

Framework for Psychosocial Support in Emergencies

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Foreword

The Ministry of Health, under the Civil Defence and Emergency Management Order 2015, is the agency responsible for coordinating the provision of psychosocial support nationally. As part of that responsibility this update to the Planning for Individual and Community recovery in an Emergency Event was commissioned through Massey University's Joint Centre for Disaster Research.

The Joint Centre for Disaster Research undertakes multi-disciplinary applied teaching and research role who provided a team of researchers and writers to produce this current version. Through international research and a comprehensive peer review process across a number of respected and renowned subject matter experts from across the globe, we can be assured that the contents of this framework will provide the most accurate and current thinking for psychosocial support across our communities in the time of an emergency and beyond.

In light of events recently affecting not only New Zealand, but many parts of the world, this framework will provide the basis in planning for psychosocial support for government departments, other organisations and agencies operating within the emergency management sector.

We know emergencies can strike at any time and with any frequency so the application of this framework and its contents will significantly enhance how our communities cope with and recover from those emergencies. It is those communities we are charged to care for and protect who should benefit from this document.

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- Lucy D'Aeth, Public Health Specialist, Canterbury District Health Board

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Framework development and review

This framework has been revised and updated to reflect current thinking on psychosocial recovery following emergencies. The framework was developed under the leadership of the Joint Centre for Disaster Research in partnership with the Ministry of Health and in consultation with local stakeholders and international specialists in the field.

In acknowledgement of the importance of evidence-informed policy and practice, an extensive international literature review formed the basis for much of the framework's content. This represents the best evidence available at the time of writing. Given the ever-evolving nature of knowledge about psychosocial recovery following emergencies, it is advisable that service providers keep a watching brief to stay up to date with any significant changes in evidence-informed good practice recommendations.

To keep the *Framework for Psychosocial Support in Emergencies* aligned with the *National Health Emergency Plan* (Ministry of Health 2015), the Ministry of Health will review it within five years of its adoption. The framework will also be reviewed and updated as required following any new developments in or substantial changes to the operations or organisation of New Zealand health and disability services. Such changes may occur if lessons are learned from a significant emergency affecting the health of communities or the health and disability sector itself, if new hazards and risks are identified, or if directed by the Minister of Health or Director-General of Health.

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Key messages

Most people affected by an emergency will experience some level of distress (that is, negative experiences and emotions that do not indicate problems with psychological functioning). In an emergency, **distress is considerably more prevalent than mental health disorders** and, for most people, the **distress is tolerable, short-lived** and depends on the duration of acute and secondary stressors.

All those involved in an emergency are likely to benefit from some form of psychosocial support. For many, the **distress they experience can be eased with the care and support of families, whānau, friends and the community**. Others, however, will need more formal or professional intervention and **a small proportion of people will need specialised mental health services. This distinction is important** as it influences the types of interventions that should be provided.

The primary objectives of psychosocial recovery are to minimise the physical, psychological and social consequences of an emergency and to enhance the emotional, social and physical wellbeing of individuals, families, whānau and communities. **Psychosocial recovery is not about returning to normality. It is about positively adapting to a changed reality.** Recovery may last for an indeterminate period, from weeks to decades.

Psychosocial support aims to improve psychosocial wellbeing, which refers to three core domains:

- 1 **supporting and promoting human capacity** (strengths and values)
- 2 **improving social ecology** (connections and support, through relationships, social networks and existing support systems of people in their communities)
- 3 **understanding the influence of culture and value systems and their importance alongside individual and social expectations.**

Psychosocial wellbeing depends on having resources from these three domains to respond to emergency conditions and events. The challenging circumstances can deplete these resources, resulting in the need for external interventions and help to bolster and build psychosocial wellbeing for individuals and communities.

People who are affected by emergencies can experience acute and/or chronic distress and may benefit from psychosocial interventions. Looking back on their experience of those events, those affected emphasise the importance of interventions that build and sustain supportive partnerships. Those partnerships may be within families or whānau, existing or new social and support networks, or wider communities. **Effective interventions to reduce distress after emergencies should focus on self-efficacy and community participation.**

No matter how long the post-emergency period continues, delivering timely and appropriate psychosocial interventions to support affected individuals and communities must be based on the **accurate assessment of psychosocial problems and associated need**. This is crucial to effectively coordinate and deliver interventions designed to provide psychosocial support.

Through both preventive and curative actions, psychosocial support can help to build resilience. Preventive actions are to help prevent or reduce the risk of negative psychosocial problems. Curative actions involve helping individuals and communities to face and overcome such problems and to adapt to changing circumstances. In this way, psychosocial interventions are focused at a population level, as well as informing and supporting individuals.

Psychosocial resilience is a process of adapting positively, of continuing to develop in response to adversity and change, rather than being a stable goal to be reached. It involves dynamic interactions between a person and the wider social, physical and cultural environments, as well as a range of individual characteristics and individual reactions to acute or chronic stressors.

Social support is the primary adaptive factor consistently identified in research and reflected in evidence-based practice.

The community's participation and involvement during ongoing recovery is integral to **building trust and engagement.** Strong social infrastructure, such as social connectedness, networks, social capital, social identity and attachment processes, has an important role in facilitating emergency response and recovery.

The psychosocial impacts of emergencies are like ripples in a pond, with consequences reaching out well beyond the main location of the event. **Psychosocial support must be the concern of all providers, locally, regionally and nationally.**

Providing effective psychosocial interventions requires:

- collaborative partnerships based on clear roles and responsibilities and effective leadership
- careful planning
- good training and support for personnel at all levels and in all agencies
- engaged, informed and resilient communities
- effective communication
- regular monitoring and evaluation.

Well-coordinated and resourced psychosocial interventions can support many people in affected communities to adapt after an emergency. Such interventions can also assist people to help others.

Effective leadership, along with a clear understanding of roles and responsibilities, will help services that are coordinating, designing and delivering psychosocial interventions to continue to effectively contribute to post-emergency adaptation and recovery in the long term.

All agencies and groups providing psychosocial interventions must undertake **planning and preparedness activities** to ensure that they can fulfil their roles and contribute to an effective response and an optimal recovery.

Key concepts

This document uses a number of terms that can have different and/or contested meanings in different contexts. In this document, these terms have the following meanings.

In keeping with New Zealand legislation and policy, this document uses the term **emergency** for situations that pose significant risk to life, health, property, livelihoods or the environment and that require a coordinated response. By their nature, emergencies have consequences that are difficult to predict. They can happen anywhere, at any time, with little or no warning, or they may unfold more slowly, giving people time to take actions to address them. An emergency can vary in scope, intensity and impact. In most cases, the response must be immediate to prevent the situation from worsening. The academic and wider literature tends to use the term ‘disaster’ to refer to such events.

Psychosocial reflects the interrelationship between individual psychological and social factors. The psychosocial approach considers individuals in the context of the combined influence that psychological factors and the surrounding social environment have on their physical and mental wellness and their ability to function. Psychosocial support during an emergency (no matter how long it lasts) is about easing the psychological, social and physical difficulties for individuals, families, whānau and communities. It is also about enhancing wellbeing and helping people to recover and adapt after their lives have been disrupted.

Mental health is defined by the World Health Organization as a state of wellbeing in which every individual realises their own potential, can cope with the normal stresses of life, can work productively and fruitfully and can contribute to their community.

This document uses **mental health disorder** to identify conditions, diagnosed most often by a psychiatrist, that may cause suffering or a poor ability to function in life. Such features may be persistent, relapsing or remitting, or occur as a single episode. **Distress** refers to negative experiences and emotions that do not indicate problems with psychological functioning.

Vulnerability is the degree to which an individual, organisation, community or system is unable to anticipate, cope with, resist or recover from the impact of hazards. It is important to recognise that people, including those who are more vulnerable, also have capacities and competencies. By acknowledging these strengths, which may occur at individual, family, whānau, community and structural levels, it is possible to move beyond the concept of vulnerability as a label that constructs a particular group as inherently at risk. A strength-based focus recognises that promoting capacities and competencies can help reduce risk and can aid recovery and adaptation after an emergency.

Resilience is about adapting positively in the face of disturbance, stress or adversity. The resilience of individuals and communities is interrelated. Resilience means more than bouncing back from crisis and challenge; it is dynamic and can be developed and strengthened over time by engaging and developing the capacity to thrive in environments characterised by change.

Psychosocial resilience is a process of adapting positively, of continuing to develop personally in response to adversity and change, rather than a stable goal to be reached. It involves dynamic interactions between a person and their wider social, physical and cultural environments, as well as a range of individual characteristics and individual reactions to acute or chronic stressors.

The primary objectives of **psychosocial recovery** are to minimise the physical, psychological and social consequences of an emergency and to enhance the emotional, social and physical wellbeing of individuals, families, whānau and communities. Psychosocial recovery is not about returning to normality. It is about positively adapting to a changed reality. Recovery may last for an indeterminate period, from weeks to decades.

This document uses **psychosocial intervention** to refer to all interventions, services and other initiatives that may be offered to affected individuals, families, whānau and communities during and after an emergency. These types of interventions tend to focus more on influencing the psychosocial context and on promoting health and wellbeing. In contrast, individually tailored treatment packages focusing on mental health disorders are **mental health treatments**.

Secondary stressors are circumstances, events or policies that are indirectly related to, or are a consequence of, an emergency. These secondary stressors can worsen problems that existed before the emergency, as well as complicate recovery when their impact becomes greater than the emergency itself.

Introduction

New Zealand emergency context

New Zealand communities are exposed to a broad range of hazards – that is, potential or existing conditions that may harm people (by causing death, injury and illness) and damage property or the social, economic, cultural and natural environments (see Appendix 1). Three broad types of hazards are:

- 1 natural disasters (eg, floods)
- 2 human-made, non-intentional technological disasters (eg, nuclear accidents)
- 3 human-made, intentional acts (eg, mass violence and terrorism).

Even where a hazard does not directly affect health or health care services, disruption to critical services can have serious consequences that can in turn endanger community health and safety and disrupt health and disability services (Ministry of Health 2015). For example, if a severe storm disrupts electricity supply over several days, residents may be unable to heat their homes, adequately refrigerate or prepare food, or boil water if needed, increasing their risk of illness. Power supplies for critical medicine storage or medical devices, such as sleep apnea machines, may also be seriously compromised.

It is imperative that health providers understand both the hazards and the risks that communities and the health and disability sector face. Only then can they make informed decisions about how to manage and reduce risk and develop the capabilities needed in an emergency. Risk is a function of the hazards to which a community is exposed and the vulnerabilities of that community, which are modified by its level of resilience.

The *Sendai Framework for Disaster Risk Reduction 2015–2030* (United Nations Office for Disaster Risk Reduction 2015) highlights concerns about human health and wellbeing that are common across disaster risk reduction, climate change and sustainable development. The framework aims to substantially reduce disaster risk and losses in lives, livelihoods and health and in the economic, physical, social, cultural and environmental assets of people, businesses, communities and countries. One significant focus is on public health, including enhancing recovery schemes to provide psychosocial support for all people in need.

Cultural context

Given New Zealand's culturally diverse population, it is important to recognise and respect the importance of culture following an emergency. Culture determines how we interpret events and relate to people. It also shapes our beliefs about what is, and is not, right to say and do.

Māori models of health acknowledge the importance of thinking about waiora – overall wellbeing – in a holistic way. Waiora recognises the spiritual, social and cultural aspects of wellbeing.

The importance of psychosocial support is embodied in the health model Te Whare Tapa Whā (Durie 1998). This model relates the four sides of the whare (house) to different forms of wellbeing:

- Hinengaro support (mental and emotional wellbeing)
- Wairua support (cultural and spiritual wellbeing)
- Tinana support (physical, practical and financial wellbeing)
- Whānau support (advocacy and extended family or whānau wellbeing).

The model Te Pae Mahutonga (Southern Cross Star Constellation) brings together elements of modern health promotion (Ministry of Health 2016). The four central stars of the Southern Cross represent four key tasks of health promotion:

- Mauriora (cultural identity)
- Waiora (physical environment)
- Toiora (healthy lifestyles)
- Te Oranga (participation in society).

The two pointers represent Ngā Manukura (community leadership) and Te Mana Whakahaere (autonomy).

These models provide a useful context for thinking about wellbeing after an emergency. In line with *He Korowai Oranga: Māori Health Strategy* (Ministry of Health 2002), this framework for psychosocial support is based on:

- **partnership** – working together with iwi, hapū, whānau and Māori communities to develop strategies for Māori health gain and appropriate health and disability services
- **participation** – involving Māori at all levels of the health and disability sector, including in decision-making, planning, development and delivery of health and disability services
- **protection** – working to ensure Māori have at least the same level of health as non-Māori, and safeguarding Māori cultural concepts, values and practices.

Pacific peoples from many Pacific Island nations call New Zealand home and each ethnic group has its own traditions, languages, values and beliefs. The traditional Pacific view is based on a holistic collective approach in which wellbeing requires equilibrium of mind, body, spirituality, family and the environment (Kingi-Uluave et al 2007).

Legislative context

The roles and responsibilities of New Zealand government agencies in an emergency are outlined in the National Civil Defence Emergency Management Plan Order 2015 (the National CDEM Plan). In line with sections 39–47 of the Civil Defence Emergency Management Act 2002, the National CDEM Plan aims to integrate and align agencies' civil defence and emergency management planning and related operational activities at the national level.

Key planning documents relating to psychosocial support include:

- *Guide to the National CDEM Plan* (Ministry of Civil Defence and Emergency Management 2015a)
- *Welfare Services in an Emergency: Director's guideline for CDEM Groups and agencies with responsibilities for welfare services in an emergency* (DGL 11/15) (Ministry of Civil Defence and Emergency Management 2015b)

- *National Health Emergency Plan* (Ministry of Health 2015)
- *Framework for Psychosocial Support in Emergencies* (this document)
- *New Zealand Influenza Pandemic Plan* (Ministry of Health 2010).

Under the National CDEM Plan, the Ministry of Health became responsible for coordinating psychosocial support for emergencies. The *National Health Emergency Plan* provides the overall strategic framework and guidance for the health and disability sector in planning for, responding to and recovering from health-related risks and consequences of significant hazards. This document is one of a collection of guidance documents and action plans covering specific aspects of emergency management that add to the *National Health Emergency Plan*. For the latest electronic versions of all of these subsidiary and related documents, go to the Ministry of Health website (www.health.govt.nz/our-work/emergency-management).

Within *Welfare Services in an Emergency: Director's guidelines* (Ministry of Civil Defence and Emergency Management 2015b), psychosocial support is one of nine welfare sub-functions:

- registration
- needs assessment
- inquiry
- care and protection services for children and young people
- psychosocial support
- household goods and services
- shelter and accommodation
- financial assistance
- animal welfare.

To recognise and respect the principles of the Treaty of Waitangi, the New Zealand Public Health and Disability Act 2000 outlines mechanisms health providers can use to effectively engage with Māori to address the relationships and obligations that come from the Treaty of Waitangi. All agencies, service providers and community groups involved in planning, coordinating and delivering psychosocial support need to consider these mechanisms.

Scope and purpose

This *Framework for Psychosocial Support in Emergencies* is designed to help those involved in planning, coordinating and delivering psychosocial interventions and mental health treatments in an emergency.

Practitioners and service managers are encouraged to read this document from start to finish so that they understand the context of psychosocial support in emergencies in New Zealand. We suggest keeping this document at hand as a resource to refer to when needed: to plan service design and delivery; for collaborative planning; for emergency action; and during exercises.

The framework:

- identifies the need to provide psychosocial support interventions for individuals, families, whānau and communities that are appropriate to their identified needs
- identifies the need to provide mental health treatment (in primary and secondary care) for those who need it
- describes the impact of emergencies on people's psychological and social wellbeing

- describes the importance of targeting services so that they meet the needs of all potentially affected members of the community
- outlines the principles and considerations that should underpin psychosocial interventions and mental health treatments offered to affected individuals, families, whānau and communities during and after an emergency
- describes the available evidence base for psychosocial interventions
- highlights the importance of addressing longer-term needs, including those resulting from secondary stressors
- promotes a focus on enabling and engaging communities, including by building on existing local resources and capacities
- promotes information gathering, monitoring and evaluation to ensure that the investments, services and initiatives put in place for individuals and communities assist them in their psychosocial adaptation and recovery.

Intended audience

This document is for all agencies, service providers and community groups involved in planning, coordinating and delivering psychosocial support. Relevant providers and groups include:

- all district health boards in their capacities as governance bodies, lead entities and service providers, including public health units
- all health providers throughout New Zealand, including providers of primary care, aged care and disability support, and other non-governmental providers such as pharmacies
- Māori health providers
- hapū and iwi Māori, marae communities and organisations
- organisations that provide psychosocial support services and initiatives, including but not limited to Red Cross and Victim Support
- organisations that provide health care information and signposting services, such as Healthline
- agencies that interact with these providers, such as ambulance, fire and police services
- community-based organisations and voluntary community groups, including (but not limited to) faith-based groups, culturally and linguistically diverse community groups, service organisations, groups working with vulnerable people, and people with disabilities (including those for whānau, families) and rural networks, providers or groups
- Ministry of Civil Defence and Emergency Management
- Civil Defence emergency management groups
- Ministry of Education, which oversees schools and early childhood services
- Ministry for Primary Industries, which funds rural support trusts and other organisations to provide psychosocial support to rural communities
- Te Puni Kōkiri, which provides links to iwi and Māori providers and advice on appropriate cultural responses.

Guiding principles

The guiding principles for health and disability services providing psychosocial support after an emergency are listed here. These principles are drawn from the evolving evidence base on the process of psychosocial recovery, and align with international best practice guidelines and the overarching principles in the *National Health Emergency Plan* (Ministry of Health 2015).

Do no harm: No action, intervention or other service response should cause harm. Wherever possible, they should promote: a sense of safety; self and community efficacy; empowerment; connectedness; calm and hope.

Human rights and health equity: Establish, maintain and develop psychosocial support interventions that are best able to meet the needs of patients/clients and their communities during and after an emergency, even when resources are limited. Promote the human rights of all affected people and make provisions for vulnerable people and hard-to-reach communities so that recovery actions do not create or increase inequalities.

Community and stakeholder engagement: In all actions, including those to plan and determine needs, actively gain maximum levels of participation from local, affected populations.

Promote self-help: In all actions, encourage individuals and communities to care for themselves and others and to seek further help. These actions should also help to restore people's agency and perceptions of themselves as effective individuals.

Integrated all-agencies approach: Develop and maintain effective, trusting relationships both in the health and disability sector and with community partners to develop and provide collaborative and coordinated psychosocial support interventions that are jointly owned by affected individuals, communities and the agencies involved.

Multi-layered targeted support: Develop and provide a layered system of adaptive psychosocial support interventions that are implemented together to meet the needs of different individuals and groups and that can be provided on a larger or smaller scale if needed. These should fully consider the unique, complex and dynamic nature of emergencies and of communities.

Continuous improvement: All agencies undertake continuous improvement, through ongoing monitoring and review and by translating lessons learned through research and experience into integrated, ethical policy, plans and services. Continuous improvement includes education and training, professional development, review, evaluation, ethical practice and community involvement.

Response and recovery workers: Acknowledge both paid and volunteer workers and take steps to protect them from harm. This protection should cover the risk of both acute and cumulative impacts on their psychosocial and mental wellbeing.

Psychosocial support

Psychosocial support aims to improve psychosocial wellbeing, which has three core domains:

- 1 support and promote **human capacity** (strengths and values)
- 2 improve **social ecology** (connections and support, through relationships, social networks and existing support systems of people in their communities)
- 3 understand the influence of **culture and value systems** and their importance alongside individual and social expectations.

Psychosocial wellbeing depends on having resources from these three domains to respond to emergency conditions and events. The challenging circumstances can deplete these resources, resulting in the need for external interventions and help to bolster and build individual and community psychosocial wellbeing.

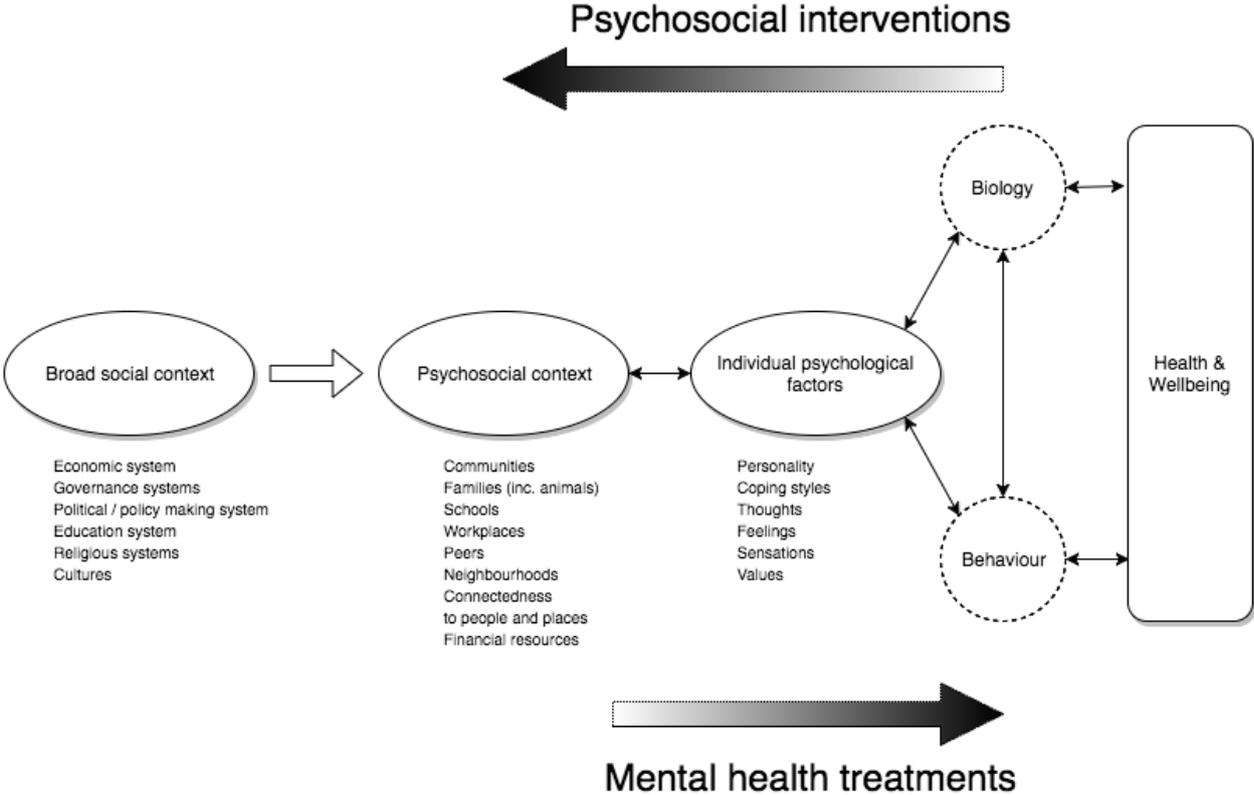
The adjective ‘psychosocial’ refers to the psychological, social and physical experiences of people in the context of particular social, cultural and physical environments. It describes the psychological and social processes that occur within and between people and across groups of people (Williams and Kemp 2016, p 83).

An individual’s experience of psychosocial wellbeing is determined largely by the context they live in. If a person’s immediate surroundings and community are disrupted, they are likely to be in some discomfort or distress, even if only in the short term. It is unlikely that many individuals in this situation will be experiencing psychosocial wellbeing. Just as contexts and individual factors are always changing, so is the experience of psychosocial wellbeing.

This dynamic nature of the experience makes it very difficult to provide a standard definition of what psychosocial wellbeing is, or how to recognise it. It is therefore critical to understand what psychosocial wellbeing means locally for an affected population before planning a psychosocial intervention to improve wellbeing. This is the only way to ensure that planned interventions and activities are relevant for an affected community, and are not just replicating something that has been used elsewhere.

Figure 1 outlines the relationship between broader social contexts, the dynamic psychosocial context and individual psychological factors, and how these may influence physical reactions and behaviour to shape health and wellbeing. Broad social factors such as economic policy and culture are relatively resistant and slow to change but can be hugely influential on how people and communities deal with emergencies. They provide the psychosocial context for the experience of everyday life – how we experience our communities, families, whānau, schools, workplaces and neighbourhoods, and our financial resources for doing so. This context includes our relationships with our peers, and our sense of connectedness with others and with the places in which we live, work and play.

Figure 1: Psychosocial support in context



This psychosocial context influences, and is in turn shaped by, our personal psychological experience. This experience consists of our thoughts, feelings and sensations, as well as our personalities, coping styles and the values that are important to us. Our psychosocial context also influences our basic biological physical reactions, as well as our behaviour, which then affects our health and wellbeing.

For example, feelings of threat and being overwhelmed by emergency events over a sustained period can lead to both acute and chronic production of stress hormones in our bodies (biology). These hormones can make us feeling tired and compromise our immune system, which makes us more susceptible to falling ill. These effects can be further compounded when the stress hormones interfere with our sleep patterns (behaviour), making us feel even more tired and increasing the risk of poor health and wellbeing.

The social context might also influence the individual experience, for example, if we have a sense of loss of people or places that are important to us. That sense can produce feelings of enduring sadness, which in turn can make us more withdrawn and less willing to socialise with others. This influences our psychosocial context and potentially our health and wellbeing through our behaviour and biology.

The issue of psychosocial support during and after emergencies is important. People who are affected by emergencies can experience acute and/or chronic distress and may benefit from psychosocial interventions. According to the available literature, looking back on their experience of an emergency, those affected emphasise the importance of interventions that build and sustain supportive partnerships – whether within families, whānau, existing or new social and support networks, or wider communities. Effective interventions to reduce distress after emergencies should focus on self-efficacy and community participation. Evidence suggests that developing existing and new social networks that help people support each other and foster a sense of control over their lives is critical for community recovery.

Effective psychosocial support ensures that other aspects of the recovery process (eg, rebuilding) do not result in further harm to individuals or their communities. It also helps to develop individual and community resilience as it empowers people to care for themselves and others by drawing on and developing their capabilities, resources and networks. (See more about community resilience under ‘Engaged, informed and resilient communities’.)

Through both preventive and curative actions, psychosocial support can help to build resilience. Preventive action helps prevent or reduce the risk of negative psychosocial problems. Curative actions involve helping individuals and communities to face and overcome such problems and to adapt to changing circumstances (see more about individual and community resilience under ‘Adaptive factors’). In this way, psychosocial interventions are focused at a population-level as well as informing and supporting individuals.

Whānau wellbeing

Family and whānau play an important role in psychosocial recovery and in building resilience. While this document uses ‘family and whānau’ to mean all aspects of this important part of the psychosocial context, research suggests that whānau resilience has a uniquely Māori interpretation. The research explored the capacity of whānau to overcome adversity, flourish and enjoy better health and wellbeing. Despite external factors, internal dynamics and financial pressures that can limit capacity, whānau demonstrated they were able to respond to these challenges, make use of limited resources, and react in positive and innovative ways (Waiti and Kingi 2014). The authors suggest a framework consisting of four resilience themes:

- 1 whanaungatanga factors (networks and relationships)
- 2 pūkenga factors (abilities and skills)
- 3 tikanga factors (meanings, values and beliefs)
- 4 tuakiri-ā-iwi factors (secure cultural identity).

Individual and community recovery

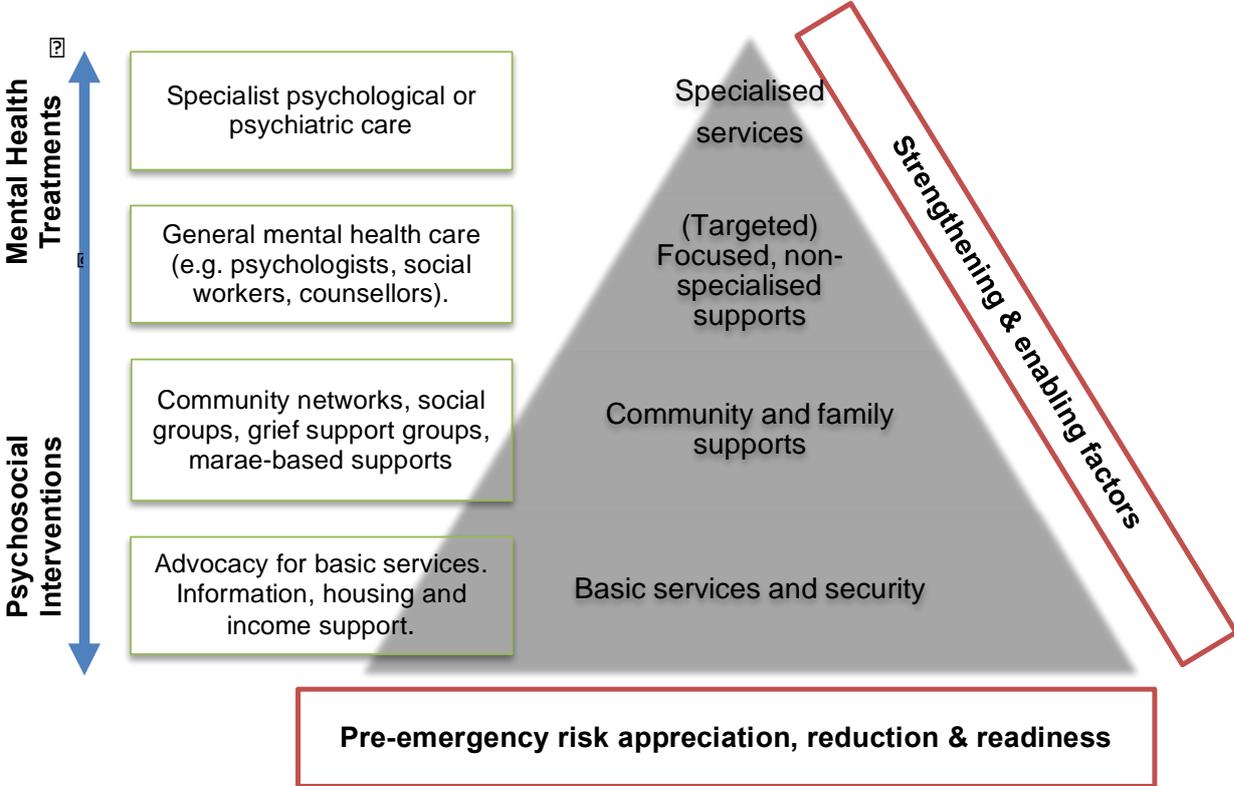
Psychosocial support requires integrated, multi-layered, targeted initiatives, activities and service coordination that address the complex, dynamic needs of individuals and communities and that can be scaled up or down as needed. Psychosocial interventions should use a multidisciplinary approach and be part of primary health care services and the overall emergency response.

Where possible, use local, trusted providers who have a strong awareness and understanding of psychosocial wellbeing, understand local circumstances, and are embedded in the affected communities.

All those involved in an emergency, no matter how they are affected, are likely to benefit from some form of psychosocial support. For many, their distress in the short term can be eased with the care and support of family, whānau, friends and the community.

Others, however, need more formal or professional intervention and a small proportion need specialised mental health services. This distinction is important as it influences the types of interventions or treatments that should be provided. Figure 2 illustrates this model.

Figure 2: Tiered model of psychosocial interventions and mental health treatments



Source: Adapted from IASC (2007)

Psychosocial support across the 4Rs

Psychosocial support considerations should be part of all aspects of emergency management – risk reduction, readiness, response and recovery. This is the way to provide appropriate, scalable activities and interventions based on identified need through an integrated, multi-layered, targeted model of service delivery.

Risk reduction

Risk reduction is about reducing the likelihood of hazards and/or reducing the potential consequences of those hazards. The health and disability sector has only limited influence on the probability of a hazard occurring (other than for specifically health-related hazards). However, it does have the ability and opportunity to lessen the vulnerability of the community and health and disability sector to hazards more generally and to reduce the consequences of them.

To lower the overall risk of poor psychosocial recovery outcomes, it is necessary to better understand the vulnerability of individuals, families, whānau and communities, and then take action to reduce this. All health and disability service providers have a responsibility to work with partner organisations and the communities they serve to reduce risks and enhance resilience. Leading, developing, engaging in or delivering community health development projects and whole-of-community health and disability services will help providers to achieve these outcomes.

Ongoing risk reduction activities include:

- building organisational resilience and reducing its susceptibility to hazards through planning and business continuity management processes
- mapping existing psychosocial services and developing relationships with those agencies, groups and organisations who can contribute to psychosocial recovery.

Readiness

The objectives of emergency readiness are to:

- build the capacity and capability of all health and disability services to effectively anticipate, respond to and recover from the impacts of emergencies
- facilitate individual, families, whānau and community response, adaptation and recovery.

Readiness activities must be based on an understanding of hazard risks and sound risk management principles.

To make sufficient and appropriate resources available for psychosocial response and recovery, all those involved in developing, providing and maintaining psychosocial support interventions must identify and address issues specifically related to their capability and capacity.

Emergency psychosocial support interventions should build on the existing clinical skills, services and preparedness within communities and be integrated with broader community emergency plans and readiness activities.

Ongoing readiness activities include:

- planning, exercising and testing arrangements
- training communities and developing appropriate skills within them
- monitoring and evaluating capacity and capability to perform across different types of emergencies.

See more on each of these activities under ‘Strengthening and enabling service delivery’.

Response

Psychosocial support response includes all actions and interventions taken during emergencies to minimise the psychosocial impacts on individuals, families, whānau and communities.

Agencies must work together to deliver services in a time of crisis and uncertainty. For example, it may be that people are still missing, the dead are yet to be identified, families are separated and little information is available.

To deal with such situations, multiple agencies must make effective, integrated responses. Those responses must be based on a readiness to act; on scalable, flexible and adaptable organisational structures and capabilities; and on clear, focused communication and information management.

Response activities focus on:

- providing for basic physical needs, including need for safety, shelter and appropriate medical intervention for any injuries
- addressing immediate, short-term financial concerns that may be a source of stress

- restoring family, whānau, social and community connections
- supporting individuals and communities to help themselves and build resilience.

An effective response at all levels will contribute to psychosocial recovery. Part of the success of the response lies in the way in which services are delivered. For example, services that help to enhance recovery are those that keep families together by providing emergency or temporary housing, give children safe spaces in which to play, and have good ongoing communication with individuals and communities.

Health and disability services should work with partner organisations and affected communities as they transition from the immediate response to longer-term recovery.

Recovery

The primary objectives of psychosocial recovery are to:

- minimise the physical, psychological and social consequences of an emergency
- enhance the emotional, social and physical wellbeing of individuals and communities.

Psychosocial recovery is not about returning to normality. It is about positively adapting to a changed reality. Recovery may last for an indeterminate period, from weeks to decades.

With effective psychosocial support, other aspects of the recovery process (eg, rebuilding) will not further harm individuals or their communities. It also helps to develop individual and community resilience as it empowers people to care for themselves and others by drawing on, and developing, their existing capabilities, resources and networks. People and communities who are able to care for themselves typically do better than those who expect others to look after them and who use coping strategies that have been shown to be unhelpful (eg, blaming and externalising responsibility).

Activities to advance psychosocial recovery may include:

- implementing a ‘whole of community’ recovery plan (developed before the emergency); and reviewing and revising the plan as needed
- making clear the roles, responsibilities and referral pathways for delivering psychosocial support interventions
- assessing individuals with ongoing psychosocial difficulties and providing interventions to meet their needs
- monitoring and supporting service providers, who may themselves be affected by the emergency
- continuing to monitor psychosocial support needs in the affected population and provide those with continuing needs with long-term access to mental health care services
- identifying and empowering social and community leaders
- providing opportunities for, or enabling, communities to come together
- providing work and rehabilitation opportunities for those affected to re-adapt to everyday life routines and be independent
- encouraging and enabling activities that promote self-help among individuals, families, whānau and communities
- anticipating and planning to deal with reminders of the emergency (such as anniversaries)
- evaluating and revising psychosocial recovery plans and arrangements.

How emergencies affect people

Most people affected by an emergency will experience some level of distress – that is, they have negative experiences and emotions that do not indicate problems with psychological functioning. During an emergency, distress is considerably more prevalent than mental health disorders and, for most people, it is tolerable and short-lived, lasting only while acute and secondary stressors continue.

Importantly, although such reactions can be seen as normal, or within the expected range of experience, they should not be dismissed. It is possible that such distress masks deeper community-level reactions that could be related to either:

- pre-existing social disparities, which can play a significant role in the ability of particular groups to immediately respond to and cope with the aftermath of an emergency, or
- the impacts of forming and implementing post-emergency policy, which may create new inequalities and widen existing ones.

It is necessary to analyse the psychosocial context and continue to monitor and assess it in order to identify and understand any emergent patterns in such responses, and to identify those needing more psychosocial support. It is also important to investigate and address any underlying causes that have not been addressed.

Mental health disorders arising from emergencies encompass far more than the experience of post-traumatic stress disorder (PTSD) or other disorders such as depression or other anxiety disorders. In most emergencies, the majority of people do not develop significant mental health disorders. Many people show resilience – that is, they are able to cope relatively well in adverse situations. Research shows that, on average, 80–90 percent of those who experience some level of distress tend to return to their regular or usual emotional range, with time, help and the use of effective coping strategies. Numerous interacting social, psychological and biological factors influence whether people develop mental health disorders or show resilience in the face of adversity.

Psychosocial problems in emergencies are highly interconnected, yet specific problems may be mainly either social or psychological in nature. Significant problems that are largely social include:

- pre-existing (pre-emergency) social problems (eg, extreme poverty, political oppression, belonging to a group that is discriminated against or marginalised)
- emergency-induced social problems (eg, separation of family or whānau, disruption of social networks, destruction of community structures, resources and trust, increased gender-based violence)
- recovery-induced social problems (eg, undermining of existing community structures, networks or social identity and attachment processes)
- the social impact of secondary stressors, which are the circumstances, events or policies that are indirectly related to or are a consequence of an emergency. Secondary stressors can worsen social problems that existed before the emergency. They can also complicate recovery when their impact becomes greater than the emergency event itself.

Similarly, problems that are mainly psychological include:

- pre-existing psychological problems (eg, mental health disorder, previous trauma, alcohol misuse)
- emergency-induced psychological problems (eg, mental health disorders caused by degree of exposure, distress during the trauma, perception of threat to life and grief may lead to depressive and/or anxiety disorders)
- recovery-related psychological problems (eg, anxiety due to a lack of information)
- the psychological impact of secondary stressors (eg, issues with uncertainty, anger associated with injustice, and loss of health, friends, family, whānau, property, employment).

On the other hand, adaptive factors that give protection and promote recovery and resilience include:

- help from others, which may involve providing information or giving tangible, social or emotional support
- individual coping: sense of safety, hope, efficacy, arousal management (eg, self-soothing abilities), problem-solving abilities, helpful thinking strategies, emotional coping abilities (eg, reframing, acceptance, humour), and activities that are pleasurable and give a sense of mastery, including returning to normal routines
- working with, helping and staying connected to others
- collective problem solving and collective helping, and keeping up supportive social networks.

Understanding how people behave and their mental health needs before, during and after disasters and major incidents is of great importance when planning for disasters because it has implications for how:

- societies, communities and families plan and prepare for all kinds of disasters
- responsible authorities provide public education and approach working in conjunction with communities to better understand and respond to their needs and preferences and ensure their continuing agency in large-scale disasters
- governments and responsible authorities communicate with the public before, during and after events
- agencies manage events and respond in the immediate, short- and medium-terms.

(Williams and Kemp 2016, p 84)

Psychosocial reactions to emergencies

Key points

- Most people will be affected in some way following an emergency.
- Research indicates that the majority of people will recover with time.
- Being exposed to an emergency can have a mild or severe, short-term or long-lasting impact on an individual's psychological and social wellbeing.
- Although the accuracy of data is uncertain because of methodological constraints, a potentially useful estimate is that up to 15–20 percent of people could be at risk of developing a mental health disorder after experiencing an emergency.
- In complex or recurrent emergencies or those that require a long period of adaptation afterwards, the risk of developing a mental health disorder may increase to one in three people.
- Most of the estimates in the literature are based on research on the first two years after an emergency. Estimates become less reliable after this period.
- Mental health disorders related to an emergency include post-traumatic stress disorder, anxiety states, depression, sleep-related problems and substance misuse.
- Post-emergency distress and mental health disorders have been associated with sociodemographic and background factors, event exposure characteristics, social support factors and personality traits.
- The concept of social capital highlights the role of social support (including social networks, and the norms of reciprocity and trust) in helping to achieve more effective response and recovery following emergencies.

Short-term reactions

Most people will be affected in some way by the experience of an emergency, either directly or indirectly. People who are affected by an emergency may experience more than one type of reaction, and reactions are likely to change over time. Adaptation and recovery are unlikely to happen in a linear way.

After an emergency, people may experience shock, disbelief, numbness, disorientation and uncertainty about the future. Emotional reactions may be postponed or displaced onto apparently trivial matters.

In the intense activity required in the aftermath of the emergency, people may lose touch with their needs and find it difficult to plan, set priorities and make decisions. They may have problems with concentration, thinking and memory, and may feel overloaded or in a state of persistent stress.

The range of emotions and reactions experienced along with the disruption to routines, lifestyle, livelihoods, roles and responsibilities can place significant strain on families, whānau and communities. Policy developments and/or politically driven actions and their impacts on different sections of the community may generate concerns and disquiet about potential negative consequences and equitable treatment. Misunderstanding and confusion may be fuelled by doubt, scepticism and a lack of trust. These reactions should not be dismissed or mollified as they may represent real hardships that community members are experiencing. Steps should be taken to hear any concerns raised and appropriate steps should follow.

Short-term reactions by individuals, families and whānau to an emergency include physical, emotional, cognitive, behavioural/social and spiritual responses (see Appendix 2 for examples of each of these). It is important to recognise that such reactions are fairly typical. Provided they do not last long, these responses can be considered to be normal within an extra-ordinary context. Indeed, these transitory reactions to emergencies not only are appropriate but, for some, may well be adaptive.

Short-term reactions are not unusual and can be useful

Many people struggle to make sense of their reactions during and after an emergency. They can feel unusual and outside their normal experience of sensations, thoughts and emotions and may be wondering if they are alone in feeling like this. For example, feeling anxious and afraid during an earthquake is not unusual. Fear is sometimes useful because it acts like your body's alarm system. Your body is telling you that you need to be alert and ready for action. Many people will feel the same way in an emergency. Fear often calms down reasonably quickly in an emergency once you are feeling safe, but if emergency events are occurring close together, these feelings may persist for some time.

Helping people to make sense of their experience and to realise that they are unlikely to be alone in having these feelings can help people to make sense of their reactions and to normalise them. This kind of help can be given through simple factsheets and/or public mental health messages. Where individuals have these reactions for more than a few weeks, it is advisable to refer them for a more thorough assessment for possible intervention.

Many of these responses may be compounded by sleep difficulties, which is one of the most widespread problems people report having after emergencies. Several nights of losing sleep, perhaps just one or two hours a night, reduces our ability to function. People take longer to finish tasks, have a slower reaction time and make more mistakes, thus increasing the economic burden on affected communities. Other significant consequences of sleep difficulties are their detrimental effects on psychological and physical health.

During this time of intense, changing emotions and adjustment, people may also experience strong feelings of togetherness, altruism and concern. Though based largely on anecdotal evidence, it appears that early emergent and community-driven responses may promote a 'honeymoon period' for a short time (two to three weeks) following an emergency. However, after this period, people seem to experience fatigue and the community mood drops. A sustained recovery period is thought to then occur. It would be wise to treat such a pattern as a possibility but not a certainty during any given emergency and post-event adaptation and recovery period. The complex characteristics of any hazard and the affected population combined with unknown secondary stressors as they emerge may lead to different patterns of community impact.

People who are well supported and able to plan and manage their recovery with an understanding of their whole situation report gaining new or increased wisdom or understanding, positive shifts in priorities for their lifestyle and value system and new or strengthened coping skills.

Longer-term reactions

While most people who experience an emergency tend to recover with time, others are at risk of experiencing more severe and long-lasting problems. For some, the impacts of the emergency may be delayed, only becoming obvious a year or so later. These impacts can include economic hardship, having to move home repeatedly, the effects of living under prolonged stress, physical health problems, loss of psychosocial resources (including usual patterns of coping and social support networks), relationship problems and mental health disorders.

Studies vary considerably in their estimates of the proportion of affected people who go on to develop mental health disorders. However, evidence suggests that approximately 15–20 percent of people may be at risk of developing a mental health disorder after an emergency. In complex or recurrent emergencies or those that require a long period of adaptation afterwards, the risk of developing a mental health disorder may increase to one in three people (Salguero et al 2011; North et al 2012; North 2014).

Research on mental health disorders after an emergency focuses on rates of PTSD but also includes some work on mood-related problems (eg, depression and suicide), anxiety, sleep problems and additional issues for children and youth. New alcohol and substance use disorders are rare after disasters and little is known about relapse rates of pre-existing substance use disorders.

The mental health disorders most typically, but not exclusively, reported after an emergency include:

- depression
- anxiety-based symptoms, including acute stress disorder (ASD) and PTSD
- sleep problems
- prolonged grief
- mood disorders, including depression
- substance misuse.

In addition, reports of unexplained physical symptoms can increase after an emergency. For some people, these symptoms are thought to be a proxy for psychological distress where cultural or perceived stigma may make it challenging for them to directly report thoughts or feelings of distress.

Many people who develop a mental health disorder may have more than one problem or co-occurring disorders. This is particularly true for those diagnosed with PTSD. The presence of comorbidity means that services should be designed and delivered in such a way as to identify and respond to the full range of people's needs.

Importantly, much of the current understanding about psychosocial and mental health reactions to emergencies is based on research focused on individuals. So the findings from this research cannot be readily generalised to groups, communities or populations. It must be recognised that psychosocial recovery is a collective activity and a shared responsibility. The overemphasis on individual responses brings the risk that the importance of group contexts will continue to be underestimated and undervalued.

Risk factors

Long-term adaptation and recovery vary significantly due to the complex interaction of psychological, social, cultural, political, environmental and economic factors. There is limited understanding of the nature and extent of the influence of risk and adaptive factors beyond those factors that are directly related to being exposed to an emergency. Despite a growing body of knowledge about resilience, risk and adaptive factors, it is difficult to predict who is likely to recover from their immediate reactions, who may experience sustained distress or who may develop a mental health disorder. However, it is likely that multiple, repeated or recurrent emergencies in the future, resulting from increased exposure to hazards such as changing rainfall patterns, will become an enduring and persistent challenge for psychosocial wellbeing.

For those involved in an emergency, their experience can differ in both type and intensity. Emergencies challenge the resources and resilience of individuals and communities. Each person has a unique personal history and set of circumstances that influence their experience of an event and their response to it. These influences include beliefs, values and resources of the individual, family, whānau and community. Earlier life circumstances, as well as stressors that happen after an event but are unrelated to it, can hinder a person's recovery. The risk factors identified in the literature (see Table 1) are simply a starting point as issues for consideration. Service providers must understand the nature and contexts of the communities they serve.

Table 1: Summary of risk factors

Pre-emergency factors
Personal capabilities and attributes
<ul style="list-style-type: none">• Low levels of personal or social support• Few current attachments• Lack of positive psychological traits (eg, optimism, self-efficacy) believed to buffer stressful life events• Female gender• Age and developmental stage (children and older adults)
Personal experiences
<ul style="list-style-type: none">• Previous mental health history• Substance misuse problems• Prior exposure to traumatic experiences• Concurrent life stressors, not related to the emergency• Disadvantage (lower socioeconomic status, migrants and marginalised groups)
Characteristics of the emergency
Nature of emergency
<ul style="list-style-type: none">• Human-made disasters• Sudden and unexpected events• Widespread death and destruction• Exposure to mass violence, grotesque scenes and sensory experiences
Impact of the event
<ul style="list-style-type: none">• Higher perceived level of threat to life (self or others)• Physical injury• High levels of personal loss (loved ones, possessions, livelihood, pets, livestock, places within which there is social attachment)• Severe disruption to physical environment and community systems• Major property damage• Proximity to and close involvement with the emergency• Serving as an emergency worker/responder

Post-emergency factors

Response to the event

- High levels of rumination
- Presence of survivor or performance guilt
- High and sustained levels of anger
- Medical illness, or chronic health problems
- Acute stress experiences
- Coping via avoidance, self-blame
- Coping via substance abuse

Secondary stressors

- Compromised/disrupted social and/or family and whānau relationships
 - Relocation or displacement
 - Social or relationship problems, marital, family and whānau discord
 - Adverse reactions from others (eg, blame, neglect, rejection)
 - Financial pressure and/or vocational problems, unemployment, loss of livelihoods
 - Problems associated with home relocation, rebuild or repair
 - Problems arising from seeking and receiving help
 - Unrecognised or de-legitimised grief (eg, companion animals, livestock, meaningful possessions)
 - Further losses post-emergency
-

Source: Adapted from Williams et al (2014) and IASC (2007)

Though an emergency may initially affect a particular geographical area, population movements may extend the area over which people feel the impacts to neighbouring areas or further afield. For example, the Canterbury earthquakes saw the largest movement of population in New Zealand since the Second World War. The consequences for the 'non-affected' areas in meeting the needs of people moving into their region include having to provide schooling and appropriate residential accommodation, and building the capacity of health and disability services to meet increased demand. In addition, those areas that are significantly depopulated may have their own consequences to deal with. It is important that neighbouring regions plan collaboratively to address these risks, using national resources to deliver complementary and additional capacity if needed.

The risk of psychiatric morbidity is greatest in those with high perceived threat to life, low controllability, lack of predictability, high loss, injury, the possibility that the disaster will recur, and exposure to the dead and the grotesque (Ursano et al 2008, p 1018).

Research has focused on some groups considered to be vulnerable or at greater psychosocial risk in emergencies, including children and adolescents, older adults, response workers, people with disabilities, disadvantaged and marginalised groups, people with pre-existing mental health disorders and those affected by secondary stressors. Key findings about each of these groups are summarised below.

Children and adolescents

Children and adolescents have distinct vulnerabilities in emergencies, including unique physiological, psychological and developmental needs. Emergencies can undermine their basic assumptions about their world being a safe, stable and largely predictable place.

Most children and adolescents exposed to traumatic events are likely to experience some psychosocial distress, which is generally short lived. For some, these experiences will not subside spontaneously and will instead become clinically significant, persistent and impairing mental health problems. These problems may include behavioural and attentional issues, depression, panic disorder, specific phobias, ASD and PTSD.

Developmental problems such as loss of previously mastered skills, known as regression, may occur at all ages, including in adults, but are a particular risk for children up to mid-adolescence. The impacts of regression will be relative to age and level of development.

In very young children, other clinical presentations may include the onset of fears not specifically associated with aspects of the trauma.

Older adults

Older adults are vulnerable to disproportionately higher health and mental health issues following emergencies. Compared with younger adults, they are more likely to experience PTSD symptoms and to develop adjustment disorder. The underlying reasons for this vulnerability are multifaceted and vary by the type of emergency as well as by individual comorbidities such as hypertension, diabetes, stroke and heart disease. Other factors, such as the need for prescription medications, low social support, visual and hearing impairment, diminished mobility and poor economic status, have also been associated with an increased risk of negative health outcomes. Older adults may also not seek help, so special care must be taken to care for this group.

However, a focus on older adults needs to be carefully nuanced. Research indicates that in comparison with those in the 60–74 years age group, those over 75 years of age are more likely to experience problems associated with access to appropriate health care, rather than problems associated with being exposed to the traumatic event itself. It is also noteworthy that the difficulties experienced after disasters seem to be particularly problematic for those aged 40–60 years, as personal, family, whānau and financial responsibilities tend to peak in middle age.

Response and recovery workers

A wide range of professional staff, volunteers and organisations play an increasingly important role in emergencies. Response and recovery workers can include the emergency services (police, firefighters, paramedics), helicopter pilots, divers, mountain rescuers, coast guards, hospital trauma care personnel, search and rescue teams, dog handlers, veterinarians, representatives of non-governmental organisations, clean-up and construction workers, health and social welfare workers as well as faith groups and volunteers.

It is important to recognise the potential impact on the mental wellbeing of rescue workers, aid workers and health care and other volunteers and staff who are involved in emergencies, as these people provide essential services during both the response and the recovery. The psychosocial and mental health impacts on response and recovery workers tend to be less intense than they are on people who were directly affected, but can still be significant.

Several reasons may explain this level of impact. For example, response and recovery workers may have greater exposure to stressful contexts as they continue to help people through a post-disaster adaptation period. Alternatively they may experience a lack of support as their organisations become increasingly overloaded and are unable to staff their core functions without putting their personnel under increasing and cumulative strain. It becomes critical then

to encourage organisations and individuals to reflect on the contexts in which they are operating, in order to take measures that protect them from significant harm.

A number of organisations (eg, Red Cross) have provided support tools for these groups to help them to identify causes of stress, individual signs of stress and strategies to reduce the impact.

People with disabilities

People with disabilities are disproportionately affected by emergencies. The limited research in this area indicates that they are at higher risk of injury, death, loss of property and difficulties during sheltering. This increased vulnerability is due to interrelated individual, environmental and social factors, such as low income and employment rates, social stigmatisation, poor housing, secondary complicating health conditions, reliance on others and potential lack of access to basic care and services.

Disadvantaged and marginalised groups

Emergencies do not affect all members of society equally and can increase existing disadvantages such as low income, low employment, lack of social support networks, social stigmatisation, poor-quality housing and barriers to accessing appropriate services and care. Therefore certain groups of society, such as those with lower socioeconomic status, migrants, former refugees and the homeless, may be at higher risk of negative consequences after an emergency.

People with pre-existing mental health disorders

People with pre-existing mental health disorders are especially vulnerable to the impacts of an emergency. Research indicates that having a mental health disorder before an emergency is one of the most important risk factors for post-emergency mental health disorders. This group may include:

- people who have had a mental health disorder in the past but are currently in a good state of mental health and wellbeing
- those with active mental health disorders who need continued care.

In the inevitable stress and disruption following an emergency, they may be displaced from their homes and be at risk of abandonment, neglect and abuse. Without their usual therapeutic and emotional support networks, they may not recognise the risks that their condition or new circumstances may lead to a relapse, or they may be unable to receive essential medication or care.

The stress associated with an emergency may trigger a relapse or increase in existing symptoms for people with a history of mental health problems. The often explicit and wide media coverage of emergencies can increase such stress. People with mild to moderate mental health problems may present at primary health care or emergency facilities with unexplained, somatic complaints. By contrast, those with severe mental health disorders may not seek help at all, for reasons such as isolation, stigma and fear of being rejected, lack of knowledge or awareness of their own situation, or limited access to services.

Therefore, it is critical that primary care and specialist mental health services have arrangements for business continuity in emergencies in order to protect these groups from relapse into further mental health disorder or from a worsening of existing problems.

Secondary stressors

Secondary stressors are circumstances, events or policies that are indirectly related to or are a consequence of an emergency event, which result in emotional strain among affected individuals and make it more difficult for them to return to what is perceived as normality. Examples of secondary stressors include ongoing financial strain, conflict in families and couple relationships, job insecurity and/or loss, difficulties in insurance claim settlement, repeated relocations, and having to give up pets when moving to other accommodation.

For some people, the secondary stressors that follow from the disruption and dislocation an emergency creates may have a greater impact than the primary event. These ongoing, unresolved factors may result in emotional distress and hinder people as they try to reconstruct their lives, livelihoods, families, social attachments and communities. Research indicates that the role of secondary stressors in developing and maintaining significant distress may have been underestimated and may significantly delay and complicate people's adaptation after an emergency. It is critical to understand secondary stressors as a significant risk factor and to take steps to learn about their nature in each emergency so that they can be reduced effectively.

Adaptive factors

The process of developing individual psychosocial resilience is not linear. It involves positively adapting, continuing to develop personally in response to adversity and change, rather than being a stable goal to be reached. It also involves dynamic interactions between a person and the wider social, physical and cultural environments, as well as a range of individual characteristics and reactions to acute or chronic stressors. Table 2 summarises potential adaptive factors.

The primary adaptive factor consistently identified in research and reflected in evidence-based practice is social support. Social support is the perception and reality that you are cared for, have help available from other people and are part of a supportive social network. These supportive resources can be emotional (eg, nurturance), tangible (eg, financial assistance), informational (eg, advice) and companionship (eg, sense of belonging).

Both perceived levels of social support available and actual support received, particularly from family, whānau and friends, buffer the effects of stress and can reduce the prevalence of distress and psychological symptoms. Support from community and agencies is also important.

The community's participation and involvement in ongoing recovery builds trust and engagement. Strong social infrastructure, such as social connectedness, networks, social capital, social identity and attachment processes, has an important role in advancing emergency response and recovery.

'Social capital' refers to resources (such as information, aid, financial resources, and practical, emotional and psychological support) accessed through social connections. The social connections may be:

- among close network members (bonding social capital)
- across heterogeneous networks and organisations (bridging social capital)
- extending to higher levels of government or to those in positions of relatively high power and status (linking social capital).

Social capital includes social networks and the norms of reciprocity and trust, which are vital to help prepare for and recover from an emergency. While trust has been shown to increase within communities and towards strangers following emergencies, in certain circumstances trust within communities can be eroded, such as when:

- people are competing for scarce relief and recovery resources
- some have more information than others
- people are displaced and forced to migrate to other communities.

Emergencies can dramatically alter the physical and social landscape and, as a consequence, can cause individuals to re-evaluate their sense of place. This sense of place consists of three aspects:

- 1 **place attachment** – the positive cognitive and emotional bond that develops between individuals and their environment
- 2 **place identity** – a part of each individual’s self-identity as it relates to their physical environment
- 3 **place dependence** – an individual’s perceptions about how suitable a given place is to meet their needs and desires.

Following an emergency, people may lose confidence in the norms, networks and mutual trust that are supposed to protect them and allow them to interact with institutions. This feeling has been defined as ‘loss of place’. Psychosocial interventions can aim to re-establish a ‘sense of place’ to make up for this loss.

For Māori, healthy ecosystems (with greater life-supporting capacity) are clearly linked to people’s cultural and spiritual wellbeing (Harmsworth and Awatere 2013). When an emergency has a negative impact on the environment, it may have a negative impact on Māori wellbeing. The Māori cultural concept of kaitiakitanga – stewardship or guardianship of the environment – is seen as an active rather than passive relationship (Roberts et al 1995). This means that there is an explicit and highly valued link between the environment and people’s wellbeing that needs care and repair when the environment is damaged, as well as being a source of strength and resilience.

People’s attachment to precious objects also needs to be considered in emergencies. Practical items such as identity documents and insurance details are very important in sorting life out after an emergency. But loss of other possessions can significantly disrupt a person’s sense of identity and meaning. Possessions may often communicate what is important in people’s lives. Although such meanings may not be obvious to others, they will be for the owners, who gain a sense of pleasure, attachment or wellbeing, and a deeper sense of identity from them. Therefore, loss of important possessions such as photographs or family heirlooms may impact on a person’s recovery and wellbeing after a disaster. The preparedness stage should include steps to identify treasured items, while the recovery stage should include help to recover such possessions if possible.

Table 2: Summary of adaptive factors

Adaptive factors
Being in a marital or de facto relationship
Higher socioeconomic status
Being in employment
Ability to plan and manage their recovery with an understanding of their whole situation
Secure sense of identity
Help from others:
• information
• tangible support
• social support
• emotional support
Individual coping:
• sense of safety
• hope
• efficacy
• arousal management (eg, self-soothing abilities)
• problem-solving abilities
• helpful thinking strategies
• emotional coping abilities (eg, reframing, acceptance, humour)
• activities that are pleasurable and give a sense of mastery, including returning to normal routines
Community coping and adaptation:
• working with, helping and staying connected to others
• collective problem solving and collective helping
• keeping up social and support networks
• focusing on values and spirituality
Distraction can help in the short term. Being engaged in other activities offers respite from constantly trying to engage with emergency-related problems that need addressing
For children, a family or whānau that provides warmth, support, consistency, predictability and a positive coping strategy. Being able to successfully regulate emotional experience also helps
Personal psychosocial resilience in which people:
• perceive that they have and are able to accept help
• have strong acceptance of reality
• have belief in themselves underpinned by strongly held values
• have the ability to improvise

Source: Adapted from Williams et al (2008)

Strengthening and enabling service delivery

The majority of people adapt to post-emergency environments well, drawing on their own resources and the support of their families and communities. For the minority of people, and for some aspects of community functioning, psychosocial recovery can take many years.

Providing effective psychosocial interventions requires:

- collaborative partnerships based on clear roles and responsibilities and effective leadership
- careful planning
- good training and support for personnel at all levels and in all agencies
- engaged, informed and resilient communities
- effective communication
- regular monitoring and evaluation.

Well-coordinated and well-resourced psychosocial interventions can support many people in affected communities to adapt after an emergency. Such interventions can also assist people to help others.

Care must be taken to carry out community-level assessments so that resources are targeted to provide effective psychosocial interventions when and where they are needed. This means conducting both needs assessment and analysis of the psychosocial context in parallel. It is important not to withdraw resources too early to avoid creating any resource gaps after spending the initial funding allocations. It is also critical to match referrals to existing services with sufficient funding as the post-emergency period progresses, so that those services can maintain and develop their capacity to meet increased workloads.

These enabling factors, relevant across all phases of an emergency, are vital to ensure that services coordinating, designing and delivering psychosocial interventions continue to effectively contribute to post-emergency adaptation and recovery in the long term. However, because the psychosocial impacts of emergencies are like ripples in a pond with consequences reaching out well beyond the primary location of an event, psychosocial support must be the concern of all providers, locally, regionally and nationally.

Leadership and coordination

Effective leadership and coordination across multiple agencies before, during and after an emergency are vital for an effective response to and recovery from the emergency. Flexible and coordinated responses are based on strong local partnerships, clear roles and responsibilities, and transparent care and referral pathways between services and agencies.

Organisations, groups and communities that have strong day-to-day relationships are generally more likely to function well following an emergency. Relationships based on trust and shared understanding can be fostered through information sharing and both formal and informal interactions such as training, workshops, and joint planning and exercises. These relationships are dynamic and will encompass a range of diverse actors, bringing different valued capabilities, capacities and resources to emergency response and recovery. Inevitably, these actors will vary in size (eg, national, regional, local) and other dimensions (eg, proportion of staff who are voluntary or paid, or whether they are established or emergent organisations). These differences should be acknowledged and proactively managed to ensure effective cooperation and understanding.

National telephone helpline

Where appropriate, national resources can be engaged to support local and regional response, especially where issues such as population movement are involved. One possible approach is to develop regional reciprocal relationships that allow an organisation to increase its capacity and staff cover during an emergency so that it can initiate and sustain psychosocial interventions and mental health assessment and treatment. Another resource to be aware of is Healthline.

Healthline is one of a number of integrated, national-level telehealth operations that take advantage of technological opportunities to deliver flexible and adaptable services to meet identified needs. When needed, this telehealth and disability service has the capability and capacity to support psychosocial initiatives and interventions, as well as mental health assessments and referrals. It can provide this support through personal interactions in voice calls with registered nurses and mental health and addictions specialists, online interaction and personalised automated advice through online assessments and guides, supported by website self-help and health information.

The Ministry of Health and the Accident Compensation Corporation co-fund Healthline. The service is free of charge to users and available 24 hours a day, seven days a week.

Roles and responsibilities

The *National Health Emergency Plan* (Ministry of Health 2015) specifies the general roles and responsibilities of the health and disability sector (including all providers of psychosocial support services) across all components of emergency management. These roles and responsibilities include:

- planning for functioning during and after an emergency
- being capable of continuing to function to the greatest extent possible (even though at a reduced level) during and after an emergency
- developing, reviewing and improving emergency plans
- responding to the emergency as required.

The Ministry of Health and district health boards (DHBs) are the agencies responsible for coordinating psychosocial support during and after an emergency.

- At the national level, the Ministry of Health is responsible for coordinating the provision of psychosocial support and provides the required health and disability services by funding, planning and providing services, including by contracting organisations.
- At the Civil Defence Emergency Management Group level, DHBs are responsible for coordinating the provision of psychosocial support services.
- DHBs advise non-governmental organisations and primary health organisations on the type and nature of services needed for ongoing psychosocial support.

Welfare Services in an Emergency: Director's guideline (Ministry of Civil Defence and Emergency Management 2015b) provides information and guidance about the welfare roles, structures and responsibilities described in the *Guide to the National Civil Defence Emergency Management Plan* (Ministry of Civil Defence and Emergency Management 2015a). The Director's guideline (Ministry of Civil Defence and Emergency Management 2015b) lists the agencies that may be required to provide support to the psychosocial support sub-function.

DHBs cannot, and should not, be the sole providers of psychosocial interventions. Many actors across the DHB regions and the wider health sector can and should be involved, for example, public health units, primary care, non-governmental organisations and specialist mental health services. The DHBs' role is to coordinate agencies and groups (both in the health sector and from the wider welfare sector) and to advise them on the type and nature of interventions, services and initiatives needed for ongoing psychosocial support.

Planning

Planning is essential to effectively reduce and manage psychosocial impacts of emergencies. It is an integral part of the readiness process and psychosocial support providers must be involved in all phases and aspects of planning.

All agencies and groups providing psychosocial interventions must undertake planning and preparedness activities to ensure that they can fulfil their roles and contribute to an effective response and optimal recovery.

Effective planning is a cyclical, deliberate process of building a programme of interrelated activities that are flexible and responsive to differing types of emergencies. Key planning activities include:

- communicating and consulting
- assessing and monitoring risk
- monitoring and reviewing arrangements
- educating and training personnel
- developing and maintaining relationships and communication with relevant partners, stakeholders and communities
- rehearsing, exercising and testing plans, including the psychosocial support plan.

The problem is that disaster plans are too often designed around the most recently impacting event, which, in probability, may not be the event that occurs next. It is a challenge to maintain a pool of disaster experience and of staff who are interested in the absence of a real threat (McFarlane and Williams 2012, p 9).

Training considerations

To effectively carry out psychosocial interventions and recovery plans and actions during an emergency, it is necessary to train, manage and support personnel to prepare them for their roles and responsibilities across all phases of an emergency. All those involved in planning or delivering psychosocial interventions to affected individuals and communities should receive ongoing training, support and supervision. This includes ensuring that those involved in delivering mental health care treatments have a good understanding of where they fit in the system.

As the needs of those affected by an emergency increase, so does the need for training for those providing psychosocial interventions. Training should, therefore, be targeted according to the activities that individuals will be engaged in and the level they will be working at. The following are three important levels of training to consider.

Foundation training

Foundation training is primarily for people actively engaged in the community and in direct contact with people affected (eg, health sector workers such as general practitioners and nurses, local government staff, non-governmental organisation personnel, school teachers and principals, and others involved in community-based psychosocial activities). The training should provide a basic awareness and understanding of: the idea of normal reactions to abnormal circumstances; the psychosocial context and impact of potentially traumatic events on individuals and communities; the reactions people are likely to have; how helpers' actions may help or hinder the recovery of others; signs that a person is struggling; where to get help and support; and how to refer people for more specialised interventions.

An example of how those trained to this level might use their training is psychological first aid (PFA). This is an approach for helping people immediately after an emergency to reduce initial distress and to foster their adaptive functioning in the short and long term. The PFA training provided by New Zealand Red Cross also includes considerations for working with Māori.

Foundation training should also be offered to media partners. Good relationships and shared understanding with media partners contribute significantly to the success of efforts to influence the psychosocial context to promote better health and wellbeing for affected communities.

Tier 1 training

Tier 1 training is for trained professionals (eg, psychologists, social workers, counsellors) providing psychosocial interventions to those affected by the emergency, including interventions that target the psychosocial context (eg, parenting workshops and peer/professional collaborative groups), or those interventions or initiatives targeted at a population level. The purpose of the training is to:

- give the professionals skills and knowledge that are specific to the needs of individuals and communities following an emergency
- build their capacity to comprehensively assess physical, psychological and social needs and, if necessary, accept referrals for the 15–20 percent of people (see ‘Longer-term reactions’) who may require more help than psychosocial interventions in the community offer.

When people are trained at this level, they may provide interventions such as psycho-education programmes for affected community members, and skills for psychological recovery, which is usually provided by psychologists, social workers or counsellors with specific training in community disaster response. (See more about possible interventions at this level under ‘Psychosocial interventions’.)

Tier 2 training

Tier 2 training is for professionals with previous training and expertise in providing specialist mental health treatment services (eg, clinical psychologists, psychiatrists, other specialist mental health practitioners). The training should add to their existing skills by providing them with an advanced understanding of the needs of existing and new mental health clients affected by the emergency.

Professionals trained to this level can undertake evidence-based clinical interventions such as trauma focused cognitive behaviour therapy for children and adolescents and other such evidence-based treatments for adults. However, it is the responsibility of mental health service providers to ensure that the clinical basis for using particular treatment protocols and interventions is well-matched to the individual, family, whānau or community in need by conducting a well-planned assessment and considering available and evidence-informed options.

Communication

Effective communication with those affected by emergencies and with the wider public is fundamental to psychosocial recovery. Communication has a critical role in all areas of emergency management, ranging from informing people of likely threats and preventive action through to enabling people to take responsibility for their own recovery.

Those agencies that are responsible for psychosocial support services should consider how the communications strategy impacts on, and can contribute to, psychosocial recovery. It is also important to recognise the two-way nature of communications, to listen to those affected and to use this information effectively in developing recovery plans and activities.

Some key considerations are to:

- acknowledge loss and grief
- inform the affected population about the emergency, relief efforts and their legal rights
- provide access to information about normal responses over time and positive coping methods
- get information about the situation and people’s concerns and provide it honestly and openly, and at levels that they can understand
- use a range of communication channels, including written leaflets, websites, social media, telephone helplines and outreach (door knocking). It may be necessary to repeat communications and to deliver them in multiple formats that are short and easy to absorb and understand, acknowledging that people may have difficulty concentrating during and after an emergency

- ensure staff working with the media follow a coordinated communications strategy
- if holding informal community meetings, be prepared to answer questions and act on community concerns. Such meetings can be helpful and reassuring for affected communities if handled sensitively but honestly. Think carefully about which staff speak at these meetings (ie, they should be suited to a public engagement role) and what preparation they need to fulfil this role.

Engaged, informed and resilient communities

Supporting individuals, families, whānau and communities to recover from emergencies requires a community-based approach that strives to include community members in all aspects of psychosocial recovery. These aspects include planning and preparedness, assessment of needs, programme development and implementation, and monitoring and evaluation.

Today, the idea of community means more than the physical infrastructure of a human settlement. Communities are made up of dynamic, networked groups of people who share common places, values, interests, and cultural, religious or other social characteristics. They also have the capacity to influence their basic common needs given their particular social and political context.

Resilience building is an ongoing adaptive process, not an end-state to be achieved. It includes complex, interrelated and dynamic elements, such as social connectedness, reciprocity and trust.

There are many different theories about, and approaches to, developing community resilience. Given communities and their social and economic contexts are enormously diverse, no single approach will apply to all of them.

A number of authors have identified various key dimensions or attributes of community resilience. According to the Post Carbon Institute (Lerch 2015), important foundations for effectively building community resilience are:

- people – it is community members who have the power to envision the future of the community and build its resilience
- systems thinking – essential for understanding the complex, interrelated crises now unfolding and what they mean for our similarly complex communities
- adaptability – a community that adapts to change is resilient. But because communities and the challenges we face are dynamic, adaptation is an ongoing process
- transformability – some challenges are so big that it's not possible for the community to simply adapt; fundamental, transformative changes may be necessary
- sustainability – community resilience is not sustainable if it serves only us, and only now; it needs to work for other communities, future generations and the ecosystems on which we all depend
- courage – as individuals and as a community, we need courage to confront challenging issues and take responsibility for our collective future.

Community resilience can only be supported through meaningful engagement that enables a community to work together to understand and manage the risks that it faces; feel supported to take ownership of psychosocial recovery plans and activities; and to care for each other. To achieve active community participation, it is important to:

- engage with communities proactively and meaningfully
- support and enhance existing networks, activities and services
- base activities on existing strengths and identified unmet needs
- enhance self-reliance for all individuals, families, whānau and groups in communities
- ensure that professional psychosocial support services and interventions do not reduce opportunities for self-determination, increase existing inequalities or create new inequalities or vulnerabilities
- meet the specific needs of individuals, families, whānau and communities where practicable.

Tools for understanding your community better

Designing an intervention involves the stages of: assessing and evaluating needs; planning an intervention; engaging stakeholders; implementing the intervention; and ensuring sustainability. Several tools can help with this work.

- Public health approaches described by *The Guide to Community Preventative Services* (Community Preventive Services Task Force 2016) offer established and evidence-informed tools to identify evidence gaps, support collaborative planning, support implementation and the monitoring and evaluation of interventions for ongoing learning and improvement.
- HealthyPeople.gov offers MAP-IT, a helpful framework for intervention design, which outlines a path to successful programmes – mobilise, assess, plan, implement and track. It includes a toolkit with helpful questions to address as you progress through each of these stages (Office for Disease Prevention and Health Promotion 2016).
- Guidance for engaging and communicating with culturally and linguistically diverse communities is also available (Christchurch City Council 2012).

Information gathering, monitoring and evaluation

All agencies providing psychosocial support are responsible for monitoring and evaluating their activities. Under the National Civil Defence Emergency Management Plan Order 2015, agencies are expected to monitor and evaluate their capacity and capability to respond to and help with recovery from emergencies by:

- measuring their performance against standards, benchmarks or performance indicators
- exercising and testing their capacity and capability
- analysing their effectiveness
- tracking their progress towards goals and objectives
- monitoring their compliance with the Civil Defence Emergency Management Act 2002.

Monitoring is an iterative process of gathering and analysing data with the goal of determining if the resources, activities and interventions provided are supporting individuals and communities in their psychosocial recovery. Monitoring may address a range of issues or questions.

- How well are the provided (and planned) activities and resources working?
 - Are they being implemented and used as planned?
 - Are they relevant to and meeting the identified needs?
 - Are they realistic and relevant to the intended aim(s)?
 - Are they effective?
- How well are ongoing needs being addressed?
 - Have new issues been identified that need to be dealt with?
 - Are existing services meeting identified needs?
 - Have new opportunities for supporting psychosocial recovery emerged?
 - Have the targeted population or the external environment changed in ways that affect planned activities?
- What monitoring is in place?
 - Are ongoing and additional threats and stressors being monitored?
 - Is there monitoring of the management of media coverage and public perception?

Monitoring should follow key research and evaluation principles to ensure that the quality of study designs and methods is good enough to allow valid conclusions to be drawn from the findings. It should occur at individual, community and societal levels. Wherever possible, the psychosocial support indicators and instruments used should be well-established and previously reported, and have standardised administration procedures.

Coordinating information gathering and sharing

As far as possible, strike a balance between respecting important privacy concerns and relieving the affected community member of the need to tell their story over and over again. Develop a core body of non-sensitive information that responsible and credentialed professionals can share – with permission – without logging information that may inadvertently be passed on to others. Be particularly careful where domestic violence and/or child protection may be a concern, or in other situations of increased vulnerability.

As psychosocial recovery is highly complex and dynamic, monitoring is an ongoing activity. Additional information should be collected through evaluations that objectively assess the degree to which activities or programmes achieved the intended goals or overall objectives. Usually more comprehensive and costly than monitoring activities, evaluations provide useful information for future planning and programme development.

Some core evaluation criteria are that the activity or programme should:

- be relevant (is appropriate to identified needs and resources)
- be efficient (has been implemented successfully in the intended timeframe and at lowest cost)
- have impact (produces changes that have the desired effect)
- be effective (achieves its objectives)
- be sustainable (its benefits are likely to continue).

Given the importance of information gathering, monitoring and evaluation, it is recommended that service providers develop partnerships with academics and researchers who can provide expert advice on robust methodology.

Delivering psychosocial support

Psychosocial interventions can have significant impacts on individuals, families, whānau and communities. They focus on promoting health and wellbeing, adaptive functioning and the connectedness between individuals and the psychosocial contexts in which they live.

Interventions may be targeted at the individual level, improving psychological, behavioural and/or biological functioning; or at the family, whānau or community level, improving the overall psychosocial context. For example, a community initiative to improve awareness of and access to green spaces and to encourage exercise may improve family, whānau and community connectedness through group activities. For individuals, the same intervention may reduce excess stress hormones (biological level) and promote relaxation and better sleep (behavioural level).

Although treatments for mental health disorders and psychosocial interventions require different approaches, they are closely related. Psychosocial problems that persist over a long time or become very severe without intervention can lead people to develop mild, moderate or even severe mental health disorders. Equally, people with mental health disorders can have psychosocial problems. Psychosocial interventions aim to help individuals improve their wellbeing and may be part of a package to assist those with mental health disorders. However, given psychosocial interventions may not be strong enough to help those with more acute or chronic reactions after an emergency, mental health assessments should be considered for these individuals. In general, psychosocial interventions tend to focus more on influencing the psychosocial context to promote health and wellbeing, rather than being individually tailored treatment packages focused on mental health disorders.

Traditionally, mental health treatments have focused on individual functioning, using pharmacological and/or talking therapy approaches to improve mental health and wellbeing. This same approach applies after an emergency. Mental health treatments should be delivered using a stepped-care approach, enabling people to access appropriate help as assessed by need. Although the majority of mental health treatments target individual psychological factors, as well as biology and behaviour, treatments can also cross into the psychosocial context, for example, through the use of family therapy.

Key elements in providing psychosocial support

Ensure access to basic services and security. Immediately after an emergency, the priority is to remove threat to life, and then to meet immediate physical care needs and protect survivors from further harm and trauma. Physical comfort, practical advice, reassurance and emotional support should be provided with respect, empathy and flexibility. Encourage self-care and planning.

Inform those affected by the emergency openly and honestly, in a way they can understand and using a variety of methods. Provide information about the emergency, relief efforts, their legal rights, normal responses and positive coping methods.

Normalise psychosocial reactions to emergencies. Some level of distress after an emergency is almost universal and is much more widespread than mental health disorders. Because people may have difficulty identifying and connecting with their emotional reactions, they should not be put under pressure to share or re-experience the events and/or their feelings before they are ready or able to. **Do not promote the expectation that mental illness is an inevitable outcome of emergencies.**

Restore relationships of individuals, families, whānau, groups and communities and support those structures that support people to undertake their own recovery. Promote conditions for communities to own and control the recovery and provide ongoing opportunities for networking and engagement.

Coordinate and deliver appropriate psychosocial interventions and mental health treatments to affected individuals based on clearly identified need.

Maintain ongoing access to timely mental health care for those people with persistent psychosocial problems and/or showing delayed indications of mental health disorder. Withdrawing or downscaling services too soon can hold back long-term psychosocial recovery.

Mobilise existing psychosocial and mental health services and embed psychosocial initiatives and interventions into the overall support and recovery system in a coordinated and integrated manner.

Prepare to allocate resource flexibly within and across services to meet identified and changing need.

Train and support all staff and volunteers involved in planning and delivering psychosocial interventions to give them the awareness, understanding, skills and knowledge they need to fulfil their roles. Monitor and support service providers for possible secondary traumatisation and burn-out symptoms and provide information about self-care. Ensure they are aware of their responsibility of doing no harm and understand the idea of normal reactions to abnormal events.

Identification of psychosocial support needs

No matter how long the post-emergency period continues, delivering timely and appropriate psychosocial interventions to support affected individuals and communities must be based on the accurate assessment of psychosocial problems and associated need. This is crucial to effectively coordinate and deliver interventions that provide psychosocial support.

Unlike physical injury, psychosocial problems are seldom obvious. It is through purposeful assessment actions and procedures that they are best identified.

The most effective interventions are those chosen on the basis of an assessment that considers people's emotional, social, physical and psychological wellbeing needs within their psychosocial context. By targeting interventions based on assessed need and with an understanding of the psychosocial context, it is possible to use limited resources in the most effective way and avoid the potential harm of inappropriate or unneeded treatments.

The type of assessment used will vary according to when it is conducted in the post-emergency period. Immediately after an emergency, people are likely to experience symptoms of distress (see Table 1), though relatively few are likely to develop long-term or clinically significant problems. As the degree of disruption and loss becomes clearer, it is important to identify people in immediate and clear need of specialist mental health services. However, in general it is inappropriate to make assumptions about mental health disorders in the early post-emergency phase, and more appropriate to practise 'watchful waiting'; that is, an active surveillance approach that allows time to pass before beginning any treatment. Watchful waiting does not mean doing nothing. Rather, it monitors individuals (eg, when they consult with a health professional) or communities (eg, in terms of patterns of appointments at services by people with specific concerns) as a way of judging whether an intervention or treatment is warranted.

As the recovery period draws out, the impact of secondary stressors becomes more significant and it can be difficult to distinguish between the symptoms of severe and/or prolonged distress and mental health disorders such as PTSD. Generally the difference lies in the severity and duration of stress, the impacts of interventions offered, and the course that the stress experiences and symptoms take. It is important, therefore, that any assessment and diagnosis of mental health disorders at this stage includes an assessment of the continuing impact of secondary stressors.

Assessment must be undertaken at individual (personal clinical evaluation) and community (screening and surveillance) levels. Ideally, pre-emergency planning and readiness activities have been developed based on knowledge of a community's mental health, vulnerabilities, resources and capacities – that is, the psychosocial support context (see Figure 1).

It is important to assess community psychosocial wellbeing and mental health needs after an emergency in order to:

- identify people at increased risk
- guide the allocation of limited resources
- inform the development of targeted psychosocial support interventions.

Surveillance and screening can be used to identify individuals at risk for mental health problems. However, it is important to recognise that symptom-screening instruments are not diagnostic tools that provide individual assessments or population-based prevalence estimates. Ideally, a positive result from screening is followed by a clinical assessment. Following up in this

way, however, will be challenging after an emergency in which screening identifies many people have been exposed to greater risk.

The type of surveillance and screening tools used should be acceptable to those being screened. Their content should also be appropriate to the context and phase of the emergency. They should be clear, concise and easy to administer and score.

To undertake the challenging task of community assessment, it is necessary to use appropriate strategies, measures and sampling techniques. Data can be collected by using focus groups, case studies and surveys and by searching private or public databases (eg, to identify changes in help-seeking behaviour).

Results from self-report symptom surveys must be interpreted with care. They cannot provide valid prevalence estimates of mental health disorders, but only rough estimates of the mental health of a community. It is also important to differentiate between:

- prevalence rates, which show the proportion of a population who have (or had) a specific illness/disorder in a given period, regardless of when they were first diagnosed
- incidence rates, which measure the number of new cases arising in the population over a given period (eg, over a month or a year after an emergency).

Psychosocial interventions

Following assessment, people must be offered appropriate interventions on the basis of their identified need. To identify an appropriate intervention, a health professional must understand the dynamic nature of the psychosocial context (see Figure 1), as well as having clear processes that are agreed in advance and included in the plans.

The majority of people experience normal stress reactions. Immediately after an emergency, people's primary concerns are about their safety and physical needs such as food, shelter and the desire to be reunited with their loved ones. Psychosocial support interventions provided during this period are usually brief and focused on the immediate present need. They aim to reduce distress, provide information and support, and normalise stress reactions.

These early interventions are indicated for the majority of those affected by an emergency and are not considered formal treatment for mental health disorders. They are usually provided in community settings by a range of agencies.

Early response to emergency events

When planning how to respond in the early stages after an emergency, be aware that practical, pragmatic support delivered with empathy is likely to strongly complement the high levels of resilience that most people exposed to potentially traumatic events show. This support is less likely to be a psychological treatment in the early stages; rather, it will be more psychosocial in nature with key elements that address people's basic needs such as housing, finances and nutrition. The evidence is not clear enough for us to prevent disorder, but we can make it easier for people to adapt and respond with resilience by increasing their access to protective factors and practices and working to remove or reduce further hazards (Bisson et al 2007).

Many of the psychosocial interventions currently in use are not supported by empirical evidence, and emergency contexts and outcomes vary widely. For these reasons, it is not possible to make definitive recommendations about effective intervention approaches, as there is no one-size-fits-all approach. While a lack of evidence does not necessarily mean a lack of effect, those providing psychosocial interventions should always do so with caution to ensure that they do no harm with the methods they choose.

The following is an evidence-informed summary of commonly used psychosocial interventions, including psychological first aid, critical incident stress debriefing, crisis counselling and psycho-education. Other interventions involving psychosocial aspects as well as practical aid and support include telephone helplines and coordination/case management services.

The information below is based on the best evidence available at the time of writing. Given the complex and dynamic nature of knowledge about psychosocial interventions, it is advisable that service providers keep a watching brief to stay up to date with any significant changes in evidence-informed good practice recommendations.

Psychological first aid

Definition and goal: Psychological first aid (PFA) is not a specific intervention but rather an approach that draws on many interventions from a wide variety of sources. Clinicians or non-clinicians may use it to reduce the initial distress caused by traumatic events. The goal is to stabilise psychological and behavioural functioning, support people to adapt psychologically and behaviourally, and help them to access further care if indicated.

Elements: The elements of psychological first aid are establishing contact through a calm, comforting and compassionate presence; meeting basic physical needs and protecting individuals from further harm; listening and information gathering; helping survivors to express their needs and concerns; meeting basic psychological needs; delivering accurate and timely information about disaster operations and available resources; providing social support and coping assistance; and helping people to connect to social support networks and get referrals for ongoing care. It can be delivered in various settings, including homes, as well as shelters, medical triage areas, disaster assistance centres, workplaces, schools and other community settings.

Evidence: PFA is seen as an ‘evidence-informed’ approach that is culturally informed and appropriate for developmental levels across all ages and can be flexibly delivered. PFA appears promising as part of a comprehensive, post-emergency intervention strategy. Despite its widespread use, the goals of PFA are not always clearly understood when it is used and there is a lack of empirical evidence demonstrating its effectiveness. This does not mean that PFA is not effective; rather, its effectiveness is yet to be demonstrated.

Critical incident stress debriefing

Definition and goal: Critical incident stress debriefing (CISD) consists of one or more individual or group sessions provided hours or days after a traumatic event. The goal is to normalise survivors’ reactions, process their trauma experiences, address psychological distress and enhance resilience.

CISD should not be confused with **organisational or operational debriefing**, which aims to identify lessons and modify arrangements to improve an organisation’s ability to respond in future emergencies. The latter has no role in providing individual psychosocial support.

Elements: CISD was designed to relieve trauma-related distress by providing opportunities for survivors to express their feelings, to understand that their responses are normal reactions to trauma, and to learn about common disaster reactions in a supportive context. Mental health workers and disaster responders typically deliver CISD in field settings, such as community shelters.

Evidence: Research indicates concerns that CISD may cause psychological harm because recipients may be re-traumatised, the intervention may be insufficient to address the multiple, complex stressors resulting from disasters and terrorism, and it may prevent people from seeking further help if they believe they have now received sufficient care. **The evidence is clear that single-session individual psychological or critical incident stress debriefing should not be used.** It is unhelpful, and it can cause harm by encouraging people who have experienced trauma to talk about what happened when in high arousal.

Crisis counselling

Definition and goal: Crisis counselling is a poorly defined, brief strengths-based psychosocial intervention delivered by trained, experienced crisis workers and para-professionals. Its goals are to support survivors, help them to cope and connect them with other services.

Elements: Conduct outreach in non-traditional community settings, provide public education, offer supportive individual and group counselling, conduct assessment and referral, and link people to resources and other services if needed.

Evidence: No evidence exists to show crisis counselling is effective immediately after emergencies. There is also a risk that providing immediate counselling may create a false belief that a person will not experience any long-term mental health disorders.

Psycho-education

Definition and goal: Psycho-education informs people about psychological reactions after a traumatic event to reduce the adverse effects by providing a cognitive framework for their experience. The goals are to support survivors of trauma to see their reactions as expected; recognise the circumstances under which they should consider seeking further counselling; increase the use of adaptive ways of coping; and help families and whānau to cope.

Elements: The elements in psycho-education in emergencies are to give information about the causes of psychosocial distress and about treatment options and to promote self-help and coping behaviour. It can be provided in individual and group settings.

Evidence: Psycho-education has been used mostly with mental health disorders and evidence indicates it is acceptable to disaster survivors. However, there is little evidence that it is effective as a standalone intervention with disaster survivors. Instead, it is recommended that it is provided as part of the provision of other services.

Skills for psychological recovery

Definition and goal: Skills for psychological recovery (SPR) is designed to follow psychological first aid in the weeks and months following a disaster or mass violence event. SPR aims to help survivors gain skills to manage distress and to cope with post-emergency stress and adversity.

Elements: SPR is not a formal mental health treatment, but uses skills-building components from mental health treatment that have been found helpful in a variety of post-trauma situations. These skills including problem solving, scheduling positive activities, managing reactions, helpful thinking, and building healthy social connections.

Evidence: As yet, there is little evidence on the effectiveness of SPR. However, research suggests that a skills-building approach is more effective than supportive counselling.

Problem management

Definition and goal: Problem management + is a low-intensity psychological intervention for adults who are impaired by distress in communities that are exposed to adversity. The programme aims to address both psychological problems (eg, stress, fear, feelings of helplessness) and, where possible, practical problems (eg, livelihood problems, conflict in the family or whānau).

Elements: Aspects of cognitive behavioural therapy have been changed so that it is feasible to apply them in communities that do not have many specialists. In addition to two assessment sessions, intervention sessions take place once a week for five weeks. All sessions are individual. The intervention also allows for involving family, whānau or friends if the client wants to. The approach involves problem management (also known as problem-solving counselling or problem-solving therapy) plus selected behavioural strategies.

Evidence: As yet, problem management + has only been tested in Nairobi, Kenya and in Peshawar, Pakistan. It is designed for use in humanitarian environments where access to trained mental health care professionals is limited. There is no evidence demonstrating its effectiveness in New Zealand or countries with a similar profile. For this reason, a watching brief is recommended for this new protocol.

Coordination/case management support

Definition and goals: Coordination/case management support is designed to provide personal support to individuals affected by emergencies. Its goal is to help people access the services they need to recover.

Elements: Elements may vary according to the nature of the emergency but usually include connecting people with available resources including financial (eg, accessing grants), practical and psychosocial support.

Evidence: Several studies explored the roles of these services, particularly in rural Australia and in Christchurch after the 2010 and 2011 earthquakes. These studies focused on use, client satisfaction and service delivery issues rather than on how these services impacted on levels of psychological distress.

Telephone helplines

Definition and goals: During an emergency, existing or new telephone helplines have been used to provide information on services available to those affected by the emergency. The goal is to give people a point of contact to access information and support.

Elements: Elements may vary according to the nature of the emergency but usually include providing information about the impact of the emergency and sources of support, and referring people to specialist services, including counselling.

Evidence: There is little evidence on how these facilities contribute to psychosocial recovery. Research focuses on how acceptable they are to users and their effectiveness in terms of providing information and referring callers to appropriate services.

Targeting psychosocial support

People do not always seek help even when they need it. Ensuring that all those who do need psychosocial support receive assistance is a challenge for service providers. It is important that service providers identify barriers to treatment and use a range of strategies to address them within the broader community response. Providers must also consider how they can best engage with all those affected by an emergency, especially those vulnerable to greater risk. These groups may include children and adolescents, older adults, people with a disability, disadvantaged and marginalised groups, those with pre-existing mental health conditions and the bereaved.

Strategies for targeting psychosocial support may include:

- providing systematic outreach to people in their homes or communities (based on screening to identify populations at risk)
- using novel intervention methods
- addressing community mental health literacy through targeted communication strategies
- monitoring the population for behaviours (eg, self-harm, aggression, or patterns of substance misuse) that may indicate risk of mental health problems.

Social media and psychosocial support

Social media can play a helpful and complementary role in psychosocial responses during and after emergencies, alongside other channels of communication and assistance. For example, Facebook was used in helpful ways during Cyclone Yasi in 2011. However, it is critical to understand that, in a changing media landscape, social media is a necessary means of communication in emergency management but insufficient on its own. Traditional forms of communication through mainstream media (radio and television), letterbox drops, and face-to-face communication in individual and /or community meetings should all continue. People will have changing needs, preferences and access issues that need to be considered (Taylor et al 2012).

Mental health treatments

People will need to be referred to formal mental health treatments if they have indications of a mental health disorder or experience an acute mental health crisis (such as suicidal ideation) or if a pre-existing mental health disorder recurs or worsens. The level of need for these specialist services will become more apparent weeks after the emergency began, as disorders such as PTSD and major depression emerge and can be diagnosed.

Specialist treatment for mental health disorders is provided following a referral to specialist trained mental health professionals, usually from primary care providers in first instance. Such care is usually provided in traditional clinical settings using standardised processes and protocols. In rare circumstances, specialist mental health treatment may be required in emergency event locations; ideally this should be integrated into the broader emergency medical response.

Further information on the evidence base

Acknowledging the importance of evidence-informed policy and practice, this *Framework for Psychosocial Support in Emergencies* was informed by:

- a brief survey of end-users
- an extensive review of existing international guidance and literature
- a review of the draft report by an international technical advisory group.

A review document was produced through an iterative process of summarising and analysing the key literature, identifying aspects that needed to be reflected in the revised framework and reworking drafts. A further document published as a GNS Science report provides additional detail on key aspects from the literature (GNS, in press).

As the body of literature is dynamic, and this Framework represents best evidence available at the time of writing, service providers are advised to keep a watching brief to stay up to date with significant changes in evidence-informed good practice recommendations.

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Appendix 1: Types of hazards

At the national level, the *National Hazardscape Report*, published by the Officials' Committee for Domestic and External Security Coordination (ODESC 2007), identifies and considers the range of natural and artificial hazards that are relevant to New Zealand from national and regional perspectives. The report identifies the following 17 types of hazards, all of which have the potential to cause emergencies that require coordination or management at the national level:

- earthquakes
- volcanic hazards
- landslides
- tsunami
- coastal hazards (eg, storm surge and coastal erosion)
- floods
- severe winds
- snow
- droughts
- wildfires
- animal and plant pests and disease
- infectious human disease pandemics (including water-borne illnesses)
- infrastructure failure
- hazardous substance incidents (including chemical, biological and radiological)
- major transport accidents (air, land and water)
- terrorism
- food safety (eg, accidental or deliberate contamination of food).

Source: ODESC (2007)

Appendix 2: Typical short-term reactions to emergencies

Emotional

- Shock, disbelief, denial
- Anxiety, fear, worry about safety
- Emotional numbing, apathy
- Depression
- Isolation
- Grief, sadness, longing and pining for deceased
- Helplessness, hopelessness and despair
- Powerlessness and vulnerability
- Anger, rage, desire for revenge
- Irritability, short temper
- Blame of self and others, resentment
- Survivor guilt
- Unpredictable mood swings
- Re-experiencing pain associated with previous trauma
- Loss of derived pleasure from regular activities
- Feeling heroic, euphoric or invulnerable
- Difficulty in giving or accepting help

Cognitive

- Confusion and disorientation
- Memory problems, complete or partial amnesia
- Impaired concentration, thought processes and decision-making
- Repeated flashbacks, intrusive thoughts, memories and images
- Dissociation (disconnected, dream-like, or on 'automatic pilot')
- Obsessive self-criticism and self-doubt
- Preoccupation with event or with protecting loved ones
- Recurring dreams or nightmares
- Reduced confidence or self-esteem

Physical

- Faintness and dizziness
- Hot or cold sensations
- Tightness in throat, chest or stomach
- Agitation, nervousness, hyper-arousal, startle response
- Chronic fatigue, exhaustion, reduced energy
- Gastrointestinal problems, nausea
- Appetite changes
- Weight loss or gain
- Headaches
- Exacerbation of pre-existing conditions
- Impaired immune response
- Insomnia, sleep disturbance
- Libido changes
- Somatic complaints
- Visual disturbances

Behavioural and social

- Jumpiness – easily startled
- Hyper-vigilance – scanning for danger, excessive worry
- Crying and tearfulness
- Interpersonal conflict, irritability
- Avoidance of reminders of trauma
- Inability to express feelings
- Withdrawal from others
- Increased use of alcohol or drugs
- Excessive activity level
- Regression
- Changes in activity level
- Difficulty communicating or listening
- Inability to rest or relax
- Decline in job or education performance, absenteeism
- Becoming accident prone

Spiritual

- Questioning of spiritual or religious beliefs
- Anger at perceived higher power
- Loss of sense of safety
- Inability to find meaning

Source: Adapted from Naturale (2015) and Williams (2007)