregiving/community-serving organizations may need to re-think their approach to working with individuals and communities affected by disaster. Carp (2010, pg. 270), a social worker, makes an eloquent plea for this:

“Agencies need to recognize that providing disaster mental health services to people after traumatic events requires additional training and skills, as well as the adoption of a perspective about the people affected by those events that is different from the one used in daily therapeutic work with clients or patients. Using a resiliency framework can and should take full advantage of our clinical training and experience, but this view insists that primacy be given to the strengths people have and use in their lives that will enable them to regain control after experiencing chaos.

Many have described this work as “holy” because responders deal with people’s basic human needs, typically in an environment of intense pain and often in the wake of the very worst of human circumstances. Good professionals are humbled by the strengths they see in people whose lives have been devastated by events over which they have no control, but whose consequences they must live with. This may not be the work some social workers thought they would be doing when they began their careers, nor is it perhaps what they were originally trained to do. But here we are in the 21st century and the world has changed, although not necessarily for the better. As we are pressed to be more accountable for evidence-based outcomes, the humanness and the artfulness of our practice must be protected because they remain an important strength that we bring to environments informed by chaos. To meet these new challenges, the perspective of professionals in the field of mental health must be one that is open to change and to continued growth, incorporating new knowledge and an enlarged vision of what it means to help people in trouble.”

Future Research and Evaluation Directions

A consistent finding in our review of the literature was the dearth of evaluation and research regarding the effectiveness of the various approaches to disaster-related psychosocial support. As noted earlier in this document, psychosocial interventions such as PFA, SPR, crisis counseling and psychoeducation have not been sufficiently evaluated to establish their benefit or harm in disaster settings (North & Pfefferbaum, 2013). A similar state exists for community-focused PSSCBR approaches. Hawe (2009) reviewed the literature regarding community recovery and concluded that the state of evidence in disaster recovery is poor despite the existence of numerous tools to evaluate the success of community capacity building strategies. She proposed development of a community-academic partnership to conduct a longitudinal evaluation of post-disaster recovery processes and suggested some potential outcomes of interest: a lower than expected burden of mental health problems; a more socially connected community; sustained community infrastructure for problem solving and addressing community needs; the retention of population and amenities; and the restoration of quality of life. A research study is now underway in Australia in this regard (see Gibbs, et al., 2013).

The state of evidence in disaster recovery is poor despite the existence of numerous tools to evaluate the success of community capacity building strategies.
(Hawe, 2009)

A key challenge in conducting research and evaluation in disaster-related psychosocial support is the chaos that accompanies disaster, and the primacy of protecting the safety and welfare of people and communities. This state of affairs requires innovative approaches to studying, understanding and assessing the provision of disaster-related psychosocial support. Many of the comprehensive models of DR-PSS integrate an evaluative component, and/or strategies to reflect upon and adapt actions along the way, or periodic debriefing to identify lessons learned and think about how things could be done differently for greater effectiveness “next time.”

Research and evaluation is required for all DR-PSS approaches and particularly in regard to implementation processes and also determining, to the extent possible, “what works, for whom, how, and under what circumstances” (Pawson & Tilley, 2011). Also required is consideration of the broad array of potential outcomes of DR-PSS interventions. DMH approaches have dominated to date, and emphasize measurement of psychopathology, including incidence and prevalence. The addition of PSSCBR interventions broadens the range of expected outcomes from individual resilience, positive mental health, to community capacity, community functioning and resilience. In addition, research and evaluation regarding DR-PSS needs to place particular emphasis on understanding the dynamic and complex contexts in which DR-PSS is undertaken and how this impacts implementation and outcomes of actions, and also, to learn how communities and helping agencies can work together to effectively provide a range of psychosocial supports and processes over the long term, not just in the immediate response and early recovery period.

Given the complexity of disasters, of communities, of collaborating across organizations, and of DR-PSS interventions, innovative approaches will be required. We suggest that developmental evaluation and/or other forms of “real-time” reflection, learning and adaptation may be particularly useful.

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Appendix A: How Disasters Disrupt a Community's Social Fabric – A Description and Some Solutions

Gordon (2009, 2004a, 2004b) believes that if we can understand how disasters disrupt the social makeup of communities, we can find ways to prevent or mend the deterioration. He outlines a general degradation of the social environment following impact of the disaster that begins with people, struggling to survive, are detached from their normal social bonds and roles and help whomever they can, regardless of previous roles.

Impact – De-bonding. At impact, individuals become highly aroused by danger, responding to the specific demands of the situation. The normal social system is set aside because the emergency requires that people work with whoever happens to be near. Emotional responses are suppressed by rational action (which may or may not be appropriate). Social roles are discarded as people respond to the immediate threat. Individuals or small groups act alone and feel isolated. While survival is uncertain, people focus on themselves and survival efforts take precedence. One's community is temporarily irrelevant and communication is lost, resulting in people becoming "de-bonded" from each other and their social system (Gordon, 2004a). The social fabric is drastically disrupted and attenuated with potentially damaging consequences for the individuals involved (Gordon, 2009).

Fusion. Soon, leaders emerge and people organize themselves into highly motivated collective agents of mutual aid. People adopt new social roles and they operate as a homogeneous group focused on a single task. At first, this liberates energy, altruism, volunteerism, a sense of togetherness and community spirit. This is what is often called the "honeymoon phase" of recovery (Ursano et al., 2007a). But the fusion is also subject to collective processes similar to crowd psychology - emotional contagion, rumours, myths, intimidation, stereotypical thinking, simplistic judgment, loss of personal and interpersonal boundaries and social comparison.

Cleavage. As time passes, however, more severely affected people become labeled as benchmarks against which other losses are judged and those with less obvious impacts become disenfranchised. Tensions begin to develop because people increasingly feel the need for recognition of their unique problems but feel unable to communicate them. As recovery proceeds, things get more complicated. Issues affect people differently and divide the group's unity (e.g., the uninsured become envious of those who are and the insured become angry when the uninsured receive appeal funds). The inequality of the disaster's effects can lead to community tensions, jealousy, rivalry and changes in friendship networks (State of Victoria, 2014). As time passes, disillusionment, misunderstandings, anger, and confusion are common and there may be doubt and skepticism about who and what can be trusted (State of Victoria, 2014; Ursano et al., 2007a). Inevitably rumours begin to circulate through the community about circumstances leading up to the event and the government response. Anger often emerges and a search for accountability and someone to blame for lack of preparation or inadequate response may begin, with mayors, police and fire chiefs often being the target of these strong emotions (Ursano et al., 2007). The fusion created during the honeymoon phase disintegrates.

Early establishment of a “recovery social infrastructure” can subvert the development and negative impact of cleavage planes by validating the needs of different groups, forming support groups around varied issues, and creating a communication system to identify needs, engage issues, process information, manage emotions and negotiate roles (Gordon, 2009). He notes that as cleavages emerge, they can be identified and various communication strategies can be developed to defuse them and promote understanding amongst groups. Examples of such strategies include newsletters, community or street meetings, outreach visits, working groups, and planning committees. Gordon cautions, however, that all assistance measures, recovery resources and agencies must be integrated into the emerging social infrastructure. Unless this is done, there is high potential for further community distress, damage to the social infrastructure, creation of more divisions, waste of resources, unhelpful efforts and failure to build survivors’ own resources:

“Lack of coordination between need and the capacity for assistance to be used results in help being inconsistently applied, poorly understood and overloading already burdened systems to create additional problems for the community (e.g., unwanted material aid, over-enthusiastic helpers offering assistance driven by their need to help rather than community requirements, and imposition of centrally determined plans and strategies that do not build survivor’s own resources” (Gordon, 2009, pg. 4).



Degradation of a community’s social fabric following disaster (adapted from Gordon, 2009; 2004b)

Based on this process of degradation, Gordon (2004b) suggests a number of post-disaster strategies for restoring a community’s social fabric. These are presented in the table below.

Practical application: Post-disaster strategies for restoring community social fabric

Re-bonding	Establish communications to link people with important others and the recovery system as soon as possible; discourage people from withdrawing and losing touch with the affected community.
Community formation	Convene the community of interest as soon as possible by defining who is affected and ensuring they are aware of each other (collectively, not personally) and form shared representations of their predicament and needs.
Normalize communication about the disaster and its effects	As early as possible, ensure anecdotes are told that encourage people to communicate about their experiences to each other and the recovery system.
Form disaster-related social representations	Encourage communication about experiences in settings that carry information about normal reactions so expectations and assumptions are adapted at the earliest opportunity.
Form a common reality	Provide facts and information about the event, its causes, consequences and the current situation to limit uncertainty and correct misunderstandings.
Form a frame of reference	Establish a body of information to form the basis for making informed evaluations about the event and their responses.
Preserve differences and complexity	Combat homogenizing tendencies of the fusion at the earliest opportunity by ensuring expression of differences and effects in a climate of mutual respect and acknowledgment.
Preserve boundaries and identities	Communication only occurs across a gap or boundary and recognition of differences and privacy become the context in which relevant matter can be communicated while personal privacy is preserved.
Facilitate reference groups	Promote opportunities for people to form informal and formal groups with similar issues. Integrate them into the recovery system as its constituents by facilitating and resourcing them.
Facilitate social representations of post-disaster life	Promote community-based cultural events to represent the disaster and its consequences including rituals, symbols and artistic forms.
Integrate services	Relate the introduction of services and assistance measures so they support social representations of the disaster. Ensure they incorporate the understanding and consolidation of the social fabric.

Source: Gordon, 2004b, pg. 21 (See also Gordon, 2009 for additional strategies.)

Appendix B: High Level Principles for the “How” and “What” of Disaster-Related Psychosocial Support

The Sphere Project: Principles for humanitarian response

The Sphere project is a community of humanitarian response practitioners working together to improve the quality of humanitarian assistance (The Sphere Project, Online). The Sphere Handbook sets out a set of common principles and four universal minimum standards in humanitarian response; it is widely known and internationally recognized. The Handbook delineates six “essential process standards shared by all sectors” that are deemed essential to achieving the Sphere’s minimum standards for humanitarian response. The principles are presented in the table below.

Sphere Project Principles for Humanitarian Response	
<i>People-centred humanitarian response</i>	People’s capacity and strategies to survive with dignity are integral to the design and approach of humanitarian response
<i>Coordination and collaboration</i>	Humanitarian response is planned and implemented in coordination with the relevant authorities, humanitarian agencies and civil society organizations engaged in impartial humanitarian action, working together for maximum efficiency, coverage and effectiveness.
<i>Assessment</i>	The priority needs of the disaster-affected population are identified through a systematic assessment of the context, risks to life with dignity and the capacity of the affected people and relevant authorities to respond.
<i>Design and response</i>	The humanitarian response meets the assessed needs of the disaster-affected population in relation to context, the risks faced and the capacity of the affected people and state to cope and recover.
<i>Performance, transparency and learning</i>	The performance of humanitarian agencies is continually examined and communicated to stakeholders; projects are adapted in response to performance.
<i>Aid worker performance</i>	Humanitarian agencies provide appropriate management, supervisory and psychosocial support, enabling aid workers to have the knowledge, skills, behaviour and attitudes to plan and implement an effective humanitarian response with humanity and respect.

Source: Sphere Project (2011)

While all of these principles are relevant to models for disaster-related psychosocial supports, the first principle, “people-centred humanitarian response” includes a number of key actions and background information that are particularly relevant to psychosocial support in disaster. Notably, there is strong emphasis on the use and building of local capacity and representative community participation, and particularly, the reactivation or establishment of supportive social networks and relationships:

“Disaster affected people possess and acquire skills, knowledge and capacities to cope with, respond to, and recovery from disasters... Self-help and community-led initiatives contribute to the psychological and social well-being through restoring dignity and a degree of control to disaster-affected populations. Access to social, financial, cultural and emotional support through extended family, religious networks and rituals, friends, schools and community activities helps re-establish individual and community self-respect and identity, decrease vulnerability and enhance resilience. Local people should be supported to identify and, if appropriate, reactivate or establish supportive networks and self-help groups” (The Sphere Project, 2011, pg. 56).

It is recognized that the extent to which people participate, and how, will be determined by how recently the disaster occurred and by various physical, social and political circumstances. However, ownership and decision making power of disaster-affected people should be progressively increased during the course of a disaster response (Sphere Project, 2011).

Inter-Agency Standing Committee (IASC) principles

The United Nations General Assembly established the Inter-Agency Standing Committee (IASC) in 1992 in response to a UN resolution on the strengthening of humanitarian assistance. The Committee is an inter-agency forum for coordination, policy development and decision-making by the executive heads of key humanitarian agencies (UN agencies, Red Cross and Red Crescent Societies and consortia of non-government humanitarian organizations). It is the primary mechanism for inter-agency coordination of humanitarian assistance and is charged with the task of developing humanitarian policies, securing agreement on division of responsibilities for humanitarian assistance, identifying and addressing gaps in that assistance, and advocating for effective application of humanitarian principles (IASC, 2007, pg. 11; IASC online).

In 2007, the IASC released its Guidelines on Mental Health and Psychosocial Support in Emergency Settings. In the table below, the principles that form the foundation of the Guidelines are presented. More detail about the IASC Guidelines is presented in the section on comprehensive models below.

IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings: Principles

Human rights and equity	Humanitarian actors should promote the human rights of all affected persons and protect individuals and groups who are at heightened risk of human rights violations. Humanitarian actors should also promote equity and non-discrimination. That is, they should aim to maximize fairness in the availability and accessibility of mental health and psychosocial supports among affected populations, across gender, age groups, language groups, ethnic groups and localities, according to identified needs.
Participation	Humanitarian action should maximize the participation of local affected populations in the humanitarian response... Participation should enable different sub-groups of local people to retain or resume control over decisions that affect their lives, and to build the sense of local ownership that is important for achieving program quality, equity and sustainability. From the earliest phase of an emergency, local people should be

Participation	involved to the greatest extent possible in the assessment, design, implementation, monitoring and evaluation of assistance.
Do no harm	Humanitarian aid is an important means of helping people affected by emergencies, but aid can also cause unintentional harm... Work on mental health and psychosocial support has the potential to cause harm because it deals with highly sensitive issues. Also, this work lacks the extensive scientific evidence that is available for some other disciplines.
Building on available resources and capacities	[A]ll affected groups have assets or resources that support mental health and psychosocial wellbeing. A key principle – even in the early stages of an emergency – is building local capacities, supporting self-help and strengthening the resources already present. Externally driven and implemented programmes often lead to inappropriate MHPSS and frequently have limited sustainability. Where possible, it is important to build both government and civil society capacities. At each layer of the pyramid..., key tasks are to identify, mobilize and strengthen the skills and capacities of individuals, families, communities and society.
Integrated support systems	Activities and programming should be integrated as far as possible. The proliferation of stand-alone services, such as those dealing only with rape survivors or only with people with a specific diagnosis, such as PTSD, can create a highly fragmented care system. Activities that are integrated into wider systems (e.g. existing community support mechanisms, formal/non-formal school systems, general health services, general mental health services, social services, etc.) tend to reach more people, often are more sustainable, and tend to carry less stigma.
Multi-layered supports	In emergencies, people are affected in different ways and require different kinds of supports. A key to organizing mental health and psychosocial support is to develop a layered system of complementary supports that meets the needs of different groups... All layers of the pyramid are important and should ideally be implemented concurrently.

Source: Inter-Agency Standing Committee (IASC) (2007, pg. 9-13)

Hobfoll et al.'s principles to guide psychosocial intervention practices

While the principles described above speak to the general way in which psychosocial supports should be conceived and provided, they do not speak to concrete actions or strategies for addressing psychosocial needs. However, work by Hobfoll et al. (2007) provides some guidance in this regard.

In recognition that no evidence-based framework existed for post-disaster psychosocial supports existed, nor was there consensus on a clear set of recommendations for immediate and mid-term post-disaster psychosocial support, Hobfoll et al. (2007) convened a worldwide panel of experts on the study and treatment of people exposed to disaster to achieve consensus on a set of “best intervention practices following major disaster and terrorist attacks for the short-term and mid-term period” (pg. 284). Rather than recommending specific intervention models (deemed inappropriate because of the heterogeneity of traumatic events and their aftermath), the panel identified five principles grounded in

empirical evidence that should be used to guide psychosocial intervention practices or policies at the early to mid-term stages after disaster: i.) Promote a sense of safety; ii.) Promote calming; iii.) Promote a sense of self- and community efficacy; iv.) Promote hope; and, v.) Promote connectedness. Hobfoll et al. provide examples of how these principles can be implemented as public health measures and as individual or group measures thereby making the principles germane to multiple levels of action (see the table below).

In our review of the literature we found that numerous authors and jurisdictions have grounded their disaster-related psychosocial support guidelines and frameworks in Hobfoll et al.'s principles, including, for example, Hawe's (2009) work on community-based strategies; Miller's (2012) work on psychosocial capacity building; Saul's description of the impact of disaster on whole communities (2014); the work of Norris and Stevens (2007); and psychosocial support frameworks developed by NATO (2008) and The European Network for Traumatic Stress (2011; 2008).

Hobfoll et al.'s five principles to guide psychosocial intervention practices

Promote a sense of safety

Examples – Individual/Group Measures

- Use “grounding techniques” to remind people of the relative safety of the present time
- Assist in developing more adaptive cognitions and coping skills

Examples – Public Health Measures

- Bring people to a safe place and make it clear that it is safe
- Provide an accurate, organized voice to help circumscribe threat and increase the perception of safety where there is no serious extant threat
- Work with media to develop messages that convey safety and resilience rather than imminent threat
- Encourage individuals to limit exposure to media and to avoid graphic media if exposure to these leads to increased distress

Promote calming

Examples – Individual/Group Measures

- Offer direct approaches in anxiety management – breathing, deep muscle relaxation, stress inoculation, yoga, mindfulness, imagery/music paired with relaxed states
- Involvement with uplifting activities not associated with the trauma

Examples – Public Health Measures

- First and foremost, engage in actions that help people directly solve concerns
- Give information re: whether family and friends are safe and if further danger is pending
- Provide large-scale community outreach and psychoeducation about post-disaster reactions, anxiety management techniques, signs of more severe dysfunction etc.

Promote a sense of self- and community-efficacy

Examples – Individual/Group Measures

- Promote activities that are conceptualized and implemented by the community (e.g., religious activities, meetings, rallies, collective healing and mourning rituals)
- Foster “competent communities”
- Collaborate with rural development and vocational skills training initiatives
- For children and adolescents – be careful re: dangers of overprotectiveness, include them in community recovery, facilitate restoration of the school community

Examples – Public Health Measures

- Individual and group administered cognitive behavioural therapy
 - Foster behavioural repertoires and skills that are the basis of efficacy beliefs
 - Teach individuals to set achievable goals
 - With children and adolescents – address developmental interruptions, promote normal and adaptive developmental progression, teach emotional regulation skills, enhance problem-solving skills in regard to post-disaster adversities
-

Promote hope

Examples – Individual/Group Measures

- Provide services to individuals to help them get their lives back in place (housing, employment, relocation etc.)
- Develop advocacy programs to help victims work through red tape
- Support rebuilding of local economies that allow people to resume their daily vocational activities
- Media, schools and natural community leaders should help people link with resources, establish systems that enable those in recovery from similar trauma to share their experience and hope with those struggling; memorializing and making meaning; accepting that their lives and environment have changed; reducing self-blame; problem solving; setting positive goals
- Building strengths that they have as individuals and communities

Examples – Public Health Measures

- CBT that: reduces exaggeration of personal responsibility and counteracts thoughts such as catastrophizing; identifies, amplifies and concentrates on building strengths; normalizes responses; indicates that most people recover spontaneously; highlights already exhibited strengths; includes guided self-dialogue
- With children and adolescents, CBT that addresses ongoing trauma related expectations; includes forward-looking exercises... to instill hope and renewed motivation for learning and future planning

Promote connectedness

Examples – Individual/Group Measures

- Help individuals to identify and linked with loved ones
- Facilitate reconnection of children with parents/parental figures
- Increase the quantity, quality and frequency of supportive interactions between trauma survivors and their social supports
- Treat temporary housing sites as villages which have: village councils, welcoming committees, churches, places to go for services, meeting places, entertainment, sports fields, recreational activities, places for teens to congregate, etc.
- Address potential negative social influences when designing interventions

Examples – Public Health Measures

- Identify and assist those who lack strong support, who are more likely to be socially isolated
- In cases of evacuation or destruction of homes, keep individuals connected, train people how to access support, provide formalized support
- Target social support via psychoeducation and skills-building
- With families, include specific strategies to address discordance among family members

Source: Hobfoll et al. (2007, pg. 302-304).

Appendix C: Other Comprehensive Frameworks and Guidelines for Disaster-Related Psychosocial Support

Inter-Agency Standing Committee (2007): Summary of Action Sheets for Minimum Response Guidelines on Mental Health and Psychosocial Support in Emergencies

Summary of IASC action sheets for minimum response guidelines on mental health and psychosocial support in emergencies

A. Common functions

1. Coordination	<ul style="list-style-type: none">Establish coordination of intersectoral mental health and psychosocial support
2. Assessment, monitoring and evaluation	<ul style="list-style-type: none">Conduct assessments of mental health and psychosocial issuesInitiate participatory systems for monitoring and evaluation
3. Protection of human rights standards	<ul style="list-style-type: none">Apply a human rights framework through mental health and psychosocial supportIdentify, monitor, prevent and respond to protection threats and failures through social protectionIdentify, monitor and respond to protection threats and abuses through legal protection
4. Human resources	<ul style="list-style-type: none">Identify and recruit staff and engage volunteers who understand local cultureEnforce staff codes of conduct and ethical guidelinesOrganize orientation and training of aid workers in mental health and psychosocial supportPrevent and manage problems in mental health and psychosocial wellbeing among staff and volunteers

B. Core mental health and psychosocial supports

5. Community mobilization and support	<ul style="list-style-type: none">Facilitate conditions for community mobilization, ownership and control of emergency response in all sectorsFacilitate community self-help and social supportFacilitate conditions for appropriate communal cultural, spiritual and religious healing practicesFacilitate support for young children (0-8) years and their caregivers
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6. Health services	<ul style="list-style-type: none"> ▪ Include specific psychological and social considerations in provision of general healthcare ▪ Provide access to care for people with severe mental disorders ▪ Protect and care for people with severe mental disorders and other mental and neurological disabilities living in institutions ▪ Learn about and where appropriate, collaborate with local indigenous and traditional health systems ▪ Minimize harm related to alcohol and other substance use
7. Education	<ul style="list-style-type: none"> ▪ Strengthen access to safe and supportive education
8. Dissemination of information	<ul style="list-style-type: none"> ▪ Provide information to the affected population on the emergency, relief efforts and their legal rights ▪ Provide access to information about positive coping methods

Social considerations in sectors

Food security and nutrition	<ul style="list-style-type: none"> ▪ Include specific social and psychological considerations (safe aid for all in dignity, considering cultural practices and household roles) in the provision of food and nutritional support
Shelter and site planning	<ul style="list-style-type: none"> ▪ Include specific social considerations (safe, dignified, culturally and socially appropriate assistance) in site planning and shelter provision, in a coordinated manner
Water and sanitation	<ul style="list-style-type: none"> ▪ Include specific social considerations (safe and culturally appropriate access for all in dignity) in the provision of water and sanitation

Source: IASC, 2007, pg. 21-29

International Federation of Red Cross and Red Crescent Societies – International Federation Reference Centre (IFRC) for Psychosocial Support/the IFRC Psychosocial Programme

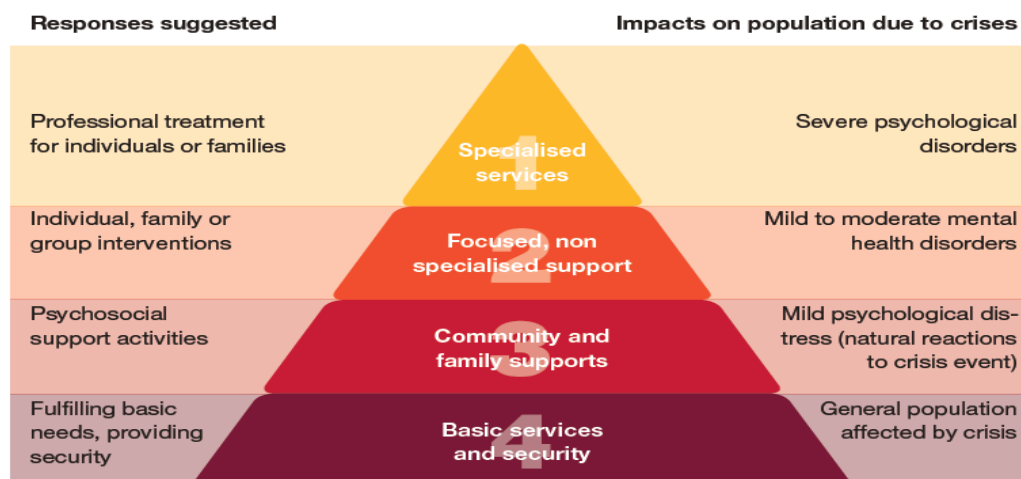
The International Federation of Red Cross and Red Crescent Societies (IFRC) Reference Centre for Psychosocial Support and its Psychosocial Support Programme was developed to help IFRC National Societies to “understand, respond and utilize evidence-based practice in meeting the psychosocial needs of vulnerable groups” (IFRC, 2013, pg. 4). The Centre has developed numerous guidance and training documents in this endeavour.

The Centre defines psychosocial support as, “a process of facilitating resilience within individuals, families and communities with “resilience” understood as the ability of individuals, communities, organizations, or countries exposed to disasters and crises and underlying vulnerabilities to anticipate, reduce the impact of, cope with and recover from the effects of adversity without compromising their long term prospects” (IFRC 2013, pg. 5). The IFRC further notes that psychosocial support can focus on promotion of psychosocial wellbeing “as a positive attribute, rather than merely the absence of psychosocial or mental health problems,” or prevention of psychosocial and mental health problems. It is noted that together, promotion and prevention contribute to building of resilience in the face of new crises or distressing life circumstances.

To guide the actions of IFRC volunteers on the ground in disaster-stricken communities, the Reference Centre published a handbook of psychosocial interventions (IFRC, 2009). The handbook is organized according to key processes of psychosocial response: assessment, planning and implementation, training, and monitoring and evaluation. Attention is given to outlining appropriate actions depending on the trajectory of a disaster (i.e., preparation, immediate response, longer term recovery).

Psychosocial wellbeing is conceived as having multiple components, experienced at personal and social levels and influenced by external factors. Since these factors are always changing, the IFRC notes that it is always essential to learn and understand what "psychosocial wellbeing" means locally for the individuals and communities impacted by disaster. "This," the handbook states, "is the only way to ensure that the planned and implemented activities are indeed relevant... and not merely a replication of psychosocial activities that worked elsewhere" (IFRC, 2009, pg. 29).

The foundation for the IFRC's approach in the 2009 handbook is the IASC pyramid of interventions that is, in essence, a layered system of complementary supports (see the figure below).



IFRC model of mental health and psychosocial support services for disaster-affected communities. (Source: IFRC, 2009, pg. 34.)

While the IFRC's approach to disaster-related psychosocial supports includes the identification and referral of people to specialized mental health supports, the primary focus is on a community-based approach to improving the psychosocial wellbeing of whole communities. "Community-based" in this context means that the intent is to engage the community as much as possible in planning, implementing, monitoring and evaluating the disaster response. The community is encouraged to take ownership and responsibility for responses to the challenge it is experiencing. The logic of this is that empowered people care for themselves and each other, which improves their self-confidence and resources, promotes positive recovery and enhances their ability to navigate future challenges (IFRC, 2009). Examples of community-based psychosocial supports include: support groups for different

populations (e.g., teenagers, children, older people); family tracing; safe spaces for children equipped with play kits; collective community actions such as cleanup activities and restoration of public institutions; collective memorial ceremonies; drama, art and cultural and religious activities; sports; and recreational activities; and efforts to return to normal activities (e.g. school, work) as soon as possible.

Given that each community and each disaster is unique, the handbook does not prescribe specific plans for supporting communities, but rather outlines a variety of options ranging from a focus only on psychosocial concerns implemented in collaboration with other areas of response to a fully integrated model using psychosocial response as an entrée to the affected population and as a platform to identify and integrate multi-sectoral responses (e.g., housing, health, livelihood, water and sanitation) and providing a broad umbrella of supports to individuals, families and communities (IFRC, 2009).

North Atlantic Treaty Organization (NATO) Joint Medical Committee (2008): Psychosocial Care for People Affected by Disasters and Major Incidents. A Model for Designing, Delivering and Managing Psychosocial Services for People Involved in Major Incidents, Conflict, Disasters and Terrorism

The 2008 NATO non-binding guidance document, “Psychosocial Care for People Affected by Disasters and Major Incidents” is “intended as a conceptual and practical resource for people who develop governmental policy, design and plan services, or provide preparatory training for the staff of the services that are required” (pg. 1-5). The document provides: i.) An overview of the impact of disasters with particular reference to impacts on psychosocial and mental health; ii.) An “evidence-informed and values-based approach” for psychosocial intervention that anticipates the response of individuals, families, groups and communities will be one of resilience but does not assume this is inevitable; iii.) Guidance for developing people’s personal resilience and also collective resilience of teams and communities *before* events occur, and for supporting their resilience during crisis and afterwards; iv.) Guidance for providing “needs-led mental healthcare at the right times and in the most appropriate ways for the people who require it” (pg. 1-6); and, v.) A description of a stepped care model based on six components in which prominence is given to strategic leadership and planning, and developing collective community resilience and providing services that are proportionate to the needs of disaster-affected people.

The Guidance is grounded in a comprehensive stepped model of care that resembles those presented by the IASC and the IFRC but with two additional levels: development of collective and community resilience, and strategic planning, preparation and evaluation by leaders. The underlying philosophy is one of supporting peoples’ resourcefulness, actively engaging people in response, and building resilience:

“The cornerstone of the plan should be to support peoples’ resourcefulness, meaning that the public should be actively engaged in delivering disaster responses and the emphasis of interventions should be on empowering communities and people who are affected. This also means that the public must be trusted with accurate information that is provided regularly by credible persons. It also means that psychosocial and mental health services should be made

available to support survivors' resilience and to complement personal and collective resilience and coping (pg. 1-10)."

This model is depicted in the figure below and described in the following table.



Figure X. NATO Strategic Stepped Model of Care (Source: NATO, 2008, pg. 1-77.)

NATO's (2008) Strategic Stepped Model of Care – Description of levels of action

Strategic leaders plan, prepare and evaluate	Comprehensive multi-agency planning, preparation, training and rehearsal of the full range of service responses that may be required.
Develop collective and community resilience	Prevention services that are intended to develop the collective psychosocial resilience of communities and which are planned and delivered in advance of untoward events.
Support and care provided by families and communities	Basic humanitarian and welfare services that should be made available to everyone and which are centred on families.
Psychological First Aid	Providing psychological first aid that is delivered by trained lay persons who are supervised by the staff of the mental healthcare services.
Primary care augmented by mental health assessment and psychological therapies	Providing screening, assessment and intervention services for people who do not recover from immediate and short-term distress.
Care provided by specialist mental health services	Providing access to primary and secondary mental healthcare services for people who are assessed as requiring them.

Source: NATO (2008, pg. 1-11)

NATO also lists a set of “minimum key actions/objectives” in psychosocial and mental health planning. These are presented in the table below.

NATO’s minimum key actions/objectives required by psychosocial and mental health planners and staff

Integrating psychosocial and mental healthcare response within the grand plan for preparing for and responding to disasters
Fully integrating psychosocial and mental healthcare responses, usually sequentially
Appointing psychosocial and mental health advisors to commanders of responses to major incidents and disasters
Empowering communities and people
Attending to the basic needs of the population first
Planning and enacting a good public risk communication and advisory strategy that involves the public and the media and which provides timely and credible information and advice
Ensuring staff are capable of working with a diversity of values and cultures
Ensuring that the psychosocial and mental health responses are comprehensive and stepped according to need, are of sufficient duration, and are well coordinated
Allocating and managing roles for mental health professionals; they should be well lead, managed, supervised and cared for
Promoting learning by planning and managing knowledge acquisition and its transfer, evaluation and performance management

Source: NATO (2008, pg. 1-42).

State Government of Victoria, Australia (2014): Psychosocial Support. A Framework for Emergencies

A number of disasters in Australia have led to the development of a number of national and state frameworks for disaster-related psychosocial support. In the state of Victoria, the most recent guidance document is the *Psychosocial Support: Framework for Emergencies* (State of Victoria, 2014). This framework builds on its predecessor, *After the Bushfires: Victoria’s Psychosocial Recovery Framework 2009*.

The 2014 Framework provides advice on principles and considerations that should underpin psychosocial support to individuals and communities impacted by disaster. This includes a description of the impact of disasters on people and community and the importance of targeting services to meet the needs of vulnerable groups (children, young people, older people, men, women, people with a disability, people with a pre-existing mental health issue, and the bereaved). The framework also encourages those agencies delivering recovery services to be aware of two key elements:

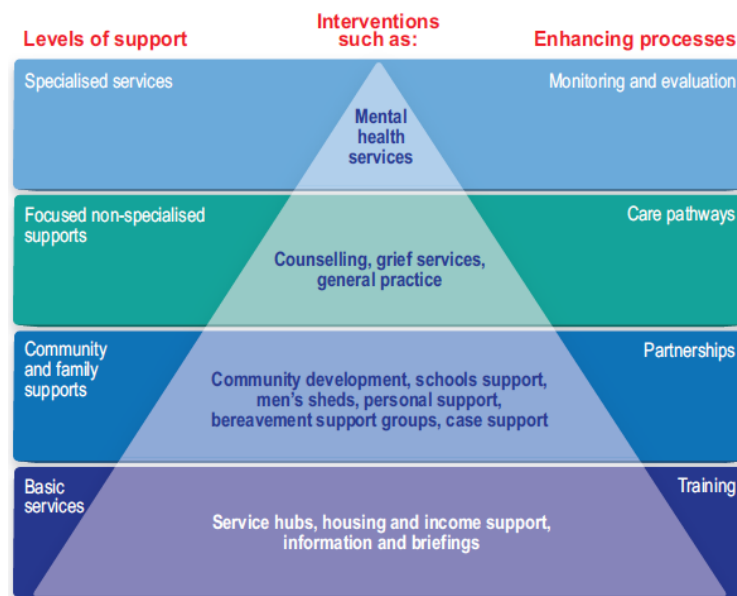
- Support for individuals and families (personal support, psychological first aid, emotional spiritual care, outreach, case support, counseling and mental health services)
- A focus on communities including community information sessions and community engagement

There is also discussion about the importance of strengthening psychosocial support services via training, partnerships and care pathways, and monitoring and evaluation which is described as, “critical in ensuring that the investments and interventions put in place for individuals and communities continue to assist them in their psychosocial recovery” (State of Victoria, 2014, pg. 3).

Principles of relief and recovery (drawn from Victoria’s State Emergency Relief and Recovery Plan) are outlined. These principles are:

- Empower and engage individuals and communities to promote self-sufficiency and, where possible, meet their own relief and recovery needs
- Be coordinated and collaborative, jointly owned by affected individuals and communities – as well as non-government organizations, businesses and government agencies that support them
- Be adaptive and scalable, recognizing the unique, complex and dynamic nature of emergencies and communities
- Focus on consequence management where everyone involved appreciates the potential consequence of their decisions and actions
- Be able to support the delivery of concurrent community, local, regional and state response, relief and recovery activities (State of Victoria, 2014, pg. 7)

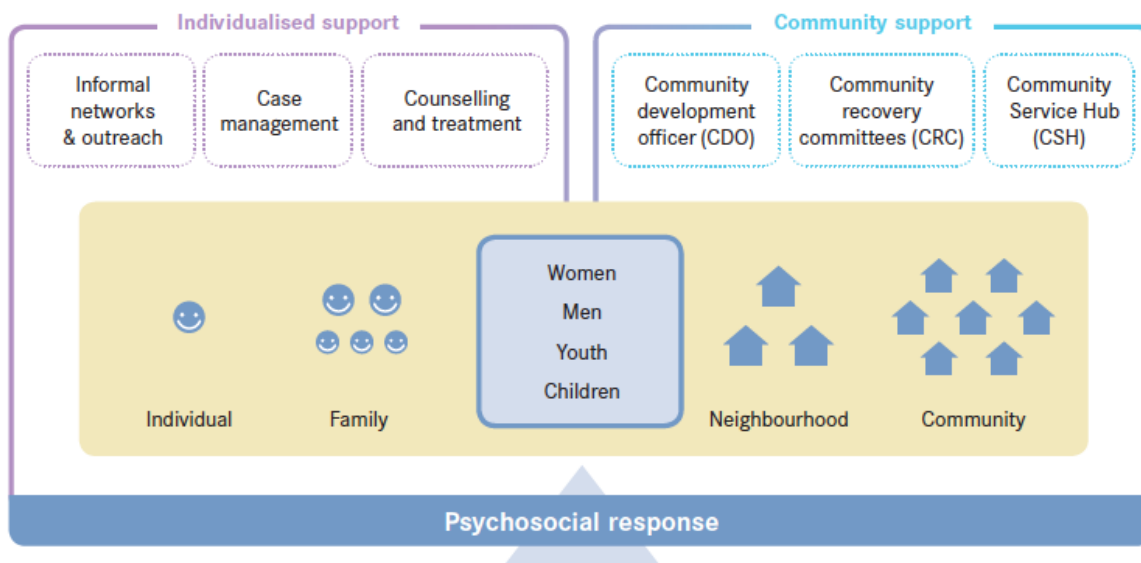
The Framework also conceptualizes intervention as a pyramid of layered supports, based on the IASC (2007) model with some customization. This is depicted in the figure below.



Victorian Government Department of Human Services (2009): After the Bushfires. Victoria’s Psychosocial Recovery Framework

The Victorian Government’s 2009 “After the Bushfires” psychosocial recovery framework was a predecessor of the more recent framework described above. While much of the content in the two

documents is similar, one interesting facet of “After the Bushfires” is a visual depiction of the spectrum of supports provided (see the figure below). The figure includes both individualized supports and community supports and provides examples of actions for each of these categories. This may be a helpful way to conceptualize the spectrum of supports that can be conceived under the broad umbrella of disaster-related psychosocial supports.



Psychosocial recovery – individuals, families and communities (Victorian Government Department of Human Services (2009, pg. 7)

Watson, Brymer and Bonnano (2011): Expert consensus efforts of disaster-behavioral intervention

In the academic literature, Watson, Brymer and Bonanno (2011, pg. 4) summarize “expert consensus efforts on disaster behavioural health intervention” which appear to integrate aspects of disaster mental health and some degree of psychosocial capacity building in the form of maximizing participation of the local affected population, building on available resources and local capacities and facilitating communal practices. This list of interventions is recreated in the table below.

Watson, Brymer & Bonanno (2011): Expert consensus efforts of disaster-behavioural intervention

Be proactive/prepared ahead of time, pragmatic, flexible, and plan on providing the appropriate services matched for phase across the recovery period

Promote a sense of safety, connectedness, calming, hope and efficacy at every level

Do no harm by:

- Participating in coordination of groups to learn from others and to minimize duplication and gaps in response
- Designing interventions on the basis of need and available local resources
- Committing to evaluation, openness to scrutiny, and external review
- Considering human rights and cultural sensitivity
- Staying updated on the evidence base regarding effective practices

Maximize participation of the local affected population, and identify and build on available resources and local capacities (family, community, school and friends)

Integrate activities and programming into existing larger systems to reduce stand-alone services, reach more people, be more sustainable, and reduce stigma

Use a stepped care approach: Early response includes practical help and pragmatic support, and specialized services are reserved for those who need more care

Provide multi-layered supports (i.e., work with media or internet to prepare the community at large; facilitate appropriate communal, cultural, memorial, spiritual and religious healing practices)

Provide a spectrum of services including:

- Provision of basic needs
 - Assessment at the individual level (triage, screening for high risk, monitoring, formal assessment) and the community (needs assessment and ongoing monitoring, program evaluation)
 - Psychological First Aid/resilience-enhancing support
 - Outreach and information
 - Technical assistance, consultation and training to local providers
 - Treatment for individuals with continuing distress or decrements in functioning (preferably evidence-based treatments like trauma-focused cognitive behavioural therapy)
-

Source: Watson, Brymer & Bonnano (2011, pg. 485)

Appendix D: Other Examples of Psychosocial Capacity Building and Resilience Models: Community-Focused

Pre-Disaster Models: Community Tools for Assessing and Building Resilience

The Communities Advancing Resilience Toolkit (CART)

The Communities Advancing Resilience Toolkit (CART) is a publicly available, theory-based and evidence-informed, community-driven strategic planning process for building community resilience to disasters (Pfefferbaum et al., 2015; 2013). CART was created by the Terrorism and Disaster Center of the National Child Traumatic Stress Network and is based on the principles of participatory action research. Community resilience is defined as, “[Entailing] the ability of community members to take deliberate, purposeful and collective action to alleviate the detrimental effects of adverse events...it is a dynamic process that must be sustained over time to support healthy adaptation” (Pfefferbaum, et al., 2013, pg. 251).

Principles underlying the CART approach include:

- Recognizing the community as a unit of identity
- Using community strengths and resources
- Facilitating collaboration
- Integrating knowledge with action for communal benefit
- Developing and maintaining partnerships
- Conducting community assessments
- Identifying policy and action implications and mechanisms for sustainability
- Disseminating findings to community partners (Pfefferbaum, et al. 2013, pg. 253).

The basic process of CART helps communities examine their strengths and challenges and find ways to use their assets to address challenges. It involves four major phases including:

1. Generation of a community profile via a CART assessment survey that helps the community assess its resilience and identify opportunities to enhance that resilience. Other assessment tools such as key informant interviews may also be employed.
2. Refinement of the community profile via community work groups, including community conversations, development of neighbourhood infrastructure maps, community ecological maps, stakeholder analysis, SWOT analysis, capacity and vulnerability assessments and other assessments as needed.
3. Development of a strategic plan, including goals and objectives, strategies and an action plan.
4. Implementation of the strategic plan by community leaders and groups, including dissemination of the plan throughout the community, widening the discussion about the plan and potentially revising the plan, and developing an evaluation plan (Pfefferbaum, et al., 2013, pg. 254).

The CART community resilience assessment tool was originally based on seven community resilience domains: connectedness, commitment and shared values; participation; support and nurturance; structure, roles and responsibilities; resources; critical reflection and skill building; and communication. These domains were subsequently refined as four domains:

1. Connection and caring – This domain includes relatedness, shared values, participation, support systems and equity.
2. Resources – This domain includes natural, physical, information, human, social and financial resources. Resilient communities acquire, invest in, allocate and use resources effectively to serve members and the community at large.
3. Transformative potential – This domain includes the ability of communities to identify and frame collective experiences, examine their successes and failures, assess their performance, and engage in critical analysis which helps community leaders to establish goals, make decisions, and develop and implement strategies to enhance the community and its members.
4. Disaster management – This domain includes disaster prevention and mitigation, preparedness, response, recovery and reconstruction. It includes activities to avoid or control a crisis, reduce risks to people and property, lessen actual or potential adverse effects, support basic human needs, maintain or restore the affected community, and help affected people rebuild their lives and their community
(Pfefferbaum et al., 2013, pg. 252).

In 2015, based on testing of the CART tool, Pfefferbaum and colleagues (2015) added a fifth domain:

5. Information and communication – This domain is about the availability of information and trust in public officials. During emergencies, people need accurate information about the dangers facing them, and the options available for avoiding these. This information should be communicated by a trusted resource.

Pfefferbaum, et al., (2013, pg.257) conclude that:

“The primary value of CART lies in its contribution to community participation, communication, self-awareness and critical reflection and in its’ ability to stimulate analysis, cooperation, skill building, resource sharing and purposeful action. Ideally, the CART process empowers communities through information, communication and assistance by identifying issues, solving problems, and planning activities. At its best, CART is an intervention that initiates and reinforces community resilience building through participatory action.”

The Los Angeles County Community Disaster Resilience (LACCDR) initiative

Wells et al. (2013) and Chandra et al. (2013) describe a community partnered participatory research (CPPR) approach to developing toolkits for community resilience and building disaster resilience in Los Angeles County. The result of this work (2013) is a series of tools and resources to help communities assess and strengthen disaster resilience. The basic community resilience toolkit includes psychological first aid, community mapping to identify capacities and locate vulnerable groups, community

engagement strategies, how to develop community leaders and training community field workers. See www.laresilience.org for additional resources/materials.

Post-disaster/Recovery Models

Hawe (2009): Strategies for community-focused recovery and rebuilding

Hawe (2009) conducted a rapid review of community recovery after the 2009 Victorian bushfires in order to inform development of a community-based, strengths-focused recovery strategy. Highlights of her findings and recommendations are summarized here.

Anticipated outcomes of community building recovery strategy would include but not be limited to:

- A lower than expected burden of mental health problems
- A more connected community socially, providing an improved platform for disaster readiness
- A sustained community infrastructure for problem solving and addressing community needs
- The retention of population and amenities
- The restoration of quality of life (Hawe, 2009, pg. 1)

Grounding her review in the principles put forward by Hobfoll et al., 2007, she describes three major strategies for community-focused recovery and rebuilding based on best practice in the community development literature. For each strategy, she describes multiple kinds of interventions, correlating them with Hobfoll et al.'s principles. A summary of the three strategies is presented in the table below.

Hawe's strategies for community-focused recovery and rebuilding	
Social network based strategies	Based on notion that people turn to their social networks in the aftermath of disaster. Examples of such strategies include: increasing emotional and mental health literacy and skills; finding ways to engage community members in constructive activities; increasing opportunities for people to network and interact more frequently; build buddy systems to ensure social isolation is overcome; identify and support natural leaders and connectors in their role as information providers and lay referral agents
Place-based strategies	These strategies recognize the crucial role that places have as a source of healing and strength. <i>Examples</i> of such strategies include: engage all parts of the community in building a vision for what a restored and improved community would look like; provide opportunities for children and youth to process the meaning of the disaster and rebuild a sense of safety, connection and belonging; provide creative and collaborative opportunities to express loss and vision for future through art; invite and encourage economic development projects that focus on reconnection of residents and visitors to place

Empowerment-based strategies Empowerment is the “process by which people, organizations and communities gain mastery over their lives.” *Examples* include: actively and authentically engage community members in all aspects of planning and reconstruction; work with community members to assess community needs and views about construction plans and priorities; ensure all parts of the community members have the skills, support and confidence they need to tackle their re-construction tasks; set up “intelligence gathering” mechanisms with all parts of the community to assess needs and how well recovery strategies are faring, designing and readjusting the course of action accordingly

Source: Hawe (2009, pg. 25 to 32)

Finally, Hawe identifies a number of critical success factors for community-based recovery strategies:

- Involving communities in all aspects of decision making
- Providing resources to enable release of community members’ time to take part
- Recognizing that different people will be at different stages and that decisions about domestic reconstruction involve grief and take time
- Recognizing that strong communities are diverse in their activities, opportunities and people
- Diverse cultural roles and activities have to be restored (play is as important as work)
- Being proactive in particular settings (schools) with evidence-based approaches known to create a sense of safety and security
- Consciously creating and building resources for recovery, be these physical, economic, social, psychological or spiritual
- Continuous research-feedback-action loops must be in place to monitor progress and ensure all parts of the community are reached (Hawe, 2009, pg. 33).

The American Red Cross: Psychosocial support activities to re-establish “sense of place”

Prewitt-Diaz and Dayal (2008) describe a process and specific techniques used by the American Red Cross to help re-establish a sense of place in communities impacted by disaster. “Place” refers to peoples’ subjective experiences of, and the meanings attributed to the locations they inhabit, have memories of, and thrive in. Place experiences include, for example, immediate feelings and thoughts, views of the world, memories, identity, history, security and vitality) (Prewitt-Diaz & Dayal, 2008) – all of which can be lost or altered after a disaster. Re-establishing a sense of place “refers to psychosocial support activities which help people to face the trauma of surviving personal losses after a disaster” (Prewitt-Diaz & Dayal, 2008, pg. 2).

In this approach to re-establishing a sense of place, the community is the main actor in the process; the Red Cross provides facilitative support. The overarching process is a participatory one, engaging a wide array of community members in various exercises (e.g., key informant interviews, various community mapping exercises) to assess community strengths and weaknesses, and to identify, prioritize and take action on opportunities to re-establish a ‘sense of place’ in the community. In the process, people are

given voice, relationships are strengthened within the community, and capacity for collective action is strengthened. Prewitt-Diaz and Dayal (2008, pg. 8) describe the process as one in which community members are “actively engaged in making their own communal decisions, taking the time and making an effort to choose their goals, identify resources, and make their own community action plans, thus empowering themselves and their communities in achieving psychosocial competence” (pg. 9).

The LINC Community Resilience Model

The Linking Human Systems (LINC) model applies resiliency theory to individuals, families and communities facing crisis or mass trauma. The goal is to “engage the extended social support systems that can help empower and inspire individuals, families and communities to reconnect and identify resources for healing” (Landau, Mittal & Wieling, 2008, pg. 196).

The core process of support includes: recruiting and coaching of community members as agents of change (“links” who connect the community with professionals and organizations); conducting detailed assessments of the community; and, designing and implementing interventions to promote healing and resilience (Saul & Bava, 2008, pg. 7). All of these processes are carried out with the agentic participation of a broad cross-section of community members. External, professional helpers facilitate the process, but the community determines the content and goals.

LINC is based on the following principles:

- Ensure we have an invitation, authority, permission and commitment from the community
- Engage the entire system of the community, including representation of individuals and subsystems from each cultural and ethnic group, all economic, cultural and status strata
- Identify scripts, themes and patterns across generations and community history
- Maintain sensitivity to issues of culture, gender and spirituality
- Encourage access to all natural and ancillary resources
- Build an effective prevention/management context by collaborating across all systems
- Build on existing resources
- Relate programme needs to goals, future directions and best interests of the community
- We provide the process, the community takes responsibility for the content and goals
- Encourage community links (natural change agents) to become leaders in their communities
- The more peripheral we are, the more successful are the program and the community
- Success of the project belongs to the community (Landau & Saul, 2004, cited in Saul & Bava, 2008, pg. 7-8)

The LINC interventions:

- Take a systems perspective, recognizing that communities comprise multiple interlocking social networks and that it is crucial to bridge all hierarchies and involve as many networks as possible
- Use a variety of maps to assess community structure, resources and histories

- Rely on respected people within the community, community links, to bridge the various levels (from grassroots to official levels) and serve as natural agents for change
- Employ links who are responsible for facilitating and sustaining change within their communities, ensuring that the community “owns” its solutions and gets credit for change, maximizing the possibility that change will be sustained over time (Landau, 2007, pg. 362).

Additional models

A number of other models are also relevant and worth exploring. See for example:

- O’Sullivan et al. (2014): The EnRICH Community Resilience Framework for High-Risk Populations
- Wulf, Donato and Lurie (2015): A model of health resilience.

Appendix E: Additional Disaster Mental Health Frameworks

National Biodefense Science Board: Disaster Mental Health Recommendations (2008)

In this report, disaster mental health is defined as, “the provision of psychological support to affected individuals and communities by trained mental health professionals” (pg. 2). Eight recommendations for disaster mental health are made, and background information to support these recommendations is provided. These recommendations include:

1. Integrate mental and behavioral mental health into all public health and medical preparedness and response activities (e.g., facilitate state-based disaster mental and behavioural health planning and operations by including language on mental health, substance abuse, and behavioural health in all appropriate legislation, regulations and grants; integrate disaster mental and behavioural health and exercising into performance benchmarks of new or existing [government] funded emergency management programs or grants).
2. Enhance the research agenda for disaster mental and behavioural health (e.g., convene a working group of expert groups to identify gaps in knowledge, areas of recent progress, and priorities for research in disaster mental and behavioural health program evaluation, early intervention, treatment for disaster-related problems, and dissemination of training in disaster mental and behavioural health interventions. Set a national agenda for this research, supported by government agencies that fund research initiatives in these areas).
3. Enhance assessment of mental and behavioural health needs during emergencies (e.g., integrate epidemiological strategies to capture information for public policy and resource allocation; utilize available surveillance systems).
4. Enhance disaster mental and behavioural health training for professionals and paraprofessionals (e.g., promote psychological resilience and effective delivery of psychological support by professionals and paraprofessionals through education in disaster mental and behavioural health and/or training in psychological first aid).
5. Promote the population’s psychological resilience (e.g., promote psychological resilience of individuals, families and communities through the development of a national strategy for the integration, dissemination and ongoing evaluation of psychological first aid).
6. Ensure that the needs of at-risk individuals and issues of cultural responsiveness are being addressed in all efforts of the National Biodefense Science Board (e.g., support the development of mechanisms to ensure the needs of vulnerable and at-risk populations and issues of cultural responsiveness are appropriately considered and served in the articulation and execution of recommendations, and in public health activities related to emergency preparedness and response).
7. Develop a disaster mental and behavioural health communication strategy (mass communication messages that deliver psychoeducation, information on sources of help, and other relevant mental/behavioral topics relevant to the nature of the disaster and specific disaster phases; identify/educate/train mental and behavioural experts to serve as consultants and interviewee for federal television/internet broadcasts and resources for the media)

8. Develop an accessible internet-based communication toolkit (e.g., a consolidated source of messages for a variety of events such as pandemic influenza, terrorism and environmental contamination).