OPSIC-Project
Operationalising Psychosocial Support in Crisis
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HANDBOOK

on

MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT (MHPSS)

PLANNING TOOLS

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INTRODUCTION

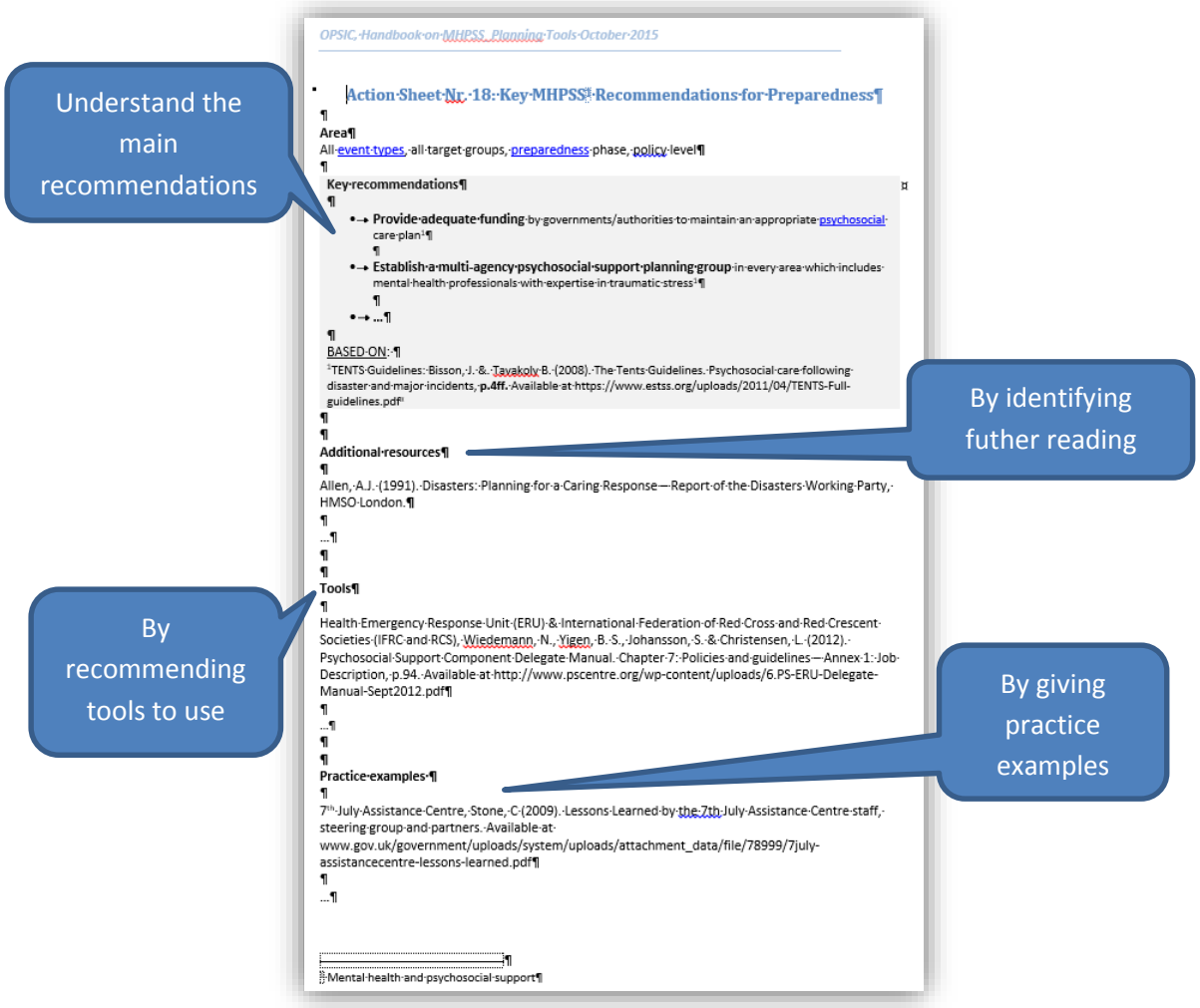
In the following you can find 51 Planning tools for Mental Health and Psychosocial support in disasters, that have been derived from an anylsis of 282 Psychosocial Mental Health guidelines and 678 Tools. The single planning tools are structured according to the most relevant topics and can be used individually.

The purpose of the Action Sheets

Each Action Sheet is a planning tool in itself that can be used individually

Each Action Sheet is an entrypoint into the main recommendations for this specific topic and gives information on further readings, tools and practice examples.

Each Action Sheet gives advice on how to plan and enhance quality in the selected area and topic.



Each Action Sheet is a planning tool. For each topic, it helps you:

The Action Sheets are divided into four groups

Action Sheets for **general aspects**

- General aspects that have to be taken into account in a disaster (Action Sheets 1-16)

Action Sheets for **intervention phase**

- What to consider in the preparedness, response and recovery phase when planning a MHPSS[1] approach (Action Sheets 17-29)

Action Sheets for **target groups**

- Specific considerations for target groups (children and adolescents including Action Sheets for school related events), helpers (staff and volunteers), older people, refugees and persons with disabilities (Action Sheets 30 to 48)

Action Sheets for **event types**

- Specific considerations for event types (Terrorist attacks, CBRN events, Flooding) (Action Sheets 49-51)

[1] Mental health and psychosocial support

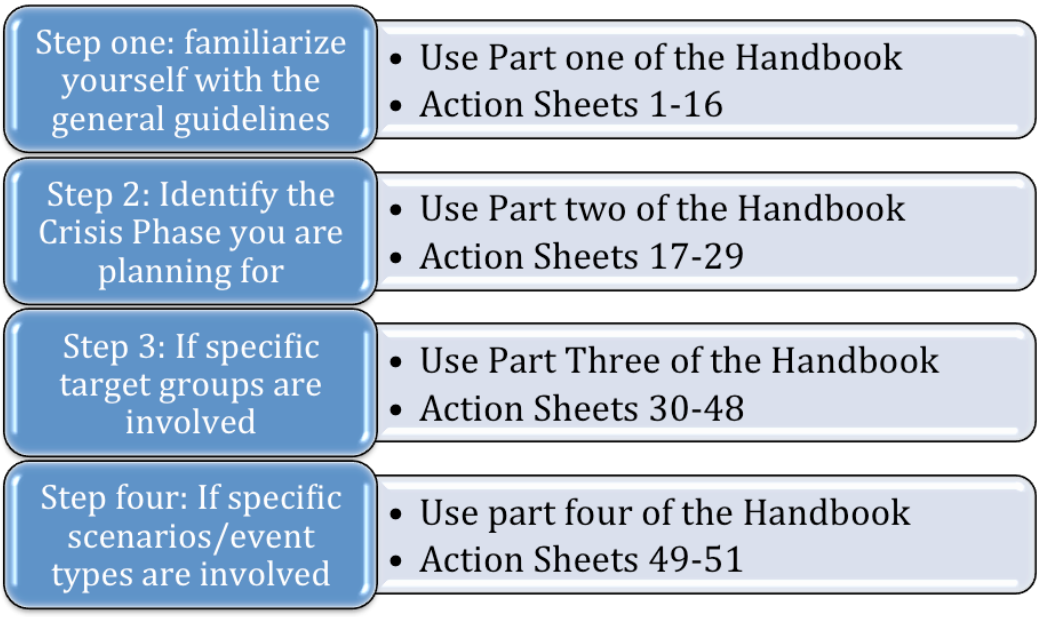
The intended user groups and the Action Sheets that are most relevant to them

Type of actionsheet	AS	General crisis managers and decision makers	PSS crisis managers and MH experts	Responsible practicioners/helpers
Part one: General	1 to 16	All	less relevant	less relevant
Part two: Phase	17 to 29	29	All	26 and 27
Part three: taget group	30 to 48	30, 34,36, 41,42,45	All	32, 34, 39
Part four: event types	49 to 51	All	All	less relevant

We suggest each group starts with the Action Sheets that are most relevant for them and then adds other topics of interest.

Steps to be taken in planning an intervention

Be aware that you have to use more than one Action Sheet for planning an intervention or programme.



How to use the Action Sheets in response

The Action Sheets are planning instruments that are to be used before the disaster strikes in planning for interventions. They contain key recommendations, links to guidelines and tools. The Action Sheets are mostly rather general because each disaster requires a slightly different approach. Key recommendations tell you what to consider when planning the response.

How to start

After having answered the first questions

- Type of event (infrastructure affected or not? Mass emergency or disaster?)[1]
- Delivery formats (Shelters needed? How to best reach the affected? Who are the most vulnerable groups and where are they?)

The following table illustrates delivery formats of psychosocial support:

Mass emergency (recommended delivery formats)	**Disaster (recommended delivery formats)**

Short-term
• Reception centres for non-injured
• Reception centre for family and friends including telephone support and websites as well as casualty bureau (police task)
• Demobilisation centre or on-scene support for emergency personnel
	Short-term
	• Shelters including the areas
	  ○ Water and sanitation
	  ○ Food, security and nutrition
	  ○ Education
	• Field hospital and basic health care
	• Evacuation centre/if a shelter is not needed
	• Distributiuon of non food Items, logistic centers

Mid and long-term
• Humanitarian assistance centre
• Community centre
• Coordination point for further support (one-stop shop)
	Mid and long-term
	• Long-term shelter (including healthcare, food, water and sanitation, education, distribution of non-food items only if still needed)
	• If no more shelters/evacuation/logistics centres are needed
	  ○ Community centre
	  ○ Coordination points for long-term care and support

You can start to plan the MHPSS intervention by using the key recommendations beginning with the key recommendations on Action Sheet 19 (see MHPSS Handbook).

[1] We define "mass emergencies" as events where infrastructure is not destroyed, and "disasters" and "catastrophes" as events where infrastructure is often destroyed and has to be at least partly replaced until recovery is fully established. This categorization has an impact on the recommended intervention designs in the psychosocial area and is therefore of high practical relevance, although it is not so relevant in disaster research and therefore often not explicitly mentioned.

1. Call in your crisis management team and set up a base
2. Send out a team to conduct a rapid assessment of needs and capacities
3. Find out how best to reach the people in need and then decide on the most appropriate forms of support (humanitarian assistance centre, PSS integrated into evacuation centres, shelters, community centres, etc.) based on the type of event and where it is located (international, national, regional event; whether family members are local or overseas, infrastructure and other relevant resources are destroyed or intact, etc.)
4. Prioritize the needs and identify the target groups that are most vulnerable in order to first support those who have the most urgent needs for support and in order to give each group appropriate support
5. Make an intervention plan
6. Make contact and coordinate PSS activities with all the relevant stakeholders
7. Design the relevant communication campaign
8. Human resources management
9. Be ready to make changes to the intervention plan based on ongoing needs assessment

Now go on with the Action Sheets that are best suitable for your type of event, target groups and disaster phase.

OPSIC/COMPASS Key documents in different languages

Analysis showed that the guidelines on mental health and psychosocial support in emergencies show more similarities than differences. Therefore we identified Key Documents that contain the most important recommendations for the European Context and most of which are available in many different languages.

GENERAL Guidelines

MHPSS Guidline	Language Versions	Link to the translated documents
IASC-Guidelines Inter-Agency Standing Committee (IASC) (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Available at www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf	• Arabic • Chinese • English • French • Japanese • Nepalese • Spanish • Tajik	http://www.who.int/mental_health/emergencies/9781424334445/en/
TENTS Guidelines Bisson, J. &. Tavakoly B. (2008). The Tents Guidelines. Psychosocial care following disaster and major incidents. Available at https://www.estss.org/uploads/2011/04/TENTS-Full-guidelines.pdf	• English • Croatian • Danish • Spanish • Finnish • Polish • Turkish • Portugese • Swedish	https://www.estss.org/tents/translated-documents/
Impact Guidelines	• English • Dutch	http://www.impact-kenniscentrum.nl/nl/producten/programma/nafase#herziene_richtlijn_psh http://disaster.efpa.eu/information/recommendations-concerning-psychosocial-support-after-disasters/

MHPSS Guidline	Language Versions	Link to the translated documents
NATO-TENTS Guidance Williams, R., Bisson, J., Ajdukovic, D., Kemp, V., Olff, M., Alexander, D., Hacker Hughes, J. & Bevan, P. (2009). Guidance for responding to the psychosocial and mental health needs of people affected by disasters or major incidents. Available at http://www.coe.int/t/dg4/majorhazards/resources/virtuallibrary/materials/uk/Principles_for_Disaster_and_Major_Incident_Psychosocial_Care_Final.pdf	• English	
WHO Psychological first Aid Guide for field workers: World Health Organization (WHO), & War Trauma Foundation and World Vision. (2011). Psychological first aid: Guide for field workers. Geneva: WHO. Retrieved from http://reliefweb.int/sites/reliefweb.int/files/resources/Full Report_149.pdf	• Arabic • Chinese • Dutch • English • Farsi • French • German • Japanese • Kiswahili • Korean • Portuguese • Romanian • Russian • Sinhala • Slovenian • Spanish • Tamil • Turkish • Urdu	http://www.who.int/mental_health/publications/guide_field_workers/en/

SPECIFIC Guidelines

MHPSS Guidline	Language Versions	Link to the translated documents
Bundesamt für Bevölkerungsschutz und Katastrophenhilfe (BBK) - Federal Office of Civil Protection and Disaster Assistance. (2011). Psychosoziales Krisenmanagement in CBRN-Lagen / Psychosocial crisis management in CBRN incidents. Available at http://www.bbk.bund.de/SharedDocs/Downloads/BBK/DE/Publikationen/Praxis_Bevoelkerungsschutz/Band_6_Psychoz_KM_CBRN_Lage.html	• English • German	http://www.bbk.bund.de/SharedDocs/Downloads/BBK/DE/Publikationen/Praxis_Bevoelkerungsschutz/Band_6_Psychoz_KM_CBRN_Lage.html
Burger, N. (2012). Guidelines: Psychosocial support for uniformed workers. Extensive summary and recommendations. Available at http://www.mvcr.cz/mvcren/file/guidelines-psychosocial-support-for-uniformed-workers.aspx	• English • German	www.mvcr.cz/.../guidelines-psychosocial-support-for-uniformed-services http://www.impact-kenniscentrum.nl/nl/producten/doelgroep/ge%C3%BCniformeerde#na_de_dienst
EUTOPA (2007). Multi-disciplinary Guideline - Early psychosocial interventions after disasters, terrorism and other shocking events. Available at http://www.eutopa-info.eu/fileadmin/products/eng/Multidisciplinary_guideline_English_complete.pdf	• English • Italian • Polish	http://eutopa-info.eu/index.php?id=249&L=0
UNHCR, IOM and MHPSS (2015). Mental health and psychosocial support for refugees, asylum seekers and migrants on the move in Europe, a multiagency guidance note. Available at http://mhpss.net/?get=262/2015-12-18-MHPSS-Guidance-note.pdf	• English • German • Croatian • Arabic • Greek • French • Italian • Portugese • Serbian • Slovenian • Spanish	http://mhpss.net/an-interagency-guidance-note-mhpss-for-refugees-asylum-seekers-and-migrants-on-the-move-in-europe-will-be-available-soon/
Juen & Stickler (2015). Psychosoziale Richtlinien für Asylwerberinnen. German version of relegant Opsic Action Sheets.	• German	http://www.pscentre.org/wp-content/uploads/Psychosoziale-Richtlinien-GV-AsylwerberInnen.pdf

KEY Tools

Key Tools	Language Versions	Link to the translated documents
International Federation of Red Cross and Red Crescent Societies (IFRC) Reference Centre for Psychosocial Support & Save the Children (2012). The Children's Resilience Programme. Psychosocial support in and out of schools. Facilitator handbook 1- Getting started. Available at http://www.pscentre.org/wp-content/uploads/Facilitator-handbook-1.pdf	• English • French	http://pscentre.org/topics/childrens-resilience-programme/
Danish Red Cross & International Federation of Red Cross and Red Crescent Societies (IFRC) Reference Centre for Psychosocial Support (n.d.). The Resilience Programme for young men – a psychosocial handbook. Available at http://pscentre.org/wp-content/uploads/The-Resilience-Programme-for-Young-Men.pdf	• English • Arabic	http://pscentre.org/topics/resilience-programme-for-young-men/
International Federation Of Red Cross and Red Crescent Society (IFRC) Reference Centre for Psychosocial Support, Danish Cancer Society (DCS), War Trauma Foundation (WTF) & University Of Innsbruck (UIBK) (2013). Lay Counselling – A Trainer's Manual. Available at http://pscentre.org/wp-content/uploads/Lay-counselling_EN.pdf	• English • German • Danish • French	http://pscentre.org/topics/lay-counselling/
International Federation of Red Cross and Red Crescent Societies (IFRC) Reference Centre for Psychosocial Support (2009). Community-based psychosocial support. A training kit. Available at http://mhpss.net/wp-content/uploads/group-documents/22/1328076457-trainersbook.pdf	• English • Arabic • French • Spanish	http://pscentre.org/topics/training-kit-publications/

PART I: MENTAL HEALTH AND PSYCHOSOCIAL ASPECTS TO BE CONSIDERED IN GENERAL DISASTER PLANNING

The 16 Action Sheets in part 1 enable decision-makers and general crisis managers to identify key mental health and psychosocial aspects that are relevant in general disaster planning.

These Action Sheets also indiciate key aspects in planning mental health and psychosocial interventions in disaster settings for psychosocial crisis managers and mental health professionals.

Action Sheet Nr. 1: MHPSS[1] Core Principles

Area
All event types, all target groups, all phases

MHPSS core principles in both IASC and NATO TENTS guidelines[1,2]

Principle 1: Ensure human rights and equity

Humanitarian actors should promote the human rights of all affected persons and protect individuals and groups who are at heightened risk of human rights violations and at the same time ensure participation.

Principle 2: Do no harm

Humanitarian aid is an important means of helping people affected by emergencies, but aid can also cause unintentional harm. Work on mental health and psychosocial support has the potential to cause harm because it deals with highly sensitive issues. In addition, it lacks an extensive evidence base that is available for some other disciplines. Humanitarian actors may reduce the risk of harm in various ways, such as:

- Participating in coordination groups to learn from others and to minimise duplication and gaps in response
- Designing interventions on the basis of valid information
- Committing to evaluation, openness to scrutiny and external review
- Developing cultural sensitivity and competence in the areas in which they intervene/work;
- Staying updated on the evidence base regarding effective practices; and
- Developing an understanding of, and consistently reflecting on, universal human rights, power relations between outsiders and emergency-affected people, and the value of participatory approaches. (Anderson, 1999).

Principle 3: Build on available resources and capacities

All affected groups have assets or resources that support mental health and psychosocial well-being. A key principle – even in the early stages of an emergency – is building local capacities, supporting self-help and strengthening the resources already present.

Principle 4: Use Integrated support systems

Activities and programming should be integrated as far as possible. The proliferation of stand-alone services, such as those dealing only with rape survivors or only with people with a specific diagnosis, such as PTSD, can create a highly fragmented care system.

Principle 5: Provide multilayered support

In emergencies, people are affected in different ways and require different kinds of supports. A key to organising mental health and psychosocial support is to develop a layered system of complementary supports that meets the needs of different groups. All layers are important and should ideally be implemented concurrently, such as in the IASC pyramid:

- Basic services and security.
- Community and family supports
- Focused, non-specialised supports
- Specialised services.

The NATO TENTS guidance suggests a stepped model of care (see Action Sheet Nr. 7). This stepped model should have its roots in providing basic services, proceed through responses that are made by communities, families and particular groups, to non-specialised, focused services and then to specialised services. Progression through these levels should be based on an assessment of people's needs.

[1] Mental health and psychosocial support

Additional MHPSS core principles from the NATO TENTS guidance[1]

Principle 6: Anticipation, planning, preparation and advice

The services, including the psychosocial and mental health services that are required following disasters and major incidents, are much more likely to work effectively if the need for them has been anticipated and defined.

This requires understanding of the dynamic shifts that occur with the passage of time and of the clarity about how these services are to collaborate with other services that offer humanitarian aid and responses to people's welfare and psychosocial needs after disasters and major incidents.

Knowledge about how people may react psychosocially to disasters and major incidents is likely to assist responsible people in making effective decisions prior to events and when they are making decisions while under strain during events.

Principle 7: Needs-oriented planning for families and communities

All aspects of psychosocial and mental health care should only be provided with full consideration of people's wider social environments, the cultures within which they live, and, particularly, their families and the communities in which they live, work and move. The service responses provided from within societies and, in the case of disasters and major incidents that cause greater devastation, the actions taken by external countries and organisations should be proportionate to the needs of the people who have been affected.

This requires a strategic stepped model of care to underpin a variety of levels of planning and preparation before events and the multi-layered support that is provided afterwards.

Principle 8: Developing, sustaining and restoring psychosocial resilience

This principle means that actions taken, including those that determine how services respond to the needs of communities and people regarding their psychosocial and mental health care, should actively maximise participation of local, affected populations whatever the degree of devastation in each area.

Restoring, first, the functioning, and second, the social fabric of communities is extremely important in how societies, communities and services respond effectively to the psychosocial and mental health effects of disasters and major incidents.

If communities are to receive comprehensive responses to their psychosocial and mental health needs after disasters and major incidents, the following types of service are required: (a) humanitarian aid; (b) welfare services; (c) services that are able to assist people and communities to develop and sustain their resilience; and (d) timely and responsive mental health services.

Principle 9: Integrating psychosocial and mental healthcare responses into policy and into humanitarian aid, welfare, social care and health care agencies' work

Achieving comprehensive psychosocial care and mental health services for moderate and large scale emergencies requires that lessons learned through research and experience are translated into integrated, ethical policy and plans at four levels. They are:

- governance policies
- strategic policies for service design
- service delivery policies
- policies for good clinical practice.

Governance policies relate to how countries, regions and counties are governed. Governance policies require the responsible authorities to develop strategic policies.

Strategy should be developed by bringing together evidence from research, past experience, knowledge of the nature of areas of the country for which they are responsible and of their populations, and the profile of risks, to design services. Responsible authorities are also responsible for evaluating and managing the performance of those services to meet the identified objectives.

Service delivery policies concern how particular services function and relate to their partner services and how affected populations are guided into and through them, based on the evidence and awareness of the preferences of people who are likely to use them. Service delivery policies include evidence-informed and

values-based models of care, care pathways and protocols and guidelines for care, as well as processes for demand management, audit and review.

Policies for good clinical practice concern how clinical staff take account of the needs and preferences of patients, deploy their clinical skills, and work with patients to agree how guidelines, care pathways and protocols are interpreted in individual cases.

Policy at each of the four levels should be informed by culture and values as well as by evidence and experience gleaned from practice. The Madrid Framework (see Annex A) can be used as a framework for benchmarking how policies deal with the values that are inherent in designing and delivering services.

Principle 10: All planners, incident commanders, practitioners, volunteers, researchers and evaluators should agree to work to a common set of standards

In certain circumstances, especially those in which there is widespread devastation, high standards may not be achievable until there has been restoration of basic community functioning and resources, including clean water and food supplies, shelter and protection, communications, and healthcare. Situations of this kind should be anticipated and covered by planning. Planning should consider the minimum standards required in a range of different circumstances.

The standards adopted have substantial implications for training, research, evaluation and information-gathering because all of these capabilities should be core parts of all disaster and major incident response plans. This means that the requirement for them is anticipated and standards for research, evaluation and information-gathering should be developed and planned before disasters occur.

Research and evaluation should identify the factors that contribute to either the success or failure of particular types of service, their organisation and delivery, and particular interventions.

Research and evaluation should include follow-up studies that are designed to identify long-term effects that may be associated with psychosocial intervention programmes.

BASED ON:

[1]NATO-TENTS guidance: Williams, R., Bisson, J., Ajdukovic, D., Kemp, V., Olff, M., Alexander, D., Hacker Hughes, J. & Bevan, P. (2009). Guidance for responding to the psychosocial and mental health needs of people affected by disasters or major incidents, **p.2ff.** Available at http://www.coe.int/t/dg4/majorhazards/ressources/virtuallibrary/materials/uk/Principles_for_Disaster_and_Major_Incident_Psychosocial_Care_Final.pdf

[2]Inter-Agency Standing Committee (IASC) (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, **p.9ff**. Available at www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf

Additional resources

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Action Sheet Nr. 2: Ethical Aspects in Disaster Management

Area
All event types, all target groups, all phases

Key principles

Principle 1: Conduct assessments of mental health and psychosocial issues (Action Sheet 2.1/ pp.38-45)
Key Actions

- Ensure that assessments are coordinated.
- Collect and analyse key information relevant to mental health and psychosocial support.
- Conduct assessments in an ethical and appropriately participatory manner.
- Collate and disseminate assessment results.

Principle 2: Initiate participatory systems for monitoring and evaluation (Action Sheet 2.2/ pp.46-49)
Key Actions

- Define a set of indicators for monitoring, according to defined objectives and activities.
- Conduct assessments in an ethical and appropriately participatory manner.
- Use monitoring for reflection, learning and change.

Principle 3: Apply a human rights framework through mental health and psychosocial support (Action Sheet 3.1/ pp.50-55)
Key Actions

- Advocate for compliance with international human rights standards in all forms of mental health and psychosocial support in emergencies.
- Implement mental health and psychosocial supports that promote and protect human rights.
- Include a focus on human rights and protection in the training of all relevant workers.
- Establish – within the context of humanitarian and pre-existing services – mechanisms for the monitoring and reporting of abuse and exploitation.
- Advocate and provide specific advice to states on bringing relevant national legislation, policies and programmes into line with international standards and on enhancing compliance with these standards by government bodies (institutions, police, army etc.).

Principle 4: Identify, monitor, prevent and respond to protection threats and failures through social protection (Action Sheet 3.2/ pp.56-63)
Key Actions

- Learn from specialised protection assessments whether, when and how to collect information on protection threats.
- Conduct a multi-sectoral participatory assessment of protection threats and capacities.
- Activate or establish social protection mechanisms, building local protection capacities where needed.
- Monitor protection threats, sharing information with relevant agencies and protection stakeholders.
- Respond to protection threats by taking appropriate, community-guided action.
- Prevent protection threats through a combination of programming and advocacy.

Principle 5: Identify, monitor, prevent and respond to protection threats and abuses through legal protection (Action Sheet 3.3/ pp.64-70)
Key Actions

- Identify the main protection threats and the status of existing protection mechanisms, especially for people at heightened risk.
- Increase affected people´s awareness of their legal rights and their ability to assert these rights in the safest possible way, using culturally appropriate communication methods.
- Support mechanisms for monitoring, reporting and acting on violations of legal standards.
- Advocate for compliance with international law, and with national and customary laws consistent with international standards.

- Implement legal protection in a manner that promotes psychosocial well-being, dignity and respect.
- Provide psychosocial support and legal protection services in a complementary fashion.

Principle 6: Enforce staff codes of conduct and ethical guidelines (Action Sheet 4.2/ pp.76-80)
Key Actions

- Establish within each organisation a code of conduct that embodies widely accepted standards of conduct for humanitarian workers.
- Inform and regularly remind all humanitarian workers, both current and newly recruited workers, about the agreed minimum required standards of behaviour, based on explicit codes of conduct and ethical guidelines.
- Establish an agreed inter-agency mechanism (e.g. the focal point network proposed by the United Nations Secretary-General) to ensure compliance beyond simply having a code of conduct.
- Establish accessible, safe and trusted complaints mechanisms.
- Inform communities about the standards and ethical guidelines, and of how and to whom they can raise concerns confidentially.
- Ensure that all staff understand that they must report all concerns as soon as they are raised.
- Ensure that all staff understand that they must report all concerns as soon as they are raised. Their obligation is to report possible violations, not to investigate the allegation.
- Use investigation protocols that comply with an agreed standard, such as the IASC Model Complaints and Investigations Procedures.
- Take appropriate disciplinary action against staff for confirmed violations of the code of conduct or ethical guidelines.
- Establish an agreed response in cases in which the alleged behavior constitutes a criminal act in either the host country or the home country of the alleged perpetrator.
- Maintain written records of workers who have been found to have violated codes of conduct, to increase the effectiveness of subsequent referral/recruitment checks.

Principle 7: Organise orientation and training of aid workers in mental health and psychosocial support (Action Sheet 4.3/ pp.81-86)
Key Actions

- Prepare a strategic, comprehensive, timely and realistic plan for training.
- Select component, motivated trainers.
- Utilise learning methodologies that facilitate the immediate and practical application of learning.
- Match trainee´s learning needs with appropriate modes of learning (brief orientation seminars).
- Prepare orientation and training seminar content directly related to the expected emergency response.
- Consider establishing Training of Trainers (ToT) programmes to prepare trainers prior to training.
- After any training, establish a follow-up system for monitoring, support, feedback and supervision of all trainees, as appropriate to the situation.
- Document and evaluate orientation and training to identify lessons learned, to be shared with partners and to enhance future responses.

Principle 8: Prevent and manage problems in mental health and psychosocial well-being among staff and volunteers (Action Sheet 4.4/ pp.87-92)
Key Actions

- Ensure the availability of a concrete plan to protect and promote staff well-being for the specific emergency.
- Prepare staff for their jobs and for the emergency context.
- Facilitate a healthy working environment.
- Address potential work-related stressors.
- Ensure access to health care and psychosocial support for staff.
- Provide support to staff who have experienced or witnessed extreme events (critical incidents, potentially traumatic events).
- Make support available after the mission/employment.

Principle 9: Facilitate conditions for community mobilization, ownership and control of emergency response in all sectors (Action Sheet 5.1/ pp.93-99)

Key Actions

- Coordinate efforts to mobilise communities.
- Assess the political, social and security environment at the earliest possible stage.
- Talk with a variety of key informants and formal and informal groups, learning how local people are organising and how different agencies can participate
- Facilitate the participation of marginalised people.
- Establish safe and sufficient spaces early on to support planning discussions and the dissemination of information.
- Promote community mobilisation processes.

Principle 10: Facilitate community self-help and social support (Action Sheet 5.2/ pp.100-105)
Key Actions

- Identify human resources in the local community
- Facilitate the process of community identification of priority actions through participatory rural appraisal and other participatory methods.
- Support community initiatives, actively encouraging those that promote family and community support for all emergency-affected community members, including people at greatest risk.
- Encourage and support additional activities that promote family and community support for all emergency-affected community members and, specifically, for people at greatest risk.
- Provide short, participatory training sessions where appropriate, coupled with follow-up support.
- When necessary, advocate within the community and beyond on behalf of marginalized and at-risk people.

Principle 11: Include specific psychological and social considerations in provision of general health care (Action Sheet 6.1/ pp.116-122)
Key Actions

- Include specific social considerations in providing general health care.
- Provide birth and death certificates (if needed).
- Facilitate referral to key resources outside the health system.
- Orient general health staff and mental health staff in psychological components of emergency health care.
- Make available psychological support for survivors of extreme stressors (also known as traumatic stressors).
- Collect data on mental health in primary health care settings.

Principle 12: Strengthen access to safe and supportive education (Action Sheet 7.1/ pp.148-156)
Key Actions

- Promote safe learning environments.
- Make formal and non-formal education more supportive and relevant.
- Strengthen access to education for all.
- Prepare and encourage educators to support learners´psychosocial well-being.
- Strengthen the capacity of the education system to support learners experiencing psychosocial and mental health difficulties.

Principle 13: Provide information to the affected population on the emergency, relief efforts and theirs legal rights (Action Sheet 8.1/ pp.157-162)
Key Actions

- Facilitate the formation of an information and communication team.
- Assess the situation regularly and identify key information gaps and key information for dissemination.
- Develop a communication and campaign plan.
- Create channels to access and disseminate credible information to the affected population.
- Ensure coordination between communication personnel working in different agencies.

Principle 14: Provide access to information about positive coping methods (Action Sheet 8.2/ pp.163-167)
Key Actions

- Determine what information on positive coping methods is already available among the disaster-affected population.
- If no information on positive coping methods is currently available, develop information on positive, culturally appropriate coping methods for use among the disaster-affected population.

- Adapt the information to address the specific needs of sub-groups of the population as appropriate.
- Develop and implement a strategy for effective dissemination of information.

Principle 15 (including Principle 3 in Cultural Considerations): Include specific social and psychological considerations (safe aid for all in dignity, considering cultural practices and household roles) in the provision of food and nutritional support (Action Sheet 9.1/ pp.168-173)
Key Actions

- Assess psychosocial factors related to food security, nutrition and food aid.
- Maximise participation in the planning, distribution and follow-up of food aid.
- Maximise security and protection in the implementation of food aid.
- Implement food aid in a culturally appropriate manner that protects the identity, integrity and dignity of primary stakeholders.
- Collaborate with health facilities and other support structures for referral.
- Stimulate community discussion for long-term food security planning.

Principle 16 (including Principle 4 in Cultural Considerations): Include specific social considerations (safe, dignified, culturally an socially appropriate assistance) in site planning and shelter provision, in a coordinated manner (Action Sheet 10.1/ pp.174-178)
Key Actions

- Use a participatory approach that engages women and people at risk in assessment, planning and implementation.
- Select sites that protect security and minimize conflict with permanent residents.
- Include communal sage spaces in site design and implementation.
- Develop and use an effective system of documentation and registration.
- Distribute shelter and allocate land in a non-discriminatory manner.
- Maximise privacy, ease of movement and social support.
- Balance flexibility and protection in organizing shelter and site arrangements.
- Avoid creating a culture of dependency among displaced people and promote durable solutions.

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Action Sheet Nr. 3: Protection Aspects in Disaster Management

Area
All event types, all target groups, all phases

Key principles (and recommended actions)

Principle 1: Apply a human rights framework through mental health and psychosocial support (Action Sheet 3.1/ pp.50-55)
Key Actions

- Advocate for compliance with international human rights standards in all forms of mental health and psychosocial support in emergencies.
- Implement mental health and psychosocial supports that promote and protect human rights.
- Include a focus on human rights and protection in the training of all relevant workers
- Establish – within the context of humanitarian and pre-existing services – mechanisms for the monitoring and reporting of abuse and exploitation.
- Advocate and provide specific advice to states on bringing relevant national legislation, policies and programmes into line with international standards and on enhancing compliance with these standards by government bodies (institutions, police, army, etc.).

Principle 2: Identify, monitor, prevent and respond to protection threats and failures through social protection (Action Sheet 3.2/ pp.56-63)
Key Actions

- Learn from specialised protection assessments whether, when and how to collect information on protection threats.
- Conduct a multi-sectoral participatory assessment of protection threats and capacities.
- Activate or establish social protection mechanisms, building local protection capacities where needed
- Monitor protection threats, sharing information with relevant agencies and protection stakeholders
- Respond to protection threats by taking appropriate, community-guided action.
- Prevent protection threats through a combination of programming and advocacy.

Principle 3: Identify, monitor, prevent and respond to protection threats and abuses through legal protection (Action Sheet 3.3/ pp.64-70)
Key Actions

- Identify the main protection threats and the status of existing protection mechanisms, especially for people at heightened risk
- Increase affected people's awareness of their legal rights and their ability to assert these rights in the safest possible way, using culturally appropriate communication methods.
- Support mechanisms for monitoring, reporting and acting on violations of legal standards.
- Advocate for compliance with international law, and with national and customary laws consistent with international standards.
- Implement legal protection in a manner that promotes psychosocial well-being, dignity and respect.
- Provide psychosocial support and legal protection services in a complementary fashion.

BASED ON:
Inter-Agency Standing Committee (IASC) (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, **pp.50-70**. Available at www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf

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- Checklist for a camp management agency: protection in a camp setting (p. 269)
- Checklist for a camp management agency: protection of persons with specific needs (p. 356).

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- Good Practice in Protection in the Context of Local Integration (p. 37)
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Action Sheet Nr. 4: Gender Aspects in Disaster Management

Area
All event types, all target groups, all phases

Key principles

Principle 1: Analyse the impact of the crisis on women and men, girls and boys
Be certain that all needs assessments include gender issues in the information-gathering and analysis phases, and that women, girls, boys and men are consulted in assessment, monitoring and evaluation processes.

Principle 2: Design services to meet the different needs of women and men, girls and boys equally
Each sector should review the way they work and make sure women and men can benefit equally from the services, for example there are separate latrines for women and men; hours for trainings, food or non-food items distribution are organised so that everyone can attend, etc.

Principle 3: Ensure equal access to services for women and men, girls and boys
Sectors should continuously monitor who is using the services and consult with the community to ensure all are accessing the service.

Principle 4: Ensure participation and representation of women, men, girls and boys
Ensure women and men participate equally in the design, implementation, monitoring and evaluation of response, that the voices of boys and girls are equally brought to bear, and that women are equally represented in decision-making positions. Where women are not represented equally, this issue should be explained, as well as what measures will be taken to ensure that the voices of women are reflected in decision-making bodies and processes.

Principle 5: Train women and men equally
Ensure that women and men benefit equally from training or other capacity-building initiatives offered by the sector actors. Make certain that women and men have equal opportunities for capacity-building and training, including opportunities for work or employment. Be aware that a significant underlying imbalance in educational levels or access to education and training may create the need for different approaches for both genders.

Principle 6: Address gender-based violence
Make sure that all sectors take specific actions to prevent and/or respond to gender based violence. The IASC Guidelines for Gender-based Violence Interventions in Humanitarian Settings should be used by all as a tool for planning and coordination.

Principle 7: Disaggregate data by age and gender
Collect and analyse all data concerning the response by age and gender breakdown, with differences analysed and used to develop a profile of at-risk populations and how their needs are being met by the assistance sector. Be aware that data collection methods may themselves build in certain gender biases (in, e.g. systemic, institutionalised ways). Hence important to consider this issue when analysing data.

Principle 8: Targeted actions for women and men, girls and boys
Based on the gender analysis, make sure that women, men, girls and boys are targeted with specific actions when appropriate. Where one group is more at-risk than others, special measures should be taken to protect that group. Examples would be safe spaces for women and measures to protect boys from forced recruitment.

Principle 9: Coordinate and set up gender support networks
Set up gender support networks to ensure coordination and gender mainstreaming in all areas of humanitarian and crisis and disaster relief work. Sector actors should be active in coordination mechanisms.

In some cases, gender mainstreaming will be in some degree of tension with prevailling views in the community (or with the views of influential actors in the community). In these cases, a culture- sensitive approach is needed and gender issues have to be negotiated wirh both men and women in a community.

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- Criteria Tip Sheets: Integrating gender and age in humanitarian actions (p. 21)
- Application: Using the Gender-Age Marker (p. 53)
- Troubleshooting: What to do, if …? (p. 69)
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- Annex I: Example of Gender-Aware Pre-Assessment Planning Checklist (p. 18)
- Annex II: Example of Gender-Aware Assessment Checklist (p. 19)
- Annex III: Example of Gender-Aware Early Recovery and Post-Disaster Recovery Planning Checklist (p. 20)

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- Assessment Tools (p. 19)
- Programme Design Tools (p. 150)
- Programme Monitoring & Evaluation Tools (p. 175).

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ADRA in Vietnam (2012). Recognise the strength of women and girls in reducing disaster risks! Stories from Vietnam. Available at http://ec.europa.eu/echo/files/policies/sectoral/recognise_strength_en.pdf

Action Sheet Nr. 5: Cultural Aspects in Disaster Management

Area
All event types, all target groups, all phases

Key principles

Principle 1: Identify and recruit staff and engage volunteers who understand local culture (Action Sheet 4.1/ pp.71-75)
Key Actions

- Designate knowledgeable and accountable personnel to undertake recruitment.
- Apply recruitment and selection principles.
- Balance gender in the recruitment process and include representatives of key cultural and ethnic groups.
- Establish terms and conditions for volunteer work.
- Check references and professional qualifications when recruiting national and international staff, including short-term consultants, interns and volunteers.
- Aim to hire staff who have knowledge of, and insight into, the local culture and appropriate modes of behaviour.
- Carefully evaluate offers of help from individual (non-affiliated) foreign mental health professionals.

Principle 2: Facilitate conditions for appropriate communal cultural, spiritual and religious healing practices (Action Sheet 5.3/ pp.106-109)
Key Actions

- Approach local religious and spiritual leaders and other cultural guides to learn their views on how people have been affected and on practices that would support the affected population.
- Exercise ethical sensitivity.
- Learn about cultural, religious and spiritual supports and coping mechanisms.
- Disseminate the information collected among humanitarian actors at sector and coordination meetings
- Facilitate conditions for appropriate healing practices.

Principle 3 (including Principle 15 in Ethical Considerations): Include specific social and psychological considerations (safe aid for all in dignity, considering cultural practices and household roles) in the provision of food and nutritional support (Action Sheet 9.1/ pp.168-173)
Key Actions

- Assess psychosocial factors related to food security, nutrition and food aid.
- Maximise participation in the planning, distribution and follow-up of food aid.
- Maximise security and protection in the implementation of food aid.
- Implement food aid in a culturally appropriate manner that protects the identity, integrity and dignity of primary stakeholders.
- Collaborate with health facilities and other support structures for referral.
- Stimulate community discussion for long-term food security planning.

Principle 4 (including Principle 16 in Ethical Considerations): Include specific social considerations (safe, dignified, culturally an socially appropriate assistance) in site planning and shelter provision, in a coordinated manner (Action Sheet 10.1/ pp.174-178)
Key Actions

- Use a participatory approach that engages women and people at risk in assessment, planning and implementation.
- Select sites that protect security and minimize conflict with permanent residents.
- Include communal sage spaces in site design and implementation.
- Develop and use an effective system of documentation and registration.
- Distribute shelter and allocate land in a non-discriminatory manner.
- Maximise privacy, ease of movement and social support.
- Balance flexibility and protection in organizing shelter and site arrangements.
- Avoid creating a culture of dependency among displaced people and promote durable solutions.

BASED ON:
Inter-Agency Standing Committee (IASC) (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, **p.38ff**. Available at www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf

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Practice examples

Seidenberg, J. (n.d.). Cultural Competency in Disaster Recovery: Lessons Learned from the Hurricane Katrina Experience for Better Serving Marginalized Communities. Available at https://www.e-education.psu.edu/drupal6/files/sgam/HT_Seidenberg.pdf

Action Sheet Nr. 6: Key Findings from the Evidence on Mental Health and Psychosocial Support

Area
All event types, all target groups, all phases

Key findings and resulting principles

Principle 1: Resilience approach [1]

Individuals and groups can be supported in accessing psychological, social, cultural and other resources in order to return to normal functioning.

Principle 2: Reactions to traumatic events are normal and to be expected for most people. They present in a broad variety of ways and are transient [1]

Helpers may assist those affected by normalizing reactions. It is helpful to provide information about reactions and coping. Take care not medicalise reactions and do not confront those affected for example by forcing them to talk about their experience.

Principle 3: Importance of secondary stressors [1]

Be aware of secondary stressors like loss of resources, loss of or disrupted social networks, missing family members.

Principle 4: There is a need for both psychosocial and mental health care[2]

A range of response is needed (as described in the stepped approach and the IASC multi-layered approach) including identifying and developing referral pathways (see Action Sheet Nr.7).

Principle 5: The majority of those affected do not need specialised mental health care, but may need psychosocial support [2]

Use a psychosocial approach before implementing specialised mental health care interventions.

Principle 6: Five elements of intervention (Hobfoll and colleagues, 2007) [1]

Ensure the following elements are included in MHPSS interventions: safety, connectedness, calming, self and collective efficacy, maintaining hope (see Action Sheet Nr.26).

Principle 7: Screen for risk factors [1]

Sreening for risk factors like lack of social support or prior history of mental health problems, etc. is recommended.

Principle 8: Screen for mental health symptoms four weeks after a disaster event especially with those who are at risk

Do a special screening for those at risk in orde to find out if they develop mental health problems that need further treatment (see recommended standardized instruments in the Annex and in the COMPASS).

BASED ON:

[1]NATO-TENTS guidance: Williams, R., Bisson, J., Ajdukovic, D., Kemp, V., Olff, M., Alexander, D., Hacker Hughes, J. & Bevan, P. (2009). Guidance for responding to the psychosocial and mental health needs of people affected by disasters or major incidents, **p.2ff.** Available at http://www.coe.int/t/dg4/majorhazards/ressources/virtuallibrary/materials/uk/Principles_for_Disaster_and_Major_Incident_Psychosocial_Care_Final.pdf

[2]Inter-Agency Standing Committee (IASC) (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, **p.11ff**. Available at www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf

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Ozer, E.J., Best, S.R., Lipsey, T.L. & Weiss, D.S. (2008). Predictors of posttraumatic stress disorder and symptoms in adults: A meta-analysis. Psychological Trauma: Theory, Research, Practice, and Policy, S(1), 3-36.

Tolin, D.F. & Foa, E.B. (2006). Sex Differences in Trauma and Post-Traumatic Stress Disorder: A Quantitative Review of 25 Years of Research. Psychological Bulletin, 132(6), p.959-992.

Tools

An overview of Standardised Instruments most frequently used in the Assessment of Mental Health Problems after Disasters and Major Incidents, Annex and COMPASS.

Action Sheet Nr. 7: MHPSS[1] Approach: The Strategic Stepped Model of Care

Area
All event types, all target groups, all phases

Key principles

Principle 1: Strategic and operational preparedness

1. **Strategic planning**
   This Is the comprehensive multi-agency planning, preparation, training and rehearsal of the full range of service responses that may be required.
2. **Prevention services**
   These are services to develop the collective psychosocial resilience of communities and which are planned and delivered in advance of disastrous events.

Principle 2: Public psychosocial care

3. **Families, peers and communities**
   Responses to people's psychosocial needs are based on the principles of psychological first aid.
4. **Assessment, interventions and other responses**
   These are based on the principles of psychological first aid that is delivered by trained lay persons, who are supervised by the staff of the mental healthcare services, and social care practitioners

Principle 3: Personalised psychosocial and mental health care

5. **Access to primary mental health care services**
   Access is for screening, assessment and intervention services for people who do not recover from immediate and short-term distress.
6. **Access to secondary and tertiary mental health care services**
   Access is for people who are thought to have mental health disorders that require specialist intervention.

BASED ON:
NATO-TENTS guidance: Williams, R., Bisson, J., Ajdukovic, D., Kemp, V., Olff, M., Alexander, D., Hacker Hughes, J. & Bevan, P. (2009). Guidance for responding to the psychosocial and mental health needs of people affected by disasters or major incidents, **p.9ff.** Available at http://www.coe.int/t/dg4/majorhazards/ressources/virtuallibrary/materials/uk/Principles_for_Disaster_and_Major_Incident_Psychosocial_Care_Final.pdf

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International Federation of Red Cross and Red Crescent Societies (IFRC) Reference Centre for Psychosocial Support, Danish Cancer Society (DCS), War Trauma Foundation & University Of Innsbruck (UIBK) (2013). Lay Counselling – A Trainer's Manual. Available at http://pscentre.org/wp-content/uploads/Lay-counselling_EN.pdf

[1] Mental health and psychosocial support

International Federation of Red Cross and Red Crescent Societies (IFRC) Reference Centre for Psychosocial Support (2009). Community-based psychosocial support. Trainer´s book. Available at http://mhpss.net/wp-content/uploads/group-documents/22/1328076457-trainersbook.pdf

Tools

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Containing:

- Annex 2: Collecting information and mapping resources on psychosocial issues (p. 98)
- Annex 3: Daily And Weekly Monitoring Form (p. 102).

The European Network for Traumatic Stress (TENTS-TP) (n.d.). Training and Practice. Available at http://www.tentsproject.eu/index.jsp?ACTION=GOCOMBO&MID=913

Practice examples

OPSIC-Team (2014). Practice examples. Comprehensive Guideline OPSIC-Project - Annex.

Council of Europe / EFPA (2010). Lessons learned in psychosocial care after disasters. Available at http://www.recoveryplatform.org/assets/publication/Lessonslearned_psycosocial%20care%20EC_EN.pdf

International Federation of Red Cross and Red Crescent Societies (IFRC) (2001). Psychosocial Support: Best Practices from Red Cross Red Crescent Programs. Available at http://helid.digicollection.org/en/d/Js2902e/

MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT ASPECTS IN CRISIS MANAGEMENT

Action Sheet Nr. 8: Key MHPSS[1] Aspects in General Crisis Management

Area
All event types, all target groups, all phases

Key actions

- **Appraise the threat and what it is about**
  Policymakers have to make sense of the critical nature of development. They must appraise the threat and what it is about

- **Making decisions in uncertainty and high risk situations- coordinate actions**
  Many decisions are not taken by individuals, but they emerge from "various loci of decision-making and coordination." Interagency and intergovernmental coordination is crucial.

- **Provide an authoritative account of what is going on**
  Authorities cannot often provide accurate information right at the outset of a crisis. However it is vital to provide an authoritative account of what is going on as soon as possible. Problems arise at these times as information comes from multiple sources.

- **Be accountable and do not engage in defensive post-crisis blaming**
  Governments cannot stay in crisis forever. Shifting back from crisis to routine mode is one aspect. 'Blame games' often start after a crisis is over. Those in charge must be accountable for their actions and not engage in blaming others or defend themselves from attack.

- **Learn from crises and use long-term studies of impact**
  Lessons are not often drawn from crisis. Long-term studies are needed to examine the impact of a crisis on society. Collective learning is very important for future crisis response.

BASED ON:
Boin, A. & t´Hart, P. (2007). The Crisis Approach. In H. Rodriguez, E. Quarantelli & R. Dynes (Eds.) Handbook of disaster research, **p. 50ff**. NY: Springer. Available at http://link.springer.com/content/pdf/bfm%3A978-0-387-32353-4%2F1.pdf

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Dekker, S. & Hansén, D. (2004). Learning under pressure: the effects of politicization on organisational learning in public bureaucracies. Journal of Public Administration Research and Theory, 14(2), 211-230.

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Deverell, E. (2009). Crises as Learning Triggers: Exploring a Conceptual Framework of Crisis-Induced Learning, Journal of Contingenices and Crisis Management, 17 (3), 179-188.

[1] Mental health and psychosocial support

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Tools

Inter-Agency Standing Committee (IASC) (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Coordination – Establish coordination of intersectoral mental health and psychosocial support, p.33. Available at http://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf

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Practice examples

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International Federation of Red Cross and Red Crescent Societies (IFRC) (2001). Psychosocial Support: Best Practices from Red Cross Red Crescent Programs. Available at http://helid.digicollection.org/en/d/Js2902e/

OPSIC-Team (2014). Practice examples. Comprehensive Guideline OPSIC-Project – Annex.

Sahin, B, Kapucu, N, Unlu, A (2008) Perspectives on Crisis Management in European Union Countries: United Kingdom, Spain and Germany European Journal of Economic and Political Studies 1, 2008, http://ejeps.fatih.edu.tr/docs/articles/49.pdf, (online document)

Action Sheet Nr. 9: Key Principles in MHPSS[1] Crisis Management

Area
All event types, all target groups, all phases

Key principles

Principle 1: There is effective command, control and coordination before, during and following a disaster or major incident

Principle 2: Appoint psychosocial and mental health trained advisers at the strategic, tactical and operational levels of command to assure full integration of the services that respond to communities' and people's psychosocial and mental health needs within disaster and major incident plans.

Principle 3: The responsible authorities, incident response commanders, service managers and professional practitioners adopt an ethical framework for planning and delivering services.

Principle 4: The responsible authorities, incident response commanders, service managers and professional practitioners adopt a framework for good decision-making.

Principle 5: Commanders should ensure that appropriate services are made available in each phase of response and recovery and this requires services that offer

- immediate humanitarian aid and welfare services for everyone who needs them;
- service responses that recognise that the intensity and duration of people's exposure to stressors, certain prior experiences, and the availability or otherwise of social support are related to their likelihood of developing more serious psychosocial problems or mental disorders;
- long-term and persistent follow-through; and
- care for responders.

Principle 6: The responsible authorities, incident response commanders, service managers and professional practitioners adopt pre-planned frameworks for:

- corporate governance; and
- clinical governance.

Principle 7: Execution of psychosocial and mental health care plans depends on effectively managing and caring for staff.
Staff and agencies should be provided with:

- clear plans;
- statements of the expectations that are likely to fall on them;
- opportunities for training and rehearsal; and
- increased supervision and social support.

Principle 8: Roles, standards and support
Staff and volunteers should have:

- clear roles and responsibilities that are agreed in advance;
- professional standards and expectations that are clear, practical and realistic;
- effective leadership and access to the support of colleagues.

BASED ON:
[1]NATO-TENTS guidance: Williams, R., Bisson, J., Ajdukovic, D., Kemp, V., Olff, M., Alexander, D., Hacker Hughes, J. & Bevan, P. (2009). Guidance for responding to the psychosocial and mental health needs of people affected by disasters or major incidents, **p.16-17** Available at http://www.coe.int/t/dg4/majorhazards/ressources/virtuallibrary/materials/uk/Principles_for_Disaster_and_Major_Incident_P

[1] Mental health and psychosocial support

sychosocial_Care_Final.pdf
[2]Boin, A. & t´Hart, P. (2007). The Crisis Approach. In H. Rodriguez, E. Quarantelli & R. Dynes (Eds.) Handbook of disaster research (pp. 42-52). NY: Springer. Available at http://link.springer.com/content/pdf/bfm%3A978-0-387-32353-4%2F1.pdf

Additional resources

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Boin, A. (Ed.) (2008). Crisis Management: Volume III. London: Sage Available at http://www.sirpa.fudan.edu.cn/picture/article/56/1d14cd6e-ceb6-463f-9e2d-898499a93625/a89b9cdc-4ba3-462f-af57-bdaf36e913e6.pdf

Rodriguez, H., Quarantelli, E. & Dynes, R. (Eds.) (2007). Handbook of disaster research. NY: Springer. Available at http://books.google.at/books?hl=de&lr=&id=zbqm1SRClU4C&oi=fnd&pg=PR7&dq=Handbook+of+disaster+research&ots=uIot6IspaK&sig=H0hB5PEdG2mZ3BSW6KO0MnaU8d0#v=onepage&q=Handbook%20of%20disaster%20research&f=false

Svedin, L. (Ed.) (2011). Ethics and Crisis Management. Charlotte: Information Age.

Tools

Philippine Department of Health - Health Emergency Management Staff (DOH-HEMS) & World Health Organisation - Emergency and Humanitarian Action - Regional Office for the Western Pacific (WHO-WPRO) (2012). Pocket Emergency Tool. Available at http://mhpss.net/wp-content/uploads/group-documents/219/1384428965-pocketemergencytoolphilippinesdeptofhealth.pdf

The European Network for Traumatic Stress (TENTS) (n.d.). Tents-E-Modules. Available at https://www.estss.org/tents/e-module/

Containing

- Planning, Preparation and Management (E-Module)
- General Components of Response, Specific Components of Response (E-Module).

Practice examples

Council of Europe / EFPA (2010). Lessons learned in psychosocial care after disasters. Available at http://www.recoveryplatform.org/assets/publication/Lessonslearned_psycosocial%20care%20EC_EN.pdf

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World Health Organisation (WHO) (2013). Building back better. Sustainable Mental Health Care after Emergencies. Available at http://www.who.int/mental_health/emergencies/building_back_better/en/

Containing:

- Part 2: Seizing opportunity in crisis: 10 case examples (p. 25)

- Part 3: Spreading opportunity in crisis: Lessons learnt and take-home messages (p. 95).

MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT ASPECTS IN CRISIS COMMUNICATION

Action Sheet Nr. 10: Key MHPSS[1] Aspects in Crisis Communication

Area
All event types, all target groups, all phases

Key principle: Establish an open, fair dialogue with all relevant stakeholders (Olsson, 2011, p. 143)

Key actions

- **Integrate the communication strategy into the decision-making process and link the communication strategy to the ongoing process of crisis development**

When crisis communication follows a process model, it is more comprehensive and systematic in addressing the entire range of strategies from pre- to post-event.

- **Plan before crisis events occur and update plans regularly**

Planning includes identifying risk areas and corresponding risk reduction; pre-setting initial crisis responses so that decision-making during a crisis is more efficient; and identifying necessary response resources. Significant case-based evidence exists, for example, that it is essential to conduct risk analysis and assessment for the management of risk and the prevention of crisis. All organisations should identify the potential hazards they face.

- **Accept the public as a partner**

Accepting the public as a legitimate and equal partner emerged from the literature as a best practice in crisis communication.

- **Listen to the public´s concerns and understand the audience and respond in an adequate manner**

In order to achieve effective dialogue, an organisation managing risks or experiencing a crisis must listen to the concerns of the public, take these concerns into account, and respond accordingly.

- **Communicate honestly**

Effective crisis communicators are honest in their public communication.,In the long run, honesty fosters credibility with both the media and the public. Moreover, a response that is less than honest may, ultimately, create the perception of wrongdoing**.**

- **Communicate with candor and openness**

Communication should be candid,and open. Be aware that there are cases where there could be good reason for not releasing all information. There is a big difference between responding to a difficult or sensitive question with an absolute lie (or even a white lie, e.g. ”I don’t know”, ”I don’t have that information”) and with either an honest acknowledgement of uncertainty, or, for example, ”I’m not prepared to answer that question.” The latter, which is honest, but not fully open, will be sometimes appropriate and sometimes not. The guiding principle could be you do not always have to say everything, but what you say must be honest and true (i.e. based on the facts that are known at the given moment).

- **Collaborate and coordinate with credible sources**

Collaborative relationships allow agencies to coordinate their messages and activities. Developing a pre-crisis network is a very effective way of coordinating and collaborating with other credible sources. To maintain effective networks, crisis planners and communicators should continuously seek to validate sources, choose subject-area experts, and develop relationships with stakeholders at all levels. Coordinating messages enhances the probability of consistent messages and may reduce the confusion the public experiences.

[1] Mental health and psychosocial support

Consistency of message is one important benchmark of effective crisis communication

- **Meet the needs of the media and remain accessible**

Since some sections of the media thrive on crisis and scandal – and others have an important democratic role in uncovering incompetence and corruption – it is necessary for senior crisis managers (above all, politicians or their representatives) to collaborate with the media at the preparedness phase to ensure that they are both able to go about their business if a crisis hits. Rather than viewing the media as a liability in a crisis situation, risk and crisis communicators should engage the media through open and honest communication, and use the media as a strategic resource to aid in managing the crisis. When communicating with the media, organisations should avoid inconsistency by accepting uncertainty and avoid any temptation to offer overly reassuring messages. Media training should be completed by crisis communicators prior to the onset of a crisis situation. Crisis spokespersons should be identified and trained as part of pre-crisis planning. Politicians and senior responders need to know that the media are reporting responsibly (rather than just trying to ”get a story” and the media need to know that politicians are being appropriately honest, open, and cooperative (rather than trying to ”spin a story”). But this is difficult, given that outside of disaster contexts, openness is not necessarily the norm.

- **Communicate with compassion, concern, and empathy**

Whether communicating with the public, media, or other organisations, designated spokespersons should demonstrate appropriate levels of compassion, concern, and empathy. These characteristics significantly enhance the credibility of the message and enhance the perceived legitimacy of the messenger both before and after an event.

- **Accept uncertainty and ambiguity**

A best practice of crisis communication is to acknowledge the uncertainty inherent in the situation with statements such as, ‘‘The situation is fluid,’’ and, ‘‘We do not yet have all the facts.’’ This form of strategic ambiguity allows the communicator to refine the message or avoid statements that are likely to be shown as inaccurate, as more information becomes available. Acknowledging uncertainty should not be used as a strategy, however, to avoid disclosing uncomfortable information or closing off further communication. In these cases, context information about the search and rescue and other actions may be of more use. Thia may include explaining that information is being gathered and has to be validated continuously in the course of the developing situation and actions have to be adapted to the changing needs of the situation.

- **Messages of self-efficacy**

The public health literature and risk communication research emphasise the importance of messages that provide specific information telling people what they can do to reduce harm. These messages of self-efficacy can help restore some sense of control over an uncertain and threatening situation. These messages may, ultimately, help reduce the harm created by a risk factor.

BASED ON:

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Action Sheet Nr. 11: Key Aspects to be considered in using Social Media

Area
All event types, all target groups, all phases

Key findings[1]

General ways of using social media in emergencies

(1) Social media to disseminate information and receive user feedback via incoming messages, wall posts, and polls
(2) Social media as an emergency management tool
   - to conduct emergency communications and issue warnings
   - to receive victim requests for assistance
   - to monitor user activities and postings to establish situational awareness
   - to collate uploaded images to estimate damage to communities, etc.,

Best practice results

- Identify target audiences for social media applications, such as civilians, nongovernmental organisations, volunteers, and participating governments
- Determine appropriate types of information for dissemination
- Disseminate information the public is interested in (e.g. linked with the phase of response)
- Identify any negative consequences from applications—such as the spread of faulty information—and work to eliminate or reduce such consequences.

Risks to be considered

- Accuracy of information is not always guaranteed.
- Malicious use of social media during disasters is not entirely controllable.
- There may be technological limitations (e.g.power outages).
- There may be administrative costs.
- There may be privacy and online surveillance issues.
- Volume of social media use and preferences for particular social networks vary across groups (e.g. age groups).
- It is important not to develop social media strategies at the expense of other 'low tech' tools (e.g. in Haiti 2010, text messaging and radio were arguably more important than social media).
- There may be ethical concerns regarding social media mining and use of social media intelligence.

Key recommendations when adopting social media as a crisis communications tool[2]

- **Identify the social networks that are most relevant to your intended audience**
- **Ensure sour social media strategy ties in with your organisation´s communications objectives and wider strategic aims**
- **Identify several trusted individuals in your organization to permit access to your social media sites, to help spread the workload**
- **Identify key members of the organization (those associated with the organization or those who are well connected) to post messages in a personal capacity in order to help amplify your message**
- **Ensure that a presence is built and maintained on social media sites before a crisis. Building a community presence is important to make sure that you are known as an authoritative and trustworthy source of information in advance**
- **In order to establish a loyal community, provide regular updates about your organisation´s work and respond to your community´s questions or concerns**
- **Identify other organisations involved in crisis communication and develop partnerships with them, in order to spread consistent messages and work together to challenge misinformation**
- **Use your community as an information source. Ask them questions about their experiences or**

concerns. Social media is a two.way communications medium and the public could prove to be an invaluable source of information.

- **During crises, monitor trending topics as they happen and make sure you have a stake in the conversation early on, by posting authoritative information that contains links to further useful resources**
- **Try not to be overly didactic in tone, but seek to strike a consistent balance between authoritative and personable**
- **Clearly communicate risk. Help users gain a better understanding of the level of risk to themselves and those in their online and offline networks**
- **Demonstrate you are listening to your users by regularly responding to their concerns**
- **Make it easy for users to share content on your website with their own networks by adding social media sharing buttons**
- **Do not confine your communications to just one social media platform. Some social media sites are liable to crashing due to high usage and it is important to ensure your message reaches as many people as possible**
- **However, if using multiple platforms, be consistent in the messages and information you convey**
- **Seek to develop resources adapted to a variety of media (factsheets, news reports, blogs, podcasts, videos)**

BASED ON:

[1]Lindsay, B.R. (2011). Social Media and Disasters: Current Uses, Future Options, and Policy Considerations, **p.1ff.** Available at http://www.infopuntveiligheid.nl/Infopuntdocumenten/R41987.pdf

[2]BMJPG (2012). D2.5 Report on new social media. TELL ME project – GA: 278723, **p.43**. Available at http://www.tellmeproject.eu

Additional resources

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Seeger, M. W. (2006). Best Practices in Crisis Communication: An Expert Panel Process. Journal of Applied Communication Research, 34(3), 232-244.

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Tinker, T. L., Dumlao, M., & McLaughlin, G. (2009). Effective Social Media Strategies During Times of Crisis: Learning from the CDC, HHS, FEMA, the American Red Cross and NPR. Public Relations Strategist.

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Action Sheet Nr. 12: Key Principles to be considered in using Social Media

Area
All event types, all target groups, preparedness

Key principles

Principle 1: Planning is fundamental and essential for success
Create a vision and a plan that is based on a thorough assessment of employees' and/or members' needs and expectations, as well as those of management.

Principle 2: Leadership must set the tone
Senior management must lead by example and spearhead the dialogue, by establishing a culture of social media use within the organisation. Sanitized "organisational speak" from communication specialists posing as executive voices does not work. It runs the risk of undermining trust with employees and/or members who want honest, direct, and simple messages.

Principle 3: Policies and training are necessary
What can and can't be done needs to be defined. Anonymous postings should not be allowed. Everyone needs to take ownership of their contributions.

Principle 4: Everything is about conversation and dialogue
Co-creating content for solutions to challenges is important. Everyone can and should participate. Actively encourage employee and member comments and contributions to blogs and wikis.

Principle 5: Social media content has to be relevant and up-to-date
A blog that is updated once a month isn't serving a purpose. Don't start a social media site and just leave it, hoping it will take off.

BASED ON:
U.S. Department of Health and Human Services & Centres for Disease Control and Prevention (2012). Crisis and emergency Risk Communication (CERC): 2012 Edition. Chapter 9: social media, **p.257ff**. Available at http://emergency.cdc.gov/cerc/pdf/CERC_2012edition.pdf

Additional resources

BMJPG (2012). D2.5 Report on new social media. TELL ME project – GA: 278723. Available at http://www.tellmeproject.eu

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Action Sheet Nr. 13: Social Media in the Preparedness Phase

Area
All event types, all target groups, preparedness phase

Key actions: Before the crisis

- **Determine social media engagement as part of the organisation's risk and crisis management policies and approaches**
  Every crisis communication plan should have a section about communicating with stakeholders and working with the media. Social media can be used to communicate directly with stakeholders and the media at the same time. More importantly, social media provides a built-in channel for stakeholders to communicate directly with organisations. Incorporating social media into the plan ensures that social media tools will be analyzed and tested before the crisis. It also requires regular updating of the communication plan as social media evolves.

- **Incorporate social media tools into environmental scanning procedures to listen to audience concerns**
  One important use of social media is the opportunity it provides, if used well, to listen to the concerns of the public and others who may be bearing risks. Incorporating social media tools into environmental scanning procedures may be helpful. When users create and manage their own content, external and internal social media monitoring becomes even more critical. In addition, tracking issues through social media and reporting the results to the crisis management team can increase the potential that a crisis will be addressed sooner. This then demonstrates to the team why social media needs to be embraced in a crisis response.

- **Use social media in daily communication activities**
  Individuals may have information that is crucial to handling the crisis. However, they probably will not share that information if they do not trust the organisation or know where to find it online. Do not wait until you are in the middle of a crisis to try using social media. To build partnerships and build trust, discussion with members of the public should already be taking place. Internally, using social media like wikis on day-to-day projects can streamline communication within the organisation and increase efficiency.

- **Follow and share messages with credible sources**
  Collaborating with trustworthy and reliable sources can enhance the credibility of the organisation and increase its reach. By cross posting and retweeting messages among partner organisations, a coalition of credible sources is established and more individuals are reached through shared networks.

BASED ON:
U.S. Department of Health and Human Services & Centres for Disease Control and Prevention (2012). Crisis and emergency Risk Communication (CERC): 2012 Edition. Chapter 9: social media, **p.268ff**. Available at http://emergency.cdc.gov/cerc/pdf/CERC_2012edition.pdf

Additional resources

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Centers for Disease Control and Prevention (CDC) (2012). Crisis emergency and risk communication. Be first – be right – be credible. Chapter 5 & Chapter 6. http://www.bt.cdc.gov/cerc/pdf/cerc_2012edition.pdf

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Action Sheet Nr. 14: Social Media in the Response Phase

Area
All event types, all target groups, response phase

Key actions: During the crisis

- **Join the conversation, help manage rumours by responding to misinformation, and determine the best channels to reach segmented audiences**

Health communicators can do more with social media than track issues. It is essential that they interact with their audience to address misinformation and establish the organisation as a credible source. Responding to posts demonstrates that the organisation cares what stakeholders think. It also demonstrates that the organisation is engaged and able to address their concerns. Reaching specific audiences with a key message is a foundation of targeted communication. However, in crisis and emergency risk communication (CERC), communicators often resort to the standard mass media push to reach everyone at once. Health communicators must consider how messages will be interpreted and who will not be reached. After all, those who face the greatest risks are often those with the least access to information. Determining the best communication channels for specific audiences online or in the community should be incorporated in communication plans.

- **Check all information for accuracy and respond honestly to questions**

Inaccurate information that is shared and retweeted, or passed on through other social media outlets, not only makes the organisation look bad, it can also look bad for the user who passes on the information. It is easier simply to skip over a post you do not want to address than it is to ignore a pointed question from the media. However, the public, like the media, will turn to other sources if the organisation stonewalls on key issues. If you do not know the answer to a question, it is better to communicate the uncertainty of the situation and explain what you are doing to find out the answer than to answer incorrectly or not answer at all.

- **Recognize that the media are already using social media**

The crisis will likely be discussed through social media, and traditional media will be part of that discussion. If the organisation is not engaged, the media will find other sources through social media to comment on the crisis. Thus, when it comes to being accessible to the media, not engaging in social media can have the same effect as not returning a reporter's call.

- **Remember social media is interpersonal communication**

Social media allow for human interaction and some degree of emotional support, and have been shown to be important to stakeholders dealing with crises. If communicators use social media to send out messages that come across as generic marketing 'blurbs', these messages will be seen as cold, callous, and impersonal. They will not encourage the relationship building and mending needed in a crisis. Organisations should be ready to pull messages, such as advertisements or campaigns, in case of a crisis. It took two days after September 11, 2001, for advertisers in Times Square, New York, to change their billboards to messages of sorrow, charity, or patriotism. Two days is a lifetime online, especially as it relates to social media. Incorporating and responding to emotional appeals are ideal uses of social media, but organisations have to be ready to move to that message exchange instantly.

- **Use social media as the primary tool for updates**

Organisations often promise to follow up with the media and public as soon as they have new information, but then wait to release that information until a press release can be drafted, refined, cleared, and sent out. Generally, it is posted to the organisation's website after the press release. Sometimes, organisations will wait until the next scheduled press conference to provide their updated information; this allows them to have a spokesperson deliver the information in an appropriate manner. However, using social media allows organisations to keep their promise of providing timely updates to the media and public..They can use social media for updates in the crisis response and recovery. This allows them to humanize the response and continue to be a reliable source without requiring all the exact details and time needed to write a press release or hold another press conference.

- **Ask for help and provide direction**

Giving people something meaningful to do in response to a crisis helps them make sense of the situation. As a partner in the crisis response, the public can provide essential information, especially if they are directly affected by the event. By providing that information, social media users are taking action. When an organisation requests useful information via social media, it helps both the organisation and the stakeholders who respond in managing the crisis. If there are actions individuals can take to reduce risks or assist in the recovery efforts, social media are an ideal forum for reaching stakeholders with the directions needed. Fundamentally, by simply forwarding, cross-posting, or retweeting the directions, users are taking action.

- **Web 2.0 is not the solution to all communication problems**

The advancements of internet technologies and the creation of various social media networks provide a new channel for information exchange with the potential for participation of huge numbers of users. For the most part, they are low cost too and easy to use. However the real value in using social media lies in the quality of the content being disseminated. It is crucial therefore that messages convey accurate information and reflect values of compassion and empathy for those affected.
Using social media is not a best practice in itself in CERC - it is a tool that can assist practitioners in best practice in their response to those affected..

BASED ON:
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Tinker, T. L., Dumlao, M., & McLaughlin, G. (2009). Effective Social Media Strategies During Times of Crisis: Learning from the CDC, HHS, FEMA, the American Red Cross and NPR. Public Relations Strategist.

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RESEARCH AND EVALUATION IN MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT

Action Sheet Nr. 15: Research and Evaluation in MHPSS[1]

Area
All event types, all target groups, all phases

Key principles

Principle 1: Well-designed and well-conducted information-gathering, research and evaluation should:

- Clarify the intentions, design, and effective conduct and delivery of specific programmes
- Be beneficial to the communities served by the programmes that are being evaluated
- Promote effective practice by the staff of programmes
- Reinforce fidelity of programme delivery with what is required by the populations involved and the intentions of the programmes' designers.

Principle 2: Research and evaluation should be used to develop curricula for training.

Principle 3: Research and evaluation should be used to collect good practice examples and define best practice criteria and formulate results in a manner that lessons learned may lead to changes in practice. This should be done by people with skills in designing and delivering services and interpreting the findings of evaluations of psychosocial care and adapting them to local situations.

Principle 4: Plans made for information-gathering, research and evaluation should be made beforehand and deal with the pressures that services may be under during a disaster or major incident and the restrictions that researchers face in meeting methodological standards in these circumstances.

Principle 5: Confidentiality, privacy and Informed consent in data collection should be ensured. Research should be done in a sensitive and ethically appropriate manner (see also Action Sheet Nr. 1: Core Principles).

Principle 6: Research and evaluation should be conducted based on transparent, acceptable and agreed ethical standards

- Design information-gathering, research and evaluation programmes from the beginning (i.e. from the time when each disaster and major incident plan is being designed, developed, tested and rehearsed)
- Include flexibility (e.g. for researching unexpected phenomena) through means such as fast-track procedures for ethical aprovals for research)
- Base the process of designing and implementing research and evaluation on agreed guidelines.

BASED ON:

NATO-TENTS guidance: Williams, R., Bisson, J., Ajdukovic, D., Kemp, V., Olff, M., Alexander, D., Hacker Hughes, J. & Bevan, P. (2009). Guidance for responding to the psychosocial and mental health needs of people affected by disasters or major incidents, **p.17f.** Available at http://www.coe.int/t/dg4/majorhazards/ressources/virtuallibrary/materials/uk/Principles_for_Disaster_and_Major_Incident_Psychosocial_Care_Final.pdf

[1] Mental health and psychosocial support

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Inter-Agency Standing Committee (IASC) (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Available at http://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf

Containing:
Assessment, Monitoring and Evaluation

- Conduct Assessments of Mental Health and Psychosocial Issues (p. 38)
- Initiate participatory systems for monitoring and evaluation (p. 46).

International Federation of Red Cross and Red Crescent Societies (IFRC) (2007). Monitoring and Evaluation in a Nutshell. Final. Available at http://www.sswm.info/sites/default/files/reference_attachments/RED%20CROSS%20and%20RED%20CRESCENT%202007%20Monitoring%20and%20Evaluation%20in%20a%20Nutshell.pdf

Containing

- Annex 1: Samples of Monitoring Checklists used by the IFRC Water and Sanitation Project (p. 16).
- Annex 2: Formats and Checklists to Facilitate Coherence in the Evaluation Process (p. 19).

International Federation of Red Cross and Red Crescent Societies (IFRC) (2007). VCA Toolbox with Reference Sheets. Available at www.ifrc.org/global/publications/disasters/resources/preparing-disasters/vca/vca-toolbox-en.pdf

Containing

- Chapter: An overview of research processes, tools and methods (p. 17)
- Chapter: Process Reference Sheets (p. 28)
- Chapter: Research Reference Sheets (p. 48)
- Chapter: Methods Reference Sheets (p. 133)
- Annex: Better Programmeing Initiative (p. 167)

International Federation of Red Cross and Red Crescent Societies (IFRC) Reference Centre for Psychosocial Support (2009). Psychosocial Interventions. A Handbook. Monitoring and Evaluation, p.153-178. Available at http://mhpss.net/wp-content/uploads/group-documents/22/1328075906-PsychosocialinterventionsAhandbookLowRes.pdf

OPSIC-Team (2014). Overview of Standardised Instruments. Comprehensive Guideline OPSIC-Project – Annex.

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Containing:

- Annex A: A guide to developing indicators (p. 126)
- Annex B: A step-by-step guide to conducting an evaluation (p. 127)
- Annex C: Key responsibilities in programme evaluation (p. 128)
- Annex D: Guidance on sample selection (p. 130).

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Action Sheet Nr. 16: Long-term Research and Evaluation in MHPSS[1]

Area
All event types, all target groups, planning and recovery phases

Key recommendations

- **Long-term monitoring of the affected population should be planned.**
  Long-term monitoring of mental health indicators and psychosocial functioning of the affected population should be planned (if possible, as long as 15 years post-disaster), as there are long-term consequences of disasters for affected populations (see Action Sheets Nr. 29, 35 and 40). This should be done by assessing a representative sample of the affected population (i.e. not only those who have previously been proven to have developed mental health problems as a result of a disaster). Special consideration should be given to monitoring populations that have been underrepresented in long-term research, such as children and adolescents, helpers and vulnerable groups or groups with special needs. Monitoring should be conducted in accordance with key principles in research and evaluation (see Action Sheet Nr. 15). Periodic assessment of the psychosocial status and needs of the affected population should be used to guide the delivery of and resource mobilization for services to support affected people. Data from monitoring can be also used for decision and policy-making. Resources for long-term monitoring should be identified.

- **When conducting post-disaster monitoring, study designs and data collection models should be of a quality that allow valid conclusions about disaster effects.**
  The effect of a disaster on the affected people or communities is usually determined by comparing findings with comparison groups of non-affected people or communities. When possible, pre-disaster data on population wellbeing should be collected in preparedness phase. Alternately the affected community should be compared to a similar, non-affected community. If this is not possible, the results of monitoring can be compared to norms (if possible, country specific, see Kessler & Üstün, 2008 in the **Additional resources** section below), or to what is known about different effects of population wellness in the long-term

- **Use MHPSS indicators and measures that will allow monitoring at the individual, communal and societal level.**
  There is a major research gap regarding effects of disasters on other than individual mental health indicators. It is important to monitor broader psychosocial functioning, community and societal level effects to determine how a community adapts (or fails to adapt) after a disaster. Results from this broader view of psychosocial wellbeing should inform practice on community-wide interventions *(see tools section of this Action Sheet).*

- **Preference should be given to instruments (tools) that have well-established metric properties, standardized administration procedures, and which have been widely used in previous studies to facilitate comparison.** (See tools section below).

- **Research and evaluation tools should be used in the ways recommended by the authors.**

BASED ON:
Ajduković, D., Bakić, H. (2015). Long-term effects of disasters on mental health and psychosocial functioning. OPSIC Team and University of Zagreb (FFZG). Unpublished report.

[1] Mental health and psychosocial support

Additional resources

Kessler, R.C. & Üstün, T.B. (Eds.) (2008). The WHO World Mental Health Surveys: Global perspectives on the epidemiology of mental disorders. New York: Cambridge University Press.
WHO study on prevalences of different mental health disorders in general populations in various countries.

Tools
A list of tools for monitoring can be found in the Annex, with detailed descriptions and recommended cut-offs, where applicable.

Monitoring for general populations and helpers:

CES-D: Radloff, L. S. (1977). The CES-D Scale: A Self-Report Depression Scale for Research in the General Population. Applied Psychological Measurement, 1(3), 385–401. doi:10.1177/014662167700100306. Available at: http://conservancy.umn.edu/bitstream/handle/11299/98561/v01n3p385.pdf?sequence=1
Open-access instrument that can be used for assessment of depression symptoms and probable depression.

GHQ: Goldberg, D. P., & Williams, P. (1988). A users guide to the General Health Questionnaire. Slough: NFER-Nelson.
Can be used for assessment of general mental health.

IES-R: Weiss, D. S. (2007). The Impact of Event Scale: Revised. In J. P. Wilson & C. S.-k. Tang (Eds.), International and Cultural Psychology Series. Cross-Cultural Assessment of Psychological Trauma and PTSD (pp. 219–238). Boston, MA: Springer US. Information on how it can be obtained can be found at: http://consultgerirn.org/uploads/File/trythis/try_this_19.pdf.
Open-access instrument that can be used for assessment of post-traumatic stress symptoms and probable PTSD.

PCL: Weathers, F. W., Litz, B. T., Keane, T. M., Palmieri, P. A., Marx, B. P., & Schnurr, P. P. (2013). The PTSD Checklist for DSM-5 (PCL-5), Scale available from the National Center for PTSD at www.ptsd.va.gov.
Open-access instrument that can be used for assessment of post-traumatic stress symptoms and PTSD.

SCID-I: First, M. B., Spitzer, R. L., Gibbon, M., & Williams, J. B. W. (1996). Structured Clinical Interview for DSM-IV Axis I Disorders, Clinician Version (SCID-CV). Washington, DC: American Psychiatric Press.
Can be used by clinicians for diagnosing DSM based disorders.

SF-36: Ware Jr, J. E., & Sherbourne, C. D. (1992). The MOS 36-item short-form health survey (SF-36): I. Conceptual framework and item selection. *Medical care*, 473-483.
Can be used for assessment of health status from the point of view of those affected (e.g. role limitations due to emotional problems).

Monitoring for children:

CDI 2: Kovacs, M. (2011). Children's Depression Inventory 2™ (CDI 2). North Tonawanda, NY: Multi Health Systems Inc. Information on how it can be obtained can be found at: http://www.mhs.com/product.aspx?gr=edu&prod=cdi2&id=resources
Instrument that can be used for assessment of depression symptoms in children and adolescents.

CRIES: Perrin, S., Meiser-Stedman, R. & Smith, P. (2005). The Children's Revised Impact of Event Scale (CRIES): Validity as a screening instrument for PTSD. Behavioural and Cognitive Psychotherapy, 33, 487–498. http://www.childrenandwar.org/measures/children%E2%80%99s-revised-impact-of-event-scale-8-%E2%80%93-cries-8/
Open-access instrument that can be used for assessment of post-traumatic stress symptoms and probable PTSD in children and adolescents.

PTSD-RI: Rodriguez, N., Steinberg, A. & Pynoos, R. (1999) Instrument information: child version, parent version, and adolescent version. Los Angeles: UCLA Trauma Psychiatry Program; UCLA PTSD Index for DSM-IV (Revision 1). Available at: http://www.istss.org/UCLAPosttraumaticStressDisorderReactionIndex.htm
Open-access instrument that can be used for assessment of post-traumatic stress symptoms and probable PTSD in children and adolescents.

READ: Hjemdal, O., Friborg, O., Stiles, T. C., Martinussen, M., & Rosenvinge, J. H. (2006). A New Scale for Adolescent Resilience: Grasping the Central Protective Resources Behind Healthy Development. *Measurement and Evaluation in Counseling and Development*, 84-96.
Instrument that can be used for assessment of resilience in adolescents.

Psychosocial/community level monitoring:

CART: Pfefferbaum RL, Pfefferbaum B, and Van Horn RL (2011). Communities Advancing Resilience Toolkit (CART): The CART Integrated System. Oklahoma City, OK: Terrorism and Disaster Center at the University of Oklahoma Health Sciences Center. Available at: http://tdc.missouri.edu/doc/cart_online-final_042012.pdf
Open-access instrument that can be used for building and monitoring community resilience.

MSPSS: Zimet, G. D., Dahlem, N. W., Zimet, S. G., & Farley, G. K. (1988). The multidimensional scale of perceived social support. *Journal of Personality Assessment*, 52(1), 30-41. Available at: http://www.yorku.ca/rokada/psyctest/socsupp.pdf
Open-access instrument for measuring social support.

RES: AMC (2013). Resilience Evaluation Scale.
Internal document. Being validated.

WHOQoL-BREF: Development of the World Health Organisation WHOQOL-BREF quality of life assessment. The WHOQOL Group. (1998) Psychol Med, 28(3), 551-558. Available at: http://www.who.int/mental_health/publications/whoqol/en/
Open-access instrument that can be used for assessment of psychological quality of life, quality of social relationships and environmental quality.

PART II: DEVELOPING MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT POLICIES FOR DELIVERING GOOD PRACTICE

The Action Sheets in part two are aimed at general crisis managers (especially the Action Sheets on governance policy), psychosocial crisis managers, mental health professionals and practitioners. They provide guidance on developing good mental health and psychosocial programming after disasters and emergencies.

PHASE A: WHAT TO CONSIDER IN THE PREPAREDNESS PHASE IN RELATION TO MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT

Preparedness is "the knowledge and capacities developed by governments, professional response and recovery organisations, communities and individuals to effectively anticipate, respond to, and recover from, the impacts of likely, imminent or current hazard events or conditions. Preparedness action is carried out within the context of disaster risk management. It aims to build the capacities needed to efficiently manage all types of emergencies and achieve orderly transitions from response through to sustained recovery. Preparedness is based on a sound analysis of disaster risks and good linkages with early warning systems, and includes such activities as contingency planning, stockpiling of equipment and supplies, the development of arrangements for coordination, evacuation and public information, and associated training and field exercises. These must be supported by formal institutional, legal and budgetary capacities. The related term, 'readiness,' describes the ability to quickly and appropriately respond when required." (UNISDR, 2009, p. 21)

Action Sheet Nr. 17: General Principles for MHPSS[1] in Disasters

Area
All event types, all target groups, all phases, policy level

Key principles

Principle 1: All actions, interventions and other service responses should promote: a sense of safety; self and community efficacy; empowerment; connectedness; calm and hope.
They should also deal explicitly with people's human rights, and facilitate appropriate communal, cultural, spiritual and religious healing practices.

Principle 2: Responses should provide general support, access to humanitarian aid, welfare services, financial services and legal advice, social support, physical support and psychological support for all people who are involved.

Principle 3: Responses should focus on families. This means enabling people who are involved to contact their families, re-uniting families as soon as possible, and providing humanitarian aid, welfare services and psychosocial support for families.

Principle 4: Local community leaders who are aware of local cultures and particular communities should be involved in local groups for planning psychosocial and mental health support responses.

Principle 5: Efforts should be made to identify the most appropriate supportive resources (e.g. families, communities, schools, friends, etc).

Principle 6: Specific formal interventions such as single session individual psychological debriefing for everyone affected should not be provided. They have not been shown to be effective, and may cause harm for some participants.

Principle 7: Formal screening of everyone affected should not be conducted, because there are not, as yet, measures of sufficient sensitivity and specificity. However, responders should be aware of the importance of identifying as early as possible those people who have problems.

Principle 8: Prioritisation and triage should be based on the needs of the people who are involved directly or indirectly.

Principle 9: Responses should include (psycho) educational services regarding reactions to disasters and major incidents and how to manage them. Furthermore, making arrangement for children to return to school, when it is safe to do so, even if in temporary facilities, is often an extremely important part of recovery plans.

Principle 10: General practitioners and local doctors should be made aware of possible psychosocial issues and mental health consequences because they should be directly involved in delivering the first level of formal mental health care.

Principle 11: Responding organisations should provide access to specialist psychological and mental health assessments, intervention and management when it is required.

Principle 12: Detailed planning should occur with existing services, local authorities and governments including the funding and provision of appropriate extra provision to augment local services for several years following disasters or major incidents.

[1] Mental health and psychosocial support

Principle 12: Memorial services and cultural rituals should be planned in conjunction with the people who have been affected.

BASED ON:
NATO-TENTS guidance: Williams, R., Bisson, J., Ajdukovic, D., Kemp, V., Olff, M., Alexander, D., Hacker Hughes, J. & Bevan, P. (2009). Guidance for responding to the psychosocial and mental health needs of people affected by disasters or major incidents, **p.13-14.** Available at http://www.coe.int/t/dg4/majorhazards/ressources/virtuallibrary/materials/uk/Principles_for_Disaster_and_Major_Incident_Psychosocial_Care_Final.pdf

Additional resources

Cabinet Office (2013). The role of Local Resilience Forums: A reference document. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/62277/The_role_of_Local_Resilience_Forums-_A_reference_document_v2_July_2013.pdf

EUTOPA (2007). Multi-disciplinary Guideline - Early psychosocial interventions after disasters, terrorism and other shocking events. Available at http://www.eutopa-info.eu/fileadmin/products/eng/Multidisciplinary_guideline_English_complete.pdf

Humanitarian Assistance in Emergencies: Her Majesty´s Government (HM Government), department for culture, media and sport (dcms) & Association of Chief Police Officers (ACPO) (n.d.). Humanitarian Assistance in Emergencies: Non-statutory guidance on establishing Humanitarian Assistance Centres. Available at www.gov.uk/government/uploads/system/uploads/attachment_data/file/61221/hac_guidance.pdf

Te Brake, H. & Dückers, M. (2012). Early psychosocial interventions after disasters, terrorism and other shocking events: is there a gap between norms and practice in Europe? European Journal of Psychotraumatology, 4. Available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3566377/pdf/EJPT-4-19093.pdf

Tools

All in Diary (AID), Richardson, L. (2014). A practical tool for field based humanitarian workers. 4th Edition. Available at http://reliefweb.int/sites/reliefweb.int/files/resources/2014-all-in-diary-single-pdf-info-pages.pdf

Improve Preparedness to give Psychological Help in Events of Crisis (IPPHEC), Gaddini, A., Scalmana, S. &. Teodori, M. (2009a). Psychosocial interventions following disasters, terrorism and other shocking events. Training Recommendations. Available at http://kg.humanitarianresponse.info/LinkClick.aspx?fileticket=dcl9gnNL2j4%3D&tabid=88&mid=511

Inter-Agency Standing Committee (IASC) (2012). Who is Where, When, doing What (4Ws) in Mental Health and Psychosocial Support: Manual with Activity codes. Available at http://www.who.int/mental_health/publications/iasc_4ws.pdf?ua=1

International Federation of Red Cross and Red Crescent Societies (IFRC) Reference Centre for Psychosocial Support, Hansen, P. (2009). Psychosocial Interventions. A Handbook. Available at http://mhpss.net/wp-content/uploads/group-documents/22/1328075906-PsychosocialinterventionsAhandbookLowRes.pdf

Containing

- planning and implementation (p.75)
- training (p.127).

Practice examples

Department for Culture, Media and Sport (2006). Literature and Best Practice Review and Assessment: Identifying people´s needs in major emergencies and best practice in humanitarian response. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/61224/ha_literature_review.pdf

International Federation of Red Cross and Red Crescent Societies (IFRC) (2001). Psychosocial Support: Best Practices from Red Cross Red Crescent Programmes. Available at http://helid.digicollection.org/en/d/Js2902e/

OPSIC-Team (2014). Practice examples. Comprehensive Guideline OPSIC-Project - Annex.

Reifels, L., Pietrantoni, L., Prati, G., Kim, Y., Kilpatrick, D., Dyb, G., Halpern, J., Olff, M., Brewin, C., & O'Donnell, M. (2013). Lessons learned about psychosocial responses to disaster and mass trauma: an international perspective. *European Journal of Psychotraumatology, 4*. Available at: http://dx.doi.org/10.3402/ejpt.v4i0.22897

Action Sheet Nr. 18: Key MHPSS[1] Recommendations for Preparedness

Area
All event types, all target groups, preparedness phase, policy level

Key recommendations

- **Provide adequate funding** by governments/authorities to maintain an appropriate psychosocial care plan[1]
- **Establish a multi-agency psychosocial support planning group** in every area which includes mental health professionals with expertise in traumatic stress[1]
- **Recruit and screen care providers** (professionals and volunteers) in advance [1]
- **Provide a psychosocial training programme** for all psychosocial providers [1]
- **Provide formal training, ongoing training, support and supervision** for all care providers[1]
  - (tailored to correspond with the roles and responsibilities of the providers of psychosocial care)[1]
- **Provide training and monitor for possible secondary traumatization** and burn-out symptoms among care providers including volunteers [1]
- **Develop a psychosocial care plan incorporated into the overall disaster/major incident plan** in every area[1]
- **Provide a full mapping of existing psychosocial services** [1]
- **Ensure inter-agency co-operative planning** and coordination [1]
- **Develop a clear communication strategy** including a clear publicity strategy (including a media outreach strategy) to inform the affected people[3]
- **Involve politicians/government officials** in management training and exercises[1]
- **Include persons who have been affected by past disasters** in developing the psychosocial and mental health care plan[2]
- **Involve senior trained and experienced members of the staff** of the social and mental health care agencies. Volunteers should be appointed as formal advisers to commanders and managers at the strategic, operational and tactical level[2]
- **Test the psychosocial care plan** using exercises[1]. We recommend to design specific exercises in order to test the psychosocial plan.

BASED ON:
[1]TENTS Guidelines: Bisson, J. &. Tavakoly B. (2008). The Tents Guidelines. Psychosocial care following disaster and major incidents, **p.4ff.** Available at https://www.estss.org/uploads/2011/04/TENTS-Full-guidelines.pdf
[2]NATO-TENTS guidance: Williams, R., Bisson, J., Ajdukovic, D., Kemp, V., Olff, M., Alexander, D., Hacker Hughes, J. & Bevan, P. (2009). Guidance for responding to the psychosocial and mental health needs of people affected by disasters or major incidents, **p.12ff.** Available at http://www.coe.int/t/dg4/majorhazards/ressources/virtuallibrary/materials/uk/Principles_for_Disaster_and_Major_Incident_Psychosocial_Care_Final.pdf

[1] Mental health and psychosocial support

[3]Humanitarian Assistance in Emergencies: Her Majesty´s Government (HM Government), Department for Culture, Media And Sport (dcms) & Association of Chief Police Officers (ACPO) (n.d.). Humanitarian Assistance in Emergencies: Non-statutory Guidance on establishing Humanitarian Assistance Centres, **p.11ff.** Available at www.gov.uk/government/uploads/system/uploads/attachment_data/file/61221/hac_guidance.pdf)

Additional resources

Allen, A.J. (1991). Disasters: Planning for a Caring Response – Report of the Disasters Working Party, HMSO London.

EUTOPA (2007). Multidisciplinary Guideline - Early psychosocial interventions after disasters, terrorism and other shocking events. Available at http://www.eutopa-info.eu/fileadmin/products/eng/Multidisciplinary_guideline_English_complete.pdf

International Federation Of Red Cross and Red Crescent Society (IFRC) Reference Centre for Psychosocial Support, Danish Cancer Society (DCS), War Trauma Foundation & University Of Innsbruck (UIBK) (2013). Lay Counselling – A Trainer's Manual. Available at http://pscentre.org/wp-content/uploads/Lay-counselling_EN.pdf

International Federation of Red Cross and Red Crescent Societies (IFRC) Reference Centre for Psychosocial Support (2009). Community-based psychosocial support. A training kit. Available at http://mhpss.net/wp-content/uploads/group-documents/22/1328076457-trainersbook.pdf

Kennedy, G., Richards, M., Chicarelli, M., Ernst, A., Harrell, A., & Stites, D. (2013). Disaster mitigation: initial response. Southern Medical Journal, 106(1), 13-16.

Te Brake, H. & Dückers, M. (2012). Early psychosocial interventions after disasters, terrorism and other shocking events: is there a gap between norms and practice in Europe? European Journal of Psychotraumatology, 4. Available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3566377/pdf/EJPT-4-19093.pdf

Tools

Health Emergency Response Unit (ERU) & International Federation of Red Cross and Red Crescent Societies (IFRC and RCS), Wiedemann, N., Yigen, B. S., Johansson, S. & Christensen, L. (2012). Psychosocial Support Component Delegate Manual. Chapter 7: Policies and guidelines – Annex 1: Job Description, p.94. Available at http://www.pscentre.org/wp-content/uploads/6.PS-ERU-Delegate-Manual-Sept2012.pdf

Inter-Agency Standing Committee (IASC) (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Human Resources – Identify and recruit staff and engage volunteers who understand local culture, p.71. Available at http://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf

International Federation of Red Cross and Red Crescent Societies (IFRC) Reference Centre for Psychosocial Support (n.d.). Caring For Volunteers. A Psychosocial Support Toolkit. Worksheet A: Recruitment and Selection, p. 35. Available at http://pscentre.org/wp-content/uploads/volunteers_EN.pdf

Keeping Children Safe Coalition (2012). Safeguarding Children in Emergencies. A Pocket Guide. Chapter: Recruitment and selection of staff - Recruitment Checklist, p.20. Available at http://www.keepingchildrensafe.org.uk/sites/default/files/KCS%20emergency%20pocket%20guide.pdf

Red Cross European Office (2009). Informed. Prepared. Together. Community-based emergency exercise guide. Available at www.informedprepared.eu/pages/common/ipt.aspx?pg=2611

Red Cross European Office (2009). Informed. Prepared. Together. Human aspects in civil protection – understanding the principles. Available at www.informedprepared.eu/pages/common/ipt.aspx?pg=2611

Red Cross European Office (2009). Informed. Prepared. Together. Human aspects in civil protection – putting the principles into practice. Available at www.informedprepared.eu/pages/common/ipt.aspx?pg=2611

Reproductive Health Response in Conflict (RHRC) Consortium (2004). Gender-Based Violence Tools Manual for Assessment & Programme Design, Monitoring & Evaluation in conflict-affected settings. Available at http://reliefweb.int/sites/reliefweb.int/files/resources/FC881A31BD55D2B3C1256F4F00461838-Gender_based_violence_rhrc_Feb_2004.pdf

Containing

- Staff recruitment do's & don'ts (p. 157)
- Sample Job Descriptions (p. 159)
- Sample staff screening tool (p. 163)
- Sample pre-hiring interview guide (p. 165)

World Health Organisation (WHO), War Trauma Foundation & World Vision International (2011). Psychological First Aid: Guide for field workers. Available at http://www.who.int/mental_health/publications/guide_field_workers/en/

Containing

Chapter V: Practice what you have learned

- 5.1 Case scenario 1: natural disaster (p.42)
- 5.2 Case scenario 2: violence and displacement (p.46)
- 5.3 Case scenario 3: accident (p.49).

Practice examples

7th July Assistance Centre, Stone, C (2009). Lessons Learned by the 7th July Assistance Centre staff, steering group and partners. Available at www.gov.uk/government/uploads/system/uploads/attachment_data/file/78999/7july-assistancecentre-lessons-learned.pdf

Department for Culture, Media And Sport (2006). Literature and Best Practice Review and Assessment: Identifying people´s needs in major emergencies and Best Practice in Humanitarian response. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/61224/ha_literature_review.pdf

International Federation of Red Cross and Red Crescent Societies (IFRC) (2001). Psychosocial Support: Best Practices from Red Cross Red Crescent Programmes. Available at http://helid.digicollection.org/en/d/Js2902e/

OPSIC-Team (2014). Practice examples. School Shooting 2008 in Finland. Comprehensive Guideline OPSIC-Project - Annex.

OPSIC-Team (2014). Practice examples. Terrorist Attack 2011 in Norway. Comprehensive Guideline OPSIC-Project – Annex.

PHASE B: WHAT TO CONSIDER IN PLANNING A MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT RESPONSE

Response is "the provision of emergency services and public assistance [including MHPSS] during or immediately after a disaster in order to save lives, reduce health impacts, ensure public safety and meet the basic subsistence needs of the people affected" (UNISDR, 2009, p. 24). It also includes public donations, incident management, coordination, search and rescue operations, damage assessments, handling of fatalities, etc.

Specifically, MHPPS response subsumes all actions and interventions taken during the phase when, for example, information is not yet fully available, when people are still missing, dead bodies have not been identified and family reunions have not yet taken place.

The term 'MHPSS response' in this guideline includes early response, late response and early recovery.

Action Sheet Nr. 19: Key MHPSS[1] Actions before Interventions begin

Area
All event types, all target groups, response phase, delivery design

Key actions

- **Call in your crisis management team and set up a base**
  - You must ensure your own basic safety, evacuation routes, food, etc.
- **Send out a team to conduct a rapid assessment of needs and capacities**
  - Use your psychosocial response plan to get feedback quickly in oder to plan your first intervention.
- **Find out how best to reach the people in need and then decide on the most appropriate forms of support** (humanitarian assistance centre, PSS integrated into evacuation centres, shelters, community centres, etc.) **based on the type of event and where it is located** (international, national, regional event; whether family members are local or overseas, infrastructure and other relevant resources are destroyed or intact, etc.).
- **Prioritize the needs and identify the target groups that are most vulnerable in order to first support those who have the most urgent needs for support and in order to give each group appropriate support**
- **Make an intervention plan**
  - Plan what activities are needed immediately and those that can come later and work out which helpers are needed - members of the community/ community leaders/volunteers/trained PSS personnel/mental health professionals. Make an initial estimate on how long the intervention might be needed. Involve all relevant groups and stakeholders in planning for psychosocial care and support.
- **Make contact and coordinate PSS activities with all the relevant stakeholders**
  - Use lists of partner organisations to contact them about the event and what activities are planned; plan coordination meetings; give regular updates on your activities; coordinate all activities in such a way that parallel structures are avoided and so that each group is giving the kind of support that they are most able to provide.
- **Design the relevant communication campaign**
  - See Action Sheets Nr.10-14: Crisis Communication.
- **Human resources management**
  - Call your teams together
  - Assign your teams according to capacity and needs.
- **Be ready to make changes to the intervention plan based on ongoing needs assessment.** Changes in needs and situation are common and may happen rapidly in the early phases of a disaster.

BASED ON:
The OPSIC Team

[1] Mental health and psychosocial support

Additional Resources

Impact (2014). Multi-disicplinary guidelines on psychosocial support and care in case of disasters and crises. Diemen.

Tools

International Federation of Red Cross and Red Crescent Societies (IFRC), Bouris, S. (2006). Working with Communities: A Toolbox. A Common Approach to Working with Communities. Part A: Analysis of the situation, p.9. Available at http://www.ifrc.org/pagefiles/95747/b.b.01.%20working%20with%20communities-tool%20box_ifrc.pdf

International Federation of Red Cross and Red Crescent Societies (IFRC) Reference Centre for Psychosocial Support, Hansen, P. (2009). Psychosocial Interventions. A Handbook. Assessment, p.53-74. Available at http://mhpss.net/wp-content/uploads/group-documents/22/1328075906-PsychosocialinterventionsAhandbookLowRes.pdf

International Federation of Red Cross and Red Crescent Societies (IFRC) & International Committee of the Red Cross (ICRC) (2008). Guidelines for Assessment in Emergencies. Available at http://www.icrc.org/eng/assets/files/publications/icrc-002-118009.pdf

Philippine Department of Health - Health Emergency Management Staff (DOH-HEMS) & World Health Organisation - Emergency and Humanitarian Action - Regional Office for the Western Pacific (WHO-WPRO) (2012). Pocket Emergency Tool. Rapid Health Assessment Forms, p. 236. Available at http://mhpss.net/wp-content/uploads/group-documents/219/1384428965-pocketemergencytoolphilippinesdeptofhealth.pdf

Practice examples

7th July Assistance Centre, Stone, C (2009). Lessons Learned by the 7th July Assistance Centre staff, steering group and partners. Available at www.gov.uk/government/uploads/system/uploads/attachment_data/file/78999/7july-assistancecentre-lessons-learned.pdf

International Federation of Red Cross and Red Crescent Societies (IFRC) (2001). Psychosocial Support: Best Practices from Red Cross Red Crescent Programmes. Available at http://helid.digicollection.org/en/d/Js2902e/

OPSIC-Team (2014). Practice examples. Comprehensive Guideline OPSIC-Project - Annex.

Action Sheet Nr. 20: Immediate MHPSS[1] Response

Area
All event types, all target groups, response phase, service delivery design

Key recommendations and resulting actions

- **Coordinate**
  Establish coordination of intersectoral mental health and psychosocial support.

- **Assess**
  Conduct assessments of mental health, needs and psychosocial issues.

- **Monitor**
  Initiate participatory systems for monitoring and evaluation.

- **Promote human rights**
  Apply a human rights framework through mental health and psychosocial support.

- **Protect**
  Identify, monitor, prevent and respond to protection threats and failures through social and legal protection.

- **Activate**
  Facilitate conditions for community mobilization, ownership and control of emergency response in all sectors of the response.

Recruit, train and support staff and volunteers

- Identify and recruit staff and engage volunteers who understand local culture
- Enforce staff codes of conduct and ethical guidelines
- Organise orientation and training of aid workers in mental health and psychosocial support
- Prevent and manage problems in mental health and psychosocial well-being among staff and volunteers.

Provide support on all levels

- Include specific psychological and social considerations in provision of general health care
- Provide access to care for people with severe mental disorders
- Protect and care for people with severe mental disorders and other mental and neurological disabilities living in institutions
- Learn about and, where appropriate, collaborate with local, indigenous and traditional health systems
- Minimise harm related to alcohol and other substance use.

Provide special support for children and adolescents

- Facilitate support for young children (0–8 years) and their care-givers
- Strengthen access to safe and supportive education.

Provide Information

- Provide information to the affected population on the emergency, relief efforts and their legal rights
- Provide access to information about positive coping methods.

Embed the psychosocial support into the overall support system

- Include specific social and psychological considerations (safe aid for all in dignity, considering cultural practices and household roles) in the provision of food and nutritional support

[1] Mental health and psychosocial support

- Include specific social considerations (safe, dignified, culturally and socially appropriate assistance) in site planning and shelter provision, in a coordinated manner
- Include specific social considerations (safe and culturally appropriate access for all in dignity) in the provision of water and sanitation as well as other sectors of support.

BASED ON:
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Additional resources

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OPSIC-Team (2014). Practice examples. Comprehensive Guideline OPSIC-Project - Annex.

Action Sheet Nr. 21: Ongoing MHPSS[1] Response

Area
All event types, all target groups, response phase, service delivery design

Key recommendations

- **Promote community mobilisation** processes and coordinate efforts to mobilise communities by involving community leaders and structures[1]
- **Assess the political, social and security environment** at the earliest possible stage[1]
- **Talk with a variety of key informants and formal and informal groups**, learning how local people are organising and how different agencies can participate in the response.[1]
- **Facilitate the participation of marginalised people** by including them into planning and delivery of aid[1]
- **Establish safe and sufficient spaces** early on to support planning discussions and the dissemination of information[1]
- **Provide safe spaces**, which allow groups to meet to plan how to participate in the emergency response and to conduct self-help activities or religious and cultural activities [1]
- **Individuals with psychosocial difficulties should be formally assessed** for further input and contacted proactively [2]
- **Treatment** with trauma-focused cognitive behavioural therapy should be available for individuals with acute stress disorder or severe acute post-traumatic stress disorder or other mental health problems[2]
- **The option of further pro-active contact** should be made to those affected and their families[2]

BASED ON:
[1]Inter-Agency Standing Committee (IASC) (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, **p.93ff**. Available at www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf
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Chapter II: Conditions Specifically Related to Stress (STR)

- Assessment and Management Guide (p. 2)
- Assessment and Intervention Details (p. 5).

Practice examples

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OPSIC-Team (2014). Practice examples. Comprehensive Guideline OPSIC-Project – Annex.

Action Sheet Nr. 22: General Recommendations for MHPSS[1] Response to Mass Emergencies

Area
All event types, all target groups, response phase, service delivery design

Key recommendations

- **A telephone helpline** staffed by trained personnel that provides emotional support should be launched
- **A website** concerning psychosocial issues should be launched
- **A humanitarian assistance centre/one-stop shop** should be established where a range of services can be based
- **If needed, other forms of intervention** are recommended (shelters, evacuation centres, etc.) Those overseeing the initial psychosocial response should work closely with the media.
- **The creation of a database** to record personal details should be considered. This should be planned well in advance in order to address concerns re privacy and data protection.

Key actions

- The initial response requires practical help and pragmatic support provided in an empathic manner including a thorough assessment of needs before intervention and an (inter-agency) intervention plan (see Action Sheet Nr. 17-18: Preparedness; see Action Sheet Nr. 25: Psychological First Aid).
- Information regarding the situation and concerns of individuals affected should be obtained and provided in an honest and open manner.
- Written leaflets with information about responses to traumatic events, helpful coping and where to seek help if necessary should be provided.
- Individuals should be offered psychoeducation about reactions to traumatic events if appropriate.
- Psychological reactions should be normalised during the initial response (see Action Sheet Nr. 6).
- Individuals should be neither encouraged nor discouraged from giving detailed accounts about their experiences.

BASED ON:
TENTS Guidelines: Bisson, J. &. Tavakoly B. (2008). The Tents Guidelines. Psychosocial care following disaster and major incidents, **p.5ff.** Available at https://www.estss.org/uploads/2011/04/TENTS-Full-guidelines.pdf

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World Health Organisation (WHO) & United Nations High Commisioner of Refugees (UNHCR) (2012). Assessing Mental Health and Psychosocial Needs and Resources. Toolkit for Humanitarian Settings. Available at http://apps.who.int/iris/bitstream/10665/76796/1/9789241548533_eng.pdf

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- Tool 1: Who is Where, When, Doing What (4WS) in Mental Health and Psychosocial Support (Mhpss): Summary of Manual with Activity Codes (p. 30)
- Tool 2: WHO-UNHCR Assessment Schedule of Serious Symptoms in Humanitarian Settings (WASSS) (Field-Test Version) (p. 34)
- Tool 3: The Humanitarian Emergency Settings Perceived Needs Scale (HESPER) (p. 41)
- Tool 4: Checklist for Site Visits at Institutions in Humanitarian Settings (p. 42)
- Tool 5: Checklist for Integrating Mental Health in Primary Health Care (PHC) in Humanitarian Settings (p. 47)
- Tool 6: Neuropsychiatric Component of the Health Information System (HIS) (p. 53)
- Tool 7: Template to Assess Mental Health System Formal Resources in Humanitarian Settings (p. 55)
- Tool 8: Checklist on Obtaining General (Non-MHPSS Specific) Information from Sector Leads (p. 59)
- Tool 9: Template for Desk Review of Preexisting Information Relevant to MHPSS in the Region/Country (p. 60)
- Tool 10: Participatory Assessment: Perceptions by General Community Members (p. 63)
- Tool 11: Participatory Assessment: Perceptions by Community Members with In-Depth Knowledge (p. 70)
- Tool 12: Participatory Assessment: Perceptions by Severely Affected People (p. 74)

Practice examples

Council of Europe / EFPA (2010). Lessons learned in psychosocial care after disasters. Available at http://www.recoveryplatform.org/assets/publication/Lessonslearned_psycosocial%20care%20EC_EN.pdf

International Federation of Red Cross and Red Crescent Societies (IFRC) (2001). Psychosocial Support: Best Practices from Red Cross Red Crescent Programmes. Available at http://helid.digicollection.org/en/d/Js2902e/

OPSIC-Team (2014). Practice examples. Comprehensive Guideline OPSIC-Project - Annex.

Action Sheet Nr. 23: MHPSS[1] Response Phase: If a Humanitarian Assistance Centre is established (I)

Caution
Action Sheets Nr. 23 and 24 specifically concern mass emergencies such as a terrorist attack in a big city where many relatives may seek information about their loved ones. This type of event is more likely in the European context. This type of response (i.e. a HAC) may not be appropriate in the event of a disaster.

Area
All event types, all target groups, response phase, first 24 hours, delivery design, humanitarian assistance centre

Key actions in the first 24 hours

- **Provide basic rest and reception centres, with links into the police casualty data bureau and investigation process (if required)**
  - Shelter and recovery for all affected persons and groups
  - Central registration of names and addresses of all affected persons/groups
  - Single point of information about event and rescue, etc. for survivors and families and friends
  - Single point of access to local responders.

- **Have a clear communication strategy, including a clear publicity strategy** (including a media outreach strategy) to inform the affected about where the rest and reception centres have been set up and what support is available.

- **Leaflet all those who arrive at or return to the scene, or those who go to local hospitals or police stations**.

BASED ON:
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Thomas-Lawson, M., Whitworth, J., & Doherty, J. (2002). The role of leadership in trauma response: Pentagon Family Assistance Center. Military Medicine, 167(Suppl9), 71-72.

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Practice examples

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OPSIC-Team (2014). Practice examples. Aircrash 2008 in Spain and Trainbombs 2004 in Spain. Comprehensive Guideline OPSIC-Project – Annex.

Action Sheet Nr. 24: MHPSS[1] Response Phase: If a Humanitarian Assistance Centre is established (II)

Caution
Action Sheets Nr. 23 and 24 specifically concern mass emergencies like a terrorist attack in a big city where many relatives may seek information about their loved ones. This type of event is more likely in the European context. This type of response (i.e. a HAC) may not be appropriate in the event of a disaster.

Area
All event types, all target groups, response phase, delivery design

Key actions in the first few days and weeks

If a **humanitarian assistance centre (HAC)** has been set up, (whether in physical or virtual form), it may be expected to run for a number of weeks and up to a few months (and potentially longer) after the event. During that time, it will be important to:

- **Maintain a constant publicity campaign**
  - to try to reach everyone who might find the HAC helpful and make them aware of its existence and location
- **Develop telephone and website services**
  - to back up what is provided by the physical HAC (if one has been set up)
- **Make sure the HAC brings in additional support services** as they are developed or the need is realised (e.g.particular benefits packages, or pro-bono legal/ financial help)
- **Put together a plan for the closure of the HAC** and the maintenance of its core services, based upon an assessment of its effectiveness through a lessons learned exercise
- **Pass on the personal details of the people affected** to a successor support service at local, regional or national level.
  - Local authorities must consider what resources they can make available in the longer-term recovery period to facilitate additional follow-up support (help lines, support networks, etc) and to contribute to memorials and anniversaries.

BASED ON:
Humanitarian Assistance in Emergencies: Her Majesty´s Government (HM Government), Department For Culture, Media And Sport (dcms) & Association of Chief Police Officers (ACPO) (n.d.). Humanitarian Assistance in Emergencies: Non-statutory guidance on establishing Humanitarian Assistance Centres, **p.12ff.** Available at www.gov.uk/government/uploads/system/uploads/attachment_data/file/61221/hac_guidance.pdf

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OPSIC-Team (2014). Practice examples. Aircrash 2008 in Spain. Trainbombs 2004 in Spain. Comprehensive Guideline OPSIC-Project – Annex.

Action Sheet Nr. 25: Psychological First Aid (PFA)

Area
All event types, all target groups, response phase, practice

Key actions in psychological first aid

- **Helping responsibly** entails four main points
  - Attend to safety, dignity and rights
  - Adapt for culture
  - Be aware of other emergency response measures
  - Practise self-care.

- **Get information**
  - Learn about the crisis event
  - Learn about available services and supports
  - Learn about safety and security concerns

- **Basic activities** (p.13)
  - **Principle - LOOK**
    - Observe for safety
    - Observe for people with obvious urgent basic needs
    - Observe for people with serious distress reactions
  - **Principle - LISTEN**
    - Make contact with people who may need support
    - Ask about people's needs and concerns
    - Listen to people, and help them to feel calm
  - **Principle - LINK**
    - Help people address basic needs and access services
    - Help people cope with problems
    - Give information
    - Connect people with loved ones and social support

- **People who need more than PFA** alone
  - Some people will need much more than PFA alone. Know your limits and ask for help from others who can provide medical or other assistance to save life.

- **People who need more advanced support immediately**
  - People with serious, life-threatening injuries who need emergency medical care
  - People who have such high level of distress that they cannot care for themselves or their children
  - People who may hurt themselves
  - People who may hurt others.

- About **the evidence** see the "Systematic Review of Psychological First Aid" by Bisson and Lewis (2009) and also the article "A Systematic Literature Search on Psychological First Aid: Lack of Evidence to Develop Guidelines" by Dieltjens (2014).

BASED ON:
World Health Organisation, War Trauma Foundation & World Vision International (2011). Psychological first aid: Guide for field workers, **p.13 & p.53ff.** Available at http://www.who.int/mental_health/publications/guide_field_workers/en/

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World Vision International & War Trauma Foundation (2010). Anthology of resources. Psychological first aid for low and middle income countries project 2009-2010. Available at http://mhpss.net/wp-content/uploads/group-documents/28/1301643800-PFA_Manual_Anthology_Logos1.pdf

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Containing

- Appendix A: Overview of Psychological First Aid (p. 99)
- Appendix C: Psychological First Aid Provider Care (p. 109)
- Appendix D: Psychological First Aid Worksheets (p. 119)
- Appendix E: Handouts for Survivors (p. 125)

World Health Organisation (WHO), War Trauma Foundation & World Vision International (2011). Psychological first aid: Guide for field workers. Psychological first aid: Pocket guide, p.53-54. Available at http://www.who.int/mental_health/publications/guide_field_workers/en/

The National Child Traumatic Stress Network (NCTSN). PFA Mobile™ app. Available at http://www.nctsn.org/content/pfa-mobile

Practice examples

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OPSIC-Team (2014). Practice examples. Comprehensive Guideline OPSIC-Project - Annex.

Action Sheet Nr. 26: MHPSS[1]: The Five Essential Elements

Area
All event types, all target groups, response phase, practice

Key elements in providing mental health and psychosocial support

- **Ensure safety**
  In this area, actions are recommended that help people to gain more objective and subjective safety, for example, by providing safe places, safe and consistent relationships to helpers, accurate information and protection.

- **Provide a calming environment**
  In this area, actions are recommended that help people calm down, for example, by providing psychological first aid and psychoeducation about symptoms and coping. Activities that help participants to gain distance from the event and experience positive emotions are recommended, e.g. play for children, rituals and other uplifting activities for children and adults to distract them from the traumatic event and its aftermath. In general it is recommended to reestablish normalcy and daily routines as soon as possible.

- **Enhance self and community efficacy**
  In this area, actions are recommended that provide people with enhanced self and collective efficacy, for example, by involving affected people as much as possible in decision-making and active coping efforts to enable them to be active survivors rather than passive victims. A general principle here is not to act for people, but with people. Activities that are planned and implemented by the community itself are key to self and community efficacy, e.g. religious and traditional activities, meetings, rallies, collaboration with local healers or collective healing and mourning rituals.

- **Enhance connectedness**
  In this area, it is strongly recommended to promote group cohesion and social support, for example, by helping individuals to identify and link with loved ones (especially with children) as fast as possible. Identify links too.between trauma survivors and social supports. In this area it is also recommended to treat temporary housing and assistance sites as villages (with village councils, welcoming comittees, meeting places, etc.)

- **Support in maintaining hope**
  In this area, all actions are recommended that help those affected to regain hope in the possibility of a positive future. This includes services that help individuals get their lives back in order, such as: housing, employment, schooling, etc; activities that involve positive emotions; and advocacy programmes to help survivors work through the tasks that emerge following mass disaster. It is also strongly recommended to provide stable support throughout the recovery phase.

BASED ON:

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Additional resources

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Hobfoll, S. E., Watson, P., Bell, C. C., Bryant, R. A., Brymer, M. J., Friedman, M. J., Friedman, M., Gersons, P. R., De Jong, J. T. V. M., Layne, C. M., Maguen, S., Neria, Y., Norwood, A. E., Pynoos, R. S., Reissman, D., Ruzek, J. I., Shalev, A. Y., Solomon, Z., Steinberg, A. M., Ursano, R. J. (2007). Five Essential Elements of Immediate and Mid-Term Mass Trauma Intervention: Empirical Evidence. Psychiatry 70 (4), 283–315. Available at http://mhpss.net/wp-content/uploads/group-documents/140/1330584195-Masstraumaintervention.pdf

International Federation of Red Cross and Red Crescent Societies (IFRC) Reference Centre for Psychosocial Support, Hansen, P. (2009). Psychosocial Interventions. A Handbook. Available at http://mhpss.net/wp-content/uploads/group-documents/22/1328075906-PsychosocialinterventionsAhandbookLowRes.pdf

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International Federation of Red Cross and Red Crescent Societies (IFRC) Reference Centre for Psychosocial Support (2009). Community-based psychosocial support. Trainer´s book. A training kit. Available at http://mhpss.net/wp-content/uploads/group-documents/22/1328076457-trainersbook.pdf

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Action Sheet Nr. 27: Key Principles and Actions in providing MHPSS[1]

Area
All event types, all target groups, response phase, practice

Key principles in providing mental health and psychosocial interventions in disaster situations[1,2]

- **Ensure that psychosocial supports are integrated** within other pre-existing community services and networks

- **Prioritize normalization of educational facilities**, even in emergency stages of operations, since this will provide significant opportunities for support to children and their caregivers

- **Ensure that mental health care is functionally linked to and integrated into the general health system**, rather than establishing parallel mental health services

- **Integrate mental health services into a system of multi-layered services** (see Action Sheet Nr. 1)

  Layer 1: Provision of basic services and security
  Ensure that provision of basic needs and essential services (food, shelter, water, sanitation, basic health care, control of communicable diseases) and security is done in a way that does not undermine psychosocial wellbeing or negatively affect mental health. This implies that the actors responsible for providing these essential services should use a MHPSS approach. This may require advocacy from MHPSS professionals to ensure that these services and assistance are inclusive for people with specific vulnerabilities including people with mental disorders, survivors of sexual and gender based violence, but avoid exclusively targetting a single group as this can lead to discrimination, stigma, and potential further distress.

  Layer 2: Strengthen community and family supports
  Affected people, just like anyone else, maintain their mental health and psychosocial wellbeing through using key community and family support. In many disaster settings there are significant disruptions of family and community networks and it is therefore important to enable communities to reestablish these support systems. Emergencies often damage the social structures between the affected and may negatively affect the ability of people to support each other effectively. Activities to foster social cohesion amongst refugee populations are therefore very important.

  Layer 3: Focused psychosocial supports
  A number of people will require more focused individual, family or group interventions by trained and supervised general health workers or community workers. Participants in these activities are usually people who have difficulty coping with their existing support network.

  Layer 4. Clinical services
  - A relatively small percentage of the population will have severe symptoms, and/ or an intolerable level of suffering, and have great difficulties in basic daily functioning. This group includes people with pre-existing mental health disorders and emergency-induced problems. Examples are people suffering from psychosis, drug abuse, severe depression, disabling anxiety symptoms, and people who are at risk to harm themselves or others. Examples of interventions at this level:
  - Delivery of basic primary mental health care by trained psychologists, psychiatrists and other mental health professionals
  - Pharmaological treatment
  - Provision of initial evidence based forms of psychotherapy (EMDR, trauma-focused cognitive behavioural therapy) by trained psychotherapists
  - Supervision and monitoring of primary care staff by mental health professionals

[1] Mental health and psychosocial support

- Outreach clinical counselling, etc.

Key actions for providing mental health care in disaster settings[1]

- Assess: Determine what assessments have been done and what information is available.
- Determine pre-existing structures,locations, staffing and resources fo rmental health care in the health sector (including policies, availability of medications, role of primary health care and mental hospitals, etc.) and relevant social services
- Determine the impact of the emergency on pre-existing services;
- Determine if local authorities and communities plan to address the needs of people with severe mental disorders who are affected by the emergency, and determine what may be done and what supports may be needed;
- Identify people with severe mental disorders
- Teach primary health care (PHC) staff to document mental health problems in PHC data
- Ensure adequate supplies of essential psychiatric drugs in all emergency drug kits
- Enable at least one member of the emergency PHC team to provide frontline mental health care.
- Establish mental health care at additional, logical points of access.
- Try to avoid the creation of parallel mental health services focused on specific diagnoses (e.g. PTSD) or on narrow groups (e.g. widows).
- Work with local community structures, to discover, visit and assist people with severe mental disorders
- Be involved in all inter-agency coordination on mental health
- Engage in strategic longer-term planning processes for mental health services.
- Use evidence based interventions

Recommendations on the basis of available evidence[3]

- It is important that those affected be provided, in an empathic manner, with practical, pragmatic psychological support. Individuals should be provided with information... about possible reactions they might have; what they can do to help themselves (coping strategies); how they can access support from those around them (particularly family and community); and how, where, and when to access further help if necessary.
- Any early intervention approach should be based on an accurate and current assessment of need.
- Individuals who experience continued symptoms a month or more after a traumatic event can benefit from psychological intervention. Use a trauma-focused cognitive behavior therapy for survivors with acute stress disorder within a month of the trauma, those with distressing traumatic stress symptoms 1 month after the trauma, and those with acute PTSD between 1 and 3 months after the trauma.
- We encourage exploration of a psychological first aid approach that takes explicit account of people's natural resilience, built on what might be termed psychological triage and proper stepped or stratified care.

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[2]IASC Mental health Guidelines: Inter-Agency Standing Committee (IASC) (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, **p.9ff**. Available at www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf

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Centre for Mental Health. New South Wales (NSW) Institute of Psychiatry (2000). Disaster Mental Health Response Handbook. An educational resource for mental health professionals involved in disaster management. Available at http://www.westga.edu/~vickir/ResourcesPublications/Professionals/Manuals,%20Guides,%20&%20Handbooks/Disaster%20MH%20Response.pdf

Pan American health organisation (2000) Mental Health services in disasters: a manual. Available at http://www.eird.org/isdr-biblio/PDF/Mental%20Health%20Services%20in%20Disasters%20manual.pdf

WHO (2005b). Mental Health Atlas. Geneva: WHO. Available at http://www.who.int/mental_health/evidence/atlas/

WHO (2005c). Model List of Essential Medicines. Geneva: WHO. Available at www.who.int/medicines/publications/essentialmedicines/en/

WHO (2006). The Interagency Emergency Health Kit: Medicines and Medical Devices for 10,000 People for Approximately 3 Months. Geneva: WHO. Available at http://www.who.int/medicines/publications/mrhealthkit.pdf

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WHO/UNHCR (1996). 'Common mental disorders'. In Mental Health of Refugees, pp.39-61. Geneva: WHO/UNHCR. Available at http://whqlibdoc.who.int/hq/1996/a49374.pdf

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International Federation of Red Cross and Red Crescent Societies (IFRC) (2001). Psychosocial Support: Best Practices from Red Cross Red Crescent Programmes. Available at http://helid.digicollection.org/en/d/Js2902e/

OPSIC-Team (2014). Practice examples. Comprehensive Guideline OPSIC-Project - Annex.

PHASE C: WHAT TO CONSIDER IN MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN THE RECOVERY PHASE AND IN THE LONG-TERM

The recovery phase involves the reinstitution of public services, the rebuilding of public infrastructure, and all that is necessary to help restore civic life, including disaster assistance, crisis counselling and various other forms of support. This also involves the process of reconstruction, which is very critical to mitigation/prevention and risk reduction. Monitoring of psychosocial community and individual resilience over time, often over several years, is necessary.

Mental health and psychosocial support recovery begins when the affected individuals, families and communities regain a certain level of normality, start to mourn losses and rebuild strength and wellbeing. The term 'late recovery' is used for the phase when missing persons have been identified and those who have died have been laid to rest.

Action Sheet Nr.28: MHPSS[1] in the Recovery Phase

Area
All event types, all target groups, recovery phase, delivery design

Key recommendations

- **Assess individuals with ongoing psychosocial difficulties** (by a trained professional) in relation to their physical, psychological and social needs before receiving any specific intervention[2]
- **Offer evidence-based interventions** for individuals with mental health difficulties such as trauma-focused cognitive behavior therapy[2,4]
- **Provide work/rehabilitation** opportunities to enable those affected to re-adapt to everyday life routines and be independent[2]
- **Facilitate conditions for appropriate healing** practices[2]
- **Plan with local authorities/governments and existing services** to fund and provide appropriate extra provision to support local services for several years following the disaster[2]
- **Link with organised service provision** (and clear referral pathways that can be used by all groups)[3]
- **Encourage the establishment of independent support groups** as well as smaller/facilitated support groups[3]
- **Organize memorial services**/acts of remembrance in close cooperation with the bereaved
- **Support survivors** (victims, as well as suspected prepetrators) during criminal inquiries/inquest process[3]
- **Identify human resources** in the local community[3]
- **Facilitate the process of community identification** of priority actions through participatory methods[3]
- **Encourage and support additional activities** that promote family and community support for all emergency-affected community members and, specifically, for people at greatest risk[3]
- **Approach local religious and spiritual leaders** and other cultural guides to learn their views on how people have been affected and on practices that would support the affected population[1]
- **Exercise ethical sensitivity** (see Action Sheet Nr. 2: ethics)[1]
- **Learn about cultural, religious and spiritual supports** and coping mechanisms (see Action Sheet Nr. 5: culture)[1]
- **Disseminate the information collected among humanitarian actors** at sector and coordination meetings in order to raise awareness about cultural and religious issues and practices[1]

BASED ON:

[1]IASC Mental health Guidelines: Inter-Agency Standing Committee (IASC) (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, **p.106ff**. Available at www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf
[2]TENTS Guidelines: Bisson, J. &. Tavakoly B. (2008). The Tents Guidelines. Psychosocial care following disaster and major incidents, **p.6ff**. Available at https://www.estss.org/uploads/2011/04/TENTS-Full-guidelines.pdf

[1] Mental health and psychosocial support

[3]Disaster Action (DA) (2008). Longer-term support for Survivor and Bereaved after Disaster, **p.1ff.** Available at http://www.disasteraction.org.uk/leaflets/longer-term_support_for_survivor_and_bereaved_after_disaster.pdf
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Disaster Action (DA) (n.d.). Longer-term Support for Survivor and Bereaved after Disaster. Available at http://www.disasteraction.org.uk/leaflets/longer-term_support_for_survivor_and_bereaved_after_disaster.pdf

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EUTOPA, Bering, R., Schedlich, C, Zurek, G., Kamp, M. & Fischer, G. (2008). Target Group Intervention Programme. Manual I. Manual for implementing the Cologne Risk Index-Disaster in the context of major

loss situations. Appendix 7: Cologne Risk Index – Disaster (CRI-D) for victims in case of disaster, p. 23. Available at http://www.eutopa-info.eu/fileadmin/products/eng/TGIP_EUTOPA_I_web_en.pdf

OPSIC-Team (2014). Overview of Standardised Instruments. Comprehensive Guideline OPSIC-Project – Annex.

Tools for monitoring
A list of tools for monitoring can be found in the Annex, with detailed descriptions and recommended cut-offs, where applicable.

Traumatic stress inventories:

LEC: Gray, M. J., Litz, B. T., Hsu, J. L., & Lombardo, T. W. (2004). Psychometric Properties of the Life Events Checklist. Assessment11, 330.

PDI: Brunet A., Weiss D. S., Metzler T. J., Best S. R., Neylan T. C., Rogers C., Fagan J., Marmar C. R. (2001). The Peritraumatic Distress Inventory: a proposed measure of PTSD criterion A2. American Journal of Psychiatry, 158 (9), 1480-5.

PDEQ: Marmar, C. R., Weiss, D. S., & Metzler, T. J. (1997). The peritraumatic dissociative experiences questionnaire. In Wilson J. P., Marmar C. R. (Eds.). Assessing psychological trauma and posttraumatic stress disorder (p. 412-428). New York: The Guilford Press.

Resilience:

RES: AMC (2013). Resilience Evaluation Scale.
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SAM: AMC (2014). An efficient assessment of resilience and stress responses in the face of adversity.
Being validated.

Social support:

SSL: Bridges, K.R., Sanderman, R. & Sonderen, E. van. (2002) An English language version of the social support list: preliminary reliability. Psychosocial reports, 90, 1055-1058.

Post-traumatic stress symptoms/ probable PTSD:

IES: Horowitz, M. J., Wilner, M., & Alverez, W. (1979). Impact of Events Scale: A measure of subjective stress, Psychosomatic Medicine, 41(3), 209-218.

IES-R: Weiss, D. S. (2007). The Impact of Event Scale: Revised. In J. P. Wilson & C. S.-k. Tang (Eds.), International and Cultural Psychology Series. Cross-Cultural Assessment of Psychological Trauma and PTSD (pp. 219–238). Boston, MA: Springer US. Information on how it can be obtained can be found at: http://consultgerirn.org/uploads/File/trythis/try_this_19.pdf.
Open-access instrument that can be used for assessment of post-traumatic stress symptoms and probable PTSD.

PCL: Weathers, F. W., Litz, B. T., Keane, T. M., Palmieri, P. A., Marx, B. P., & Schnurr, P. P. (2013). The PTSD Checklist for DSM-5 (PCL-5), Scale available from the National Center for PTSD at www.ptsd.va.gov.
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PC-PTSD: Prins, A., Ouimette, P., Kimerling, R., Cameron, R. P., Hugelshofer, D. S., Shaw-Hegwer, J., Thrailkill, A., Gusman, F. D., & Sheikh, J. I. (2003). The primary care PTSD screen (PC-PTSD): development and operating characteristics, 1, 9-14.

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Practice examples

Government of Bangladesh (2008). Cyclone Sidr in Bangladesh. Damage, Loss and Needs Assessment for Disaster Recovery and Reconstruction. Available at http://gfdrr.org/docs/AssessmentReport_Cyclone%20Sidr_Bangladesh_2008.pdf

OPSIC-Team (2014). Practice examples. Tsunami 2004 in South-East Asia_Swedish Perspective. Comprehensive Guideline OPSIC-Project – Annex.

Russian Red Cross, International Federation of Red Cross and Red Crescent Societies & IFRC Reference Centre for Psychosocial Support (2008). Red Cross Psychosocial Response to the hostage crisis in Beslan, North Ossetia, Russia 2005-2007. Final Assessment Report April 2008. Available at http://www.ukt.cervenykriz.eu/en/wp-content/uploads/2013-11-PSP-Head-of-Operation_Beslan-report-2008.pdf

WHO (2013) Building back better. Sustainable Mental Health Care after Emergencies. Available at http://www.who.int/mental_health/emergencies/building_back_better/en/

Containing

- Part 2: Seizing opportunity in crises: 10 case examples (p.25)
- Part 3: Spreading opportunity in crises: lessons learned take home messages (p.9)

Action Sheet Nr.29: Long-term Consequences to be considered in MHPSS[1]

Area
All event types, general affected population, recovery phase

Key recommendations

- **Ensure long-term access to mental health care services for the affected**
  Research shows that in the long-term people affected by disasters have several-fold higher risk for mental ill health in comparison to unaffected people: Prevalence of PTSD diagnoses is about four times higher and prevalence of depression diagnoses is about five times higher about ten years post-disaster. Furthermore, prevalence of PTSD and depression diagnoses remain relatively stable in the long-term, with about 16% of those affected having PTSD diagnoses and about 13% depression diagnoses. The individuals with such problems should have access to specialised mental health services. Data show that increased need for such services may be evident even 15 years after a disaster.

- **Ensure long-term support to attend to the general mental health needs of the affected population**
  Research in the long-term shows that those affected have more post-traumatic stress symptoms, depression symptoms and poorer general mental health at both 12 months and four to seven years post-disaster in comparison to unaffected people. Furthermore, rates of post-traumatic stress symptoms, probable PTSD and poor general mental health remain roughly the same over the long term. About 20% of those affected have probable PTSD and about 47% report poor general mental health at 3.5 years post-disaster on average. This shows that there is a need to attend to the subclinical mental health needs of the general affected population in the long-term. Data show that increased mental health support services may be needed as long as four years post-disaster.

- **Promote overall psychological adaptation in the long-term**
  In the long-term those affected by disasters have poorer psychological outcomes than those who are not affected. Emotional problems may lead to difficulties in functioning. There is likely to be poorer psychological adaptation and overall quality of life, and those affected are likely to continue to hold negative beliefs about the effects of disasters. Support should be available to help them reintegrate usual life roles and promote quality of life Communicating accurate information about effects of the disaster may help to mitigate negative beliefs. Key principles in crisis communications should be followed in the long-term period (*see Action Sheet Nr. 10*).

- **Promote resilience factors that can be affected in the long term**
  Some resilience factors may be depleted in the long-term, such as social embeddedness (i.e. size and connectedness of an individual's network of interpersonal relationships) and the quality of the community environment. People may wish to move away from the affected community. Attention should be given to maintaining social ties in the community and maintaining and/or re-establishing of community services.

- **Keep in mind that some disaster types can have worse consequences**
  Man-made disasters in most cases lead to worse consequences for those affected than natural disasters. It is vital to regularly monitor population wellbeing, mental health and psychosocial functioning so as to plan and implement inteventions that are appropriate to the specific disaster type.

BASED ON

Ajduković, D., Bakić, H. (2015). Long-term effects of disasters on mental health and psychosocial functioning. OPSIC Team and University of Zagreb (FFZG). Unpublished report.

[1] Mental health and psychosocial support

Additional resources

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A report on long-term effects of disasters.

Norris, F., Friedman, M., Watson, P., Byrne, C., Diaz, E., & Kaniasty, K. (2002). 60,000 disaster victims speak: Part I. An empirical review of the empirical literature, 1981-2001. Psychiatry: Interpersonal and Biological Processes, 65(3), 207–239.
A systematic review of effects of disasters.

Norris, F. H., Stevens, S. P., Pfefferbaum, B., Wyche, K. F., & Pfefferbaum, R. L. (2008). Community Resilience as a Metaphor, Theory, Set of Capacities, and Strategy for Disaster Readiness. American Journal of Community Psychology, 41(1-2), 127–150. doi:10.1007/s10464-007-9156-6
This paper explores understandings of community resilience and indicates different set of capacities that can be strengthened in order to promote it.

Norris, F., Tracy, M., & Galea, S. (2009). Looking for resilience: Understanding the longitudinal trajectories of responses to stress. Social Science & Medicine, 68(12), 2190–2198.
This research deals with trajectories of traumatic stress after two different disasters, and offers insight into different patterns of (potential) recovery after disasters. It also shows that for a certain number of affected people, there is stability in adverse effects of disasters.

Tools

OPSIC-Team (2014). An overview of standardised Instruments. MHPSS Comprehensive Guideline OPSIC-Project – Annex.

Tools for monitoring
A list of tools for monitoring can be found in the Annex, with, detailed descriptions and recommended cut-offs, where applicable.

Traumatic stress inventories:

LEC: Gray, M. J., Litz, B. T., Hsu, J. L., & Lombardo, T. W. (2004). Psychometric Properties of the Life Events Checklist. Assessment 11, 330.

PDI: Brunet A., Weiss D. S., Metzler T. J., Best S. R., Neylan T. C., Rogers C., Fagan J., Marmar C. R. (2001). The Peritraumatic Distress Inventory: a proposed measure of PTSD criterion A2. American Journal of Psychiatry, 158 (9), 1480-5.

PDEQ: Marmar, C. R., Weiss, D. S., & Metzler, T. J. (1997). The peritraumatic dissociative experiences questionnaire. In Wilson J. P., Marmar C. R. (Eds.). Assessing psychological trauma and posttraumatic stress disorder (p. 412-428). New York: The Guilford Press.

Resilience:

RES: AMC (2013). Resilience Evaluation Scale. Internal document.
Being validated.

SAM: AMC (2014). An efficient assessment of resilience and stress responses in the face of adversity.
Being validated.

Social support:

SSL: Bridges, K.R., Sanderman, R. & Sonderen, E. van. (2002) An English language version of the social support list: preliminary reliability. Psychosocial reports, 90, 1055-1058.

Post-traumatic stress symptoms/probable PTSD:

IES: Horowitz, M. J., Wilner, M., & Alverez, W. (1979). Impact of Events Scale: A measure of subjective stress, Psychosomatic Medicine, 41(3), 209-218.

IES-R: Weiss, D. S. (2007). The Impact of Event Scale: Revised. In J. P. Wilson & C. S.-k. Tang (Eds.), International and Cultural Psychology Series. Cross-Cultural Assessment of Psychological Trauma and PTSD (pp. 219–238). Boston, MA: Springer US. Information on how it can be obtained can be found at: http://consultgerirn.org/uploads/File/trythis/try_this_19.pdf.
Open-access instrument that can be used for assessment of post-traumatic stress symptoms and probable PTSD.

PCL: Weathers, F. W., Litz, B. T., Keane, T. M., Palmieri, P. A., Marx, B. P., & Schnurr, P. P. (2013). The PTSD Checklist for DSM-5 (PCL-5), Scale available from the National Center for PTSD at www.ptsd.va.gov.
Open-access instrument that can be used for assessment of post-traumatic stress symptoms and PTSD.

PC-PTSD: Prins, A., Ouimette, P., Kimerling, R., Cameron, R. P., Hugelshofer, D. S., Shaw-Hegwer, J., Thrailkill, A., Gusman, F. D., & Sheikh, J. I. (2003). The primary care PTSD screen (PC-PTSD): development and operating characteristics, 1, 9-14.

PTCI: Foa, E. B., Ehlers, A., Clark, D. M., Tolin, D. F., & Orsillo, S. M. (1999). The post-traumatic cognitions inventory (PTCI): Development and validation. Psychological Assessment, 11, 303-314.

Practice examples

Government of Bangladesh (2008). Cyclone Sidr in Bangladesh. Damage, Loss and Needs Assessment for Disaster Recovery and Reconstruction. Available at http://gfdrr.org/docs/AssessmentReport_Cyclone%20Sidr_Bangladesh_2008.pdf

OPSIC-Team (2014). Practice examples. Tsunami 2004 in South-East Asia_Swedish Perspective. Comprehensive Guideline OPSIC-Project - Annex.

Russian Red Cross, International Federation of Red Cross and Red Crescent Societies & IFRC Reference Centre for Psychosocial Support (2008). Red Cross Psychosocial Response to the hostage crisis in Beslan, North Ossetia, Russia 2005-2007. Final Assessment Report April 2008. Available at http://www.ukt.cervenykriz.eu/en/wp-content/uploads/2013-11-PSP-Head-of-Operation_Beslan-report-2008.pdf

WHO (2013) Building back better. Sustainable Mental Health Care after Emergencies. Available at http://www.who.int/mental_health/emergencies/building_back_better/en/

Containing

- Part 2: Seizing opportunity in crises: 10 Case examples (p.25)
- Part 3: Spreading opportunity in crises: Lessons learned, take-home messages (p.9).

PART III: SPECIFIC MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT RECOMMENDATIONS FOR TARGET GROUPS

The recommendations in part three are aimed at general crisis managers (especially the Action Sheets on governance policy), psychosocial crisis managers, mental health professionals and practitioners. The Action Sheets focus on good psychosocial programming and interventions in relation to the specific needs of the following target groups:

- children and adolescents
- helpers (staff and volunteers)
- older people
- refugees
- disabled persons

Action Sheet for Target Groups Nr. 30: MHPSS[1] Policy Recommendations for Children and Adolescents in Disasters

Area
All event types, children and adolescents, response to recovery

Key principles for supporting children and adolescents in disasters

Principle 1: Human rights
All programmes assisting to children in unstable situations must be designed and carried out in a way that promotes respect for their human rights.

Principle 2: Non-discrimination
Psychosocial programmes should be provided to all children without discrimination of any kind.

Principle 3: Best Interest of the child
Psychosocial programmes and their outcomes should not be used for any purpose other than the psychosocial development of the participants. The long-term development of the individual and the potentially harmful consequences of any short-term activities should be taken into account when implementing programmes.

Principle 4: Gender
Psychosocial programmes should take gender into account.

Principle 5: Values and culture
Psychosocial programmes should be based on a situational assessment that includes information about the culture and values of the community into which the child is being reintegrated and allow the expression and observance of the child's own culture.

Principle 6: Child participation
Children should participate in all programmes that are designed to foster their wellbeing. Participation includes the right to take part in groups, to express their own opinions and views, to make decisions and to have access to information and knowledge that is appropriate to their psychological recovery and social reintegration.

Principle 7: Family and community-oriented approach
All programme activities should promote the cohesion of family and community in the process of addressing the child's psychosocial needs. Where possible, children without families should be provided a family-like environment.

Principle 8: Wellbeing and prevention
The overall objective of psychosocial programmes is to re-establish a state of wellbeing that is necessary for the healthy development of children. Psychosocial programmes should be implemented in a way that protects children from further harm. This includes having a rigorous selection and screening procedure for those who work with children.

Principle 9: An integrated approach
An integrated approach to psychosocial work is recommended where programmes are integrated with education, healthcare and other helping services. In a holistic approach all of the sectors including education, health, advocacy, protection and community-building are essential in promoting the psychosocial wellbeing of children

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- Appendix One: Promoting resilience in children: teaching and discussion strategies (p. 33)
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- Chapter 4: Education for all in Emergencies and Reconstruction – Tools and Resources (p. 20)
- Chapter 5: Rural Populations - Tools and Resources (p. 17)
- Chapter 8: Children with Disabilities – Tools and Resources (p. 10)
- Chapter 9: Former Child Soldiers - Tools and Resources (p. 13)
- Chapter 10: Learning Spaces and School Facilities – Tools and Resources (p. 15)
- Chapter 11: Open and Distance Learning – Tools and Resources (p. 11)
- Chapter 12: Non-Formal Education – Tools and Resources (p. 12)
- Chapter 13: Early Childhood Development – Tools and Resources (p. 11)
- Chapter 14: Post-Primary Education – Tools and Resources (p. 17)
- Chapter 15: Identification, Selection and Recruitment of Teachers and Education Workers – Tools and Resources (p. 12).

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Action Sheet for Target Groups Nr. 31: MHPSS[1] Intervention Design for Children and Adolescents in Disasters

Area
All event types, children and adolescents, response to recovery

Key recommendations for intervention designs with children and adolescents

- **Keep families together and promote family reunions as fast as possible**[1]
  Keep children with their mothers, fathers, family or other familiar caregivers
- **Provide a child friendly environment**[1]
  Facilitate play, nurturing care and social support
- **Support caregivers - care for care-providers**[1]
- **Promote safe learning environments and establish schools as soon as possible**[1]
- **Adapt learning environment to special needs**[1]
  - Make formal and non-formal education more supportive and relevant
  - Strengthen access to education for all
  - Prepare and encourage educators to support learners' psychosocial wellbeing
  - Strengthen the capacity of the education system to support learners experiencing psychosocial and mental health difficulties.

Child friendly spaces (CFS)[2]
The following five principles are essential and should be built into all the actions outlined below:

1. Take a coordinated, inter - agency, and multi - sectoral approach
2. Use CFSs as a means of mobilizing the community
3. Make CFSs highly inclusive and non - discriminatory
4. Ensure that CFSs are safe and secure
5. Make CFSs stimulating, participatory, and supportive environments

The actions cover the following:

a. Conduct an assessment
b. Organize integrated supports and services
c. Provide ongoing training and follow - up support for animators and staff
d. Monitor and evaluate CFS programs
e. Phase out or transition in a contextually appropriate manner

BASED ON:

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- Main Principles of Child-Friendly Spaces (p. 9)
  - Principle 1: CFS are secure and safe environments for children (p. 9)
  - Principle 2: CFS provide a stimulating and supportive environment for children (p. 10)
  - Principle 3: CFS are built on existing structures and capacities within a community (p. 11)
  - Principle 4: CFS use a participatory approach for the design and implementation (p. 12)
  - Principle 5: CFS provide or support integrated programmes and service (p. 12)
  - Principle 6: CFS are inclusive and non-discriminatory (p. 13)
- Practical Guidance for establishing a Child-Friendly Space
  - Action Sheet 1: Assessment (p. 20)
  - Action Sheet 2: Planning and Design of Programmes (p. 37)
  - Action Sheet 3: Structural Design and Implementation (p. 53)
  - Action Sheet 4: Operations and Capacity-building (p. 70)

  - Action Sheet 5: Monitoring and Evaluations (p. 93)
- Action Sheet 5: Monitoring and Evaluations - Toolbox
  - Checklist for Monitoring (p. 101)
  - Sample Monthly Monitoring Report (p. 102)
  - Sample of Save the Children Monitoring Sheet for Parents & Caregivers (p. 104)
  - Sample Monitoring Plan (p. 105).

Practice examples

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Action Sheet for Target Groups Nr. 32: MHPSS[1] Practice with Children and Adolescents

Area
All event types, children and adolescents, response to recovery

Key actions in supporting children and adolescents

- **Find ways to protect children from further harm and from further exposure to traumatic stimuli**
  If possible, create a safe haven for children and adolescents. Protect young people from onlookers and the media covering the story.

- **Kind. but firm, direction is needed**
  When possible, direct children who are able to walk away from the site of violence or destruction, away from severely injured survivors, and away from continuing danger.

- **Identify children in acute distress and stay with them until initial stabilization occurs**
  Acute distress includes panic (marked by trembling, agitation, rambling speech, becoming mute, or erratic behaviour) and intense grief (signs include loud crying, rage, or immobility).

- **Use a supportive and compassionate verbal or non-verbal exchange**
  If appropriate, use a hug, to help a child feel safe. However brief the exchange, or however temporary, such reassurances are important to children.

- **After violence or a disaster occurs, the family is the first-line resource for helping. Among the things that parents and other caring adults can do are:**
  - Explain the episode of violence or disaster as well as you are able.
  - Encourage the children to express their feelings and listen without passing judgment. Help younger children learn to use words that express their feelings. However, do not force discussion of the traumatic event.
  - Let children and adolescents know that it is normal to feel upset after something bad happens.
  - Allow time for the young people to experience and talk about their feelings. At home, however, a gradual return to routine can be reassuring to the child.
  - If your children are fearful, reassure them that you love them and will take care of them. Stay together as a family as much as possible.
  - If behaviour at bedtime is a problem, give the child extra time and reassurance. Let him or her sleep with a light on or in your room for a limited time if necessary.
  - Reassure children and adolescents that the traumatic event was not their fault.
  - Do not criticize regressive behaviour or shame the child by saying they are babyish.
  - Allow children to cry or be sad. Don't expect them to be brave or tough.
  - Encourage children and adolescents to feel in control. Let them make some decisions about meals, what to wear, etc.
  - Take care of yourself so you can take care of the children.
  - Encourage children to develop coping and problem-solving skills and age-appropriate methods for managing anxiety.

- **Hold meetings for parents to discuss the traumatic event, their children's response to it, and how they and you can help**
  Involve mental health professionals in these meetings if possible.

- **Most children and adolescents, if given support such as that described above, will recover almost completely from the fear and anxiety caused by a traumatic experience within a few**

[1] Mental health and psychosocial support

weeks
However, some children and adolescents will need more help perhaps over a longer period of time in order to heal. Grief over the loss of a loved one, teacher, friend, or pet, may take months to resolve, and may be reawakened by reminders such as media reports or the anniversary of the death.

- **In the immediate aftermath of a traumatic event, and in the weeks following, it is important to identify the children or adolescents in need of more intensive support and therapy because of profound grief or some other extreme emotion**
  Young people who have more common reactions including re-experiencing the trauma, or reliving it in the form of nightmares and disturbing recollections during the day, and hyper-arousal, including sleep disturbances and a tendency to be easily startled, may respond well to supportive reassurance from parents and teachers.

- **Don't try to rush back to ordinary school routines too soon**
  Give the children or adolescents time to talk over the traumatic event and express their feelings about it.

- **Respect the preferences of children who do not want to participate in class discussions about the traumatic event**
  Do not force discussion or repeatedly bring up the catastrophic event; doing so may re- traumatize children.

- **Hold in-school sessions with entire classes, with smaller groups of students, or with individual students**
  These sessions can be very useful in letting students know that their fears and concerns are normal reactions. Counties and school districts may have teams that will go into schools to hold such sessions after a disaster or violent incident. Involve mental health professionals in these activities if possible.

- **Offer evidence based forms of therapy for young children in school** (see "Teaching Recovery Techniques" by Smith et al. (2002) or the website http://www.childrenandwar.org/)

- **Be sensitive to cultural differences among the children**
  In some cultures, for example, it is not acceptable to express negative emotions. A child who is reluctant to make eye contact with a teacher may not be depressed, but may simply be exhibiting behaviour appropriate to his or her culture.

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Open-access instrument that can be used for assessment of post-traumatic stress symptoms and probable PTSD in children and adolescents.

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Practice examples

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Action Sheet for Target Groups Nr. 33: MHPSS[1] Policy for Schools after School-related Disasters

Area
All event types, children and adolescents, all phases

Key principles for psychosocial interventions in schools

Principle 1: Preparedness (crisis plan and crisis team)

- Every school should have a plan for school-based crisis intervention
- Instead of a single person being solely responsible in times of crisis, the school administration is advised to form a small planning committee of school staff; hence, having a school-based crisis team
- The crisis team needs to identify a team leader
- The team should receive general training with respect to crisis intervention
- The crisis team starts to map community resources
- The social media Action Sheets should be considered (see Action Sheet Nr.11-14).

Principle 2: Response (focus on commmunication and provision of interventions)

- The school head teacher is responsible to mobilize the team when needed
- The crisis team should prepare and set in motion procedures to:
  - Gather and disseminate accurate information to students, staff, parents
  - Assess immediate needs
  - Ensure sufficient medical and psychological first aid
  - Ensure referral of students, staff and parents in need to psychological first aid resources
  - Coordinate resources and ensure they are maintained as long as needed
  - Keep administration informed
- Be prepared to coordinate communication and control rumours (see Action Sheet Nr. 10-14)
- Be prepared to deal with the media: It is important to have a trained person as a media coordinator
- Be prepared to distribute handouts to staff and parents
- Be prepared to hold meetings for parents
- Be prepared to organise interventions in the aftermath of a disaster.

Principle 3: Long-term (psychoeducation and long-term support for all groups)

- A comprehensive crisis intervention approach provides ways for school staff, students, and parents to return to normalcy as quickly as feasible
- Be prepared to provide teachers with accurate information about the event, to circulate a handout to all school staff regarding what they should watch for in the aftermath of a disaster and what they can do if students appear to be particularily upset
- Provide written information for parents on the event and the interventions being implemented, as well as information on what to watch out for and how to support their children if they are particularily upset/distressed
- Provide support to caregivers (take care of caregivers)
- Ensure that individuals receive follow-up assistance if needed
- At a later date it is recommended to evaluate procedures to find out what revisions are needed and to indicate planning implications for the future.

BASED ON:
Center for Mental Health in Schools at UCLA (2008). Responding to Crisis at a School. A Resouce Aid, **p.6ff**. Available at http://smhp.psych.ucla.edu/pdfdocs/crisis/crisis.pdf

[1] Mental health and psychosocial support

Additional resources

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Tools

Inter-Agency Network for Education in Emergencies (INEE) (2004). Minimum Standards for Education in Emergencies. Chronic Crises and Early Reconstruction. Available at http://www.unicef.org/violencestudy/pdf/min_standards_education_emergencies.pdf

Containing

- Minimum Standards Common to All Categories
  - Appendix 1: Assessment Framework (p. 29)
  - Appendix 2: Planning in an Emergency: Situation Analysis Checklist (p. 30)
  - Appendix 3: Information Gathering and Needs Assessment Framework (p. 33)
- Access and Learning Environment
  - Appendix 1: Psychosocial Checklist (p. 49)
  - Appendix 2: School Feeding Programme Checklist (p. 51).

Norwegian Refugee Council (NRC), Omdal, G. R. & Munden, J. (2005). Psychosocial Support. Teachers Training. Available at http://toolkit.ineesite.org/toolkit/INEEcms/uploads/1126/Teacher_Training_Psychosocial_Support.pdf

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Containing

- Designing a Response
  - Tool: Steps in Planning a Response (p. 26)
  - Inclusion Strategies for Education (p. 30)
  - Tool: Balancing Immediate and Long-Term Impact (p.32)
- Tools to use
  - Emergency Preparedness (p. 52)
  - Assessment (p. 59)
  - Staffing (p. 67)
  - Supplies (p. 76)
  - Safe Spaces (p. 84)
  - Teacher Training (p. 96)
  - Learning Content (p. 107)
  - Psychosocial Support (p. 117)
  - School Committees (p. 128)
  - Monitoring and Evaluation (p. 137).

United Nations Children´s Fund (UNICEF) (n.d.). Safe School in Safe Territories. Reflections on the Role of the Educational Community in Risk Management. Annex 1: A Guide for the production of school participatory risk management plans (p.89) Available at http://www.eird.org/publicaciones/safe-schools.pdf

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Containing

- Chapter 4: Education for all in Emergencies and Reconstruction – Tools and Resources (p. 20)
- Chapter 5: Rural Populations - Tools and Resources (p. 17)
- Chapter 8: Children with Disabilities – Tools and Resources (p. 10)
- Chapter 9: Former Child Soldiers - Tools and Resources (p. 13)
- Chapter 10: Learning Spaces and School Facilities – Tools and Resources (p. 15)
- Chapter 11: Open and Distance Learning – Tools and Resources (p. 11)
- Chapter 12: Non-Formal Education – Tools and Resources (p. 12)
- Chapter 13: Early Childhood Development – Tools and Resources (p. 11)

- Chapter 14: Post-Primary Education – Tools and Resources (p. 17)
- Chapter 15: Identification, Selection and Recruitment of Teachers and Education Workers – Tools and Resources (p. 12)
- Chapter 16: Teacher Motivation, Compensation and Working Conditions – Tools and Resources (p. 10)
- Chapter 17: Measuring and Monitoring Teacher´s Impact – Tools and Resources (p. 10)
- Chapter 18: Teacher Training: Teaching and Learning Methods – Tools and Resources (p. 14)
- Chapter 19: Psychosocial Support to Learners – Tools and Resources (p. 10)
- Chapter 20: Curriculum Content and Reviews Processes – Tools and Resources (p. 14)
- Chapter 23: Environmental Education – Tools and Resources (p. 7)
- Chapter 27: Textbooks, Educational Materials and Teaching Aids – Tools and Resources (p. 11)
- Chapter 28: Assessment of Needs and Resources – Tools and Resources (p. 12)
- Chapter 29: Planning Process – Tools and Resources (p. 14)
- Chapter 30: Project Management – Tools and Resources (p. 8)
- Chapter 32: Community Participation – Tools and Resources (p. 12)
- Chapter 33: Structure of the Education System – Tools and Resources (p. 12)
- Chapter 34: Data Collection and Education Management Information Systems (EMIS) - Tools and Resources (p. 13)
- Chapter 35: Budget and Financial Management – Tools and Resources (p. 15)
- Chapter 36: Human Resources: Ministry Officials – Tools and Resources (p. 10)
- Chapter 37: Donor Relations and Funding Mechanisms – Tools and Resources (p. 10)
- Chapter 38: Co-Ordination and Communication (p. 11).

Practice examples

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OPSIC-Team (2014). Practice examples. School Shooting 2008 in Finland. Comprehensive Guideline OPSIC-Project – Annex.

Action Sheet for Target Groups Nr. 34: MHPSS[1] Intervention Design for Schools after School-related Disasters

Area
All event types, children and adolescents, all phases

Key actions in classroom activities

Immediate classroom activities

- **Give accurate information and explanations of what happened and what to expect**
  - Never give unrealistic or false assurances (see Action Sheets Nr.10-14: Crisis Communication)
- **Informing and discussing a traumatic event with students is best done in small groups where questions can be answered, rumours dealt with, and concerns addressed**
  - Some students may choose not to participate in discussion, and some may even express a desire to be excused. Don´t force the situation; honour the students' wishes.
- **Focus on restoring equilibrium**
  - Be calm, direct, informative, authoritative, nurturing and oriented towards problem-solving
  - Talk with students about their emotional reactions and encourage them to deal with such reactions as a way of countering denial and other defences that interfere with restoring equilibrium
  - After expressing themselves, let them know that what they are thinking and feeling is very natural under the circumstances and that (for some of that) it may take a while before such thoughts and feelings are worked through
  - Convey positive expectation – that while crises change things, there are ways to deal with the impact
- **Move students from 'victim' to 'actor'**
  - Plan positive, realistic actions with students that they can do when they leave you
  - Build on the coping strategies students have already demonstrated
  - If feasible, involve students in assisting with efforts to restore equilibrium
- **Connect students with immediate social support (e.g. peer buddies, family, etc.)**

BASED ON:
Center for Mental Health in Schools at UCLA (2008). Responding to Crisis at a School. A Resouce Aid, **p.21ff**. Available at http://smhp.psych.ucla.edu/pdfdocs/crisis/crisis.pdf

Key actions in classroom activities following a disaster

The list of key actions below indicate the range of activities that can be done in the classroom to enable students to express their feelings about the event.
As a general recommendation, interventions that enable students to work through the experience should be done and/or supervised by mental health professionals. Interventions aimed at restoring a sense of safety and connectedness can be done by teachers supervised by mental health professionals.

Pre-school and kindergarten activities

- **Use toys such as fire trucks, rescue trucks, dump trucks, ambulances**
  that encourage play reenactment of students' experiences and observations during a traumatic experience that help integrate the experiences.

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- **At this age children need lots of physical contact with familiar trusted caregivers to regain a sense of security during times of stress**
  Games involving structured physical touching help meet this need.

- **Playing with puppets can be effective in reducing inhibitions and encouraging children to discuss their feelings**

- **Have the children draw individual pictures about the event and then discuss or act out elements of their pictures**
  This activity helps children realise that others have similar fears or worries.

- **Read stories to the children about other children's (or animals') experiences in a disaster**
  This helps to show how people resolve feelings of fear.

- **When children are restless or anxious, any activities that involve large muscle movements are helpful**

Elementary school activities

- **Children often respond more freely to a puppet asking what happened than to an adult asking the questions directly**
  Help or encourage children to make up puppet shows about what happened in the event (featuring positive aspects and also elements that may have been frightening or disconcerting).

- **Have the children draw their own pictures and then talk about them in small groups**
  It is important in the group discussion to end on a positive note. It is important to legitimize feelings to help students feel less isolated.

- **Have the children brainstorm their own classroom or family disaster plan**
  What would they do if they had to evacuate their school? How would they contact parents? How should the family be prepared? How could they help the family?

- **Read aloud, or have the children read, stories or books that talk about children or families dealing with stressful situations, pulling together during times of hardship, and similar themes**
  Emphasise creative problem-solving and positive resolutions in the face of hardship.

- **In small groups use discussion questions** such as
  "If you were an animal, what would you do when some traumatic event occurred?" Have the children take turns acting out an emotion in front of the class, without talking. Ask the rest of the class to guess what the emotion is and why the student might be feeling this way. Do this for positive as well as negative feelings.

Middle and high school activities

- **Group discussion of their experiences is particularly important among adolescents**
  Students need the opportunity to express their feelings, as well as to normalize the extreme emotions they may be experiencing. A good way to stimulate a discussion is for the teacher to share his or her own reactions to the event. It is important to end such discussions well, such as giving examples of positive coping.

- **Break the class into small groups and have them develop a disaster plan for their home, school or community**
  This can help students regain a sense of mastery and security, as well as having practical merit. The small groups can then share their plans in a discussion with the entire class.

- **Conduct a class discussion and/or organise a class project on how the students might help the community recovery effort**
  It is important to help students to find concrete ways of helping with the community recovery effort. Community involvement can help overcome feelings of helplessness and frustration, and deal with

survivor guilt and other common reactions in disaster situations.

- **Encourage students who have had first aid training to demonstrate basic techniques to the class**
- **Organise projects on stress, physiological response to stress, and how to deal with stress**
- **Invite guest speakers from public health and/or mental health and from the fire department to school**

BASED ON:
Center for Mental Health in Schools at UCLA (2008). Responding to Crisis at a School. A Resouce Aid, **p.21ff**. Available at http://smhp.psych.ucla.edu/pdfdocs/crisis/crisis.pdf

Additional resources

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Tools

Australian Child and Adolescent Trauma, Loss and Grief Network (ACATLGN), Roberts, M. (2009). Resources for Teachers School Recovery Tool Kit. Victorian Bushfire Support & Training for Affected Schools Project. Available at http://mhpss.net/wp-content/uploads/group-documents/57/1370409356-resourcesforteachers_schools_bushfire_toolkit.pdf

Containing

- Self care (p.2)
- Behaviour management: Ten tips for creating a trauma-sensitive classroom (p. 6)
- Kepping track of your students - Observation sheets (p.10).

Center for Mental Health in Schools at UCLA (2008). Responding to Crisis at a School. A Resouce Aid. Finding Hope Beyond Grief, p. 107. Available at http://smhp.psych.ucla.edu/pdfdocs/crisis/crisis.pdf

Center for Mental Health in Schools at UCLA (2008). Responding to Crisis at a School. A Resouce Aid. Helping to survive a loss, p. 108. Available at http://smhp.psych.ucla.edu/pdfdocs/crisis/crisis.pdf

Center for Mental Health in Schools at UCLA (2008). Responding to Crisis at a School. A Resouce Aid. Grief – Sharing the Burden, p. 109. Available at http://smhp.psych.ucla.edu/pdfdocs/crisis/crisis.pdf

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Center for Mental Health in Schools at UCLA (2008). Responding to Crisis at a School. A Resouce Aid. Families Facing Loss, p. 111. Available at http://smhp.psych.ucla.edu/pdfdocs/crisis/crisis.pdf

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Save the Children (n.d.). How to Help Children Cope with Disasters: Tips for teachers. Available at http://mhpss.net/wp-content/uploads/group-documents/219/1385136362-howtohelpchildrencopewithdisasters_tipsforteachers.pdf

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Practice examples

Council of Europe / EFPA (2010). Lessons learned in psychosocial care after disasters. Chapter: School schooting in Erfurt. Available at http://www.recoveryplatform.org/assets/publication/Lessonslearned_psycosocial%20care%20EC_EN.pdf

Action Sheet for Target Groups Nr. 35: Long-term Consequences to be considered in MHPSS[1] for Children and Adolescents

Area
All event types, children and adolescents, recovery phase

Key recommendations

- **Ensure long-term access to mental health care services for children and adolescents**
  Although results on long-term effects of disasters remain somewhat inconclusive**,** it seems that children and adolescents can suffer from severe effects of disasters in the long-term. Prevalence of PTSD in the long-term range from 19% to 36%, which is several fold higher than in the unaffected population. About three years post-disaster, children and adolescents may have a higher prevalence of PTSD diagnoses in comparison to the adult affected population. Easy and non-stigmatizing access to mental health services and mental health professionals should be provided to children and adolescents affected by a disaster at least three years post-disaster.

- **Monitor long-term effects of disasters on children and adolescents**
  Periodic assessment and monitoring of mental health status of the affected children and adolescents may be necessary as long as three years post-disaster (for general information on monitoring, see Action Sheets Nr. 15 & 16).

- **Use instruments specifically designed for children and adolescents**
  See tools section below for examples.

BASED ON:
Ajduković, D., Bakić, H. (2015). Long-term effects of disasters on mental health and psychosocial functioning. OPSIC Team and University of Zagreb (FFZG). Unpublished report.

Additional resources

Ajduković, D., Bakić, H. (2015). Long-term effects of disasters on mental health and psychosocial functioning. OPSIC Team and University of Zagreb (FFZG). Unpublished report.
Report on long-term effects of disasters.

Norris, F., Friedman, M., Watson, P., Byrne, C., Diaz, E., & Kaniasty, K. (2002). 60,000 disaster victims speak: Part I. An empirical review of the empirical literature, 1981-2001. Psychiatry: Interpersonal and Biological Processes, 65(3), 207–239.
Systematic review of effects of disasters.

Tools
A list of tools for monitoring can be found in the Annex, with detailed descriptions and recommended cut-offs, where applicable.

CDI 2: Kovacs, M. (2011). Children's Depression Inventory 2™ (CDI 2). North Tonawanda, NY: Multi Health Systems Inc. Information on how it can be obtained can be found at: http://www.mhs.com/product.aspx?gr=edu&prod=cdi2&id=resources
Instrument that can be used for assessment of depression symptoms in children and adolescents.

CRIES: Perrin, S., Meiser-Stedman, R. & Smith, P. (2005). The Children's Revised Impact of Event Scale (CRIES): Validity as a screening instrument for PTSD. Behavioural and Cognitive Psychotherapy, 33, 487–

[1] Mental health and psychosocial support

498. http://www.childrenandwar.org/measures/children%E2%80%99s-revised-impact-of-event-scale-8-%E2%80%93-cries-8/
Open-access instrument that can be used for assessment of post-traumatic stress symptoms and probable PTSD in children and adolescents.

READ: Hjemdal, O., Friborg, O., Stiles, T. C., Martinussen, M., & Rosenvinge, J. H. (2006). A New Scale for Adolescent Resilience: Grasping the Central Protective Resources Behind Healthy Development. *Measurement and Evaluation in Counseling and Development*, 84-96.
Instrument that can be used for assessment of resilience in adolescents.

PTSD-RI: Rodriguez, N., Steinberg, A. & Pynoos, R. (1999) Instrument information: child version, parent version, and adolescent version. Los Angeles: UCLA Trauma Psychiatry Program; UCLA PTSD Index for DSM-IV (Revision 1). Available at:
http://www.istss.org/UCLAPosttraumaticStressDisorderReactionIndex.htm
Open-access instrument that can be used for assessment of post-traumatic stress symptoms and probable PTSD in children and adolescents.

Practice examples

Council of Europe / EFPA (2010). Lessons learned in psychosocial care after disasters. Chapter: School schooting in Erfurt. Available at
http://www.recoveryplatform.org/assets/publication/Lessonslearned_psycosocial%20care%20EC_EN.pdf

Russian Red Cross, International Federation of Red Cross and Red Crescent Societies & The IFRC Reference Centre for Psychosocial Support (2008). Red Cross Psychosocial Response to the hostage crisis in Beslan, North Ossetia, Russia 2005-2007. Final Assessment Report April 2008. Available at
http://www.ukt.cervenykriz.eu/en/wp-content/uploads/2013-11-PSP-Head-of-Operation_Beslan-report-2008.pdf

Action Sheet for Target Groups Nr. 36: MHPSS[1] Policy for Helpers

Area
All event types, helpers, all phases

Key recommendations for staff and volunteer support

- **Define staff and volunteer rights and responsibilities** and provide written guidance and rules[2]
- **Acknowledge staff and volunteers and their achievements**[2]
- **Recognise the value of a diverse staff and volunteer workforce**, and actively recruit staff and volunteers, irrespective of race, ethnicity, gender, sexual orientation, religious belief, disability or age[2]
- **Have a concrete plan in place** to protect and promote staff and volunteer wellbeing for the specific emergency[1]
- **Prepare staff and volunteers for their jobs** and for the emergency context through the provision of relevant training and emergency exercises[1]
- **Facilitate a healthy working environment** including physical and mental health by providing regular risk assessments and by developing measures against identified risks for physical and mental health of staff and volunteers[1]
- **Address potential work-related stressors** for staff and volunteers (physical and mental health)[1]
- **Ensure access to health care and psychosocial support** for staff and volunteers[1]
- **Provide support to staff and volunteers** who have experienced or witnessed extreme events (critical incidents, potentially traumatic events)[1]
- **Make support available to staff and volunteers before, during and after** the mission/employment[1]

BASED ON:
[1]IInter-Agency Standing Committee (IASC) (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. IASC Action Sheet 4.4: prevent and manage problems in mental health and psychosocial well-being among staff and volunteers, p.86ff. Available at www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf
[2]International Federation of Red Cross and Red Crescent Societies (IFRC) (2011). Volunteering Policy, **p.2**. Available at www.ifrc.org/Global/Governance/Policies/volunteering-policy-en.pdf

Additional resources

Action Without Borders/Idealist.org (2004). Website with resources on stress management for aid workers, managers and workers' families. Available at http://www.psychosocial.org

Ehrenreich, J.H. (2002). A Guide for Humanitarian Aid Workers, Health Care and Human Rights Workers. Caring for Others, Caring for Yourself. Available at http://www.dochas.ie/Shared/Files/4/Caring_for_Others_Caring_for_Yourself.pdf

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McFarlane, C. (2004). Adjustment of humanitarian aid workers. Australasian Journal of Disaster and Trauma Studies. ISSN: 1174-4707, Volume 2004-1.

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United Kingdom Psychological Trauma Society (UKPTS) (2014). Traumatic Stress Management Guidance. For organisations whose staff work in high risk environments. Available at http://www.ukpts.co.uk/site/assets/UKPTS-Guidance-Document-120614.pdf

Tools

Headington Institute, Bosch, D. (2013). After a Critical Incident. Available at http://www.headington-institute.org/files/after-a-critical-incident_84450.pdf

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International Federation Of Red Cross and Red Crescent Society (IFRC) Reference Centre for Psychosocial Support, Danish Cancer Society (DCS), War Trauma Foundation (WTF) & University Of Innsbruck (UIBK) (2013). Lay Counselling – A Trainer's Manual. Available at http://pscentre.org/wp-content/uploads/Lay-counselling_EN.pdf

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International Federation of Red Cross and Red Crescent Societies (IFRC) (2009). Managing stress in the field. Exercises, p.19. Available at http://www.ifrc.org/global/publications/health/managing-stress-en.pdf

World Health Organisation, War Trauma Foundation & World Vision International (2011). Psychological first aid: Guide for field workers. Available at http://www.who.int/mental_health/publications/guide_field_workers/en/

Practice examples

IFRC Reference Centre for Psychosocial Support (2012). Caring for volunteers. A Psychosocial Support Toolkit. Chapter 3: Response Cycle and Volunteer Psychosocial Support: Before, During and After, p. 31. Available at http://pscentre.org/wp-content/uploads/volunteers_EN.pdf

Tehrani, N. (2008). Trauma support for emergency services. Crisis Response, 4(3) 42-43. Available at http://www.crisis-response.com/ (registration fee required)

Volunteers of America (n.d.). Disaster Related Volunteerism. Best Practice Manual Based on Lessons Learned from Hurricanes Katrina and Rita. Available at http://www.handsonnetwork.org/files/best_practices_manual_-_disaster_related_volunteerism-1.pdf

Action Sheet for Target Groups Nr. 37: MHPSS[1] Policy for Volunteers

Area
All event types, volunteers, all phases

Key principles for organisations with volunteers

Principle 1: Insurance
Ensure that an appropriate insurance policy is in place for volunteers, covering eventual risks of accident or illness directly related to the volunteer activity.

Principle 2: Reimbursement
Reimburse any expenses incurred by volunteers in fulfilling their volunteer tasks, based on the terms agreed.

Principle 3: Infrastructure
Provide volunteers with appropriate resources for the discharge of their duties.

Principle 4: Information
Provide appropriate information to their volunteers on the nature and condition of their voluntary assignment.

Principle 5: Training
Provide volunteers with appropriate training.

Principle 6: Safety
Ensure safe, secure and healthy conditions at work, in relation to the volunteer activity.

Principle 7: Accreditation
Provide volunteers with relevant accreditation for their volunteer role, where appropriate, and at the end of their service provide a certificate acknowledging their contribution.

Principle 8: Third party liability
Assume third-party liability for any damages or injuries volunteers may cause by any action or omission in the course their voluntary work, provided that the volunteers act with due diligence and in good faith.

BASED ON:
International Federation of Red Cross and Red Crescent Societies (IFRC) & UN Volunteers Interparliamentary Union (2004). Volunteerism and Legislation. A Guidance Note, **p.21**. Available at www.unv.org/en/news-resources/resources/on-volunteerism/doc/guidance-note-on-volunteerism-1.html

Additional resources

IFRC & Red Crescent Societies (2011). The value of volunteers. Imagine how many needs would go unanswered without volunteers. Geneva: IFRC. Available at www.ifrc.org

Liu, C., & Robinson, P. (2013). Better organisation of volunteers in disaster settings is needed: lessons for all from China. Australian & New Zealand Journal of Public Health, 37(6), 595-596.

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[1] Mental health and psychosocial support

http://www.informedprepared.eu/pages/ResourceLibrary/db_GetResource.document?rid=347&uid=269

United Kingdom Psychological Trauma Society (UKPTS) (2014). Traumatic Stress Management Guidance. For organisations whose staff work in high risk environments. Available at http://www.ukpts.co.uk/site/assets/UKPTS-Guidance-Document-120614.pdf

Tools

HandsOn Network (n.d.). Top 15 Things to Know When Managing Volunteers in Times of Disaster. Available at http://www.handsonnetwork.org/files/resources/Top_15_Things_to_Know_When_Managing_Volunteers_in_Times_of_Disaster.pdf

Health Emergency Response Unit (ERU) & International Federation of Red Cross and Red Crescent Societies (IFRC and RCS), Wiedemann, N., Yigen, B. S., Johansson, S. & Christensen, L. (2012). Psychosocial Support Component Delegate Manual. Available at http://www.pscentre.org/wp-content/uploads/6.PS-ERU-Delegate-Manual-Sept2012.pdf

Containing

Chapter 5: Training

- Training kit 3
  - A: Volunteer Training (p. 72)
  - B: Briefing session on psychosocial issues (p. 80)

Annex 5: Checklist for Organizing trainings (p. 105).

Inter-Agency Standing Committee (IASC) (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Available at http://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf

Containing

- Human Resources
- Identify and recruit staff and engage volunteers who understand local culture (p. 71)
- Enforce staff codes of conduct and ethical guidelines (p. 76)
- Organise orientation and training of aid workers in mental health and psychosocial support (p. 81)

International Federation of Red Cross and Red Crescent Societies (IFRC) (2009). Volunteer manual for Community-based health and first aid in action (CBHFA). Available at http://www.ifrc.org/PageFiles/53437/CBFA-volunteer-manual-en.pdf

International Federation of Red Cross and Red Crescent Societies (IFRC) Reference Centre for Psychosocial Support; Snider, L. (2010). Caring for Volunteers. A Psychosocial Support Toolkit. Available at http://www.google.at/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CCUQFjAA&url=http%3A%2F%2Fwww.informedprepared.eu%2Fpages%2FResourceLibrary%2Fdb_GetResource.document%3Frid%3D495%26uid%3D586&ei=zHSYU42BG_LV4QS02oDICQ&usg=AFQjCNFC5GGgswedrmElvTp1UdFQGUfi7A&bvm=bv.68693194,d.bGE

International Federation of Red Cross and Red Crescent Societies (IFRC) & British Red Cross (2012). Volunteers, Stay Safe! A security guide for volunteers. Available at http://www.scribd.com/doc/114746357/Volunteers-stay-safe-A-security-guide-for-volunteers.

Points of Light Foundation & Allstate Foundation (1999). Ready to Respond. Disaster Preparedness and Response for Volunteer Centers. Available at http://www.energizeinc.com/art/subj/documents/ready_to_respond.pdf

Practice examples

IFRC Reference Centre for Psychosocial Support (2012). Caring for volunteers. A Psychosocial Support Toolkit. Chapter 3: Response Cycle and Volunteer Psychosocial Support: Before, During and After, p. 31. Available at http://pscentre.org/wp-content/uploads/volunteers_EN.pdf

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Volunteers of America (n.d.). Disaster Related Volunteerism. Best Practice Manual Based on Lessons Learned from Hurricanes Katrina and Rita. Available at http://www.handsonnetwork.org/files/best_practices_manual_-_disaster_related_volunteerism-1.pdf

Action Sheet for Target Groups Nr. 38: MHPSS[1] Intervention Design for Helpers: Peer Support Programmes

Area
All event types, helpers, all phases

Key recommendations for psychosocial support (delivery and service design) for helpers

- **Peer support programmes should have a clear definition of peer support, describing the role peers supporters undertake within the organisation[2]**
  The definition of peer support and the specific role within the organisation should take account of the the type of services the organisation provides and their target group(s), etc.

- **The peer support programme should be carefully planned, with development tasks defined for the programme over a set period of time[2]**

- **The programme should have a clearly defined selection process, with suitable candidates chosen based on a set of desirable criteria[2]**
  This process should take account of the various demographics reflective of the organisation, including gender, age, experience, rank, location, ethnicity, etc.

- **In order to become a peer supporter, the individual should [1]**
  - be a member of the 'target population'
  - be someone with considerable experience within the field of work of the target population
  - be respected by his/her peers (colleagues)
  - undergo an application and selection process prior to appointment that should include interview by a suitably constituted panel.

- **Peer supporters should [1]**
  - provide an empathetic, listening ear
  - provide low level psychological intervention
  - identify colleagues who may be at risk to themselves or others
  - facilitate pathways to professional help.

- **Peer supporters should be trained in basic skills to fulfil their role, meet specific standards in that training before commencing their role and participate in ongoing training, supervision, review, and accreditation[1]**

- **Peer supporters should not limit their activities to high-risk incidents [1]**
  They should also be part of routine employee health and welfare, but not generally see 'clients' on an ongoing basis. They should seek specialist advice and offer referral pathways for more complex cases and maintain confidentiality

- **The peer support programme should be promoted regularly throughout the organisation to make sure that staff and volunteers understand the role of peer support in assisting collegues[1]**

- **Peer supporters should normally be offered as the initial point of contact after exposure to a high-risk incident unless the member of staff/volunteer requests otherwise[1]**
  In other situations, staff and volunteers should be able to self-select their peer supporter from a pool of accredited supporters.

[1] Mental health and psychosocial support

- **The peer support programme should have a documented referral policy to guide peer supporters in assisting colleagues with problems which are beyond the peer support role[2]**

- **In recognition of the potential demands of the work, single peer supporters should [1]**
  - not be available on call 24 hours per day
  - be easily able to access care for themselves from a mental health practitioner if required
  - be easily able to access expert advice from a clinician
  - and engage in regular peer supervision within the programme.

- **Mental health professionals should be involved in programme development, supervision and training[1]**

- **The peer support programme should be endorsed and given tangible support by the management of the organisation at all levels[2]**

- **The peer support programme should provide for its on-going functioning with a documented succession plan[2]**

- **Peer support programmes should establish clear goals that are linked to specific outcomes prior to commencement[1]**
  - They should be evaluated by an external, independent evaluator on a regular basis and the evaluation should include qualitative and quantitative feedback from users. Objective indicators such as absenteeism, turnover, work performance, and staff and volunteer morale, while not primary goals of peer support programmes, may be collected as additional data as part of the evaluation.

- **Key principles and key actions**

- **Provide organised peer support[3]**
  The task of organised peer support is to support colleagues who have experienced a shocking event. In executing this task, attention must be given to the following:
  - the provision of practical assistance
  - the stimulation of a healthy recovery process
  - early identification of possible (psychosocial) problems and timely referral to professional help
  - monitoring of the recovery process
  - activation of the social network
  - buffering (negative) reactions from the environment.

- **Steps to be taken[3]**
  In the execution of organised peer support, four steps can be distinguished:
  - Identification of the need for the use of peer support (i.e. establishing that there was exposure to a shocking event)
  - Calling in peer support/appointing a peer supporter
  - Supporting a colleague in accordance with the above-mentioned aspects
  - If necessary, advising the staff and volunteers to contact professional help.

BASED ON:

[1]Australian Centre for Post-traumatic Mental Health (ACPMH), Varker, T. (2011). Development of Guidelines on Peer Support. Using the Delphi Methodology. Final Report, **p.43f**. Available at http://www.acpmh.unimelb.edu.au/resources/resource-peer_support.html

[2]Emergency Support Network, Tunnecliffe, M. (2007). Best Practice in Peer Support, **p.1ff**. Available at www.emergencysupport.com.au/articles/PeerSupport_BESTPRACTICE.pdf

[3]Burger, N. (2012). Guidelines: Psychosocial support for uniformed workers. Extensive summary and recommendations, **pp. 27-32**. Available at http://www.mvcr.cz/mvcren/file/guidelines-psychosocial-support-for-uniformed-workers.aspx

Additional resources

Antares Foundation (2012). Managing stress in humanitarian workers. Guidelines for good practice. (3rd ed.) Available at https://www.antaresfoundation.org/guidelines#.VopOknuFE4b

Campbell, J. (2005). The historical and philosophical development of peer-run support programmes. In S. Clay, B. Schell, P. W. Corrigan & R. Ralph (Eds.), On our own, together: Peer programmes for people with mental illness (pp. 17–65). Nashville, TN: Vanderbilt University Press.

Creamer, M.C., Varker, T., Bisson, J. et al. (2012). Guidelines for peer support in high-risk organisations: an international consensus study using the Delphi method. Journal of traumatic stress, 25 (2), 134-41.

International Federation of Red Cross and Red Crescent Societies (n.d.). community-based psychological support – Modul 6 Helping the helpers. Available at http://mhpss.net/?get=58/1354772532-Mod06CommBasedPSSSupport-HelpingtheHelpers.pdf

Levenson, R. L., Jr., & Dwyer, L. A. (2003). Peer support in law enforcement: Past, present, and future. International Journal of Emergency Mental Health,5, 147–152.

Norris, F. H., & Stevens, S. P. (2007). Community resilience and the principles of mass trauma intervention. Psychiatry, 70, 320–328.

Solomon, P. L. (2004). Peer support/peer provided services: Underlying processes, benefits, and critical ingredients. Psychiatric Rehabilitation Journal, 27, 392–401.

United Nations (n.d.). Manual on human rights monitoring. Chapter 12: Trauma and self-care. Available at http://www.ohchr.org/Documents/Publications/Chapter12-MHRM.pdf

Website

Gift From Within – PTSD Resources for Survivors and Caregivers: http://www.giftfromwithin.org/html/What-is-Compassion-Fatigue-Dr-Charles-Figley.html

Headington Institute – Online Training Programs: http://www.headington-institute.org/

Tools

Antares Foundation (n.d.). Podcasts and Videos on Stress Management for Emergency. Available at https://www.antaresfoundation.org/

Containing

- Introduction: Stress Management for Emergency responders - Introduction
- Part 1: Stress Management for Emergency Responders – Understanding Responder Stress
- Part 2: Stress Management for Emergency Responders – What Responders Can Do
- Part 3: Stress Management for Emergency Responders – What Team Leaders Can Do
- Part 4: Stress Management for Emergency Responders – What Agencies Can Do

Emergency Support Network, Tunnecliffe, M. (2007). Best Practice in Peer Support. Available at www.emergencysupport.com.au/articles/PeerSupport_BESTPRACTICE.pdf

Health and Human Rights Info (HHRI) (n.d.). Compassion Fatigue, Secondary PTSD, Vicarious PTSD, Differences – You tube video. Available at https://www.youtube.com/watch?v=Q3hJn_tWzLw

Health and Human Rights Info (HHRI) (2015). Newsletter No.4 November 30th 2015 – How to avoid secondary traumatization. Available at http://www.hhri.org/newsletter/

International Federation of Red Cross and Red Crescent Societies (IFRC) Reference Centre for Psychosocial Support. (2010). Caring for Volunteers. A Psychosocial Support Toolkit. 3.4 Peer Support, p.45. Available at http://www.google.at/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CCUQFjAA&url=http%3A%2F%2Fwww.informedprepared.eu%2Fpages%2FResourceLibrary%2Fdb_GetResource.document%3Frid%3D495%26uid%3D586&ei=zHSYU42BG_LV4QS02oDICQ&usg=AFQjCNFC5GGgswedrmElvTp1UdFQGUfi7A&bvm=bv.68693194,d.bGE

Pan American Health Organization, Bryce, C.P. (2001). Insights into the concept of Stress. Available at http://www1.paho.org/english/ped/stressin.pdf

Pan American Health Organization, Bryce, C.P. (2001). Stress Management in Disasters. Available at http://www1.paho.org/english/ped/stressmgn1.pdf

Saakvitne, Pearlman & Staff (1996). Self-Care Assessment Worksheet. Available at https://www.ecu.edu/cs-dhs/rehb/upload/Wellness_Assessment.pdf

The National Child Traumatic Stress Network (NCTSN) (n.d.). Secondary Traumatic Stress – A Fact Sheet for Child-Serving Professionals. Available at http://www.nctsn.org/sites/default/files/assets/pdfs/secondary_traumatic_tress.pdf

United Nations (1995). United Nations Stress Management Booklet. Available at http://reliefweb.int/report/world/united-nations-stress-management-booklet

World Health Organisation (WHO), War Trauma Foundation & World Vision International (2011). Psychological first aid: Guide for field workers. Chapter IV: Caring for yourself & your collegues, p.37-40. Available at http://www.who.int/mental_health/publications/guide_field_workers/en/

Practice examples

IFRC Reference Centre for Psychosocial Support (2012). Caring for volunteers. A Psychosocial Support Toolkit. Chapter 3: Response Cycle and Volunteer Psychosocial Support: Before, During and After, p. 31. Available at http://pscentre.org/wp-content/uploads/volunteers_EN.pdf

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Volunteers of America (n.d.). Disaster Related Volunteerism. Best Practice Manual Based on Lessons Learned from Hurricanes Katrina and Rita. Available at http://www.handsonnetwork.org/files/best_practices_manual_-_disaster_related_volunteerism-1.pdf

Action Sheet for Target Groups Nr. 39: MHPSS[1] for Helpers/Practice

Area
All event types, helpers, all phases

The following recommendations are aimed at staff and volunteers (particularly volunteers in the field of search and rescue, psychosocial support, first aid, etc.)

Key actions in peer support

- **Psychoinformation/psychoeducation and preventive training**
  Psychoinformation/psychoeducation is focused at increasing the practical self-efficacy of staff and volunteers and relates to the acknowledgment and recognition of the (shocking) experience. Psychoinformation/psychoeducation also emphasises the importance of aspects like watchful waiting (to identify which reactions are normal and which are a cause for concern), risk assessment, and the promotion of adequate help-seeking behaviour. Psychoinformation/psychoeducation should be included in training as preparation for the field, as well as being provided directly following an incident,

- **Operational debriefing**
  An operational debriefing is defined as a post-event discussion with an operational character, where determining the facts is the main objective. The emphasis is not focused on the emotional experience as other interventions are considered to be more appropriate for this. An operational debriefing is important for answering factual questions ('completing of the puzzle') and to avoid repeating mistakes in the future. It also enhances group cohesion and mutual support as well as an understanding of the event.
  It is important for staff and volunteers to have the opportunity to tell his or her own story, during which emotions may be expressed. However it is not advised to actively ask questions about feelings and emotions immediately after an incident. Research has shown that this kind of psychological debriefing is not effective. There are indications that it may worsen the psychosocial consequences. The techniques involved in a psychological debriefing are therefore not advised.

- **Peer support interviews**
  Peer support is usually offered in a number of 'interviews,' comprised of a first interview, followed by a number of follow-up interviews if these are found to be necessary. The timing of the first interview with a peer supporter is significant. If this is too soon after the incident, it can be harmful for natural recovery. It is also important that the affected person is not kept too long within the peer support system. If professional help is needed, the individual should receive such help as soon as possible. It is therefore recommended to carry out a maximum of three interviews; if problems persist, the person should be referred to professional assistance.

- **Monitoring and risk assessment**
  Monitoring staff and volunteers who have been exposed to a shocking event is important for detecting psychosocial problems promptly. Preliminary risk assessment can be done by peer supporters in their initial interviews, using general questions to screen for psychosocial problems. Clinical screening tools should only be used by mental health professionals.

- **Timely referral to professionals**
  Timely recognition and referral is important and recommended. Psychological triage means that after a shocking event, a distinction should be made between 1) people who are able to recover on their own; 2) people who are at risk of developing more severe, chronic complaints; and 3) people who show clear signs of a disrupted recovery process and who need direct professional care. For the first and second group, a 'watchful-waiting' policy is advisable during the first four to six weeks. Also, a supportive context is particularly relevant in this phase. The third group needs to be referred immediately to the relevant mental health services.

[1] Mental health and psychosocial support

BASED ON:
Burger, N. (2012). Guidelines psychosocial support for uniformed workers Extensive summary and recommendations, **pp. 27-32**. Available at http://www.mvcr.cz/mvcren/file/guidelines-psychosocial-support-for-uniformed-workers.aspx

Additional resources

Cronin, M. S., Ryan, D. M., & Brier, D. (2007). Support for staff working in disaster situations: A social work perspective. Apoyo a quienes trabajan en situaciones de desastre: una perspectiva del trabajo social., 50(3), 370-382.

Rose, S., Bisson, J., Churchill, R., Wessely, S. (2007). Psychological debriefing for preventing post traumatic stress disorder (PTSD) (Review). In: The Cochrane Library, 2007, Issue 1.

Ulman, K. H. (2008). Helping the helpers: Groups as an antidote to the isolation of mental health disaster response workers. Group, 32(3), 209-221.

Tools

EUTOPA, Bering, R., Schedlich, C, Zurek, G., Kamp, M. & Fischer, G. (2008). Target Group Intervention Programme. Manual I. Manual for implementing the Cologne Risk Index-Disaster in the context of major loss situations. Appendix 7: Cologne Risk Index – Disaster (CRI-D) for victims in case of disaster, p. 23. Available at http://www.eutopa-info.eu/fileadmin/products/eng/TGIP_EUTOPA_I_web_en.pdf

Headington Institute, McKay, L. & Hulme, B. (2009). Family Matters: Self Care for family Members of Humanitarian Workers. Available at http://www.headington-institute.org/files/family-matters-moduletemplate2_edited_40378.pdf

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International Federation of Red Cross and Red Crescent Societies (IFRC) (2009). Managing Stress in the Field. Available at http://www.ifrc.org/Global/Publications/Health/managing-stress-en.pdf

Pan American Health Organisation (PAHO), Bryce, C. P. (2001). Insights into the Concept of Stress. Available at http://www1.paho.org/english/ped/stressin.pdf

Practice examples

IFRC Reference Centre for Psychosocial Support (2012). Caring for volunteers. A Psychosocial Support Toolkit. Chapter 3: Response Cycle and Volunteer Psychosocial Support: Before, During and After, p. 31. Available at http://pscentre.org/wp-content/uploads/volunteers_EN.pdf

Tehrani, N. (2008). Trauma support for emergency services. Crisis Response, 4(3) 42-43. Available at http://www.crisis-response.com/ (registration fee required)

Volunteers of America (n.d.). Disaster Related Volunteerism. Best Practice Manual Based on Lessons Learned from Hurricanes Katrina and Rita. Available at http://www.handsonnetwork.org/files/best_practices_manual_-_disaster_related_volunteerism-1.pdf

Action Sheet for Target Groups Nr. 40: Long-term Consequences to be considered in MHPSS[1] for Helpers

Area
All event types, helpers, planning phase

Key recommendations

- **Watchful monitoring should be provided to helpers within the emergency organisations as a routine**
  In the long-term, about four years on average, helpers who have participated in post-disaster interventions do not differ in terms of post-traumatic stress symptoms or general mental health from helpers who were not deployed. Compared to the general unaffected population, helpers have higher level of distress and related mental health difficulties. However, prevalence of probable PTSD, poor general mental health and post-traumatic stress symptoms in helpers who participated in post-disaster interventions remain stable over time. Three years post-disaster about 6% of helpers are likely to have PTSD diagnoses, about 10% probable PTSD, and about 26% poor general mental health. Compared to the pre-disaster period, helpers deployed to post-disaster interventions show increased levels of job absenteeism due to health problems. Mental health status and psychosocial functioning of helpers should therefore be monitored after deployment to post-disaster operations, and in the long-term as a part of routine human resource management within emergency organisations (for long-term monitoring, see Action Sheet Nr. 16).

- **Continuous provision of non-stigmatizing and easy access to mental health services should be ensured for helpers**
  While helpers report fewer mental health problems than the general population affected by disasters, prevalence of PTSD in is almost twice that found in the general unaffected population (6% compared to <3.5% in Kessler & Üstün, 2008 in the Additional Resources section of this Action Sheet). Helpers experience high levels of distress in everyday work. Non-stigmatizing access to mental health professionals and to peer support should be ensured, regardless of specific problems that may arise after deployment to post-disaster interventions (for general policy on helpers, see Action Sheet Nr. 36; for recommendations on peer support see Action Sheets Nr. 38 & 39).

BASED ON:
Ajduković, D., Bakić, H. (2015). Long-term effects of disasters on mental health and psychosocial functioning. OPSIC Team and University of Zagreb (FFZG). Unpublished report.

Additional resources

Ajduković, D., Bakić, H. (2015). Long-term effects of disasters on mental health and psychosocial functioning. OPSIC Team and University of Zagreb (FFZG). Unpublished report.
Report on long-term effects of disasters.

Berger, W., Coutinho, Evandro Silva Freire, Figueira, I., Marques-Portella, C., Luz, M. P., Neylan, T. C. & Mendlowicz, M. V. (2012). Rescuers at risk: a systematic review and meta-regression analysis of the worldwide current prevalence and correlates of PTSD in rescue workers. Social psychiatry and psychiatric epidemiology, 47(6), 1001–1011.
Systematic review of PTSD in the population of rescue workers.

Kessler, R.C., and Üstün, T.B. (Eds.) (2008). The WHO World Mental Health Surveys: Global perspectives on the epidemiology of mental disorders. New York: Cambridge University Press.

[1] Mental health and psychosocial support

WHO study on prevalences of different mental health disorders in the general population in various countries.

Tools

A list of tools for monitoring can be found in the Annex, with detailed descriptions and recommended cut-offs, where applicable.

CES-D: Radloff, L. S. (1977). The CES-D Scale: A Self-Report Depression Scale for Research in the General Population. Applied Psychological Measurement, 1(3), 385–401. doi:10.1177/014662167700100306. Available at: http://conservancy.umn.edu/bitstream/handle/11299/98561/v01n3p385.pdf?sequence=1
Open-access instrument that can be used for assessment of depression symptoms and probable depression.

GHQ: Goldberg, D. P., & Williams, P. (1988). A users guide to the General Health Questionnaire. Slough: NFER-Nelson.
Can be used for assessment of general mental health.

IES-R: Weiss, D. S. (2007). The Impact of Event Scale: Revised. In J. P. Wilson & C. S.-k. Tang (Eds.), International and Cultural Psychology Series. Cross-Cultural Assessment of Psychological Trauma and PTSD (pp. 219–238). Boston, MA: Springer US. Information on how it can be obtained can be found at: http://consultgerirn.org/uploads/File/trythis/try_this_19.pdf.
Open-access instrument that can be used for assessment of post-traumatic stress symptoms and probable PTSD.

PCL: Weathers, F. W., Litz, B. T., Keane, T. M., Palmieri, P. A., Marx, B. P., & Schnurr, P. P. (2013). The PTSD Checklist for DSM-5 (PCL-5), Scale available from the National Center for PTSD at www.ptsd.va.gov.
Open-access instrument that can be used for assessment of post-traumatic stress symptoms and PTSD.

SCID-I: First, M. B., Spitzer, R. L., Gibbon, M., & Williams, J. B. W. (1996). Structured Clinical Interview for DSM-IV Axis I Disorders, Clinician Version (SCID-CV). Washington, DC: American Psychiatric Press.
Can be used by clinicians for diagnosing DSM based disorders.

SCL-90-R: Derogatis, L.R. & Savitz, K.L. (2000). The SCL-90-R and the Brief Symptom Inventory (BSI) in Primary Care. In M.E.Maruish Handbook of psychological assessment. Volume 236 Mahwah, NJ: Lawrence Erlbaum Associates, pp 297-334.
Can be used for assessment of symptoms and caseness of different indicators of mental health, among which are depression, anxiety, hostility, interpersonal sensitivity, and general mental health.

SF-36: Ware Jr, J. E., & Sherbourne, C. D. (1992). The MOS 36-item short-form health survey (SF-36): I. Conceptual framework and item selection. *Medical care*, 473-483.
Can be used for assessment of health status from the point of view of the affected (e.g. role limitations due to emotional problems).

Practice examples

IFRC Reference Centre for Psychosocial Support (2012). Caring for volunteers. A Psychosocial Support Toolkit. Chapter 3: Response Cycle and Volunteer Psychosocial Support: Before, During and After, p. 31. Available at http://pscentre.org/wp-content/uploads/volunteers_EN.pdf

Tehrani, N. (2008). Trauma support for emergency services. Crisis Response, 4(3) 42-43. Available at http://www.crisis-response.com/ (registration fee required)

Action Sheet for Target Groups Nr. 41: MHPSS[1] Policy for Older People

Area
All event types, older people, all phases

Key principles in the development of policies for older people

Principle 1: Enhance visibility of older people in policies and legislation
- Awareness-raising of all stakeholders
- Inclusion of older people's needs in planning
- Implementation of responses to older people's needs in disaster laws and plans

Principle 2: Awareness-raising in health organisations
- Awareness-raising, training of health personnel
- Strengthening institutional capacities

Principle 3: Provision of specialised education and training for all stakeholders

Principle 4: Public education

Principle 5: Identification and registration of vulnerable older people
- Vulnerability and capacity assessment
- Vulnerable peoples register
- Mapping systems and lists of key organisations

Principle 6: Improve access to care and health services
- Emergency plans for homecare
- Ensure access to services, outreach and homecare
- Ensure access to supplies
- Multi-disciplinary approaches (medical, psychological, social)

Principle 7: Improve coordination/collaboration between agencies
- Pre-disaster relationship between agencies
- Involvement of gerontologists and regional social services, medical services and others in emergency planning

Principle 8: Adapt communication systems before and during disaster to take account of older people's needs and capacities
- General information and communication
- Accessible warning systems
- Communication lines and links to resources

BASED ON:
Enhancing disaster management preparedness for the older population in the EU, ECHO/SUB/2013/661043, Project Acronym, PrepAGE D-C.1 Desk Research Report, **p. 67-68**. Available at http://www.prepage.eu

[1] Mental health and psychosocial support

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Containing

- Appendix 1: Vulnerable individual checklist (p. 22)
- Appendix 2: Orissa cyclone relief support to older people (p. 23)
- Appendix 3: Post-disaster village needs assessment (p. 24).

World Health Organisation (WHO), Ageing and life course (ALC), Family and Community Health (FCH), Emergency Preparedness and Capacity-building (EPC) & Health Action in Crises (HAC), Hutton, D. (2008). Older people in emergencies: Considerations for action and policy development. Available at www.who.int/ageing/publications/Hutton_report_small.pdf

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Chapter 8: Preparedness Phase

- Objective 1: increase visibility and raise awareness among health agencies and humanitarian organisations of older people's needs and priorities in emergencies (p. 29)
- Objective 2: develop essential medical and health resources for older people in emergency practices (p. 30)
- Objective 3: develop emergency management policies and tools to address older people's health-related vulnerabilities (p. 30)

Chapter 9: Emergency Response and Operations Phase

- Objective 1: Ensure that older people are aware of and have access to essential emergency health care services (p. 31)
- Objective 2: provide age-sensitive and appropriate health and humanitarian services to maintain older people's health (p. 32)
- Objective 3: promote cross-sectoral planning and coordination to raise awareness of older people's needs in crises and reduce their risk of marginalization and deteriorating health in emergencies (p. 32)

Chapter 10: Recovery and Transition Phase

- Objective 1: build institutional capacity and commitment to ensuring the health and safety of older people in emergencies (p. 33)
- Objective 2: strengthen the capacity of ministries of health and health care systems to meet the needs of older people in emergencies (p. 34)
- Objective 3: develop mechanisms to ensure continuing development and exchange of expertise as these relate to older people in emergencies (p. 34)
- Objective 4: promote active ageing as a strategy to reduce vulnerability and develop resiliency to disasters (p. 35).

Practice examples

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Action Sheet for Target Groups Nr. 42: MHPSS[1] Policy for Older People - Preparedness

Area
All event types, older people, preparedness

Key recommendations for supporting older people in disasters

- **Develop a simple, inexpensive, cohesive, integrated and efficient national tracking system** for older people and other vulnerable adults that can be used at the state and local levels during disasters
- **Designate separate shelter areas** for older people and other vulnerable adults
- **Involve gerontologists** (geriatricians, geriatric nurse practitioners, gerontological social workers, or other aging experts, etc.) **in all aspects of emergency preparedness** and care delivery
- **Involve region-specific social services**, medical and public health resources, volunteers, and facilities in pre-disaster planning for older people and vulnerable adults
- **Involve gerontologists** (geriatricians, geriatric nurse practitioners, gerontological social workers, or other aging experts, etc.) **in the training and education** of front-line workers and other first responders about frail adults' unique needs
- **Utilize a public health triage system** like the SWiFT Tool for older people and other vulnerable populations in pre- and post-disaster situations
- **The personnel charged with overseeing older people and vulnerable adults should maintain a clear line of communication with the shelter's central command**. Communication within the shelter should involve technology such as cellular telephones and walkie-talkies
- **Provide protection from abuse and fraud** to older people and other vulnerable adults
- **Develop coordinated regional plans for evacuations** of residents of long-term care facilities and for homebound persons with special needs (i.e., ventilator-dependent adults)
- **Conduct drills and research on disaster preparedness plans** and the use of a triage tool, such as SWiFT, to ensure their effectiveness and universality.

BASED ON:
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[1] Mental health and psychosocial support

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- SWIFT Level tool in the post disaster phase (p.10)
- SWIFT screening tool (p. 11)
- SWIFT Policies and procedures (p. 12).

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- Key action points to address health interventions for older people in emergencies (p. 10)
- Annex 1: Sex and Age Disaggregated Data Methodology (p. 28)
- Annex 2: Essential list of generic drugs for chronic diseases (p. 29)
- Annex 3: List of basic aids and hygiene kits for older people (p. 30)
- Annex 4: Sample advocacy plan (p. 31).

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Containing

Chapter 8: Preparedness Phase

- Objective 1: increase visibility and raise awareness among health agencies and humanitarian organisations of older people's needs and priorities in emergencies (p. 29)
- Objective 2: develop essential medical and health resources for older people in emergency practices (p. 30)
- Objective 3: develop emergency management policies and tools to address older people's health-related vulnerabilities (p. 30).

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Action Sheet for Target Groups Nr. 43: MHPSS[1] Intervention Design for Older People

Area
All event types, older people, all phases

Key recommendations for supporting older people in disasters

- **Do continuous needs assessments**
- **Focus on special psychosocial support requirements for older people**
- **Focus on special nutritional needs of older people in disasters**
  - Nutrition plans
  - Accessible locations
  - Sensitivity for physical changes
  - Assessment
- **Focus on special requirements in the recovery phase**
  - Family reunion and reintegration
  - Systems for follow-up and care
  - Housing
  - Integration of older people's needs in return programming
- **Provide appropriate transport and evacuation methods**
- **Provide appropriate support for older people in shelters**
  - Training for personnel and management
  - Access to facilities and goods
  - Access to medical supplies
  - Personal assistance
  - Older friendly spaces
- **Focus on the protection and rights of older people**
- **Promote participation of older people in emergency planning and preparedness procedures**
- **Ensure that older people's special vulnerabilities and needs are included in MHPSS handbooks and tools**
- **Promote further research and evaluation concerning the support needs of older people in disasters**

BASED ON:
Enhancing disaster management preparedness for the older population in the EU, ECHO/SUB/2013/661043, Project Acronym, PrepAGE D-C.1 Desk Research Report, **p. 67-68.** Available at http://www.prepage.eu

[1] Mental health and psychosocial support

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- Appendix 1: Rapid vulnerability assessment form (p. 23)

- Appendix 2: Health checklist for older people living in IDP camps (p. 24)
- Appendix 3: Health follow-up monitoring form (p. 25)
- Appendix 4: Nutrition monitoring form (p. 26)
- Appendix 5: Disability assessment form (first home visit interview) (p. 27)
- Appendix 6: Extremly vulnerable individual case card for housebound and cases for regular follow-up (p. 28).

World Health Organisation (WHO), Ageing and life course (ALC), Family and Community Health (FCH), Emergency Preparedness and Capacity-building (EPC) & Health Action in Crises (HAC), Hutton, D. (2008). Older people in emergencies: Considerations for action and policy development. Available at www.who.int/ageing/publications/Hutton_report_small.pdf

Containing
Chapter 9: Emergency Response and Operations Phase

- Objective 1: Ensure that older people are aware of and have access to essential emergency health care services (p. 31)
- Objective 2: provide age-sensitive and appropriate health and humanitarian services to maintain older people's health (p. 32)
- Objective 3: promote cross-sectoral planning and coordination to raise awareness of older people's needs in crises and reduce their risk of marginalization and deteriorating health in emergencies (p. 32).

Practice examples

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Action Sheet for Target Groups Nr. 44: MHPSS[1] Intervention Design for Older People - Shelter

Area
All event types, older people, all phases

Key recommendations for supporting older people in shelters

Health[1]

- Older persons have access to the health services and disability aids they need
- Medications for chronic diseases are included in emergency health kits
- Staff attitudes, skills and training on older persons´ health issues are ascertained
- Data disaggregated by age and sex are collected to determine the number and specific needs of older persons

Water, sanitation and hygiene[1]

- Appropriate water carrying containers are provided to older persons
- Latrines are designed in such a way that older persons can use them e.g. handrails
- Older women´s role in hygiene promotion is emphasized

Food and nutrition[1]

- Older persons have access to food distribution points and are able to carry rations for long distances
- Older persons´access to appropriate nutritious foods is guaranteed
- Older persons´ inclusion in nutritional assessments and monitoring is guaranteed

Shelter

- Assistance with early warning and evacuation to safe places is provided[1]
- Particular attention for the ill and disabled is ensured, e.g. provision of mattresses, warm blankets and clothing[1]
- Assistance is provided to older persons to construct shelter if they are without family support[1]
- Consultation of older persons on cultural practices and privacy issues is guaranteed[1]
- Participation of older people is promoted [2]
- Communication styles are adapted to the special needs of older people[2]
- Age-friendly features are included in both household and community shelters[2]
- Coordination, cooperation and sharing are promoted[2]

Camp coordination and management[1]

- Identification of housebound, vulnerable older persons is guaranteed, as is assistance with replacing or accessing relevant documentation
- Inclusion of age/sex disaggregated data in camp population figures is ensured

Early recovery[1]

- Livelihood programmes target older persons, particularly those who are alone or caring for children
- Return programmes take into account the needs of older persons

Protection[1]

- All data are disaggregated by sex and age to determine the numbers and kind of protection needed
- Older persons´ involvement in decision-making and in humanitarian prevention and response activities is facilitated
- The protection of older persons left without caretakers is ensured
- Older displaced persons are included in tracing and re-unification activities
- Protection strategies include:
    - older persons caring for young children

[1] Mental health and psychosocial support

- older persons caring for persons with disabilities
- addressing abuse of older persons and older women as victims of gender-based violence and sexual abuse, and
- land/property rights for women, in particular for widows.

BASED ON:

[1]Inter-Agency Standing Committee (IASC) (2008). Humanitarian Action and Older Persons. An essential brief for humanitarian actors, **p.5**. Available at www.who.int/hac/network/interagency/iasc_advocacy_paper_older_people_en.pdf

[2]HelpAge International and International Federation of Red Cross and Red Crescent Societies (2011). Guidance on Including Older People in Emergency Shelter Programmes, **p.4f**. Available at http://www.helpage.org/what-we-do/emergencies/guidance-on-including-older-people-in-emergency-shelter-programmes/?keywords=older+people+in+emergency+shelter

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Practice examples

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Containing

- Accessible shelter and latrines
  - Case study: Kyrgyzstan (p. 2)
  - Good practice action points (p. 2)
- Access to food and accurate registration
  - Case study: northern Uganda (p. 4)
  - Good practice action points (p. 4).

Action Sheet for Target Groups Nr. 45: MHPSS[1] Policy for Refugees

Area
All event types, refugees, all phases

Key principles in developing policies for refugees

Principle 1: Governments and decision-makers should provide political leadership and set the tone in public debate on tolerance and non-discrimination.

Principle 2: Citizenship should be a key policy instrument for facilitating integration and acknowledging full refugee membership in the society of durable asylum.

Principle 3: There should be close links and multi-sector alliances of social actors involved in refugee issues

Principle 4: Refugees should participate as service users and providers in the conception, development, organisation and evaluation of integration services and policies.

Principle 5: Refugees should be enabled to use their own resources and skills to help each other, in particular newcomers, and to represent their interests and those of their family and community to service providers and decision-makers.

Principle 6: Policy-makers and service providers should be trained in the consequences of language difficulties, physical and psychological trauma and cultural/religious differences on the integration process of refugees.

Principle 7: The objective of integration programmes and policies is the establishment of a **mutual and responsible relationship between refugees and their communities**, civil society and host states. This should encourage self-determination and sustainable self-sufficiency for refugees while at the same time promoting positive action in the public and government domain.

Principle 8: Interventions need to incorporate a gender perspective and involve refugee women in the design, implementation and evaluation of integration programmes.

Principle 9: The basic human right of shelter plus dignity, integrity and security must be guaranteed.

Principle 10: Access to health care services should be provided for.

Principle 11: Reunification of refugee families should be incorporated into service provision.

Principle 12: Interventions should be needs-led and based upon a recognition of the diversity of refugee populations.

BASED ON:
The European Council on Refugees & Exiles (ECRE) Task force (2002). Good Practice Guide on the Integration of Refugees in the European Union – Introduction, **p.29ff**. Available at www.ecre.org/component/downloads/downloads/185.html

[1] Mental health and psychosocial support

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Action Sheet for Target Groups Nr. 46: MHPSS[1] Intervention Design for Refugees

Area
All event types, refugees, all phases

Key recommendations in supporting refugees[1]

- **Treat all people with the dignitiy and respect and support self reliance**
- **Respond to people in distress in a humane and sensitive way**
- **Provide information about services, supports and legal rights and obligations**
- **Provide relevant psychoeducation and use appropriate language**
- **Priorotize protection for children in particular for children who are separated, unaccompanied or with special needs**
- **Strengthen family support**
- **Identify and protect persons with specific needs**
- **Make interventions culturally relevant and ensure adequate interpretation**
- **Provide treatment for people with severe mental disorders**
- **Do not start psychotherapeutic treatment when follow up is not unlikely to be possible**
- **Monitoring and managing wellbeing of staff and volunteers**
- **Do not work in isolation: cooperate and coordinate with others**

Key actions in supporting refugees[2]

- **Steps in developing an intervention plan**
  - Arrange a safe, quiet and private space: Refugees often have to live in cramped quarters without privacy. Being a refugee often takes away a person´s self-respect. Whenever possible the helper must help refugees to regain their dignity.
  - Build a helping relationship based on trust.
  - Listen effectively. You need to have a great deal of information to be able to understand a person´s real problems. Let people know that you hear not only their words but also their emotions. Many of the feelings and stories of refugees are very sad.
  - Helpers should encourage the self-efficacy of those they want to help. Although you are available to help at a difficult time, your usefulness is temporary.
  - Before you can develop a plan of action, you need to assess the problems. Often the problems presented to you initially are not the only issues to be considered.
  - Develop a plan of action for the person you want to help: State the problems clearly; determine the goals; decide which problem to tackle first; set up the plan of action; make a written record.
  - The type of follow-up will vary from case to case. In some situations you will need to meet the person regularly.

- **Provide psychoeducation**
  - Refugees often experience enormous amounts of stress. This may be because they do not know where their relatives are, or because they feel insecure about their future, or for various other reasons. Educating people about stress and advising people how to deal with stress is important. People need to be encouraged to change their behaviour in order to:
  - restore the normal pattern of sleep at night, and engage in useful and enjoyable activity in the day
  - find positive ways of dealing with stress
  - stop harmful ways of dealing with stress.

[1] Mental health and psychosocial support

- **Do a thorough health screening (including mental health and other health problems) and give appropriate treatment**
    - Screen people with functional complaints, mental illness and people with alcohol and/other drug problems etc.

- **Provide a good environment for children, promoting the following factors to improve the mental health and wellbeing of refugee children:**
    - A return to the security that a strong and stable family can offer
    - Living in a stable environment which does not change from day to day. Children need goals that are attainable as well as structure and a sense of purpose in their lives
    - Provision of material needs such as food, water and medical care
    - Help for both parents and children in recovering from emotional shocks
    - Refugee children needs positive role models
    - A belief in the future and the opportunity to influence what happens to them
    - Some understanding and acceptance of what has happened to them and why it happened
    - The opportunity to complete all the normal stages of child development
    - The time and opportunity to recover after their experiences and to grieve over the deaths of those they were close to.

- **Build cooperation with traditional practitioners (traditional medicine and traditional healers)**

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Crisis overview: http://www.acaps.org/img/documents/b-acaps-start-bn-the-balkans-asylum-seekers-migrants-and-refugees-in-transit-17-nov-2015.pdf

Information sharin portal Syrian refugees: https://data.unhcr.org/syrianrefugees/regional.php

MHPSS network: http://mhpss.net/groups/current-mhpss-emergency-responses/mediterranean-migrant-crisis/

Omitial contact with distressed children, animated movie: http://resourcecentre.savethechildren.se/library/save-children-psychological-first-aid-training-manual-child-practitioners

Parents and caregiver distress animated movie: http://resourcecentre.savethechildren.se/library/save-children-psychological-first-aid-training-manual-child-practitioners

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- How to recognize people with levels of stress (p.18)
- Text to read or hand out to people under stress (p.24)
- Text for relaxation exercise (p.26)
- Roles that will help restore normal sleep (p.29)
- Text for breathing exercise (p.30).

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- Identification of Women and Girls at Unacceptable Risk (p. 34)

- Good Practice in Protection During Displacement (p. 35)
- Good Practice in Protection in the Context of Local Integration (p. 37)
- Good Practice in Protection During Return and Reintegration (p. 38).

Action Sheet for Target Groups Nr. 47: MHPSS[1] for Disabled Persons in Disaster

Area
All event types, disabled persons, all phases

Key recommendations for supporting for disabled persons

- **Ensure staff are aware of the rights of persons** with disabilities and give emphasis to the Convention on the Rights of Persons with Disabilities
- **Ensure identification and registration**
  - Ask civil society actors and relevant public bodies, non-governmental organisations, religious groups, community-based organisations and disabled persons organisations for information about persons with disabilities and their location
- **Create an effective referral system** by mapping who can do what, where, when and how, in liaison with disabled persons organisations, government agencies, relevant international and local organisations, or other service providers
- **Raise awareness and provide a supportive environment**
  - Involve family members and caregivers in outreach activities, information campaigns and other communication initiatives, and in planning support, where appropriate
- **Make education accessible for children with disabilities**
- **Use appropriate information, dissemination and communication**
  - Prepare key messages, particularly those specifically targeting persons with disabilities, in multiple and appropriate formats
- **Make distribution food and non-food items suitable**
  - Involve persons with disabilities in programme design and delivery and ensure distributions are accessible and appropriate
- **Prioritise persons with disabilities in reunification efforts and include their caregivers in reunification activities**
  - Ensure that durable solutions respect the rights of disabled persons to family life and to live independently in the community
- **Make shelter, housing and offices accessible**
  - Ensure that infrastructure and accommodation are safe, accessible and appropriate
- **Make transportation accessible**

BASED ON:
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Action Sheet for Target Groups Nr. 48: MHPSS[1] Intervention Design for Disabled Persons in Disasters

Area
All event types, disabled persons, all phases

Key recommendations in supporting disabled persons[1,2]

- **Cooperation, Networking, Communication, Exchange with all organisations, including faith-based organisations, that work with and support the disability community before disasters and in preparedness and mitigation**[1,2]
- **Use and adapt existing structures and services, try to find universal designs. Services should be offered all over the country and should not be centralized**[2]
- **Facilitate ongoing contact between people with disabilities and their family members and caregivers.** Try not to separate impaired individuals from each other or their relatives/friends as these people promote their feeling of security and their chance to communicate and receive information[1,2]
- **Children with special health care needs**[1]
  - Train family members to assume the role of in-home health care providers who may not be available during a disaster
  - Keep up-to-date emergency information to provide health care workers with the patient's medical information in case the regular care provider is not available.
- **Service animals must be permitted in emergency transport**[1]
  - If possible do not separate a person from his or her service animal for emergency transport

Preparedness

- **Establish a voluntary database of people with disability for easier contact, crisis communication and warning**[2]
- **Prepare for evacuation of people with psychiatric disabilities** (This includes sufficient medications and durable medical equipment to meet these individuals´ needs) **and also other disabilities** (like blindness or deafness etc.)[1,2]
- **Individual preparedness**[1]
  - Encourage all individuals with sensory impairments or other disabilites to have in the home a device tailored to specific needs that can receive accessible emergency warning information
  - Encourage individuals with disabilities to assemble personal disaster kits.
- **Sensitization of population (possible zero-responders) and professionals about disabled persons (e.g. blindness or deafness)**. Sensitization via: school-education, information material (e.g. via Flyer in Braille, Internet & media), trainings[2]
- **Provide specialised training for emergency planners and responders**[1]
- **Disabled people should take part in disaster drills and simulations**[1,2]

[1] Mental health and psychosocial support

Response

- **Include appropriate COMMUNICATION methods in disaster response**[1,2]
  - Incorporate auditory and visual alerts with appropriately detailed messages into automated alert radios[1]
  - Add full descriptive text messages to audible emergency community alerts in public places[1]
  - Develop local networks of emergency alert services, including Personal Emergency Response System (PERS) services), and outbound automated messaging systems for individuals with disabilities and anyone requiring assistance. Provide detailed descriptive messages for an emergency alert through these networks to visually impaired individuals[1]
  - Ensure public announcements broadcast over television regarding ongoing recovery efforts are communication accessible, e.g., are provided with captions, graphics or other visual display of information provided orally, and provided in such a way that is it not obstructed by other images[1]
  - Messages sent to broadcasters for dissemination should include captions, graphics, or other visual display of information provided orally, and that it should not be obstructed on the screen by other images[1]
  - Emergency preparedness materials available to the public must be reexamined to offer recommendations for customized messages for people with special needs. These materials must also be made available in accessible formats[1]
  - Provide written fact sheets on follow-up care for medical and mental health conditions[1]
  - Prepare tools to communicate with people who for example have hearing loss (Hearing Assistive Technology [HAT], written instruction, pen and paper, etc.) [1]
  - Make available telephone hot lines accessible via TTY, detailed information on websites, and visual and audio information accessible on broadcast television stations[1]
  - Provide written copies of medical reports, including follow-up care and information on any needed medications, on discharge; include names and phone numbers of contact people if additional information is needed[1]
  - Communication advice for example for blind/visual impaired individuals: always introduce yourself, tell them your name and function. Communicate using more details (e.g. information about what is happening, what environment looks like, next steps, etc.), be careful of emotional suddenly pronounced statements like „Oh, my god!“. That may be very confusing and increases anxiety of the blind/visual impaired person, if you do not add more information[2]

    COMMUNICATIONS IN SHELTERS[1]
    - Place visual displays of audible announcements (e.g., electronic signs, open- captioned video, or handwritten white or blackboard displays) in a central location
    - Include universal language signs and international symbols on picture boards. Make sign language interpreters, Video Remote Interpreting (VRI), CART, and hearing assistive technology (HAT) available. Mandate open-captioned display for any televised emergency information
    - Make telecommunication options (e.g., videophones, video relay services [VRS], TTYs, captioned telephones, amplified phones) available when telephones are provided
    - Develop agreements between telecommunication organisations and the local community to facilitate accessibility in emergency situations, to assure availability of appropriate analogue lines for TTY users and CART access in shelters.

Recovery

- **Provide for continuity of care**[1]
  - Create a mechanism, including a point of contact between available resources and the potential consumers, at the county or equivalent level to ensure that resources are kept up to date

- **Make their preferred way of communication possible**. For example a sign language interpreter should automatically be provided – it should not be the responsibility of the hearing impaired individual[2]

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PART IV: MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT ACTION SHEETS FOR SPECIFIC EVENT TYPES

The following Action Sheets have been developed for general crisis managers, psychosocial crisis managers, mental health professionals and other practitioners. They contain recommendations on good psychosocial programming and interventions for specific event types.

These event types have been selected for their specific complexity with regard to psychosocial issues as well as for their relevance in the European context:

- terrorist attacks
- CBRN incidents
- flooding

Action Sheet for Specific Event Type Nr. 49: MHPSS[1] Aspects in Terrorist Attacks

Area
Terrorist attacks, all target groups, phases: mainly response and recovery

Key principles for psychosocial Interventions after terrorist attacks

Principle 1: Expect sadness, fear, anxiety, but also anger, to be the predominant feelings of the affected (Giner-Sorolla & Maitner, 2013, p. 1078 f.; Brandon & Silke, 2007, p. 178 f.; McDermott & Zimbardo, 2007, p. 364 f.)

Directly and indirectly affected people usually have more difficulties to integrate and understand the horrific event due to its hostile nature. Natural disasters and more 'ordinary' crimes, such as robbery, are less difficult to comprehend for most people. Terrorist attacks are sometimes a series of incidents which makes everyone feel unsafe, including rescue and support personnel. (Pfefferbaum, 2003, p. 180 f., Brandon & Silke, 2007, p. 181)

Principle 2: Expect effects on broad communities

Terrorist attacks are usually prominently featured by traditional and social media. Intimidating large populations is a core element of terrorism as a form of psychological warfare. Mitigating psychosocial effects of terrorist attacks therefore can be seen as an important element of a counter-terrorist strategy. (Maeseele et al., 2008, p. 52, Maeseele et al., 2008, p. 51; Pfefferbaum, 2003, p.177).

Principle 3: Crisis management has to strongly support those affected and the general public in the process of sense-making and meaning-making

The political context is even more important in response to terrorist attacks than in other types of disaster. Everyone will will need an answer to the question: "Why did this happen?" – not just those directly affected. (Brandon & Silke, 2007, p. 181 f.; Park et al., 2012, p. 198 f.)

Principle 4: An orchestrated communication and media-strategy is crucial

The effects of terrorist attacks can be mitigated by a well-planned communication strategy. Important elements include: one official, trustworthy voice; focus on rescue and support activities; relevant information for those affected; honest information which is not alarming (e.g. exploitation of the situation for blaming specific groups, organisations, countries etc. often strongly escalates the situation). (Maeseele et al., 2008, p. 65, McDermott & Zimbardo, 2007, p. 357 f.; Pfefferbaum, 2003, p. 183 f.; Sheppard et al. 2006, p. 226 f)

Principle 5: Very close coordination between rescue services, psychosocial support and legal/administrative/investigative authorities is needed

Scene of the event is also a crime scene. (OVC & ARC, 2005, p. 4)

Principle 6: The people affected will usually need more time of aftercare and support after terrorist attacks

Set up more permanent MHPSS support, as well as other types of support (e.g. legal help, assistance centres, controlled online portals) as soon as possible. Community-based interventions are especially important after terrorist attacks. (Ruzek et al., 2007, p.257 ff., p. 260; Ben-Gershon et al., 2005, p. 750)

BASED ON:
As these principles have been developed from the literature, please see references below.

[1] Mental health and psychosocial support

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Action Sheet for Specific Event Type Nr. 50: MHPSS[1] Aspects in CBRN Incidents

Area
All target groups, phases mainly response and recovery

Key recommendations after CBRN incidents (chemical, biological and radiological incidents)

- **Expect uncertainty and fear to be the predominant emotions**
  Many CBRN agents are not directly recognizable without special equipment so people can't assess by themselves whether they are currently endangered or in a safe area. Uncertainty about the location and situation of family members, friends and colleagues – and for rescue workers and other professionals in the field - will require effective communication systems.

- **Anticipate high demand for services**
  The routine health care system will be over-burdened quickly. Fully functioning field hospitals and shelters will be needed immediately. A triage system has to be established straight away.

- **Protective gear is required for most activities**
  Training and exercises in the use of protective gear needs to be offered on a regular basis. Many activities – especially regarding psychosocial support – will be impaired due to restrictions caused by the protective gear and the lack of trained personnel and/or protective equipment. Close coordination is needed between those working on the frontline and those with expertise in MHPSS. Some tasks may have to be delegated to those without training in MHPSS who are able to work in the contamined area.

- **Most CBRN incidents require evacuation**
  It must be made clear to those affected why the evacuation is necessary or even unavoidable. Those affected should be actively involved in the evacuation and in other processes as much as possible. Special focus should be put on the loss of leaving behind loved belongings, animals or even deceased friends and family members. Give the affected a chance to say goodbye if this is in any way possible. Social distancing measures such as quarantine or isolation after a CBRN incident may warrant specific guidelines, since they could well exarcebate psychosocial issues.

- **CBRN incidents may require long-term aftercare and community support** because the mid- and long-term effects of exposure to CBRN agents are often very hard to predict.

- **Communication/information/media policy is crucial**
  Information has to be prompt and truthful and must help those directly and indirectly affected to answer such questions as "What is going on? What do I have to look out for? What should I do? Where am I safe? Where can I get further information and support?" Information should be disseminated in as many ways and media formats as possible, and depending on the situation, in as many languages as necessary. Those affected need access to Information about the location and situation of family members, friends and colleagues and ways of contacting them.

- **Training and preparedness is absolutely essential** due to the complex range of response needed.

BASED ON:
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Containing

I. Chapter: CBRN Protection - a Current Topic
- Psychosocial aspects as part of CBRN protection – why? (p. 62)

II. Chapter: Psychosocial Stress in CBRN Incidents and its Impact
- Psychosocial stress profile during CBRN incidents: Directly affected people, general population and emergency response personnel (p. 77)

III. Chapter: Knowing how to act with Confidence thanks to Psychosocial Knowledge and Actions.
- Acting on the basis of psychological and sociological findings concerning CBRN missions (p. 79)

IV. Chapter: Recommended Procedures for the CBRN Mission
- Basic rules of psychological first aid administered by emergency response personnel (p. 85)
- Prompt and truthful information as the central cornerstone of psychological first aid (p. 88)

V. Chapter: Psychosocial Aspects of Risk and Crisis Communication in CBRN Situations
- Risk and crisis communication of crisis staff and politically responsible persons (p. 94)

VII. Chapter: Recommendations to Incident Commanders concerning the Preparation of Missions (p.98).

Practice examples

Council of Europe/EFPA (2010). Lessons learned in psychosocial care after disasters. Chapter: France - AZF disaster in Toulouse, September 2001, p. 21. Available at http://www.recoveryplatform.org/assets/publication/Lessonslearned_psycosocial%20care%20EC_EN.pdf

Council of Europe/EFPA (2010). Lessons learned in psychosocial care after disasters. Chapter: Spain - Terrorist attack in Madrid, March 2004, p. 50. Available at http://www.recoveryplatform.org/assets/publication/Lessonslearned_psycosocial%20care%20EC_EN.pdf

Action Sheet for Specific Event Type Nr. 51: MHPSS[1] Aspects in Flooding

Area
Flooding, all target groups, all phases

General principles of the response (see Action Sheet Nr.20 immediate response)[1]

- **Coordinate: Establish coordination of intersectoral mental health and psychosocial support**
- **Assess: Conduct assessments of mental health needs and psychosocial issues**
- **Monitor: Initiate participatory systems for monitoring and evaluation**
- **Promote human rights: Apply a human rights framework throughout mental health and psychosocial support**
- **Protect:** Identify, monitor, prevent and respond to protection threats and failures through social and legal protection
- **Activate:** Facilitate conditions for community mobilization, ownership and control of emergency response in all sectors of the response
- **Recruit, train and support staff and volunteers** including cultural and ethical issues
- **Provide support on all levels** following the multilevel approach (see stepped model of Care Action Sheet Nr.7)
- **Provide special support for children and adolescents** including safe places of education
- **Provide Information to the affected population**
- **Embed the psychosocial support into the overall support system**

Key actions in flooding response (OPSIC team)[2]

- **Do regular and continuous needs assessments and provide support accordingly**
  - Especially after flooding, people´s needs may change quickly, so that continuous needs assessments are recommended.
  - If needs are assessed, support should be organized accordingly (daily needs assessments in the beginning has to be followed by daily (re) organisation of support teams and goods to be distributed
  - Multi-disciplinary teams are recommended for needs assessments, e.g. medical, rescue, psychosocial and other responders.
- **Embed psychosocial support into evacuation centre structures**
  - In the European context and in flooding, people do not often live in shelters, but are housed by friends and family. In this scenario, evacuation centres can provide support when people come back during the day to work on their houses or when people seek support in accessing food and non-food item distribution, information, medical support etc.. Psychosocial support must be integrated into these support structures, and not be provided separately.
- **Embed psychosocial support into logistics centre structures**

[1] Mental health and psychosocial support

  - The same applies to logistics centres that provide for the collection and distribution of non-food items. Psychosocial support should also be integrated here.

- **Use mobile teams providing a range of support, including psychosocial support**
  - Mobile teams are recommended to ensure that everybody in need gets support, especially in the initial stages of response. This enables teams to reach those who are not in shelters. Mobile teams should be mixed, providing practical information and support (like distribution of water bottles). This enables teams to reach those needing psychosocial support too.

- **Provide information regularly at special information points and information meetings**
  - Regular information can be given at designated information points at evacuation and logistics centres. Information can also be provided at information meetings where people have the chance to ask questions and consult experts about their most urgent questions and needs. Mental health and psychosocial issues should be integrated into these meetings. This has to be done in close cooperation with local authorities and organisations involved, and may include a wide range of professionals that has occurred, e.g. geologists, meteorologists, insurance experts, mental health professionals, etc.)

- **Provide special support for children and adolescents** including safe spaces to play and for education (see Action Sheet 30-32)
  - If schools and kindergartens are not open, provide safe places for education and recreation especially if parents are working on their houses and have no one to take care of the children.
  - Psychosocial support and counselling for teachers and parents regarding the specific needs of children and adolescents is also recommended.

- **Provide special support to older people** (see Action Sheet 41-43)

- **Combine medical and mental health/psychological contact point**
  - In the case of flooding, mental health and psychological care is usually provided together with medical care, through an outpatient care point in the evacuation centre, if a shelter or field hospital is not needed. Mental health interventions should be available for those in need from the very beginning in the form of a stepped care approach.

- **Work closely with authorities in family tracing services and family reunions**
  - If people are missing and/or casualties are suspected, close cooperation between authorities and psychosocial helpers is recommended in family tracing, identification of dead bodies and family reunions.

- **Provide coordination points for further care**
  - After evacuation centres have been closed, it is recommended to keep coordination points for the provision of long term support and proactive care (mostly in the form of one-stop shops).

BASED ON:

[1]Inter-Agency Standing Committee (IASC) (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, **p.25ff**. Available at www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf1

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ANNEX

Glossary

The purpose of this glossary is to support the readability and comprehensibility of material in the COMPASS, especially the comprehensive guideline and its components.

Term	Description
ADAPTATION	Adaptation is "the adjustment in natural or human systems in response to actual or expected […] stimuli or their effects, which moderates harm or exploits beneficial opportunities" (UNISDR, 2009, p. 4)
ASSESSMENT	Assessment is "the process of gathering data and analysing it to create information" (IFRC, 2009, p. 183) for various purposes. E.g. assessment of needs of an affected population, assessment of volunteers for psychosocial services; **Needs assessment:** Is the first step in designing a long-term response, and focuses on the needs and resources of the affected population. If used to develop clearly defined indicators, a needs assessment can be useful in providing baseline data that can be compared against to evaluate impact and effectiveness of the programme as it is implemented (IFRC, 2012b, p. 12) **Rapid assessment**: Is undertaken as soon as possible following a crisis to determine both the needs and resources of the affected population. They are usually done quickly and can last from a few days to a few weeks (IFRC, 2009a, p. 58) **Ongoing (continuous) assessments:** Take place throughout the implementation of an intervention. They have to be incorporated into the planning and design of the response, being a regular and obligatory activity. These assessments play a vital role in monitoring activities, ensuring that the interventions are responding to the actual needs of the targeted population, as these are likely to change with time (IFRC, 2009a, p. 61)

Term	Description
CAPACITY	Capacity is "the combination of all the strengths, attributes and resources available within a community, society or organisation that can be used to achieve agreed goals. Comment: Capacity may include infrastructure and physical means, institutions, societal coping abilities, as well as human knowledge, skills and collective attributes such as social relationships, leadership and management. Capacity also may be described as capability. Capacity assessment is a term for the process by which the capacity of a group is reviewed against desired goals, and the capacity gaps are identified for further action." (UNISDR, 2009, p. 4-5) See resilience
CATASTROPHE	As disasters are more than large scale mass emergencies, catastrophes are more than disasters. According to Quarantelli (2006) the "more" that makes the difference between disasters and catastrophes consists of 1. Most or all of the community built structure is heavily impacted. In addition, in catastrophes, the facilities and operational bases of most emergency organisations are themselves usually hit. critical facilities 2. Local officials are unable to undertake their usual work role, and this often extends into the recovery period. 3. Help from nearby communities cannot be provided. 4. Most, if not all, of the everyday community functions are sharply and concurrently interrupted. 5. The mass media system (especially in recent times) socially constructs catastrophes even more than it does disasters. 6. Finally, because of the previous five processes, the political arena becomes even more important than in disasters. All disasters of course involve, at a minimum, local political considerations. But it is a radically different situation when the national government and the very top officials become directly involved (Quarantelli, 2006) See Event Types

Term	Description
CBRN INCIDENTS	Chemical, biological and radiological incidents
CLINICAL PRACTICE	Policies for good clinical practice concern how clinical staff take account of the needs and preferences of patients, deploy their clinical skills, and work with patients to agree how guidelines, care pathways and protocols are interpreted in individual cases. (Williams et al., 2009: *NATO-TENTS-guidance*, p. 11) See Quality
COMMUNICATION STRATEGY	See ETHICAL CRISIS COMMUNICATION
COMMUNITY	"A group of people who live together in an environment, or who share common cultural, religious or other social characteristics. For example, those who belong to the same ethnic group; go to the same church; work as farmers, or those who are volunteers in the same organisation." (IFRC, 2009a, p. 183) Community refers to a social unit that shares common values, places or interests. Communities may consist of persons who live together but they may also be bigger entities who share certain values or interests without having close contact. A community may involve a group of people in a geographical area who have a particular social structure, a sense of belonging or community spirit and the daily activities of a community may take place within a certain geographical area. Different types of community may include some or all of these elements. A person can belong to more than one community. (OPSIC consortium meeting, Vienna, 2013)
COMMUNITY BASED PSYCHOSOCIAL SUPPORT	Community based psychosocial support is focused on enhancing the resilience of communities. "The term 'community-based' does not in fact refer to the physical location of activities. Rather it stresses that the approach strives to involve the community itself as much as possible in the planning, implementation and monitoring and evaluation of the response. It is an approach that encourages the affected community to gain ownership of and take responsibility for the responses to their challenges. Community participation [and mobilisation] is therefore an integral aspect of a community-based approach." (IFRC, 2009a, p. 43) See Community, Psychosocial interventions, Psychosocial support]

Term	Description
CONTINGENCY PLANNING	Contingency planning is "a management process that analyses specific potential events or emerging situations that might threaten society or the environment and establishes arrangements in advance to enable timely, effective and appropriate responses to such events and situations. Comment: Contingency planning results in organized and coordinated courses of action with clearly identified institutional roles and resources, information processes, and operational arrangements for specific actors at times of need. Based on scenarios of possible emergency conditions or disaster events, it allows key actors to envision, anticipate and solve problems that can arise during crises. Contingency planning is an important part of overall preparedness. Contingency plans need to be regularly updated and exercised." (UNISDR, 2009, p. 7-8)
COPING (CAPACITY)	Coping capacity is "the ability of people, organisations and systems, using available skills and resources, to face and manage adverse conditions, emergencies or disasters. Comment: The capacity to cope requires continuing awareness, resources and good management, both in normal times as well as during crises or adverse conditions. Coping capacities contribute to the reduction of disaster risks." (UNISDR, 2009, p. 8) Coping is a constant process of cognitive (e.g. thoughts and knowledge), emotional and behavioural adaptation to deal with or manage unpleasant or even adverse events, states or situations. Coping is mainly about dealing with personal crises arising from significant or traumatic life events. Whenever something unusual happens, people need to somehow make situations manageable, adapt to new circumstances and after some time return to a – maybe new and changed – mode of normality. Coping can be done in appropriate and healthy ways, but some people can get stuck in ways that might continue or deepen problems and make a return to 'normality' very difficult (IFRC, 2011, p. 65)
CRISIS	A crisis entails undesirable circumstances which are perceived to be characterized by substantial uncertainty, time pressure and threat to core values (variable, but for example health, safety, and in more severe circumstances death, etc.) (see Hermann, 1963; Brecher, 1993; Rosenthal et al., 1989; Stern and Sundelius, 2002; Boin et al., 2005). A Crisis can come out of any type of emergencies and disasters and affords a substantial amount of discourse between crisis managers and community members as well as stakeholders. See Ethical Crisis Communication, Crisis Management, Disaster, Emergency, Catastrophe, Event Types

Term	Description
CRISIS MANAGEMENT	"Crisis management deals with threats before, during and after they have occurred." (Shrivastava et al., 1988, p. 287) Citizens who experience a threat expect authorities to protect them. Officials are expected to make crucial decisions and give directions. Crisis management has become the task of managing the challenges arising from a Crisis. Boin and ´t Hart (2007, p. 49-52) define five challenges of crisis management: Sense making, Decision making, Meaning making, terminating and learning. • Sense Making: As most crises take some time to fully develop, policymakers have to make sense of the critical nature of development. They must appraise the threat and what it is about (Boin & t´Hart 2007). Crisis managers often find it hard to face this challenge. • Decision making: Making decisions is the second challenge. These decisions are taken under uncertainty and often bear a high risk. Many of these decisions are not taken by individuals but they emerge from "various loci of decision making and coordination" (Boin & ´t Hart,2007, p. 50). Interagency and intergovernmental coordination is crucial during crisis. • Meaning making is aiming at reducing uncertainty and providing authoritative account on what is going on. Choices are made according to the definition of the situation. Problems arise because leaders are not the only ones who give and shape information and authorities often cannot provide correct information right from the beginning. The process of meaning making for the individual person is also depending on his/her previous knowledge, emotional and physical state and other personal factors. • Terminating a crisis is the next challenge mentioned by Boin and 't Hart. Governments cannot stay in crisis forever. Shifting back from crisis to routine mode is one aspect. Blame games often start after termination of the crisis. Leaders must be able to cope with accountability and not involve in defensive blame avoidance. • Learning from a crisis is the last challenge mentioned by the authors. Lesson drawing is often not done: Long term processes are needed to study the impact of a crisis on the society. Collective learning after a crisis is a very important factor that has high implications for further crises and how they are dealt with. Sahin et al. (2008, p. 2) state, that "Crisis/Disaster/Emergency management can be defined the rescue, preparedness, and mitigation efforts spent by governments, volunteer organisations or other local departments before, during and/or after an 'unexpected, uncontrolled public damage that disrupts or impedes normal operations, draws public and media attention, threaten reputation/public trust and that can be perceived' and prepared against (Stallings and Quarantelli, 1985; Alexander, 2005)". See Governance

Term	Description
CRITICAL FACILITIES	Critical facilities are the "primary physical structures, technical facilities and systems which are socially, economically or operationally essential to the functioning of a society or community, both in routine circumstances and in the extreme circumstances of an emergency. Comment: Critical facilities are elements of the infrastructure that support essential services in a society. They include such things as transport systems, air and sea ports, electricity, water and communications systems, hospitals and health clinics, and centres for fire, police and public administration services." (UNISDR, 2009, p. 8-9)
CULTURAL COMPETENCE	Ability to think, plan and act in ways that respect and include the cultural background of the persons concerned. Cultural sensitivity is the adequate use of cultural competence in a specific situation. See culture
CULTURE	"Culture consists in patterned ways of thinking, feeling and reacting, acquired and transmitted mainly by symbols, constituting the distinctive achievements of human groups, including their embodiments in artefacts; the essential core of culture consists of traditional (e.g. historically derived and selected) ideas and especially their attached values" (Kluckhohn, 1951, p.86, cit. in Hofstede, 2001).
DEBRIEFING	Debriefing in general means "to officially question (someone) about a job that has been done or about an experience" (http://www.merriam-webster.com/dictionary/debriefing). In the context of psychosocial activities and crises this term usually refers to various techniques of structured group-interventions whose possible effects and side-effects are discussed critically in recent years (see Kenardy, 2000).

Term	Description
DISASTER	According to UNISDR (United Nations Office for Disaster Risk Reduction, 2009, p. 9): a disaster is a "serious disruption of the functioning of a community or a society involving widespread human, material, economic or environmental losses and impacts, which exceeds the ability of the affected community or society to cope using its own resources". According to Quarantelli (2006) emergencies and disasters differ in the following aspects. At the organisational level alone there are at least four differences (Quarantelli, 2006): 1. *"In disasters compared to everyday emergencies, organizations have to quickly relate to far more and unfamiliar converging entities. […]* 2. *Adjustment has to be made to losing autonomy and freedom of action. […]* 3. *Different performance standards are applied. […]* 4. *There is a much closer than usual public and private sector interface. The need for the quick mobilization of resources for overall community crisis purposes often leads to a pre-emption of everyday private rights and domains. […]"* See Emergency, Event Types
DISASTER MANAGEMENT	The International Federation of Red Cross Red Crescent Societies (IFRC) defines disaster management as the organisation and management of resources and responsibilities for dealing with all humanitarian aspects of emergencies, in particular preparedness, response and recovery in order to lessen the impact of disasters (http://www.ifrc.org/en/what-we-do/disaster-management/)
DISASTER RISK MANAGEMENT	Disaster risk management is "the systematic process of using administrative directives, organizations, and operational skills and capacities to implement strategies, policies and improved coping capacities in order to lessen the adverse impacts of hazards and the possibility of disaster. Comment: This term is an extension of the more general term "risk management" to address the specific issue of disaster risks. Disaster risk management aims to avoid, lessen or transfer the adverse effects of hazards through activities and measures for prevention/mitigation and preparedness." (UNISDR, 2009, p. 10)

Term	Description
DISTRESS	Stress is a state of pressure or strain that comes upon human beings in many different situations. It can be caused by any change – positive or negative. It is an ordinary feature of everyday life and is positive when it makes a person perform optimally, for example in doing a written school exam. However stress becomes distress, when an individual is unable to adapt to the stress they are experiencing and often implies a certain degree of suffering. It is however a normal reaction when experiencing an abnormal situation (IFRC, 2012a, p. 19). See Stressor(s), Reactions to Trauma
EMERGENCY	The United Nations relief web glossary (2008) definition of emergency "A sudden and usually unforeseen event that calls for immediate measures to minimize its adverse consequences." Levels of emergency defined by Alexander (2002, p. 1-2) are • Routine dispatch problem – the most minor of emergencies, involving first responders Incident – any emergency a jurisdiction can handle without needing to call in outside help • Disaster – an incident or catastrophe involving substantial destruction and mass casualty • National (or international) disaster – a disaster of substantial magnitude and seriousness See Event Types, Emergency Services
EMERGENCY SERVICES	Emergency services are "the set of specialized agencies that have specific responsibilities and objectives in serving and protecting people and property in emergency situations. Comment: Emergency services include agencies such as civil protection authorities, police, fire, ambulance, paramedic and emergency medicine services, Red Cross and Red Crescent societies, and specialized emergency units of electricity, transportation, communications and other related services organizations." (UNISDR, 2009, p. 14)

Term	Description
ETHICAL CRISIS COMMUNICATION	Ethical Crisis communication is a process in which all stakeholders are engaged in a fair and open dialogue aimed at reaching consensus (Olsson, 2011). Here the question of how governments cope with the task of shaping the communication process into a dialogue with all stakeholders comes into view. Good crisis management therefore involves leading as opposed to managing (Svedin, 2011, p. 12) and this is based on dialogue as a two way process. Therefore the focus has to shift from what to communicate to whom to communicate with. This means that stakeholder relations are coming into view. According to Olsson crisis research *"moved away from traditional communication management aimed at information dissemination toward organisational tasks such as observation, interpretation and choice (Hale, Dulek & Hale, 2005)"* (Olsson, 2011, p. 145). Inclusion of relevant stakeholders and engagement in an ongoing dialogue is therefore one of the main governmental tasks in a crisis. Stakeholders have to be seen not as passive receivers of information but as actors in their own right. Particular focus has to be put on people with special needs, disabilities and others, who are hindered in their full autonomy. Especially those groups, who are usually perceived as being more vulnerable, also have to be treated as actors on their own. Ethical and effective crisis management in this sense is one and the same. When we take not only single organisations but national governments into account the situation gets even more complicated because there political actors have to balance out their different interests or strategies. Olsson states that *"from the perspective of ethical crisis communication, actors have to balance particular and universal values in order to promote dialogue with various key stakeholders"* (Olsson, 2011, p. 146)
EVENT TYPES	European Union member countries define emergency as "spatially limited events, where sufficient resources are available to deal with the emergency" and state, that it is "still used as an umbrella term for incident, accident, disaster" (Europa, 2007). Similarly, disaster is "a spatially and temporally expanded event where resources are insufficient to deal with; it is based on different statutory regulations, it may develop suddenly or develop out of an emergency" (Europa, 2007). See Emergency, Disaster, Catastrophe
EXPOSURE	Exposure of "people, property, systems, or other elements present in hazard zones that are thereby subject to potential losses. Comment: Measures of exposure can include the number of people or types of assets in an area. These can be combined with the specific vulnerability of the exposed elements to any particular hazard to estimate the quantitative risks associated with that hazard in the area of interest." (UNISDR, 2009, p. 15)

Term	Description
GENDER	"Gender refers to the social differences between females and males throughout the life cycle that are learned, and though deeply rooted in every culture, are changeable over time, and have wide variations both within and between cultures. "Gender," along with class and race, determines the roles, power and resources for females and males in any culture. Historically, attention to gender relations has been driven by the need to address women's needs and circumstances as they are typically more disadvantaged than men. Increasingly, however, the humanitarian community is recognizing the need to know more about what men and boys face in crisis situations." (IASC, 2006, p.12)
GENDER BALANCE	"is a human resource issue. It is about the equal participation of women and men in all areas of work (international and national staff at all levels, including at senior positions) and in programmes that agencies initiate or support (e.g. food distribution programmes). Achieving a balance in staffing patterns and creating a working environment that is conducive to a diverse workforce improves the overall effectiveness of our policies and programmes, and will enhance agencies' capacity to better serve the entire population." (IASC, 2006, p.12) See Gender, Culture
GENDER EQUALITY	"or equality between women and men refers to the equal enjoyment by females and males of all ages and regardless of sexual orientation of rights, socially valued goods, opportunities, resources and rewards. Equality does not mean that women and men are the same but that their enjoyment of rights, opportunities and life chances are not governed or limited by whether they were born female or male" (IASC, 2006, p.1). See Gender, Culture
GENDER-BASED VIOLENCE	"is an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (gender) differences between females and males. The nature and extent of specific types of GBV vary across cultures, countries and regions. Examples include sexual violence, including sexual exploitation/abuse and forced prostitution; domestic violence; trafficking; forced/early marriage; harmful traditional practices such as female genital mutilation; honour killings; and widow inheritance." (IASC, 2006, p.12) "Acts of GBV violate a number of universal human rights protected by international instruments and conventions. Many — but not all — forms of GBV are illegal and criminal acts in national laws and policies." (IASC, 2005, p.7) See Gender, Culture

Term	Description
GOVERNANCE	"Governance policies relate to how countries, regions and counties are governed. Policies at this level are required that set the overall aims and objectives for responses to disasters and major incidents. They should specify the need for services to be designed, developed and delivered that offer psychosocial and mental health care that is integrated into all disaster response plans. Strategic policies are then required that translate political imperatives into the intent and direction of development of specific components of the plans. Governance policies require the responsible authorities to develop strategic policies. Strategy should be developed by bringing together evidence from research, past experience, knowledge of the nature of areas of the country for which they are responsible and of their populations, and the profile of risks, to design services. Responsible authorities are also responsible for evaluating and managing the performance of those services to meet the identified objectives." (Williams et al., 2009: *NATO-TENTS-guidance*, p. 7). See Crisis Management, Ethical crisis communication
HELPER	Umbrella term for all personnel in a crisis situation, helping and supporting affected people; includes volunteers and professionals.
HUMANITARIAN ASSISTANCE CENTRE (HAC)	A HAC is a focal point for the provision of information and assistance to all those affected by an emergency, and will also provide support to survivors of an emergency. These will include those injured – from those with critical injuries requiring long-term hospitalisation to the walking wounded who may be able to self-treat with basic medication and equipment at home – and those not physically affected, but traumatised by the emergency, including those directly involved, as well as witnesses and local responders, families and friends. HAC is only one part of the emergency response. Other, more immediate sources of information and help may be provided in the first 24 hours (casualty bureau, rest centre, family and surviviors reception centre). Casualty bureau immediate: initial point of contact for receiving/assessing information about victims, to: – inform the investigation– trace and identify people – reconcile missing persons – collate accurate information for dissemination to appropriate parties, responsibilty, police Survivors reception centre Immediate: A secure area in which survivors not requiring acute hospital treatment can be taken for short-term shelter and first aid. Evidence might also be gathered here., responsibility: organisation in charge of immediate response, authorities Family and Friends reception centre, First 12 hours: To help reunite family and friends with survivors – it will provide the capacity to register, interview and provide shelter for family and friends. responsibility: organisation in charge, authorities Rest centre, A building designated or taken over by the local authority for temporary accommodation of evacuees/homeless survivors, with overnight facilities. responsibility: organisation in charge, authorities HAC guidance, 2009, p. 14 and 15

Term	Description
INTERSECTIONALITY	"Intersectionality, minted in 1989 by Kimberlé Crenshaw (1989), is the favoured term for - in part - describing what during the 1970s and 80s was typically (and insufficiently) referred to as double, triple or multiple jeopardy - circumstances where for example gender, ethnicity, sexual orientation, and/or handicap combine in varying constellations, resulting typically in compound disadvantage. Importantly, intersectionality is used as a means for posing reflexive and reflective questions around how different norms are formed, changed, interconnected, and often reinforce one another (Rosén, 2010, p 72)." (cited from Newlove-Eriksson, 2012, p 3).
MEDICALIZATION	"Medicalization describes a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illness and disorders." (Conrad, 2007, p. 4)
MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT (MHPPS)	The specific details differ, but overall there is broad consensus on what in the context of OPSIC/COMPASS is referred to as MHPPS (Mental Health and Psychosocial Support): Mental health and psychosocial support are "any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder". (IASC, 2007, p. 1) "Mental health and psychosocial approach is a way to engage with and analyse a situation, and provide a response, taking into account both psychological and social elements. It is a way of providing a humanitarian response in ways that are beneficial to the mental health and psychosocial wellbeing of affected people." (UNHCR, 2013, p. 74) "Mental health services are services offered with the goal of improving individuals and families' mental health and functioning with a particular focus on mental disorders. Comment: Services may include psychotherapy, medication, counselling, behavioural treatment, etc." (UNHCR, 2013, p. 74) See Psychosocial Support
MITIGATION	Mitigation is "the lessening or limitation of the adverse impacts of hazards and related disasters." (UNISDR, 2009, p. 19) (see: Prevention/Mitigation, Phases of action)
MONITORING	Monitoring in general is "the act of observing something (and sometimes keeping a record of it)" (http://www.thefreedictionary.com/monitoring). "Monitoring is the regular and continuous process of collecting and analysing data to assess progress and development. It is an internal responsibility carried by whatever programme is involved and is a way of keeping a regular check on the planned inputs, outputs and outcomes of a response" (IFRC, 2009a, p. 155). Example: monitoring the stress levels of helpers in an emergency response;

Term	Description
MULTI AGENCY PSYCHOSOCIAL CARE PLANNING GROUP	All relevant agencies engaging in a specific crisis scenario should communicate on a common level and closely tune their activities. A good way to do so is to set up planning groups for relevant issues (with psychosocial care being one) in which all agencies are represented.
MULTI-LAYERED SUPPORT	In emergencies, people are affected in different ways and require different kinds of supports. A key to organising mental health and psychosocial support is to develop a layered system of complementary supports that meets the needs of different groups. Multi-layered supports can be illustrated by a pyramid, with each layer representing the approximate amount of the target groups: level 1 (largest): Basic services and security, level 2: Community and family supports, level 3: Focused, non-specialised supports, level 4 (smallest): Specialised services; (IASC, 2007, p. 11-13)
OLDER PEOPLE	Older people are generally defined according to a range of characteristics including: chronological age, change in social role and changes in functional abilities. In high-resourced countries older age is generally defined in relation to retirement from paid employment and receipt of a pension, at 60 or 65 years. With increasing longevity some countries define a separate group of oldest people, those over 85 years. In low-resourced situations with shorter life-spans, older people may be defined as those over 50 years. The age of 50 years was accepted as the definition of older people for the purpose of the WHO Older Adult Health and Ageing in Africa project (WHO, http://www.who.int/healthinfo/survey/ageingdefnolder/en/#)
OVERALL DISASTER/MAJOR INCIDENT PLAN	A disaster plan involves procedures that that clearly detail what needs to be done, how, when, and by whom before and after the time an anticipated disaster occurs. The part dealing with the first and immediate response tot he event is called emergency management plan (http://www.businessdictionary.com/definition/disaster-plan.html)
PHASES OF ACTION	Adapted version from the Hyogo Framework (UNISDR, 2007), see links: • PREVENTION/MITIGATION • PREPAREDNESS • RESPONSE • RECOVERY

Term	Description
PREPAREDNESS	Preparedness is "the knowledge and capacities developed by governments, professional response and recovery organizations, communities and individuals to effectively anticipate, respond to, and recover from, the impacts of likely, imminent or current hazard events or conditions. Comment: Preparedness action is carried out within the context of disaster risk management and aims to build the capacities needed to efficiently manage all types of emergencies and achieve orderly transitions from response through to sustained recovery. Preparedness is based on a sound analysis of disaster risks and good linkages with early warning systems, and includes such activities as contingency planning, stockpiling of equipment and supplies, the development of arrangements for coordination, evacuation and public information, and associated training and field exercises. These must be supported by formal institutional, legal and budgetary capacities. The related term "readiness" describes the ability to quickly and appropriately respond when required." (UNISDR, 2009, p. 21)
PREVENTION/MITIGATION	"Mitigation is the effort to reduce loss of life and property by lessening the impact of disasters. Mitigation is taking action now—before the next disaster—to reduce human and financial consequences later (analysing risk, reducing risk, insuring against risk)." (FEMA, n.d.) Mitigation includes efforts to prevent or decrease effects of human-made or natural disasters by the assessment of threats to a community. These assessments include the likelihood of an attack or disaster taking place. We suggest to also include the long-term effects of disasters on communities or parts of communities in regard to their enhanced or reduced resilience. In the CG the term prevention is used to refer to this phase of action. In the area of MHPSS (metal health and psychosocial support) we subsume all efforts to enhance the resilience of populations at risk including a vulnerability and capacity assessment in this phase. See Phases of Action
PROGRAMME (psychosocial support p.)	A community intervention aimed at providing psychosocial support that can differ in length (weeks, months, years), scope (variation in themes) and organisation (number of partner organisations at different levels) (Dückers & Thormar 2014).
PROMOTIVE FACTORS	See PROTECTIVE, PROMOTIVE and RISK FACTORS
PROTECTIVE, PROMOTIVE AND RISK FACTORS	Protective and promotive factors are measurable characteristics of groups and/or individuals or their situation that predict positive outcome (resilience). However, protective factors work only under adversity, while promotive factors (or assets) predict positive outcomes regardless of risk level. Both protective and promotive factors are important for predicting well-being. Risk factors are measurable characteristics of groups and/or individuals or their situation that predict negative outcomes. (modified from Masten et al., 1990) See Resilience, Vulnerability

Term	Description
PROTECTION	"encompasses all activities aimed at securing full respect for the rights of individuals — women, girls, boys and men — in accordance with the letter and the spirit of the relevant bodies of human rights, humanitarian and refugee law. Protection activities aim to create an environment in which human dignity is respected, specific patterns of abuse are prevented or their immediate effects alleviated, and dignified conditions of life are restored through reparation, restitution and rehabilitation." (IASC, 2006, p.12)
PSYCHOEDUCATION	Psychoeducation refers to the provision of knowledge and skills to a given target group which involves teaching and exchange of relevant information that can be done in a broad variety of ways. Psychoeducation means the provision of information to the affected persons and groups as well as the initiation of a dialogue about the nature of stress, posttraumatic and other symptoms, and what to do about them. The provision of psychoeducation can occur before possible exposure to stressful situations or after exposure. The intention is to ameliorate or mitigate the effects of exposure to extreme situations. Educational information can be imparted in a number of ways and should – whenever possible – not be given only as one way information but also in the form of a dialogue. It may include the provision of knowledge as well as the training of skills. Interventions may involve discussion groups, briefings, informational leaflets, dialogue with peers, possibilities for dialogue and answers to FAQ in the Internet and many others (Wessely, S. Bryant, R.A., Greenberg, N. Earnshaw, M. Sharpley, J., Hacker J. Hughes, J. 2008 , p. 287)
PSYCHOINFORMATION	See Psychoeducation
PSYCHOLOGICAL FIRST AID	**IMPORTAINT NOTICE: THE USE OF THE TERMS "PSYCHOLOGIST", "PSYCHOLOGY" AND "PSYCHOLOGICAL" IS LEGALLY PROTECTED OR REGULATED IN SOME COUNTRIES. ALWAYS MAKE SURE THAT YOUR PLANS, ACTIONS AND TERMINOLOGY ARE IN ACCORDANCE WITH YOUR (NATIONAL) LEGAL REQUIREMENTS!** Psychological First Aid (PFA) is an element of psychosocial support that can be effectively applied by trained lay-people including volunteers but is also used by professionals. According to Sphere (2011) and IASC (2007), Psychological First Aid (PFA) describes a humane, supportive response to a fellow human being who is suffering and who may need psychosocial support. PFA is an established intervention format that generally contains the following elements • Providing practical care and support, which does not intrude; • Assessing needs and concerns; • Helping people to address basic needs (for example, food and water, information); • Listening to people, but not pressuring them to talk; • Comforting people and helping them to feel calm; • Helping people connect to information, services and social supports; • Protecting people from further harm. (WHO, 2011, p. 3)

Term	Description
PSYCHOSOCIAL	"The word psychosocial refers to the two-way relation between psychological factors (the way an individual feels, thinks and acts) and social factors (related to the environment or context in which the person lives: the family the community, the state, religion, culture) (PSW, 2003). Psychosocial is an adjective that needs to be followed by a noun, e.g. a psychosocial problem, a psychosocial intervention, a psychosocial approach." (UNHCR, 2013, p. 75)
PSYCHOSOCIAL SUPPORT	Psychosocial support (PSS) is an umbrella approach, following the intervention principles named by Hobfoll et al. (2007) with the aim of promoting resilience of individuals, groups and communities in crisis. Psychosocial support includes a broad variety of interventions promoting the resources of individuals, families or groups as well as the community as a whole. It can prevent distress and suffering from developing into something more severe as it aims to help overcome adversities, stimulate recovery processes and restore (a new form of) normality after crisis. Psychosocial support activities range from • psychological first aid in immediate phase after emergencies or other critical events to • Psychoeducation, • individually provided treatment and support programmes, and • family & community support after crisis to • more focused non-specialised services like for example special programmes for children and adolescents to overcome the death of a caregiver. Psychosocial support includes all processes and actions that promote the holistic well-being of people in their social world. It includes support provided by family, friends and the wider community. It includes what people (individuals, families and communities do themselves to protect their psychosocial well-being, and the interventions by outsiders to serve the psychological, social, emotional and practical needs of individuals, families, and communities, with the goal of protecting, promoting and improving psychosocial well-being. (UNICEF, 2011) See Mental Health and Psychosocial Support (MHPSS)
PUBLIC AWARENESS	Public awareness is "the extent of common knowledge about disaster risks, the factors that lead to disasters and the actions that can be taken individually and collectively to reduce exposure and vulnerability to hazards. Comment: Public awareness is a key factor in effective disaster risk reduction. Its development is pursued, for example, through the development and dissemination of information through media and educational channels, the establishment of information centres, networks, and community or participation actions, and advocacy by senior public officials and community leaders." (UNISDR, 2009, p. 22-23)

Term	Description
QUALITY (of MHPSS approaches)	The quality of post-disaster psychosocial support can be expressed in scores per criterion i.e. need centeredness, effectiveness, safety, timeliness, efficiency, and equity (also see Donabedian, 1988; Berwick, 2002; Eccles et al., 2009). The quality of a post-disaster psychosocial support programme is reflected in the programmes structure, process, and outcome (Dückers & Thormar, 2014). "Structure" describes the relatively stable context in which services are delivered, including people, financial resources, tools, and equipment. "Process" denotes transactions between clients and providers throughout the service delivery system, activities, and technical and interpersonal aspects of the performance. Finally, "outcome" refers to effects on the well-being and health of individuals and populations (Donabedian, 1980). Quality improvement In a post-disaster psychosocial support context quality improvement can be defined as "the combined and unceasing efforts of everyone – professionals and trained volunteers, affected ones and the people close to them, researchers, funding bodies, planners and educators – to make the changes that will lead to better health outcomes and well-being, better system performance, and better professional development (learning)" (Dückers & Thormar, 2014, p. 4).
RISK FACTORS	See PROTECTIVE, PROMOTIVE and RISK FACTORS
REACTIONS TO TRAUMATIC EVENTS	In the wake of traumatic events it is expected that we may experience stress as part of a NORMAL reaction to that trauma. Normal reactions to traumatic events can include: • Recurring thoughts or nightmares about the event • Having trouble sleeping or changes in appetite • Feeling anxiety when exposed to situations reminiscent of the trauma • Being on edge, being easily startled or becoming overly alert • Feeling depressed, sad and having low energy • Seeking relief through alcohol, drugs and/or tobacco • Feeling "scattered" and unable to focus on school or daily activities • Feeling irritable, easily agitated, or angry and resentful • Feeling emotionally "numb", withdrawn, disconnected or different from others • Spontaneously crying, feeling a sense of despair and hopelessness • Feeling extremely protective of, or fearful for, safety of self and others • Avoiding activities or places that remind you of the event For many these reactions will be temporary and subside on their own within a few weeks. However, persistent signs of distress may require professional help. (http://www.counseling.msu.edu/resource/common-reactions-traumatic-events)

Term	Description
RECOVERY (after disasters and catastrophes)	The phase of recovery involves cleaning, the reinstitution of public services, the rebuilding of public infrastructure, and all that is necessary to help restore civic life, including disaster assistance, crisis counselling and various other forms of support. This also involves the process of reconstruction, which is very critical to mitigation/prevention and risk reduction. Monitoring of psychosocial community and individual resilience over time, often over several years is necessary MHPSS (mental health and psychosocial support) recovery begins when the affected individuals, families and communities have regained a certain amount of everyday routine and normality and start to mourn the losses and rebuild their strength and wellbeing. Often this is not possible before missing persons have been found, death notifications are delivered, dead bodies have been viewed and first rituals have taken place. Therefore we refer to late response/early recovery as the (often overlapping) phase when for some of the affected family reunions have taken place, death notifications are already given but for others uncertainty remains. Later response means the phase when for most of the affected mourningcan start because death notifications have been given, dead bodies have been viewed and buried. On an individual and community level the process of recovery is very closely related to coping and resilience.
RECOVERY (from mental disorders, …)	Recovery (from mental disorders and/or substance use disorders) is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. (SAMHSA, 2012, n.p.)
RESILIENCE	Resilience is the capacity of an individual or group to buffer from and recuperate after adverse events within reasonable time psychologically, socially and physically and without lasting detriment to self, relationships or personal development with adequate use of available resources (see Williams, 2007). It is important to state here, that resilience is not identical to a lack of physical impairment or losses, but it is recuperation in spite of loss and impairment. Resilience includes the "preservation and restoration of essential basic structures and functions" (UNISDR, 2009, p. 24). "In the context of exposure to significant adversity, resilience is both the capacity of individuals to navigate their way to the psychological, social, cultural, and physical resources that sustain their wellbeing, and their capacity individually and collectively to negotiate for these resources to be provided in culturally meaningful ways." (Ungar, 2011, p. 14)

Term	Description
RESPONSE	Response is "the provision of emergency services and public assistance [including MHPSS] during or immediately after a disaster in order to save lives, reduce health impacts, ensure public safety and meet the basic subsistence needs of the people affected." (UNISDR, 2009, p. 24) It also includes public donations, incident management, coordination, search and rescue operations, damage assessments, handling of fatalities, etc. Specifically MHPPS (mental health and psychosocial support) response subsumes all actions and interventions taken during the phase when information is not yet fully available, when people are still missing, dead bodies have not been identified and family reunions have not yet taken place. Therefore we refer to this phase as early and late response. Early response in MHPSS means that no death notifications have been given, no identifications have taken place, no family reuinions have been yet possible whereas in late response first family reunions have taken place, first death notifications have been given but for many of the affected uncertainty still remains. As the phases overlap here we name the phases earlyresponse and late response/early recovery. This is relavant for MHPSS interventions.
RISK ASSESSMENT	Risk assessment is "a methodology to determine the nature and extent of risk by analysing potential hazards and evaluating existing conditions of vulnerability that together could potentially harm exposed people, property, services, livelihoods and the environment on which they depend." (UNISDR, 2009, p. 26)
SCREENING	"Screening tests are ubiquitous in contemporary practice, yet the principles of screening are widely misunderstood. Screening is the testing of apparently well people to find those at increased risk of having [or developing] a disease or disorder" (Grimes & Schulz, 2002, p. 881). Comment: Usually screening is faster and more easily applicable than full diagnostic procedure – but also less accurate and reliable. In situations of emergency, disaster or catastrophe, full diagnostic procedures usually are neither necessary nor available to be used on a large number of people. Results of screenings should be seen as a first (pre-diagnostic) step to have a relatively solid basis for further decisions or clarification.
SELF AND COMMUNITY EFFICACY	Self-efficacy is the sense that an individual beliefs that his actions are likely to lead to generally positive outcomes, principally through self-regulation of thoughts, emotions, and behaviour. This can be extended to collective efficacy, which is the sense that one belongs to a group that is likely to experience positive outcomes (Hobfoll et al., 2007, p. 293).
SERVICE DELIVERY	"Service delivery policies concern how particular services function and relate to their partner services and how affected populations are guided into and through them according to the evidence and awareness of the preferences of people who are likely to use them. Service delivery policies include evidence-informed and values-based models of care, care pathways and protocols and guidelines for care as well as processes for demand management, audit and review." (McFarlane & Williams, 2012, n.p.)

Term	Description
SOCIAL MEDIA	Social media are "forms of electronic communication (as Web sites for social networking and microblogging) through which users create online communities to share information, ideas, personal messages, and other content (as videos)" (http://www.merriam-webster.com/dictionary/social%20media).
STAKEHOLDER	Term used in a very basic meaning here – that might differ from the use and meaning in some very specific economic contexts: A person or organisation with a legitimate interest in a given situation, action or enterprise. (http://www.merriam-webster.com/dictionary/stakeholder) In the context of crises, preparation and response, relevant groups of stakeholders could be for example the following: first responders, programme officers, beneficiaries, key response personnel, general public, target groups, the affected/survivors, lay people, internally displaced groups, professionals, volunteers; It is a crucial task to organize and manage the various dynamic interactions and relations of all stakeholders in a constructive and productive way. See Ethical Crisis Communication
STEPPED APPROACH	The stepped model of care is an approach recommended by the NATO TENTS guideline in order to make sure that alllevels of support are provided. It involves the following steps 1. **Strategic planning - comprehensive multi-agency planning, preparation, training and rehearsal** of the full range of service responses that may be required; 2. **Prevention services that are intended to develop the collective psychosocial resilience** of communities and which are planned and delivered in advance of untoward events; 3. **Basic humanitarian and welfare services** that should be made available to everyone and which are centred on families; 4. **Providing psychological first aid** that is delivered by trained lay persons who are supervised by the staff of the mental healthcare services; 5. **Providing screening, assessment and intervention services** for people who do not recover from immediate and short-term distress; and 6. **Providing access to primary and secondary mental healthcare services** for people who are assessed as requiring them. Nato Tents guidance, 2009, p. 12
STRESSOR(S)	Stressors: Any change, positive or negative, which triggers a stress response. Stressors may be external or internal. External stressors are conflicts, change of jobs, poor health, loss, lack of food, noise, uncomfortable temperatures, lack of personal space, privacy etc. Internal stressors include thoughts, feelings, reactions, pain, hunger, thirst, etc. (IFRC, 2009b, p. 107) See Distress

Term	Description
TRAUMA (individual)	Trauma (individual) is a result of an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being. (SAMHSA, 2012, n.p.)
TRAUMA-SPECIFIC INTERVENTIONS	Trauma-specific interventions are specific practices that have been developed to address the trauma experienced by individuals, families, and communities. These practices are most often used by a practitioner trained in the use of these interventions. (SAMHSA, 2012, n.p.)
TRAUMA-SPECIFIC SERVICES	Trauma specific services are programmes that address trauma with a continuum of interventions from screening to treatment to recovery supports. (SAMHSA, 2012, n.p.)
TRAUMATIC EVENT	Traumatic event: A traumatic event is an experience that causes physical, emotional, psychological distress, or harm. It is an event that is perceived and experienced as a threat to one's safety or to the stability of one's world (MedlinePlus, http://www.nlm.nih.gov/medlineplus/ency/article/001924.htm) See Crisis, Distress, Reactions to Traumatic Events
TRIAGE	Triage "is the sorting into pre-established priorities. In reference to medical care and disasters, it means that scarce resources will be used to provide the maximum benefit to the population at large. The traditional triage is the transvertical triage (takes place within a short time frame). Longitudinal triage means sacrificing victims at the moment for the benefit of future victims." (Sundnes & Birnbaum, 2002, p. 160) Comment: With regards to psychosocial issues triage is relevant in two ways: 1. In large scale incidents there might be more need for psychosocial support than the responding agencies are capable to provide at a given time → triage as an "element" within the organisation of psychosocial support 2. For many medical professions (e.g. paramedics, surgeons, etc.) triage might be an abhorred duty and severe stressor; for some affected people triage might be a reason for (temporary) deprivation → triage as a "reason" for psychosocial support
VOLUNTEER	In the contexts of psychosocial support, usually such people are declared "volunteers" who do provide help and support, but who do not have formal (academic) training in the specific field. So very often volunteers providing psychosocial support activities are no formal mental health experts like psychologists, psychotherapists or psychiatrists. (see IFRC, 2011, p. 5)
VULNERABILITY	"A range of factors that may decrease an individual's or community's ability to cope with distress experiences. E.g. poverty, mental or physical health disabilities, lack of social network, lack of family support, age and gender." (IFRC, 2009a, p. 185) See Intersectionality; Protective, promotive and risk factors

Term	Description
WELL-BEING	"Well-being refers to the condition of holistic health and the process of achieving this condition. Well-being has physical, cognitive, emotional, social and spiritual dimensions. The concept includes 'what is good for a person' such a participating in meaningful social roles, feeling happy and hopeful, living according to good values as locally defined, having positive social relations and a supportive environment, coping with challenges through the use of healthy coping mechanisms, having security, protection and access to quality services and employing." (UNHCR, 2013 p. 78)

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OPSIC Practice Examples

This chapter provides an overview of examples derived from practice/practical experience on psychosocial support in disasters. On the one hand, we have interviewed stakeholders from different European countries about their experiences with psychosocial support in different event types. On the other hand, we have collected reports, guidelines and handbooks with narrations of affected individuals or groups (from the general population, children/youth, disabled people, older people) or helpers.

In the first part you find the results of the interviews:

- Aircrash 2008 in Spain (Spanair Flight 5022)
- Bombings in the subway system 2005 in United Kingdom
- British Red Cross Psychosocial Support Team Responses from 2008-2010
- Financial Crisis 2008 in Iceland
- Flooding 2009 in United Kingdom
- Flooding 2013 in Austria
- School Shooting 2008 in Finland (Kauhajoki school shooting)
- Shooting at a shopping mall 2011 in Netherlands
- Terrorist Attack 2011 in Norway (Utøya)
- Toxic Train Incident 2013 in Belgium
- Trainbombs 2004 in Spain (Madrid train bombings)
- Tsunami 2004 in South-East Asia (Swedish Pesrpective)

You can also find one evaluation example about the disaster during the Music festival 2000 in Denmark

The second part gives an overview about practice examples derived from literature categorized into different target groups:

1. Practice examples focused on the general population
2. Practice examples focused on children/youth
3. Practice examples focused on disabled people
4. Practice examples focused on older people
5. Practice examples focused on helpers
6. Practice examples focused on event types

Interview results - Practice Examples

Aircrash 2008 in Spain (Spanair Flight 5022)

Event type: Airplane crash
Place of the event: Madrid, Baraja Airport
Date of the event: 20th August 2008
Event characteristics:

- **Number of casualties: 154**
- **Damage to livelihood: no**
- **Number of people supported: 274**
- **Support for helpers: yes (32 FRs supported)**

Length of the PSS-Interventions: midterm
Experts Organisation: SAMUR Madrid
Experts Position: Crisis Manager (medical, not PSS)

Description
In august, 20th, 2008 Flight JK 5022 was on a codeshare with Lufthansa, flight LH 2554 from Madrid to Las Palmas de Gran Canaria. The plane crashed and broke apart after failing to lift off at Barajas airport at 14:23 local time.
Madrid-112 Dispatch Center received a call from a witness of the crash at 14:27,
112- Dispatch Center transferred the information to SAMUR-Protección Civil, who confirmed the accident with Madrid Air Route Traffic Control Center.
20 people were rescued alive and tranferred to the hospital.
154 people were killed in the accident.
The accident occurred inside Madrid-Barajas Airport, on runway 36L.

Who responded?

Psychologists (staff and volunteers):	76
Professional medical staff	180
Volunteers	360

How was the response organized?
The transfer of the corpses to a IFEMA , which is a fairground already used as a temporary morgue after the terrorist attack of march 11, 2004, began to be organized 30 minutes after the accident.
The transfer of the corpses from the scene to the fairground started around 8 pm.

At that time, Security Coordinator of Madrid City Council appointed SAMUR-CP responsible for the coordination of the **family assistance and support operations center** which main purpose was provide psychological and logistical support and services to victims' familiy members. That center was going to be arranged at IFEMA fairground.

By then, a group of psychologists from SAMUR-CP staff came into IFEMA and were sent to the Airport to give psychological support and reorient the confused families who went there looking for information about their relatives. This was a critical moment to deal with.

The family assistance and support operations center consisted of :

- A general coordination room, where the Emergency General Coordinator and SAMUR-PC managers were located. The role of this center can be described as a coordinator to integrate the resources of the local government, the airline, the country government, NGOs, social services, mental health services and other organisations to meet the needs of victims' family.

- A reception room for volunteer mental health professionals (psychologists and psychiatrists) an clergy members of several creeds to meet spiritual or religious needs. A psychologist from SAMUR-CP was appointed as a coordinator of mental health support. In this room, groups of volunteer and professional from different institutions (Official College of Psychologists, Ministry of Defence, Mental Health Services, Social Services, Red Cross, etc), were organized. A procedure of performance to be followed in reception, filiation, accompanying families, assignation of a psychosocial professional to each family, etc
- Reception room for victims' relatives where a form was filled in with the number of casualties in the family, contact data, essential needs (food, clothing, shelter, etc). A psychologist was assigned to each family for companion and support since the begining of the process, although areas to grieve privately were also provided. Relatives of 117 victims were registered at 9 pm.
- Infirmary to meet medical needs.
- Reception room for foreign embassies personnel since people from Germany, Japan and Indonesia were in the plane.
- Four rooms were fitted out as a forensic processing center to take biological samples from the corpses. In some cases, it was necessary to ask the family to bring in personal belongings that helped to firm up a successful DNA match.
- One room to communicate the family the data about the DNA testing process and results and included a basic explanation of how DNA is used in mass fatality incidents.
- Two rooms for individual psychological support.

ORGANIZACION OF THE VICTIMS IDENFITICATION PROCESS

- Police Forensic Services reported to SAMUR-PC manager in charge of the family assistance and support operations center the identification of a victim.
- The family of the victim was then contacted and informed that the identification has been made.
- The information was given by the SAMUR-CP manager in charge always in the presence of the psychologist.
- A SAMUR staff member accompanied the family to the morgue to identify the body and provide assistance with the funeral arrangements.
- August 20th at 11 pm the first victim was identified.
- During the following 24 hours the victims identification process was carried out in IFEMA, where the first 50 victims were identified.
- August 21th at 23:00 operation at IFEMA fairground was over and transferred to 2 different locations:
    - HOTEL AUDITORIUM, next to the Airport and provided by the Airline:
        - Families accommodation.
        - General coordination office.
        - Medical room.
        - Mental health services.
        - A volunteer employee from the Airline was assigned to each family to accompany them and provide logistical support.
    - CEMETERY. La Almudena the biggest cemetery in Madrid where there is enough facilities to set up the following:
        - Morgue
        - Medical Examiner Office
        - Mental Health Service

PROCEEDING BETWEEN LA ALMUDENA CEMETERY AND HOTEL AUDITORIUM

- Forensic Officer reported by phone to the responsible for the general coordination office the identification of a victim.
- The responsible for the general coordination office at the hotel set up an individual interview to notify family members about a positive identification.

- Local Police agents and a volunteer from the airline drove the family from the hotel to the cemetery.

PROCEEDING AT LA ALMUDENA CEMETERY

- Judicial arrangements for the diposal of human remains.
- Funeral arrangements
- Possibility of seeing human remains.
- Possibility of going to the Airport to recognize personal belongings and keep them.
- Tranfer back to the hotel.

All these procedures were done in the presence of a pshychologist providing companion and support to the victims' family

What were the strong points according to your opinion?

- The effectiveness of a procedure of performance to manage this type of incidents has been proved.
- It is also very important to have a clear concept of who is in charge of the"family assistance and support operations center"

What were the lessons learnt (weak points) according to your opinion?

- Team members need to be rotated to allow time away from the work site in order to avoid stress reactions. Do not allow staff to donate time to assist on site when they are off duty.
- Psychological support is neccesary during all the proccess but space for intimacy should be respected.
- Institutions with competence in Human Support (social services, mental health services, etc) should get involved.

Conclusion and recommendations for further programmes

- All personnel involved in providing services to assist the victims' family should be trained in crisis response and must demonstrate compassion, sympathy, technical expertise and professionalism to deal with this kind of situations.
- Ethical issues may arise in this type of events and we have to be prepared to deal with them (unexpected DNA testing results, unknown relatives appearing at this time, etc)

Bombings in the Subway System 2005 in United Kingdom

Event type: Four bombings in the UK subway system
Place of the event: London
Date of the event: 7 July 2005
Experts Organisation: British Red Cross
Experts Position: At the time of the incidents, the expert was Civil Protection/Emergency Planning Advisor to the British Red Cross and Chair of the Voluntary Sector Civil Protection Forum.

The focus of this text is the short-term psychosocial response to the terrorist bombings that took place in July 2005 in London, England. The activity is dealt with under a series of headings: a summary of the planning arrangements pertaining in London; an outline of the four incidents; the psychosocial response; the reviews; and lessons learned and good practice.
The content is limited to the humanitarian response and so does not address the other aspects of the incidents and the response, particularly the contribution of the primary responding organisations.

1. A summary of the planning arrangements pertaining in London

At the time of the bombings, the aim of the London Resilience partnership was to ensure that the Capital was as well prepared against emergencies as possible. London Resilience comprised Government, the Mayor, the Greater London Authority and all London's key responding agencies – police, fire, ambulance, health service, local authorities, the transport operators, the Port of London Authority, the utilities, voluntary agencies, plus the military, the London business community and representatives of London's main faiths. The partnership was led by the London Regional Resilience Forum.

2. An outline of the four incidents

7 July 2005:

- four separate but connected explosions occurred in central London when four terrorist suicide bombers detonated bombs on the public transport system
- the first three bombs detonated within 50 seconds of each other on the Underground rail network. The first exploded at 08.50 on an east-bound Circle line train near Aldgate, the second on the West-bound Circle line at Edgeware Road and the third on the South-bound Piccadilly line between King's cross and Russell Square stations. Just under one hour later, at 09.47, a fourth bomb was detonated on a double-decker London bus travelling through Tavistock Square
- 56 people were killed (including the four suicide bombers), and more than 760 people were injured, many very seriously, with life changing injuries
- while each of these events was a serious incident in its own right, their unprecedented cumulative effect was to spread public confusion and speculation, particularly about whether further attacks were imminent.

8 July:

- in the evening, the Gold Co-ordinating Group (chaired by Metropolitan Police Service) decided to establish a Family Assistance Centre; the Queen Mother Sports Centre at Victoria was selected as a suitable emergency location and work began overnight to prepare the Centre. The British Red Cross was involved in site selection and the development of the facility
- the London bombings relief charitable fund was established
- at 01.00, the Police and the London Resilience Team began the provision of the specially constructed temporary mortuary on the site of the Honourable Artillery Company on City Road; the build was completed by 22.00. The first bodies were received at the temporary mortuary at 22.25.

9 July:

- the British Red Cross was requested to provide support at the temporary mortuary
- at 14.00, the Family Assistance Centre opened in the temporary facilities at the Queen Mother Sports Centre. The facilities were subsequently found to be unsuitable and an alternative site was identified as the Royal Horticultural Hall in Westminster; work began to prepare the venue.

12 July:

- the Family Assistance Centre relocated to the Royal Horticultural Hall
- the 7th July Family Assistance Telephone Support Line opens at the British Red Cross UK Office.

26 July:

- support at the temporary mortuary ends.

5 August:

- Assistance Website launched.

20 August:

- the Family Assistance Centre closes and moves to a smaller but longer term operation in premises in Westminster, renamed as the 7th July Assistance Centre.

26 August;

- the Telephone Support Line closes at British Red Cross UK Office and transfers to the 7th July Assistance Centre.

3. Psychosocial response

3.1 Family Assistance Centre

In the UK, emergency planning protocols dictate that, where practicable, uninjured survivors should be looked after at a Survivor Reception Centre. They also state that a Friends and Family Reception Centre should be created to provide a location where those seeking news of their loved ones may receive information. These centres were not established following the London bombings, for operational and specific reasons. The need to set up a Family Assistance Centre (FAC) was identified on 8 July, although there had been no pre-planning for this facility because the Guidance Document, which was in development, was still a draft document and not yet in the public domain, nor had it been seen by responders.

At the request of the Gold Co-ordinating Group on the evening of 8 July, the London Resilience Team convened a meeting of relevant partners. This meeting was chaired by the Chief Executive of Westminster Council and included: Westminster emergency staff, the Metropolitan Police, the British Red Cross, the London Resilience Team, and a liaison officer from the Civil Contingencies Secretariat of the Cabinet Office. The meeting designed the Family Assistance facility, and selected and inspected an initial venue (the Queen Mother Centre).

The Metropolitan Police and Westminster City Council then led the construction of the FAC and it was opened by the Government Culture Secretary, 14 hours later. This was the first time a FAC had been established in the UK. On 12 July, the FAC was significantly improved and relocated to better premises (the Royal Horticultural Hall) where it remained until 19 August when the centre moved to a smaller facility and renamed as 7th July Assistance Centre, in line with the reduced demand for its services.

The purpose of the FAC was to provide a:

- 'one stop shop' to enable those affected to gain information about family members or friends
- offer a range of facilities to enable families or survivors to make informed choices
- ensure a seamless multi-agency approach to providing support
- and help responders ensure that bereaved families, survivors and communities received coordinated, clear, compassionate and professional advice and assistance.

During the time the FAC was open, support was provided to over 600 visitors. In the initial period the FAC was fully staffed for 24 hours per day but this was reduced to 8am to 10pm, seven days a week. A small team of Police Family Liaison Officers and Local Authority Social Services Staff were present at all times the facility was open.

3.2 Resilience Mortuary (Temporary de-mountable structure)

The London Mass Fatality Plan had been prepared over a number of years under the aegis of a multi-agency planning group that included representatives of all the key relevant agencies. It was approved by the Forum in March 2005 and formally circulated to all stakeholders at the end of June, just days before the bombings.

After initial preparatory work by the London Resilience Team (LRT), the Plan was triggered by the coroners at noon on 7 July and the decision was taken to set up a 'Resilience Mortuary' (a demountable structure). A Mass Fatality Co-ordination Team was set up as required by the Plan, consisting of the three coroners involved, the Metropolitan Police Senior Investigating Officer and Senior Identification Manager, Westminster City Council (as lead council), the military, the Anti-Terrorist Branch, LRT, the Home Office and the contractors who were formally requested to construct the mortuary.

The Plan worked well. The coroners, police, local authorities, pathologists, LRT, Home Office, National Health Service, and others worked in close partnership to deliver a 'Resilience Mortuary' that was ready to receive deceased victims in 24 hours and fully functioning in 72 hours. An existing stockpile of £130,000 of mortuary equipment (purchased and stored by LRT and jointly funded by the Home Office and the British Airports Authority) proved invaluable in the rapid deployment of the mortuary. The mortuary included facilities for bereaved families to view their loved ones. The Salvation Army provided many valuable services at this facility.

Viewings were facilitated for 28 families and involved 120 people visiting the mortuary. Specilaised viewing areas were constructed with attention to the emotional, spiritual and physical needs of distressed families.

3.3 Disaster Fund

Preparation of a London Disaster Fund Plan was commissioned by the Forum and developed by the Greater London Authority (GLA) as part of the suite of plans prepared under the aegis of the London Resilience banner. The intention was to cover any emergency occurring in the London area and to avoid a situation of several competing funds being established. Legal arrangements for the Fund were developed by the GLA and arrangements for its practical administration were developed for the GLA by the British Red Cross.

The Forum's 7 July debrief found that the London Bombings Relief Charitable Fund had worked very efficiently and effectively, raising £11.5 million in all and making its first payments within two weeks of the bombings, and paying out £10.5 million by 6 July 2006.

3.4 Police Casualty Bureau

The Police Casualty Bureau is a telephone facility operated by the Police Service to collate information about casualties and record details from members of the public concerned about persons who may be involved. Ultimately the Casualty Bureau provides an information and enquiry service to the public and assists the Police Service and the Coroner to in the identification of victims process.

3.5 7th July Family Assistance Telephone Support Line

The need for a telephone support line to complement the FAC was recognised by both the Police Casualty Bureau and the FAC Management Team. The 7th July Family Assistance Helpline aimed to:

- assess callers' needs
- offer on-the-spot emotional support
- listen to concerns
- offer advice and practical support
- signpost callers to other organisations that could provide more in-depth assistance.

The British Red Cross was invited to provide this facility in association with the Voluntary Sector Civil Protection Forum. The line was opened at 2pm on 12 July (to coincide with the relocation of the FAC to

the new premises) and operated from the BRCS UK Office.
Partners who worked alongside the BRCS in staffing the line were drawn from other key volunteer agencies, including the Samaritans and the Salvation Army. In total 336 volunteers contributed 600 shifts on the support line, a total of approximately 2,700 hours. Volunteers were drawn from UK Office, London, the South East and South West of England and Wales. Police Family Liaison Officers were also present on all the shifts of the support line because of the terrorist nature of the incidents and the need to be able to refer callers with information that could assist victim identification or in reporting missing persons.
A total of 1,250 calls were received by the support line. The pattern of calls varied considerably from day to day and some shifts were busier than others. The highest number of calls was received one week after the bombings.

3.6 National Health Service

The National Institute for Clinical Excellence has produced guidance for Post-Traumatic Stress Disorder (www.nice.org), which recognizes that overall people are resilient and will recover from an event such as 7th July without long-term problems. However, for those whose symptoms do not subside over time, e.g. 2 months, they may require professional support. NHS London established the NHS Trauma Response Project to co-ordinate the establishment of a screening and treatment programme, drawing on resources from most of London's mental health trauma services.
Following the bombings, the Health Protection Agency (HPA) agreed with the Department of Health (DH) that a long-term health follow-up be established for those individuals at potential risk of delayed effects on their health. No prior protocol existed for such a follow-up in the UK so this process represented a pioneering activity. There is now a national protocol for the public health response to major incidents in the future.

4. Reviews

There were a number of reviews undertaken by Government and a range of organisations. In summary, they showed that London's responders and emergency plans were tested in extremely difficult circumstances and were shown to be effective. The overall multi-agency emergency response to the 7th July bombings had been very successful. The quick, professional and effective action at the scene of each of the bombings, enabled the situation to be contained and the potential additional loss of life and suffering considerably reduced. Planning and exercises had clearly paid great dividends. Co-operation and co-ordination between responders had been effective and there was a willingness to work through issues jointly to achieve a successful response. The events of 7th July did not exceed the capacity of the responding agencies to contain and deal with the situation. The response did provide an opportunity to identify areas that required further work to increase London's ability to deal with future emergencies on a similar, or greater scale.

4.1 - The London Resilience Forum Review particularly noted success in the following areas:

- Familiarity with roles and partners was evident
- The initial response by London Underground staff was exemplary – the result both of solid training and individual dedication and courage
- London Buses reacted quickly and effectively, by initially withdrawing services from central London and then maintaining staff morale in order to reinstate the network, other than in the incident areas, in time for the evening peak
- The emergency services' response was rapid and effective
- London emergency plans were successfully deployed including the London Emergency Services Liaison Panel (LESLP) Major Incident Plan, Operation Benbow (joint operation by London's police forces), and the London Command and Control Protocol, Local Authority Gold Protocol, First Alert Protocol, Public Information Plan, Mass Fatality Plan and Disaster Fund Plan

- Hospitals were rapidly made ready and reserve capacity identified. 1200 hospital beds were made ready in three hours
- Mutual aid arrangements worked well. London Fire Brigade and London Ambulance Service's mutual aid arrangements were successfully triggered. London Ambulance Service was also well supported by voluntary sector ambulances
- London Underground's evacuation procedures worked well. This was only the second evacuation of the entire network in living memory
- The 'Local Authority Gold' Protocol (under which one chief executive represents all 33 London local authorities at the Gold Co-ordinating Group) was successfully triggered and worked well. 'LA Gold' had an important role in co-ordinating the pan-London local authority response including providing advice to schools on 7 July, mobilising construction and staffing of the temporary mortuary, construction and staffing of the Family Assistance Centre, and co-ordination of flowers, tributes and books of condolence. Subsequently, 'LA Gold' ensured there were arrangements in place to manage the recovery period after the attacks
- The London Mass Fatality Plan worked well. The coroners, police, local authorities, pathologists and the London Resilience Team worked in close partnership to deliver a 'Resilience Mortuary' which was ready to receive deceased victims in 24 hours and fully functioning in 72 hours
- Although no pre-prepared plan existed, a number of agencies came together (police, local authorities, voluntary sector, London Resilience Team, National Health Service and Transport for London) to put rapidly in place a Family Assistance Centre
- Police and local authority arrangements for communication with minority communities worked well and community cohesion was maintained
- The Disaster Fund Plan was implemented as per the London Resilience plan and worked very efficiently. The London Bombings Relief Charitable Fund raised £11.5 m in all, made its first payments within two weeks of the bombings, and had paid out £10.5m by 6 July 2006. The Fund won an award for effectiveness and was also recognised for the excellent work it had done in making payments speedily to the victims of 7 July
- The debrief was extensive and, whilst confirming the successful activation of contingency plans, it also revealed a number of areas where further work and improvement were required. The Forum particularly noted the exhaustion of staff in the days following the bombings and agencies' concern about responding to a sustained bombing campaign. Individual agencies were already acting on the lessons identified in their own debriefs.

4.2 The London Assembly Report - was to identify lessons learnt from the events and aftermath of 7th July attacks, identify successes and failings and improvements, and ensure systems and communications were put in place to facilitate the best response to the needs of those caught up in an incident. The Committee's approach was to consider the 7th July response from the perspective of a member of the public caught up in the attacks and response rather than that of the emergency planners and responders themselves.

The report concluded that "Undoubtedly the emergency plans and exercises that had been put in place during the preceding months and years contributed to what was, in many respects, an outstanding response." It acknowledged that those responsible for co-ordinating the response on 7th July were faced with "a situation of extraordinary pressure, uncertainty and complexity" and the dangers of "twenty-twenty hindsight".

The report's main criticism of the 7th July response was a 'lack of consideration of individuals caught up in major or catastrophic incidents', the focus being on incidents rather than individuals, process rather than people. It suggested that plans should be recast from the perspective of the people involved rather than the emergency services.

Their key concerns:

a) the telecoms difficulties experienced by some responders;

b) serious London Ambulance Service difficulties with telecoms and supply of medical and other equipment;

c) a need for non emergency hospitals near an incident to be briefed;

d) improvements in communication to the media, public, business and schools;
e) improvements to the Family Assistance Centre arrangements; and
f) failure to look after uninjured survivors and collect their details.

5. Lessons learned and good practice

5.1 Family Assistance Centre

- The multi-agency debrief found that the word 'family' had been unhelpful and misleading, deterring some individuals from attending. In future the title should be 'Humanitarian Assistance Centre'
- It identified the need for formal guidance, a detailed London plan, and identification of suitable sites for Assistance Centres across the Capital
- A whole range of other improvements were identified, including information gathering, arrangements for running the centre, the range of assistance to be offered and expertise required, the roles of supporting agencies and the welfare of staff working at the centre, both during and in the weeks after the period of the operation
- A media and marketing strategy needs to be prepared with a pre-agreed budget to ensure that the existence of the centre is made as widely known as possible
- The FAC became known as the '7th July Assistance Centre' after considerable negative reaction in respect of the name 'Family Assistance Centre'. The centre was set-up for all those affected by the events of 7 July – in particular to relatives and friends of those who died, and survivors, whether or not physically injured
- It aimed to provide an integrated multi-agency response, in the form of a secure and private focal point for assistance from a range of professional and voluntary services. This was in addition to existing local support arrangements.

Key lessons drawn from the FAC delivery were to:
a) Define what the service will be and do:

- base strategy on the most updated research findings
- consider the service as a preventative health service
- make clear what the service will not or cannot do
- decide who can use the service
- don't pretend it is possible to be a 'one-stop-shop'
- become a familiar place
- provide a virtual drop-in centre
- be a safe space
- get the right building if there is a building
- have the administration, helpline, counseling and drop-in in one location
- a centre will be much more than a physical space
- provide a seamless or at least a joined-up service
- responsibility comes with referrals
- be responsive and flexible
- build up trust through being reliable
- introduce a call-back system
- complementary therapy eg massage and reflexology
- make suggestions and gentle offers of help
- keep your promises

b) Anticipate your clients' needs

- do not underestimate dear and loss of security but do not underestimate resilience
- many people will not seek nor ant mental health services

- take the care to those who need it – do not pathologies survivors
- remember access to PTSD and other treatment may be slow
- consider providing separate services for bereaved and survivors
- prepare for anger and blame
- don't underestimate practical needs
- symbols and signs are significant
- every individual affected has an individual response and journey to recovery
- some individuals will not need you
- remember vulnerability, children and young people.

c) Encourage self-help and reliance
d) Be informed and pass it on
e) Plan to close and publicise that
f) Seek feedback continuously
g) Work with partners
h) Recruit, train and retain resilient personnel
i) Manage volunteers as you would staff.

5.2 Resilience Mortuary

- The facilities provided for families visiting the mortuary to view their loved ones as part of their grieving (not for identification purposes which was completed through primary identification by scientific methods) were highly praised by expert visitors and faith leaders, but most importantly by the families themselves
- This important aspect of the plan benefited significantly from the services of The Salvation Army, whose dedication and hard work were important to the success of the Family Viewing Area in its role as the mortuary's principal public interface
- The role of the BRCS and volunteers was not altogether clear and some difficulties were experienced in trying to establish the contribution that they could make to complement the responsibilities of other partners. The needs at the mortuary highlighted the importance of developing more accomplished, skilled and divers volunteers who are able to offer the breadth and depth of support required
- The London Mass Fatality Plan had only just been circulated when the bombings took place and many at the Gold Co-ordinating Group and among local responders were unaware of the Plan. There is a strong need for wider dissemination of the Plan and for middle management in key organisations such as the police and local authorities to be aware of the plan
- The three coroners involved worked very closely and successfully together, despite the fact that there was no protocol to establish a lead coroner in a multi-site incident, or for coroners to work together, or for agreement on the location of a mortuary. Such procedures would be helpful and could avoid confusion in a future multi-sited emergency
- A need was identified for training and exercising of the Plan, particularly for the three police forces involved, Disaster Victim Identification and the local authorities.

5.3 7th July Family Assistance Telephone Support Line

- Much of the Support Line operation was highly successful and the logistical and operational arrangements were widely praised for their professionalism
- Some volunteers experienced frustration if they worked on shifts that were not very busy. It was very difficult to predict the pattern of demands on the Support Line and volunteers needed to understand the nature of the work
- The Support Line operated over an extended period and it was challenging to ensure adequate coverage of shifts over this duration

- Many of the considerations about the importance of recruiting, training and supporting suitable volunteers that rose around the FAC were also relevant to those working on the Support Line.

5.4 Assistance Website

- Westminster City Council led on the creation of an **Assistance Website** which went live on 5 August and launched on the 7 August, to coincide with the one month anniversary of the incidents
- The website was intended as an accessible, one stop source of information on support services available from all agencies.

5.5 Disaster Fund

- The Fund had been very successful in meeting its goals and should be considered as a model for other cities, counties and regions.

5.6 Casualty Bureau

- The Assembly report found that the Police Casualty Bureau was: set up too slowly because of an avoidable error, that the volume of calls could never have been coped with, that new technology now being put in place will enable calls to be redirected to bureaux outside London (NB this was already the case) and that more could have been done by explaining the purpose of the bureau through the media to limit the volume of calls
- Following the 7 July attacks the Metropolitan Police Service (MPS) has increased its capability to efficiently collate casualty information from receiving hospitals and from those persons affected who present themselves at designated survivor reception points. This has been done by securing portable systems for remote data collection, linked directly.

5.7 Survivor arrangements

- This was not an area specifically identified in the Forum's debrief beyond the need to widen and improve the facilities and information provided by the Assistance Centre
- The Assembly report points to a lack of planning for those survivors who were traumatised but uninjured
- Existing police practice is, wherever practicable, for uninjured survivors to be looked after at Survivor Reception Centres and for their details to be logged. Local authorities' role is to support the police by providing suitable premises near to the incident. Unfortunately on 7th July the pressure of events was such that this could not be done and priority was given to the rescue of the injured and (given the danger of further bombs) to evacuation of the sites
- The Family Assistance Centre which was set up on 9th July provided a great deal of assistance for both survivors and bereaved, but this was too late to provide the initial support and data gathering that would ideally have been provided
- London's police and other emergency services have, since 7th July, urgently reviewed existing protocols and practice. They have taken on board feedback from voluntary organisations such as Disaster Action, which have been in close contact with the survivors. They have also taken comments from their own Family Liaison Officers
- Survivors and the bereaved have been invited to meetings with Ministers at the Department of Culture Media and Sport (DCMS) and the Home Office. They have been consulted on their experience of 7th July and the support they received in the months that followed and their views have been fed into detailed planning
- The importance of, where possible, establishing immediate reception centres, the need to streamline the collection and sharing of survivors' personal data, and the value of getting basic information out to those affected quickly at the scene will be stressed in the guidance to be

issued by DCMS and ACPO. However, responders' ability to provide this number of facilities and level of support must be subject to the circumstances of the emergency and response. The first priority must always be saving life, the rescue and treatment of the seriously injured, and protection from further danger.

5.8 Voluntary Sector

- The debrief agreed that the London Regional Resilience Forum Voluntary Sector Sub-committee (which consists of the voluntary agencies involved in emergency response in London) should draw up a protocol to set out their potential roles in an emergency and their position on funding
- The voluntary agencies played a significant role. They responded to the incident sites, assisted at the temporary mortuary, set up and provided staff for the Support Helpline, set up First Aid Posts at main line stations, and provided personnel at the Police Casualty Bureau
- They played an important role in establishing and providing on-going support to the FAC (and subsequent 7th July Assistance Centre), working with Westminster City Council and the Metropolitan Police Service. The agencies provided invaluable expertise and assistance. Key voluntary sector organisations included the British Red Cross, the Salvation Army, St. John Ambulance, Disaster Action, Cruse Bereavement Care and Victim Support
- The various agencies had different funding expectations with some expecting (and needing) immediate reimbursement and others being opposed to funding as a point of principle.

5.9 General Lessons Learned

Sustainability

- Renewed training efforts to ensure each agency has a sufficient number of staff able to give service over a long period of time
- The exercise programme should capture additional personnel within responding organisations who could provide relief to staff, thereby sustaining the tempo of operations over prolonged periods of activity
- The exercise programme should also confirm the adequacy of training/refresher regimes
- Mutual aid arrangements should also be revisited to review the scope for additional assistance in a sustained response.

Communications

- While the telecommunications challenges presented difficulties, they did not significantly affect the emergency services' ability to respond effectively.
- Overdependence on mobile phones: On 7 July the mobile telephone networks did not crash but were heavily congested and users had extreme difficulty making calls. (If the operators had not managed the situation the effects would have been far worse). This made it impossible to establish reliable communications between mobile telephone users which had ramifications throughout the whole of the multi-agency response
- Responders' overdependence on mobile phones raised major concerns. While this related mainly to managers (most front-line operatives of responding agencies used radios), there was nevertheless some reliance on mobile phones by frontline staff
- The public relies heavily on mobile telephones as their primary means of communication and would want to use them in a crisis to reassure family and friends
- The mobile network was vital for public reassurance, but there was a need to educate the public to be disciplined in using their phones in a crisis (for example, use text messages to be brief, only use mobile phones for essential purposes, only make short calls to establish people's safety, then stay off the network).

Warning and informing the public

- Media coverage during the morning of 7 July was synchronised by the Media Cell with the key

messages that were being given. The initial messages, including the key message to avoid travelling if possible, were successfully relayed to the public by the media. However, despite a steady flow of press conferences and briefings subsequent information was not always used as effectively

- In the afternoon some confusion arose over messages about the status of the transport system. In particular, it became evident that the media were continuing to use out of date information as if it were live, which created a misleading impression. As a result the message that the public should begin their journeys home was only conveyed in a very patchy manner
- Press officer support had been provided to the Incident Coroner and briefing had been provided on the complexity of the victim identification process but only in response to media concern
- Significant problems had occurred with the international media at some hospitals and action (including, if possible protocols) was required to encourage foreign media to use the media centre in future, and not gather at hospitals
- The media cell had succeeded in delivering a broad range of messages to the media and public but the debrief identified the need to pre-plan cascade routes, so that in future specific information can be targeted at different sections of the public (for example to local residents, commuters, minority communities, employers, schools, and off duty responders such as transport and emergency service staff).

Red Cross comment

- Staff and volunteers were involved in highly demanding activity and worked extremely hard over an extended period of time
- A great deal was learned in terms of working with partners and developing an emergency response offer, building on guidance on humanitarian assistance in emergencies
- This development would have to be contingent on the demonstrated credibility and competence of the organisation
- At the heart of the challenge is the need to ensure that properly trained, skilled, organised and supported volunteers are ready to meet the practical and emotional needs of people in emergencies whether at UK, national, regional or local levels.

British Red Cross psychosocial support team responses from 2008 - 2010

Event type: Diverse events abroad
Place of the event: Bahrain, Mumbai, Haiti Madeira
Date of the event: 2006, 2008, 2010, 2010
Event characteristics: Capsize of a dhow in Bahrain, terrorist attacks in Mumbai, multiple earthquakes in Haiti, mudslides in Madeira
Length of the PSS-Interventions: acute, midterm, longterm
Experts Organisation: British Red Cross
Experts Position: Head of psychosocial support

Description of the Events

In 2010 a piece of research was undertaken which aimed to find out from people who had been assisted by the British Red Cross' Psychosocial Support Team, whether the support they had received had been beneficial. The researcher contacted those who had received support following a number of events, and subsequently interviewed people involved in the following events:

- The capsize of a dhow in Bahrain 2006;
- Terrorist attacks in Mumbai 2008;
- Multiple earthquakes in Haiti 2010
- Mudslides in Madeira 2010.

Who responded?

In 2002, the UK's Foreign and Commonwealth Office (FCO) established Rapid Deployment Teams (RDTs) to provide prompt and effective assistance to UK nationals in the event of a major incident abroad. From 2005 (following the South-East Asian tsunami), Psychosocial Support Teams (PSTs) from the British Red Cross were deployed as part of the RDTs to work with individuals to strengthen safety, normalise responses and facilitate information sharing and coping. They were also used to provide consultation to promote prevention and early intervention.

The PSTs were formed of members of the British Red Cross with experience of delivering psychosocial support to people in crisis, as well as psychosocial professionals such as clinical psychologists and social workers. A robust recruitment process was established together with an induction which covered psychosocial skills, first aid, security and health and safety. Members of the PST were then required to attend annual update weekends, usually involving large role plays with actors.

How was the response organized?

Following the above events, members of the British Red Cross' PST were deployed as part of the RDTs to go out to Bahrain, Mumbai, Haiti and Madeira in support of the consular officers within the RDTs and to deliver psychosocial support to British Nationals affected by the events. The following sections are taken from the piece of qualitative research conducted with those who the PST supported at each of these events.

The strong points

Overall, participants were very positive about their experience of the service they received from the PST, both in terms of the support they received and their overall experience of dealing with them. There was a high level of consensus between participants in terms of their experiences and the aspects they found to be particularly useful.

Participants' needs varied according to their situation and the support provided by the PST was reported to reflect these individual needs and served to emphasise the importance of tailoring their response to the individuals with whom they are working.

The aspects participants reported finding particularly useful were:

> The PST being *"clued up"* – that is their preparedness, awareness of the context in which incidents took place, their knowledge and experience of dealing with matters abroad. Also of significance was the fact that the PST members usually came from the same country as those they were assisting and therefore were able to communicate with ease with them, as well as understand their cultural context.
> The PST's actual presence – participants reported finding their presence reassuring and valued being looked for, located and not being forgotten. They also valued the consistency the PST provided; knowing someone was there for them in the almost immediate aftermath of the incident.
> The holistic approach taken by the PST– that is the concern they showed for the "bigger picture" as well as the different types of support they provided including both practical and emotional.
> Being followed up – especially in relation to feeling that the PST's involvement was more than just a one-off visit and that they were not subsequently forgotten.

The lessons learnt

A number of recommendations for practice were made, including for psychosocial personnel to:

> Provide participants with information and support regarding dealing with the media both whilst abroad and once they are home.
> Repeat introductions to those receiving support to ensure that the people they are supporting know who they are being supported by.
> Provide people with the required practical resources, e.g. toiletries.
> Provide contact information that is relevant to the country where those being supported will remain.
> Signpost people to a point of contact and/or additional support services they can access following the current psychosocial support ending.

The findings from this study suggested that the PST were being effective in providing psychosocial support to individuals following their involvement in a major incident abroad.

Conclusion and recommendations for further programmes

The findings from the study highlighted the importance of the PST and the benefits for participants of psychosocial support being provided in the immediate hours, days and weeks following being involved in the major incidents. The research focused on exploring people's experiences and on furthering an understanding about what is valued and what was not experienced as useful in relation to such a service.
It is recommended that the service continues to be developed in line with the latest guidelines and evidence, whether this is practice or research based. It is hoped that this study highlights the benefits of seeking beneficiary feedback and that this could be done on a more regular basis, in order that practice can continue to be informed by what beneficiaries report as finding useful or otherwise. The British Red Cross should also consider having beneficiaries to consult to in the development of the service.
Where governments send out consular teams to respond to the needs of their population, National Societies may wish to offer their governments this type of resource. It should be noted however, that when the BRC does act in support of the UK government in this way, the PST do not wear the Red Cross emblem in order to avoid any confusion with either the local National Society, the IFRC or ICRC

Furthermore, the National Society is always contacted about such deployments, as well as the IFRC and ICRC if they are active in the same region as the response.

Financial crisis 2008 in Iceland

Event type: Economical crisis
Place of the event: Iceland – on a national level
Date of the event: Autums 2008
Event characteristicsf: No casulaties but thousands affected economically. Thus direct financial damage to livelihood and from that much resources loss for thousands of people. Approximately 40.000 people badly affected. This was 1/8 th of the whole nation.
Length of the PSS-Interventions: acute and longterm
Experts Organisation: Icelandic Red Cross
Experts Position: Psychosocial Crisis Manager

Description

In the autumn of 2008 the people of Iceland was the first country to be hit gravely by the global financial crisis. Iceland was critically hit practically overnight as the economy of the country broke down. In the space of just a few short days, Iceland's three biggest commercial banks crashed and went into receivership. The bubble which seemed like it could expand forever simply burst.
The country's payment system teetered on the edge of collapse. A population accustomed to easy credit for anything from groceries to luxury cars faced the very real threat of being unable to use its plastic cards for anything, even cash was in short supply.

Iceland's external debt at the time was 50 billion euro – for a population of just 315,000. More than 80 per cent of the debt was caused and held by the banking sector. In comparison, Iceland's gross domestic product in 2007 was 8.5 billion euro.
On 6 October 2008, the Icelandic parliament rushed through emergency legislation giving the government unprecedented powers over the banks and the running of the economy.
On the night of 8 October, the Icelandic Central Bank gave up and abandoned the Icelandic Krona. The Krona sunk like a rock in water well over 100%, and trading of the currency was practically halted. The next morning many affluent Icelanders, loaded with foreign currency loans, woke up poor and bewildered.

Who responded?

The Icelandic Red Cross contacted other Nordic National Societies for advice. They too had responded to severe economic crises in their own countries during the 90s. It also looked at its own capacity in the light of the reality, compared it with the assistance other agencies and organisations were providing and eventually decided to focus on psychosocial support.
Icelandic Red Cross quickly realized that instead of anything resembling a financial 'collapse', this was a large scale disaster of historic proportions traumatizing the whole population. Because of this, the Icelandic Red Cross switched to full blown disaster mode.
The 24-hour Red Cross Helpline, 1717, had to be strengthen because it was ringing red hot with calls from people who probably never in their wildest imagination had thought of calling for help. The number of calls soon more than doubled and stayed that way for about one and a half year.
The Icelandic Red Cross embarked on several new programmes catering for new groups of people affected. Many of them were well educated people like architects, engineers and people in the computer buissiness. Many of those who almost overnight found themselves unemployed. These were people facing financial ruin and individuals living through a daylight nightmare of deep anxiety were also included.
A series of television spots, where the Red Cross psychologists discussed trauma and how to deal with it, were produced and aired, on prime time, on the country's main state run television station.

How was the response organized?

In Iceland, the role of the Red Cross within the civil protection system during possible disasters is clearly defined and it was decided to respond to the economic crisis by the same means, basing actions on the disaster response expertise of the National Society.
In March 2009 they opened a mass gathering centre in the capital Reykjavik where people were provided with psychosocial support and counseling. The centre started recreational programmes such as a venue for diverse social activities, great variety of workshops and seminars, access to computers, a coffee corner, magazines, books and a playground for the children, so that the unemployed could set up a schedule for their days and fill the void. Support and counselling for individuals and families was offered for free both from special trained volunteer and proffesionals. Financial counselling was an important element, as well as providing information on people's rights and assistance available with the existing social security network. After initial success in Reykjavik, these programmes were rolled out to other branches. A strong emphasis was put on volunteering, and volunteers took care of daily chores and played a decisive role in peer support, whereas paid programme managers were hired to coordinate these centres.

Icelandic Red Cross also worked closely with authorities in the fields of unemployment and welfare for vulnerable groups. One of the programmes included three months of one-on-one mentor support for socially excluded unemployed people. An agreement with the authorities addressed social isolation and over-dependence on welfare systems trying to activate jobless people. Icelandic Red Cross made a contract with the Directorate of Labour and had a representative in the so-called Welfare Watch, a committee that was established by the Ministry of Welfare and remains active even today. A special programme was designed for young unemployed and free-of-charge summer activities were offered to parents who could no longer afford recreational summer holiday activities for their children. Many companies, organisations and government agencies could offer free access to various recreation. Red Cross volunteers gather information about all these activities and filed them in a binder that was kept in the Centre for visitors to look in to.
Icelandic Red Cross has now switched back into normal mode. The strategy was to respond as the organisation would to a sudden disaster but as time has passed, this has become a normalized situation.

What were the strong points

The Red Cross used its knowledge and experience in disaster response to meet this economic crises Iceland was facing. That meant going in to emergency preparedness mode, tending basic needs, psychosocial needs and opening a centre. So it was not necessary to invent something new and unfamiliar.
This initiative that the Red Cross took got wide support both from the authorities and the public. People throughout the country was very well aware of what the Red Cross was doing.
The intervention carried out by the Red Cross seemed to meet the needs. Having a centre like the Red Cross house which provided information, consultation and recreation was well received.
Red Cross branches throughout the country where able to use the same ideology and open their own Centre but less extent.
Recruiting new volunteers was easier than we thought.
All actions taken, involved volunteers so they found them self's as a big part of the actions.
Red Cross was facing a strange but a happy dilemma. Once the volunteers had been trained and started working as such, they seem to find it easier to get a new job. So the turnover of volunteers was great.
When the Red Cross input was no longer needed it pulled out. Referred those who were still coming to the Centre to services managed by the government or the communities.

What were the lessons learnt (weak points)

More aid could have come from the govurenment in form of donations which could have been used in producing more material such as leaflets, tv-programmes etc.

Red Cross could have reach out to more people by having presentations in companies, on the radio and in television.
Today the Icelandic Red Cross is officially responsible for psychosocial support following crisis and disasters. That would have helped when Iceland was going through the economic crisis. Then the Red Cross would have had more oversight over actions that were put in place by other parties and managed them better.

Conclusion and recommendations for further programmes

In the meantime, the economic crisis has left the Icelandic Red Cross with dwindling revenues and the challenge of adjusting to the new reality. It is clear that the experience and knowledge of IcRC in response to different kind of disasters proved useful in the financial crisis.
It was a right decision to open the Red Cross House as an aid to affected people because it met needs. It might even have been better if it had opend earlier.
It is important that there is an exit strategy from the beginning. The Red Cross House is a programme that is not supposed to last for ever. It should be clear that the Red Cross will refear people who have been visiting the RCH to appropriate organisations.
Today, authorities in Iceland have signed an agreement with the Icelandic Red Cross to have a leading role in the psychological support regarding disasters. It is important for the IcRC to have a as accurate information as possible from beginning to give to the authorities about what is needed in order to implement PS in different disasters. These information are e.g. on personnel, funds and for how long time it is neccessary to run the programme. This would be helpful for the authorities when deciding how much funding is needed.

Flooding 2009 in United Kingdom

Event type: Flooding
Place of the event: Cumbria UK
Date of the event: 2009
Event characteristics: A record 314.4mm of rain fell in 24 hours - the heaviest rainfall ever recorded in the U.K. This led to significant flooding in the Cockermouth and Keswick areas.
Length of the PSS-Interventions: acute, midterm, longterm
Experts Organisation: British Red Cross
Experts Position: Head of psychosocial support

Description of the Event

Britain's Meteorological Office stated that in mid-November 2009, a record 314.4mm of rain fell in 24 hours - the heaviest rainfall ever recorded in the U.K. This led to significant flooding in the Cockermouth and Keswick areas. Emergency services said that more than 200 people were rescued in Cockermouth, and at least 996 homes were flooded after a day of unprecedented rain. A Major Incident was declared by the statutory authorities at 2pm on Thursday 19th November 2009.

The information in this document is taken from a formal evaluation report, conducted by people not involved in the emergency response, which was published in May 2010.

Who responded?

During the response, and then immediately afterwards, the Red Cross were asked to:

- Provide welfare personnel for rest centres in Keswick and Cockermouth.
- Co-ordinate offers of accommodation for non-vulnerable people not over 75 years (the local authority cared for the over 75 year olds).
- Facilitate the supply of water and clothing to those involved in the incident
- Provide dry clothes.
- Organise food deliveries.
- Provide torches and lanterns, with batteries.
- Provide first aiders for rest centres.
- Register people affected by the incident.

Following the response, BRC was asked to join the Welfare Group (a sub group of the Major Recovery Group). This group was run by the local authority. Recovery work started on 21st November 2009, and focussed on:

- Collecting information on vulnerable people.
- Leafleting.
- Providing empathy.
- Signposting people to other agencies and resources.
- Tracking dependencies - i.e. when one situation causes another.

How was the response organized?

The rest centres were managed by staff from the local authorities and Red Cross worked with local voluntary groups to ensure that those within them had the necessary resources. BRC fundraising staff worked with various large retailers (who the Red Cross already had links with) to obtain socks, blankets and clothing for the rest centres. Mutual aid was activated to get 200 clothing packs from Leicester. Red Cross personnel also got involved in the local response by opening the local Red Cross shop so that people could get dry clothing.

The Red Cross, in conjunction with the RNLI, Mountain Rescue and Fire and Rescue Service rescued 200 people and searched 929 properties. The ambulance teams assisted 30 people, and the 2 rest centres in Cockermouth assisted 194 people. The flood information centres registered 302 people within the first 2 weeks of the incident.

The psychosocial support response was provided by trained personnel from BRC's first aid and therapeutic care services, and took place mostly in the rest centres. Staff and volunteers had received training in a variety of psychosocial skills including listening with empathy and enabling and resourcing people to support their coping using the BRC's CALMER framework and training courses (see Davidson, 2010 for further details).

The work of the Red Cross was reported extensively in the national, regional and local media. Approximately 76 pieces of coverage were generated, reaching an audience estimated to be circa 4million people.

The strong points

The BRC built on the relationships forged before and during the emergency – particularly those with the voluntary agencies who worked with the Red Cross in the Cockermouth Rest Centres. Staff and volunteers were brought in from neighbouring BRC Areas (through a process known as mutual aid) in order to meet the needs. BRC registered over 800 persons who needed support during the recovery phase.

By undertaking a range of roles in this emergency the BRC were able to deliver, for some people, what effectively became a continuous care programme starting with their evacuation, then being transported by ambulance, being looked after in the rest centre and then having support through the recovery. The involvement of the Red Cross in all these stages meant that there were more opportunities to identify vulnerable people who needed help.

The view expressed by a member of one of the voluntary agencies that worked alongside the Red Cross in the rest centre was that: *"they were lovely people who really made a difference, obviously knew what to do and just got on with things. They worked well with everybody else who were involved and were really good at listening to people who had been evacuated."*

Welfare Arrangements for volunteers and staff worked well. All personnel being deployed were given a pre deployment briefing – face to face if possible, or over the phone. This briefing included outlining risks and covering health and safety issues and was supported by information sheets (deployment action cards) where appropriate.

Personnel for the rest centres and ambulance work were generally deployed in groups, who travelled together, and who were given vehicles that were fully fuelled. "Safe" fuel stations were identified and personnel advised to not travel with less than ½ a tank of fuel. Accommodation etc was organised partly by command and control admin support and in the initial stages by staff on the scene. Admin support was a key element to the management and deployment of these responders.

Safe muster points were identified to get people together to travel as a team. It was felt that travelling together built team spirit, and that when the personnel arrived they looked better than them straggling in as individuals. Only liveried vehicles were used – this helped the responders gain access to the affected Area.

The formal evaluation noted that the range of ways that the Red Cross personnel helped showed an innovative approach and a good understanding of what can be called upon.

The lessons learnt

During the period of the emergency response, in addition to their normal workload the BRC were supporting the statutory services with other routine and emergency work. Staff did not take a break after the response, and continued to work on into the recovery phase. Whilst they noted some pressure from the additional workload, they were supported by the management, who ensured that problems and issues were resolved on an on-going basis. The small size of the management team and the fact that they were all based in the same office appeared to be a key factor in this being an effective way to

monitor how staff coped with making sense of what they were involved in, and how they reacted to the increased workload pressures. This approach is illustrated by the manager spending time talking about the response and recovery work, allowing people to talk about things in an informal way, whilst she looks out for any signs of stress/anxiety. However, it should be noted that there may be times when external support is required from those who are not directly involved, and time off should be facilitated.

It was useful to follow up on issues raised in debriefs with something to say about what the resolution of the issue was. This is helpful enabling closure, and debriefing and diffusing skills should be part of the skills training given to personnel

Conclusion and recommendations for further programmes

This emergency response incorporated ambulance support and rest centres. Being deployed in advance of the situation made a big impact on the effectiveness of what BRC could do. The use of mutual aid to supplement the resources in the Area worked very well. In addition, early involvement in the recovery stage, and the experience that the BRC could offer, has enabled BRC to advocate on behalf of those affected and ensure that the welfare programme developed by the local authority is robust and addresses the needs of those affected both in the short term and also the medium and long term.

Flooding 2013 in Austria

Event type: Flooding
Place of the event: Austria
Date of the event: 01.06.2013
Event characteristics:

- **no casualties;**
- **damage: 340 houses, 30-40 enterprises, 80-100.000.000€ damage;**
- **500 affected people;**
- **Support for helpers: each evening the head of operation was present for the helpers and held a final meeting with food and drinks, were the evening could be started and one could talk about the events of the day (demobilization) These meetings lasted for 1 and a half months and were extremely important.**

Length of the PSS-Interventions: acute, midterm
Experts Organisation: Red Cross
Experts Position: Psychosocial Crisis Manager

Description
Warning of severe rainfall. Followed by severe increase of rivers and flooding. The village that has been affected most (ca. 2.500-3.000 inhabiltants) was not part of the so declared crisis area. During the night rainfall was above 100 l and many landslides and floodings of streets lead to a situation where the village could not be reached any more from the outside.
A natural hole in a rock where the river which is around 10m broad leads to a narrowing of the river at around 3m. This narrow hole was the critical point where a severe amount of water was held back and led to the disaster.
At around 1 o clock in the morning the officer in the sewage disposal facility gave alarm because the water was getting to high, firefighters and water rescue saw what had happened and immediately started to evacuate. About 100 houses had to be evacuated immediately and without any prior warning. Time frame 2 hours. No more power, no telephone, no mobile phones, no internet. Some people did not want to go, for example one marriage party had tob e evacuated by the police. Older person who could not walk.
2 evacuation centres on both sides of the river (hotel, gymnastic hall)
One part of the village was totally flooded (in total 340 houses and 30-40 enterprises. Firefighters station in the flooded area.
One day after the event the water sank and on day two the center of the village could be reached again. On day two some parts of the village had power again.
On day 4 streets were open again and the village could be reached from the outside.
damage

- 340 houses
- 30-40 enterprises (carpenter, car shop…)
- 80-100.000.000€ damage

Who responded?

- 200 firefighters
- 150 soldiers
- 80 Red Cross Personnel

How was the response organized?

- **Evacuation**

All affected persons were brought into two evacuation centres: gymnasstic hall, hotel (200 gym hall, 50 hotel) all people could find private places to stay overnight so no rest centre had tob e built up.

- Command staff (village) and command staff (resion) start planning next steps.
- Opening of a reception centre (day two) for giving out food and information to the affected in the gym hall. Also medical support was available there. There were showers and toilets available.
- The reception centre was the only place where people could get food and water (the only shop was flooded). The gym hall was beside an old people´s home, the kitchen of the home could be used in oart. Part of the cookig had to be done by red cross.
    - 500 affected people (who were first there because evacuated and then worked on their houses during the day and had tob e given food)
    - 200 firefighters
    - 150 soldiers
    - 80 Red Cross Personnel
- Also the restraurants who were near the gym hall had tob e integrated in the cooking. From 08:00-21:00 the reception centre was open each day.
- Reception centre was coordinated by Red Cross

Good planning and logistics/coordination were necessary for food storage and cooking as well as eating places and order. Also donations (clothing etc.) was stored in the reception centre. One person had tob e named who coordinated only the donations which were coming in. For one month the reception centre was active afterwards it was decreased gradually.

- Water was distributed first directly at the site where people worked and later in the centre.
    - First step: no more transport of water to the site, people had to come and get the wate rat the centre.
    - Step two: no more breakfast in the centre and no more dinner - just lunch (food store had opened again)
    - Step three: no more food at centre only drinks (just to get rid of storage)
- **Logictic centre**

uncontrolled donations (clothing, shovels**..**in an old gym hall of school building. Extreme high need for peronnel and logistics: controlling, sorting through,… in the beginning people did not need clothing, more need was for shovels and working gloves. Then people needed clothing and cleaning materials. Washing machines were needed very much. Also cutout switches for current.

- The logistics centre was open for a longer time than the food providance**.** Also the liogistic centre was taken down gradually (opeining hours, only in the evening, then on demand)
- Two heads of operation (one day each in irder to give hem breaks)

Psychosocial Interventions

- Psychosocial interventions integrated into general support approach: Head of PP support invoved from the very beginning
    - PSS in combination with distribution of goods
    - PSS had the chance to go out and give the donation appropation formst for immediate financial support by Red Cross. This made the contact very easy and helped also when doing a first needs assessment.
    - PSS at critical places
    - From day two PSS was actively involved in the receptioncentre, in the logistics centre, in the red cross office, in the operation centre and iat the site when distributing food, water.
    - PSS assessment of needs
    - From day three on the donation forms were filled out and during this task PSS personnel made a first needs assessment using an evaluation form: what do you need most at the present moment? One question was about the amount of damage to the beneficiaries´properties the other about the most urgend need. Additionally we asked about the kind of help that was needed for example with shoveling, cleaning up the cellar etc. etc.)

  - Based on the needs assessment the PSS operation was planned one week ahead. Each evening the evaluation forms were controlled and a plan for the next day was done including PSS and other forms of support for the affected families. Volunteers were thus organised according to needs.
  - Each day three mobile pss teams were visititng the sites for around one week.
- PSS as extra intervention: after 6 to 7 days, after the first realisation phase people started to need psychosocial interventions as such (not integrated into other forms of support) during week two and three pss teams wer called rather often. Afterwards needs went down again.
- PSS team consisted of 24 persons, working according to an action plan with enough resting time for the teams (2 people) On weekkends a team from another resgion helped out.
- In the reception center the red cross was situated directly beside the entrance: medical support was done there, as the offices oft he doctors were flooded they held their office hours in the red cross office at the reception centre. Medical support was given from 8 to 12 each day.
- Information point in the reception centre: an infrmation board with informations wasset up, every four days also the authorities put up an information board both in the reception vcentre and in the logistic centre.
- Information meetings: two weeks after the event an information meeting was held with around 1000 people present. Information was given on all relevant topics ba´y the major, the geologist, the insurances, the banks, the disaster fund and PSS. Each oif these people was allowed to speak fort he whole areá (especially important in insurances and banks). Frequently asked questions were collected ahead and after the presentation of each topic questions were taken from the audience.
- Kindergarden on weekends: On the weekends kindergarden ws opened in ordert o give parents the chance to have some free time for cleaning and building. Kindergarden experts were brought in from other regions in order to allow breaks for the local kindergarden personnel. Regular school and kindergarden was open from day two.
- Peer support: helpers worked from 8 a.m. to 6 p.m. Head of operation: each evening the head of operation was present for the helpers and held a final meeting with food and drinks, were the evening could be started and one could talk about the events of the day (demobilization) These meetings lasted for 1 and a half months and were extremely important.
- Drawings from the children with a thank you were shown to them at the food point and posters were made out of these drawings and set up in the town hall.
- 6 weeks after the event a thank you party was organised for all 170 helpers and everybody got a thank you certificate.

Costs/Funding

Two different aspects regarding financial issues in disaters have to be considered:

1) Direct financing in case of disasters
2) A preventive aspect, i.e. financing the formation of a psychosocial network and training of psychosocial professionals in the network

1) Financing in case of diasters

In Austria financing is dependent from declaring a state of catastrophe/emergency, i.e. the major, governor etc. declare a state of emergency from the political side which consequently leads to financing the operation by using the disaster funds from that moment on. The disaster fund includes money that a country or nation has to cover costs in case of disasters; this can also vary depending on the impact of the disaster.

In a concrete case, an organisation (e.g. the Red Cross) pre-finances all costs and after the operation the nation gets the expenses reimbursed. The particular organisation covers all costs for smaller operations or when a state of emergency is not declared

Food or beverage donations can also partly cover meals for relief forces. In terms of donation it should be stated that the impact of the disaster plays a vital role for donations. During and after the flooding in this case example a large amount of donations were given; the disaster situation affected a manageable small area and neibourghing municipalities gave a lot of donations. For example the flooding in Upper Austria covered a larger area, but comparably less donations were available. Infrastructure (bigger firms etc.) in proximity were still in good order, a circumstance that is not present when larger areas are affected and then, naturally, the supply will be more difficult and also more expensive.
Operation for 2-3 days are not such a big expense, financially speaking, but after some days the financial aspect becomes more central.
Regarding financial aspects, financing psychosocial support in flooding only needs a comparatively very little amount of money. The estimation in this case would be that the ARC needed about 0.-1% of the expenses used for the whole operation. In psychosocial support we hardly any equipment for relief forces is needed compared to other tasks or at night usually no human resources are needed. The psychosocial support in disasters represent a very, very important aspect for the affected population and entails hardly any costs.

2) Financing the formation and training of a psychosocial network

In our case (Austria) financing the formation of a psychosocial network that is especially needed in case of catastrophes, has to be looked at separately. Because in this case the financing has to be covered by the organisation (ARC) in preparation to the events. To be prepared in the psychosocial area when disaster strikes, about 20 psychosocial professionals should be trained for about 60.-70.000 inhabitants. Our estimation for the costs of such a psychosocial professional regarding training etc. is about 1.000€. Thereafter the costs for this small area are about 300-400€/person/year. Equipment, infrastructure etc. are provided by the organisation. As already mentioned the psychosocial area needs only little money compared to other areas. Naturally speaking, relief forces also from different organisations should be taken care of and a peer-system should be established. In Austria the Red cross has a total of 1200 volunteers and staff continuously active in PSS and this is a rather high amount of money that is only partly covered by governments and donations.

What were the lessons learnt (weak points) according to your opinion? (Problems/Challenges)

- **Disaster alarm**: Sirens worked but no communication between disposal centre and radio station no alarm information could get out to the population.
- **Power cut off**. No more internet no telephone, no digital radio only the old systems worked.
- **Risky Rescue Operation:** Water damaged door and windows, so the danger was there that windows and doors could explode and water could have come in in a flush. Very risky and difficult for the firefighters who never knew if they went into a house one way if they coudl get out the same way.
- **Contamination of the water:** Many oil tanks were destroyed, oil in the water everywhere. Pumping works had to be supervised by special expert teams.
- **Extreme amount of garbage**: intermediate depots had tob e set up on parking spaces.
- **Political challenges**: Military was there but could only be sent on day two because first the firefighters had tob e sent in before military could be used officially.
- **Fire department** under water.
- **Uncontrolled Donations**: Extreme amount of donatons coming in, limit of storing capabilities were soon reached.

School Shooting 2008 in Finland (Kauhajoki school shooting)

Event type: School Shooting
Place of the event: Seinäjoki University of Applied Science in Western Finland
Date of the event: 23th September 2008
Length of the PSS-Interventions: acute and midterm
Experts Organisation: Finnish Red Cross
Experts Position: Head of Psychosocial Support and Mental Health

Description
The Kauhajoki school shooting occurred on 23 September 2008, at Seinäjoki University of Applied Science in Western Finland. The gunman, a student of the school shot and fatally injured ten people before turning the gun upon himself. The perpetrator carried fuel with him which he used to start several fires in the building. There were about 260 students at the school. Need for psychosocial support caused by the incident was considerable.

Who responded and how was PSS response organised?
Crisis management was immediately initiated under the lead of the local health centre's chief physician and specialised emergency psychiatrist. On the day of the event, immediate crisis management was carried out by municipal public health nurses, social workers, local crisis teams, and volunteers of the Finnish Red Cross. Crisis psychologists of the Seinäjoki Central Hospital also provided expert assistance immediately on the day of the event. The day after the event, a psychosocial first aid team was set up by the South Ostrobothnia Health Care District. Members of FRC's preparedness group of psychologists arranged class-specific debriefings for the school's students in co-operation with local operators during the week of the event. Church workers also initiated assistance measures quickly. For example, youth workers and volunteers of the Red Cross kept youth centres open.

After the immediate crisis management efforts, after-care was organised by the Kauhajoki project managed by the Seinäjoki Central Hospital. A Kauhajoki work group coordinated the care activities throughout the autumn of 2008. Student support measures were implemented in close co-operation with the management and personnel of the Joint Municipal Authority for Education in such a way that the services were closely integrated into regular academic work. Both the University and the Kauhajoki project recruited additional employees to focus on student welfare services and support for University staff. The psychosocial after-care was implemented in phases. Preparations were made for events that were likely to trigger crisis reactions (such as returning to the renovated building, releasing the pre-trial investigation material, anniversaries), and additional support measures and staff members were deployed according to needs. Psychosocial support was offered at individual, class and community level. The support focused on psychoeducation about the normal reactions caused by such crises, as well as calming methods, relaxing and other forms of self-care. The goal was to reinforce feelings of coping and belonging, and understanding of the fact that even strong reactions are understandable and remedies are available for disturbing symptoms. The threshold for getting help was kept as low as possible. Regular scanning methods were also used to reach students with possible post-traumatic symptoms, and personal trauma-focused discussions and psychotherapy sessions were provided for those who needed them. Professionally managed peer support sessions were arranged for the victims' families, the most severely exposed students and their families, as well as the family of the perpetrator. Active after-care measures at the University continued with a planned gradual decrease in resources until the end of 2010. The main responsibility for identifying any delayed traumatic symptoms and providing the required support has been shifted back to the basic health care and student welfare services. Some ongoing courses of psychotherapy, practical psychotherapy arrangements and care need assessments were completed within the Kauhajoki Project in 2011 (Ala-aho and Turunen 2011).

The role of the Red Cross was to support public authorities.

The Red Cross's contribution

- The Red Cross had two public psychosocial support points manned with volunteers.
- Red Cross volunteers supported public authorities in providing psychological support at the Kauhajoki Youth Centre (6 days) and in parents' events.
- Volunteers answered the health centre's service phone and worked as assisting receptionists at the health centre.
- Street patrols – low threshold, "eyes and ears", creating feelings of safety
- Members of the preparedness group of psychologists participated in supporting the local crisis team
- The Red Cross established a telephone Helpline (3 days, 30 volunteers and 7 members of the psychologists' preparedness group)
- Members of the preparedness group of psychologists compiled information releases and contributed to the provision of public support through the media
- Instructions published online: "Toiminta kouluissa" (Activities to take at schools) and instructions on arranging a crisis session at school.
    - A total of 160 volunteers participated in the aid work at the site and 30 volunteered for the Helpline service. Many volunteers participated in multiple activities. The largest number of preparedness group psychologists simultaneously present and participating in the planning and implementation of crisis management was 13. The preparedness group of psychologists was actively involved in crisis management between 23 September and 9 October 2008.
    - Volunteers came from several different Red Cross departments, and a lot of attention was paid to their well-being: debriefings were arranged before they went home after their tasks, and further debriefing sessions took place later.
    - The Red Cross had a representative in the after-care steering group, and local-level co-operation was also conducted. The Red Cross organised a money collection with regard to the Kauhajoki school shooting. Funds allocated to Kauhajoki from the Red Cross Disaster Relief Fund were used to support recovery in the school community: re-decorating the burned class, setting up a memorial stone in the schoolyard, preventive activities and targeted youth work.
    - Employees of the Vaasa office of Victim Support Finland participated in supporting both the families of the victims and the volunteer workers. The presence of Victim Support was deemed necessary especially during the first moments and days immediately after the shooting. The Victim Support representatives had an emphasised role as experts and consultants.

What were the strong points according to your opinion?

The City of Kauhajoki and the South Ostrobothnia Health Care District assumed official responsibility and handled the after-care arrangements. The Kauhajoki Project was praised for its flawless functionality. The State of Finland contributed to the funding of after-care.
Finnish Red Cross

- Availability and readiness of volunteers
- The right people were found to perform various tasks
- Flexible organisation: Red Cross departments and volunteers worked across organisation (department, branch) boundaries. The multi-department co-operation worked well. Volunteers can be transferred according to needs and resources.
- Competent, flexible co-operation between volunteers, departments, and the central office

- The Red Cross possesses both volunteer competencies and professional expertise (preparedness group of psychologists)
- Well-functioning preparedness plans at the central office and department levels
- Training and exercises are key elements to good preparedness and the quality of the contribution.
- The Red Cross coordinates the Voluntary Rescue Service, which is an association of 50 organisations. The Voluntary Rescue Service can help with a wide range of tasks, for example, searches and primary care tasks such as food, accommodation or clothing provision.

What were the lessons learnt (weak points) according to your opinion?

- In exceptional and prolonged situations, a deputy system is required both at department and central office level.
- The readiness of the local branch to support the community after an incident – additional support would have been needed – since the community is also a victim.
- The perspective of preparedness must be clear during the recruitment and training of everyone within the Red Cross. Training in psychosocial first aid and support must be mandatory for all volunteers. Local and nationwide exercises are an important learning arena for good preparedness.
- Improve external communication. Training for staff and volunteers is needed. Given the size and scope of the Red Cross, as well as its visibility and position in the community, the Red Cross must be particularly careful about the impression they make.
- Internal reporting. The Red Cross needs better routines for internal reporting, the flow of information and logging in emergency situations in which many districts are involved.

Conclusion and recommendations for further programmes

Since the school shootings, increased efforts have been made to enhance safety at schools, for example, through the Internal Security Programme of the Ministry of the Interior.

The National Board of Education has produced a school safety guide, a pupil and student welfare guide, and a web-based crisis material set for teachers.

The new Act on student welfare (1287/2013) will take effect on 1 August 2014. The new act will cover pupil and student welfare services from pre-school to upper secondary education and increase the municipalities' obligations, particularly with regard to the provision of services for students of upper secondary schools and vocational schools.

When the act becomes effective, municipalities must have the services of a school welfare officer, school welfare manager and student welfare psychologist available for the students of all educational institutes located in the municipality. Municipalities must provide statutory services for all students of educational institutes located in the municipality, regardless of the ownership of the institute. According to the Act, a student must be guaranteed an opportunity to discuss in confidence with a student welfare psychologist or school welfare officer no later than seven working days after the student makes the request. In urgent cases, the discussion must be arranged on the same day or the following day.

It would still be important to place an increased focus on municipal crisis teams and reinforce their position, and also to extend the nationwide coverage of the crisis team network.

Securing the funding of after-care after accidents and other such special situations would also be important.

Finnish Red Cross

- Basic and further training in psychosocial support must be available for volunteers nationwide. Knowing and mastering the basics of psychosocial support is a civic skill.
- Increased focus should be placed on branches' preparedness plans. It is important to maintain the preparedness plans and keep them up-to-date.
- Increased focus should be placed on the distribution of information and the provision of training and induction for new employees and volunteers at branch, department and central office level.

Longer-term intervention: *"Professionally led peer support is an excellent form of support in this stage, and it has yielded good results, provided that the participants share the same traumatic event and the groups are homogeneous. Professional supervision is, however, a necessary condition for successful peer support*" (Finnish ministry of the Interior, 2010, p.89).

Finnish ministry of the Interior (2010). Kauhajoki School shooting: report of the investigation commission. Available at http://oikeusministerio.fi/fi/index/julkaisut/julkaisuarkisto/392010kauhajokischoolshootingon23september2008-reportoftheinvestigationcommission/Files/OMSO_39_2010_Kauhajoki_School_Shooting_194_s.pdf

Further information: Kauhajoki School Shooting on 23 September 2008 – Report of the Investigation Commission, http://oikeusministerio.fi/fi/index/julkaisut/julkaisuarkisto/112010kauhajoenkoulusurmat23.9.2008.tutkintalautakunnanraportti/Files/OMSO_11_2010_Selvitys_180_s.pdf

Further Source: Haravuori, Suomalainen, Turunen, Berg, Murtonen, Marttunen, Jokelan ja Kauhajoen ampumissurmille altistuneiden oppilaiden ja opiskelijoiden selviytyminen, tuki ja hoito – kahden vuoden seurantatutkimusten loppuraportti. Reports by the Finnish National Institute for Health and Welfare 4/2012. Pages 12-13 http://www.thl.fi/thl-client/pdfs/c6bd9224-ba1f-4327-a4fb-d684c821a454

Shooting at a shopping mall 2011 in Netherlands

Event type: Shooting at a shopping mall
Place of the event: Alphen aan den Rijn, Netherlands
Date of the event: 9th of April 2011
Event characteristics:
Number of casualties: 6 dead, 16 severely injured
Damage to livelihood: no
Number of people supported: hundreds
Support for helpers: yes
Length of the PSS-Interventions: longterm
Experts Organisation: Director of publich health for middle of Holland
Experts Position: Crisis Manager (medical, not PSS)

Description

Around noon on Saturday 9th of April 2011 a car stopped on the parking site of a shopping-centre in Alphen aan den Rijn, a young man came out of the car, walked towards the shopping-centre and started shooting with a semi-automatic weapon randomly. One bystander was shot while putting his groceries in the back of his car, five more were killed when the shooter entered the shopping-centre and walked around for several minutes, shooting with three different weapons. He killed himself by a shot in the head, leaving six people dead, 16 severely injured and some 20 people with smaller injuries.
The shopping-centre is at the first floor and consists of three corridors and a central square, with approximately 40 shops. People fled into the different shops, while shop-owners tried to close their shops when they heard the shooting coming their way. Others tried to hide themselves or fled from one of the three exits from the shopping-centre.
The first units of police and ambulance arrived after a few minutes to find the shooter dead and people in despair. People were either hiding, caring for their next-of-kin, neighbor or fellow citizen, had gone home or to a first-aid centre or were waiting outside the shopping-centre. All people who were still in the centre were guided outwards by the police, as it was handled as a crime-scene. Ambulance-staff and police units did their best for the wounded. 17 people were transported to a local hospital, most of them were out of the hospital within one week.
After one-and-a-half hour all severely wounded had been brought to a hospital. Within the shopping-centre only police-units and the dead victims could be found.
Next to the shopping-centre was a community centre annex church, called 'De Bron' (the Source). The pastoral worker opened the centre as soon as possible, so that all the involved people could shelter and exchange their experiences. In the course of the afternoon the number of people outside the shopping-centre slowly decreased. Some 50 people were brought to the police-station, to be heard as a witness. The bodies were identified during the night and transported to the morgue; a formal list of dead victims was available on Sunday morning. Tuesday 12th of April the shopping-centre re-opened.

Who responded

Police
Ambulance services
Regional operational team
Municipal crisis policy team
The public prosecutions office

How was the PSS organized?

In the Dutch crisis organisation, 23 different processes can be 'activated', depending on the nature of the incident. Those 23 processes are divided between the municipality, police, fireservices and medical-aid-organisations. Important processes for the municipality in this incident were communication, taking care for shelter and necessities, registration of victims, inventory of damage and aftercare. The activated processes for the medical-aid-organisations were acute medical aid and psychosocial care.
Police-cars and ambulances rushed to the site, seconds after the first reports were received by the emergency call-centre. When it became clear that it was an incident with big impact, the Regional Operational Team and the Municipal Crisis Policy Team were alarmed and started their operations. The Public Prosecutions Office joined both teams due to the nature of the incident.

In the process of psychosocial care following this incident three phases can be distinguished. The first phase is the psychosocial care 'on the spot', directly after the incident, in the shelter. The second phase is the psychosocial care during the first weeks, when many people experience the impact of the incident, Memorial Services are held, the incident is still in the news, a 'silent march' is organized and people try to put their lives together. The third phase starts after a few weeks, but can last for years.

Phase 1. Saturday 9th of April

Through another call-centre a Core Team for Psychosocial Care and 2 operational teams for psychosocial care were alarmed. Both kind of teams are composed of employees of mental health institutes, regional public health service, institutes for Social Work, institutes for youth-care and the national institute for victim support.
The tasks of the operational teams are:

1. identify people with lack of coping skills;
2. identify people with an urgent need for psychiatric or psychological care;
3. early detection of lack of coping and facilitate coping;
4. organize and improve social support from the direct environment of the 'victims';
5. detection of and first response to practical questions.

The Core Team has to coordinate the work of the operational teams, make a plan for psychological care in the first days and organize the transfer to regular care.
The Core Team went to the city hall, the operational teams went to 'De Bron' to support the people, who were in this shelter. Later that day one team went to the police-station, to support the people who were brought there for questioning. The shelter closed in the course of the evening, the members of the operational teams for psychosocial care went home and the Core Team organized the conveyance to the second phase on Sunday morning. People who reported themselves to the members of the operational team for further support were registered and visited by employees of the national institute for victim support in the weeks following. The Core Team stopped their activities on Sunday morning after the conveyance of their findings, facts and advises to the 'regular' Calamities Team, which is coordinated by the Regional Public Health Service and consists of employees of the same organisations as the operational and Core Team for psychosocial care.

Phase 2. The weeks following the incident

The Calamities Team is a team of professionals, that can support municipalities, schools, sports organisations and all other kind of institutions when they are confronted with a situation, which has big impact on (mostly) children, such as the death of a classmate, extreme violence or a sex-crime. They advise institutions concerning communication, approach, actions, etc. Unfortunately, not everyone of the 25 safety regions in the Netherlands has such a Calamities Team; the incident in Alphen proved its added value.

On Saturday afternoon the first members of the CT reported in and got in touch with the municipality to get access to the municipal database. As soon as the names of the victims would be known, they could

link these names to the names of related children and the schools they attend, so that the schools could be informed and advised. When the names of the victims became available on Sunday morning, they were able to inform all schools in Alphen aan den Rijn on Sunday evening.
Monday morning the CT team members went to the schools where the impact would be big, due to the fact that children on these schools lost their parents, were injured themselves or were involved in the incident otherwise.
The CT team also coordinated the psychosocial care in the second phase, for example during the Memorial Service with the Queen and during different meetings that took place in the first weeks. The team also advised the municipality on the aftercare process by making a concept plan, which was adopted by the municipal executive board a week later. This plan was formulated with the help of the national institute COT, using their guidelines for aftercare planning. Two advisors were present from Saturday afternoon on. The plan describes all actions in the aftercare, including financial aid, evaluation, psychosocial care, memorial activities and practical support to shopkeepers and civilians.

The national institute for victim support has two other roles, besides their role in the operational teams. They are also called in by the police to accompany the families of the deceased persons and the severely injured victims. A fixed contact person is assigned to each family and victim. Their third role is to assess referrals to the mental health institute in the weeks following the incident, because they are better trained than the most General Practitioners (GP's) to evaluate if a referral is needed or regular care by the GP with medication, relaxation exercise and conversation is sufficient.

Phase 3: when the incident disappears to the background (for most people)

After a few weeks the psychosocial care has shifted from a collective to an individual level. People are seen by their GP's, community nurses or social workers or are client at a mental health institute. The incident isn't in the news on a daily basis, but many people experience the consequences every day. The psychosocial recovery of these people is hindered by a lot of practical problems, such as loss of work or income, not been able to live in the neighborhood any more, the need voor adjustments because of a handicap, not been able to finish school, etc. An integrated approach in aftercare is essential, but hard to establish. Social services, housing corporations, health care insurance companies and other institutions have there own rules and procedures and are not focused on cooperation, when this is needed for a holistic approach of the problems people encounter as a result of the incident.

What were the strong points according to your opinion

- The composition of the Core team, the operational teams and the Calamities team of employees of different institutions proved to be a strong point, because the routing to the different back offices was easy and the mix of competences was valuable.
- People know each other from their regular working activities. That made it a lot easier to cooperate.
- National guidelines for aftercare and psychosocial care proved to be useful. They could easily be adapted into the local aftercare plan and made it possible to write such a plan in just over one day.
- Every victim had a fixed contact person of the national institute for victim support for a period of three months. If wanted by the victim the contact could be prolonged. The evaluation showed that these contacts were highly appreciated.
- GP's organized a kind of training course for psychosocial care

What were the lessons learnt (weak points) according to your opinion

- The conveyance from the Core Team to the Calamities Team didn't go as smoothly as it could have been gone, because both teams didn't know what to expect from each other and haven't

trained this conveyance. Both teams were at work on Saturday, but only came in contact with each other on Sunday morning.
    - The registration of victims and otherwise involved people is essential, but was hindered by the fact that the most involved people were questioned by the police and not registered at the shelter. The Public Prosecutors Office was very reluctant to make these data available.
- The fact that the incident was handled as a criminal act, as if the criminal has to be prosecuted, made it difficult to speak to the people concerned in the first essential hours after the incident, because they wouldn't be useful as witnesses as they have spoken with others about their experiences.
- The special municipal organisation for aftercare was disbanded after three months, which meant that the victims had to turn to the regular municipal organisation. From interviews we know that some people experienced that there was little understanding for the fact that they were victim of the incident. Because of the signals an alderman was made responsible for the aftercare and the municipal aftercare organisation was put in place for a longer period.
- When healthcare organisations met to discuss the results of an evaluation more than a year after the incident, they concluded that there should have been more communal meetings in the period after the incident. They didn't know what the policy of other organisations was and how other organisations dealt with the specific problems concerning this incident.

Conclusion and recommendations for further programmes

1. Focus on psychosocial care from the begin of the incident. If the focus is on prosecution and validity of witness reports, the psychosocial care has a bad start.
2. Since the incident, we have integrated the processes of psychosocial care in crisis situations and in regular situations in our safety region. The Calamities Team coordinators are also the process leaders in times of crisis. The training of the Calamities Team, Core Team and operational teams is integrated.
3. The formation of a Calamities Team in each safety region has added value. This should be emphasized by the Ministry of Health.
4. Each municipality cannot be prepared in detail for the psychosocial care in all kinds of crisis situation. Establish a national expertise centre, that is available for each municipality directly after an incident has taken place.
5. Acknowledge the need for an integrated approach in the aftercare, which can take a period of years.
6. Organize a training programme on psychosocial problems and care for the most involved GP's in the first week after an incident, tuned in accordance with the specific characteristics of the incident. These training programmes should be on the 'shelf' of a national expertise centre.
7. Organize regular (monthly) meetings with the involved healthcare organisations, following an incident.

Terrorist Attack 2011 in Norway (Utøya)

Event type: Terrorist Attack
Place of the event: Oslo and also the island of Utøya
Date of the event: 22th July 2011
Experts Organisation: Norwegian Red Cross
Experts Position: Mental Health Professional

Description

On the afternoon of 22. July 2011, Norway came under large-scale terrorist attack. Large areas of the government quarter in Oslo were destroyed and shortly after, the youth camp on the island of Utøya was under direct attack by a gunman. On this day, all of Norway's emergency services as well as the Red Cross were severely tested.

The 2011 Norway attacks were two sequential lone wolf terrorist attacks against the government, the civilian population and a Workers' Youth League (AUF)-run summer camp in Norway on 22 July 2011, claiming a total of 77 lives.

The first was a car bomb explosion in Oslo within Regjeringskvartalet, the executive government quarter of Norway at 15:25 PM. The car was placed in front of the office block housing the office of Prime Minister Jens Stoltenberg and other government buildings. The explosion killed eight people and injured at least 209 people, twelve of them seriously.

The second attack occurred less than two hours later at a summer camp on the island of Utøya in Tyrifjorden, Buskerud. The camp was organized by the AUF, the youth division of the ruling Norwegian Labour Party (AP). A gunman dressed in a homemade police uniform and showing false identification gained access to the island and subsequently opened fire at the participants, killing 69 of them,[and injuring at least 110, 55 of them seriously; the 69th victim died in a hospital two days after the massacre.

It was the deadliest attack in Norway since Second World War and a survey found that on average, 1 in 4 Norwegians knew "someone affected by the attacks". The Norwegian Police arrested Anders Behring Breivik, a then 32-year-old Norwegian right-wing extremist, on Utøya island and charged him with both attacks.

Who responded?

In the initial and acute phase, the police had the legal operational responsibility for initiating and organizing the emergency response.

In the following, only the medical efforts related to 7.22 will be described briefly, then the psychosocial dimension. Red Cross' role will be addressed separately when relevant.

When the serious and large-scale nature of the attacks at Utøya became clear, all medical response units in the region mobilized and were directed to the island. Anesthetists, general practitioners, ambulance crew and the Red Cross preformed primary triage at the casualty clearing stations at Utvika quay. Those patients who were not triaged for hospital were brought to Sundvolden hotel for treatment at a temporary emergency medical center.

Psychosocial follow-up of victims and relatives was undertaken promptly. The use of Sundvolden Hotel and the outstanding manner in which the hotel management and staff responded in the situation was crucially important.

All stakeholders in the medical and psychosocial field worked in an exemplary manner. However, according to the Norwegian Directorate of Health "there is room for improvement and the health services preparedness plans for dealing with providing services to relatives must be brought up to date. Training in psychological first aid and training and preparation for dealing with crises, accidents and disasters must be given priority".

Non-organized volunteers such as the guests at Utvika camp site, neighbors, boat owners, the camp site owner etc also made a considerable contribution during the acute phase.

The Red Cross's contribution involved over 1,000 individual volunteers, while many more were alerted and ready to turn out. Many volunteers participated in multiple activities. It is estimated that:

- 418 volunteers participated in search and rescue work around Utøya
- Between 40 and 60 people provided psychosocial first aid and support in Sundvolden
- 26 volunteers were active in Oslo (not including the Dialogue service)
- 86 hosts were involved in the Return to Utøya operation on 19 and 20 August
- 37 volunteers acted as hosts in the Return to Utøya operation on 1 October
- 550 individual volunteers were active in their local communities or had organisational duties (including the Dialogue service)
- Around 65 Red Cross premises remained open for between one day and one week
- Between 60 and 70 employees had duties directly linked to the terrorist attack
- 15 ambulances from Østfold, Oslo, Akershus and Drammen were active
- 37 boats were involved in the search of Lake Tyri (Tyrifjorden)

How was the response organized?

From early evening of 22.07 psychosocial support was provided to the victims and affected families who had gathered near Utøya island. They had access to psychiatrists, psychologists, nurses, priests, imam and Red Cross volunteers. The psychosocial support from all actors was organized in 4 units from . 2:00am 23. July. This amounted to a total of 250 caregivers. NRC volunteers were represented in all units. Support from the PSS-units was available 24 hours a day at The Center for the victims and affected families, which was established near the site of the attack, until 26 July. In addition to this, the NRC was present with between 40 and 60 volunteers at the Center. These volunteers were not organized in the units, however they did provide PSS.

What were the strong points according to your opinion?

Below are the strong points relating to the Red Cross operation only. For overall assessment see the national evaluation of the concerted efforts during the 22.7 terror attacks (Ministry of Justice, Norway)

- Swift mobilization and response; the organisation was proactive in regard to needs, in terms of both search and rescue and care, including on a national scale. Volunteers operational on the spot within a few hours.
- Nationwide contribution and presence (availability), strong desire to contribute and staying power.
- Initiatives and activities were directed by needs; extensive variation and breadth in activities and services and strong diversity among volunteers was an important advantage in the first phases of the operation.
- The Search and Rescue Corps generally have good search and preparedness competencies.
- The psychosocial support provided by Red Cross Care was of good quality.
- The assistance from the districts in the management of the operation (KO) in Buskerud was substantial.
- Training and exercises are key elements to good preparedness and the quality of the contribution.
- Persistent focus on volunteer tasks to support victims, survivors and relatives.
- RC searched for missing people until all were found
- Every family had a NRC volunteer contact to guide them through the trips back to the site/Utøya and the Memorial day.
- Methodical and systematic, mandatory one year follow up for the NRC volunteers and staff, facilitated by SOSCON – external Institute of Crisis management. See previous written survey-response dated 08.05.2013 Result of the Programme: Approx. 10% of volunteers and staff in need of further support
- Same PSS follow up for volunteers and staff –all treated equally in the follow-up

- Important with preparedness and response plans that also included whom to ask for support and assistance
- NRC as facilitators of National Support Group after 22.07 terrorist attacks, see previous written survey-response dated 08.05.2013.
- Good professional advice regarding reactions and psychosocial support was used actively within and outside of the organisation.
- Immediately after the attacks, NRC liaised with prof. dr. med Are Holen and developed national advice aimed at different target groups (e.g. the general public, children and youth) regarding reactions to the attacks. Red Cross focused on "All reactions are normal reactions to an abnormal event".
- See previous written survey-response dated 08.05.2013.

What were the lessons learnt (weak points) according to your opinion?

Below are some of the main lessons learnt relating to the Red Cross operation only. For overall assessment see the national evaluation of the concerted efforts during the 22.7 terror attacks (Ministry of Justice, Norway)

- Personnel control. In general, volunteers engaged in the operation were notified in accordance with the notification plans. But in addition to this, some individual volunteers and volunteer groups joined the operation based on their own initiative. An important lesson is that in disaster response, NRC must be fully in charge of internal mobilisation and be proactive. This requires both excellent internal control of and an overview of internal personnel. Volunteers must be aware of all command lines and must report to the Red Cross management on site. In the chaotic situation that occurred, there were gaps in the immediate organisation of the work, which could represent a safety risk.
- Holistic preparedness. An important lesson after the events of 22 July is that the entire organisation must be prepared for unforeseen events. Only a few local branches and districts had preparedness plans, notification lists or resource overviews covering Care or Youth. Awareness and competency regarding preparedness must be strengthened in parts of the organisation (Red Cross Care, Red Cross Youth and parts of the secretariat). Focusing on roles, responsibilities and leadership levels (political, strategic, tactical and operational) on a day-to-day basis produces better crisis management. All parts of the organisation should have a clear role in (or outside of) notification plans and contributions and descriptions of duties must be available for all functions.
- Command structure must be clear for whole organisation. The Command structure was clear and functional for rescue teams – not that clear for other groups within NRC.
- Interaction with external parties. NRC must focus on the organisation's role in the the interaction between different stakeholders who are organized in the Norwegian contingency planning, see figure 1 in previous written survey-response 08.05.2013. A stronger awareness about this structure may result in better cooperation and clarification of roles in relation to others involved in the search and rescue services, and may contribute to an even better climate of cooperation. In addition, NRC must work on establishing better formal cooperation and involvement regarding municipal risk and vulnerability assessments and preparedness plans.
- Clarification of roles. The authorities' lack of knowledge about the supporting role of the Red Cross and Red Cross principles may place inappropriate pressure on volunteer managers. The Red Cross must contribute to training of working partners and public authorities.
- Improve supplies and infrastructure. It was clear that NRC could have strengthened supplies and infrastructure provision in such heavy long-term operations. It is important to provide hot food, drinking water, dry clothes and toilets for both volunteers and victims. Infrastructure must also be organized in a manner which is sensitive to the operation – e.g. ensure that rest area is completely separate from the area for handling of dead bodies.
- Division between different "categories" of affected persons. In the acute phase of the Utøya operation, the survivors and lighter wounded victims searching for loved ones, parents who

found their children as well as relatives who had lost their loved ones and response personnel and support staff all were provided with the same facilities for dining, waiting etc. This was unfortunate and did not take into account the different needs of the various groups. It was largely a result of oversight from the police in charge, however future operations must take this into account.

- Training needs. The perspective of preparedness must be clear during the recruitment and training of everyone within the Red Cross. Training in psychosocial first aid and support must be mandatory for all volunteers , and this has now been adopted by the Red Cross National Board and out of 40 000 volunteers in the NRC, 9000 volunteers and staff has completed training in NRCs Programme for pro Psychosocial First aid. Exercises (action oriented training) are the most important learning arena for good preparedness. Exercises must be given higher priority for both employees and volunteers. Finally, use of the Red Cross assessment must be strengthened and the assessment must be implemented as a general tool within the organisation.
- Improve external communication. Given the size and scope of the Red Cross, as well as its visibility and position in the community, the Red Cross must be particularly careful about the impression they make. Even in chaotic disaster situations, it is important to ensure that the primary goal of media coverage/advocacy campaigns is to meet humanitarian needs.
- Internal reporting. The Red Cross needs better routines for internal reporting, the flow of information and logging in emergency situations in which all districts are involved.

Conclusion and recommendations for further programmes

Overall conclusion from NRC

In its response following the terrorist attack of 22 July, the Red Cross fulfilled the intended role of the organisation, in line with internal guidelines, as stated in the mandate, principles and governing documents, and externally in its role of supporting and cooperating with the search and rescue services. The Red Cross's contribution was characterised by swift mobilisation and response, a huge presence and staying power at all levels. They felt that the Red Cross's strength in this situation was the breadth and presence of their organisation when the disaster hit in Oslo, Buskerud and other local communities. The diversity of activities and nationwide presence allowed the Red Cross to fulfil its supporting role and helped to prevent and alleviate humanitarian need and suffering.

Relevant recommendations from the Directorate of Health:

The Directorate of Health's review of selected emergency preparedness plans in Norway shows that psychosocial measures are generally dealt with to a limited extent.

Recommendation: The services' emergency preparedness plans must be more comprehensive in the psychososial field, drilled regularly and include everyone who is expected to have a role. The plans must describe contact points for alerts, specific measures and lines of command for the invividual phases of crises, and guidelines for bringing in external expertise. The role of resources centres/specialists in relation to emergency preparedness must be clarified.

The requisitioning of Sundvolden Hotel drated a sound framework for the acute follow-up work aimed at the young people and their relatives who were gathered there.

Recommandation: A sympathetic setting must be provided for survivors and their relatives, with food and refreshment and privacy rooms. The use of hotels should be incorporated into the municipal emergency preparedness plans.

During the first days, situations rose where there was uncertainty in the health service and other emergency services as to what organized volunteers were capable of and willing to assist with, and what understanding they had of their role.

Recommandation: The role of organized volunteers must be made clearer, in terms of both what they are to do do and what they may not do. Cooperative routines between health personnel and volunteers must be clarified, and the municipalities should sign agreements of intent with the NGOs.

Among response personnel, in both the immediate emergency and in long-term follow-up, some uncertainty was signaled as to how to deal with traumatized victims, and when is was necessary to use specialist health personnel such as psychologists.

Recommendation: Emphasis should be given to instructing relevant health personnel in the treatment of patients with serious psychosocial trauma, and health personnel should be trained/prepared to deal with such situations.

Recommendations from NRC

The unexpected terrorist attacks of 22 July challenged Norwegian society in many different ways. They felt that the Red Cross's preparedness could not be designed according to an extraordinary incident of a scope such as the terrorist attack of 22 July. At the same time, they felt that a good, well-functioning preparedness organisation during minor crises and incidents will also function when the big, extraordinary incidents occur. Preparedness based on the principles of responsibility, equality and closeness will ensure this. The recommendations are based on and lay the groundwork for the Red Cross having preparedness that covers the entire organisation and which meets the Red Cross's social responsibility as a contributory party in the community preparedness, on the basis of its mandate, principles and supporting role.

Recommendations from EFPA

It is important to provide professionally led peer support and other psychological interventions (e.g. individual therapy) for longterm support after such events. Longterm support (peer groups, individual therapy,…) has to be planned and led by crisis psychologists.

Toxic train incident 2013 in Belgium

Event type: Train accident – toxicity involved
Place of the event: Belgium
Date of the event: May 4th 2013
Event characteristics:

- **1 casualty;**
- **Couple of thousand affected people; (very difficult to estimate, about 400 evacuated, hundreds to thousands voluntarily left the area)**
- **damage: railinfrastructure severly damaged, one house, pollution of surrounding area (soil, surface water,sewage, air, ground water)**
- **100 people in hospitals because of intoxication, 400 to hospitals for check up, thousands screened.**
- **Support for helpers: Weeks following the emergency, all PS responders, both Red Cross volunteers and local psychosocial responders were invited to take part in a post-crisis group intervention. There were 9 group interventions carried about by Red Cross, one for each PS-sub team. Firefighters have own PS support for personel.**

Length of the PSS-Interventions: acute, midterm
Experts Organisation: Belgian Red Cross (Flanders)
Experts Position: Red Cross Psychosocial expert – Crisis psychologist

Description

In this text we focus on the immediate psychosocial response following a toxic train incident in Belgium. We first set the scene by describing the incident, then we focus on the psychosocial responders and how the response was organised. Good practices and lessons learned are followed by some conclusive remarks.
We want to stress that this text by no means reflects the efforts of all other responders from fire brigades, medical services, police, civil defence, authorities, etc.
On Saturday, May 4, 2013 early morning six wagons of a train carrying toxic goods derailed near the centre of Wetteren, a municipality of 24.000 inhabitants (660inh/km2). At first a huge fire ball lighted the sky but it was the toxics entering the sewer system and subsequent unpredictable chemical reactions, which caused most of the chaos the following hours and days.

Immediately hundreds of people were evacuated as a 500m safety perimeter was declared. Within a perimeter of 1km people were asked to close windows and stay indoors. As later that day more and more people reported to feel ill, it was discovered that toxics had entered the sewer system. The perimeter doubled, hence more people were evacuated. Two reception centres had to relocate outside the new perimeter and even the crisis centre from where the authorities coordinate the emergency had to move to the nearby municipality of Wichelen.
These unexpected events caused unease among the inhabitants of Wetteren. Until then one judged some safety measurements annoying rather than worrying. The following days the restlessness rose and people left the area. Outside the safety perimeter parts of the town were deserted.
On day 2 a return to the houses was announced, later that day one had to reconsider this idea.
On day three a return was announced but ill prepared: few people could return to their houses. This slow return was caused by the safety measure that each house had to be scanned with specialised equipment.
Some alarming levels of toxics where discovered in an old part of the sewer system the fourth day, resulting in the re-evacuation of some of those that had just returned the night before. The evening day 4 brought a cloud burst that washed all toxics out of the sewers.
A return of the majority of evacuees started day 5 lasting several days. A smaller group of people had to wait three weeks, they had to wait till the wagons carrying toxics were cleared.

The death toll was limited to one person; about 100 people were brought to the hospital. From those taken to the hospital some had no complaints because of the toxics, but were in need of specialised care due to their pre-existing state of health.

Who responded?

In Belgium, Psychosocial support is part of the Contingency planning. The Psychosocial Intervention Plan (PSIP) describes the coordination of the psychosocial responders from immediate phase over the transition phase to the after-care.
As to the immediate phase there are two important players: the local psychosocial support networks (PSH) and the Belgian Red Crosses Psychosocial Intervention Team (DSI).

- **Psychosocial Support network - (PSH)**

Local Psychosocial support networks are in place in a minority of the Belgian municipalities. The members are mainly personal form local social services. The teams receive a short 2-day training in which they are introduced in: basic tasks in the Reception Centre and Telephone Inquiry Centre; how to register people affected and an psychosocial first aid.

- **Psychosocial Intervention team - Belgian Red Cross (Flanders) - (DSI)**

The Belgian Red Cross Psychosocial Intervention team is active since 1980. These volunteers are mental health professionals who received an in-depth training on psychosocial support in emergencies. A second group is trained in data processing and administration during emergencies. They produce lists of people affected based on the registration forms from all locations.
In Wetteren 117 Red Cross-Psychosocial responders were active in more than 200 shifts

How was the psychosocial response organized?

The psychosocial response was carried out as described in the psychosocial intervention plan.
This plan describes what centres need to be set up:

- Reception Centres (RC) for people affected
- Shelters (RC with sleeping arrangements)
- Telephone Inquiry Centre (TIC)
- Central Information processing Point (CIP)

The first eight hours, responders from the local psychosocial support network (PSH) and Red Cross worked together setting up the reception centres. Tasks were divided later that day: the PSH Wetteren ran the telephone line, BRC responders focussed on the reception centres andinformation processing. PSH teams from neighbouring municipalities assisted the BRC.
The first day 5, reception centres were opened: three, set up the first eight hours, had to be evacuated and were moved to two locations the following hours. Four locations served as shelter (a school, 2 youth hostels and one hotel). The TIC was active from early morning till late evening during the first nine days.
The CIP (central information point) operated in the proximity of the crisis centre and TIC.
Teams of the BRC assisted the structured return of the families during four days by offering psychosocial support.
An Information desk for the public was opened near the edge of the safety perimeter as the public went to the site to gather information.

What were the strong points according to your opinion

Planning and preparation

1. **Psychosocial Intervention Plan, part of the emergency planning**
   In Belgium a psychosocial intervention plan is part of the National Emergency planning. The plan

describes the immediate psychosocial response well. Undeniably this is a strong starting point for a quick deployment.

2. **Local psychosocial Intervention team:**
   The municipality has got a Psychosocial Support network that performed well. The network received the assistance of nearby local PSH. These networks had received their training by Belgian Red Cross-Psychosocial Intervention service staff. This contributed to the smooth an efficient cooperation.
3. **Red Cross-Psychosocial Intervention Service Volunteers: trained, experienced, flexible**
   The BRC-psychosocial intervention service's operational structure is tailored for interventions as the one in Wetteren. Tasks are clear, co-ordinators know how to brief their volunteers. The volunteers are experienced, loyal and flexible.
   The policy to limit a shift to 8 hours doesn't exhaust the responders. Working this way several people were active in more than one shift that week.

Operational

1. **Hobfoll principles in practice**
   Since 2011 the BRC-Psychosocial intervention team fully incorporates the Hobfoll principles in their trainings and operations. From afar our interventions seem fairly similar to those five years ago but the focus on resilience based interventions does make a big difference on two levels.

   First: they offer a tool in order to quickly judge the PS measures in place. A reception centre can be operational, but did we manage to install a sense of safety? Did we succeed in creating a calm environment? Do people have a sense of control? etc.

   Secondly: The Hobfoll principles offer a useful vocabulary in the communication to other key players in the emergency response, psychosocial or not. We can easily explain to a major why it is important to work in a specific way by referring to the principles.
2. **Direct line with the coordination committee**
   The proximity of the TIC and PS-coordination cell to the coordination committee gave us the opportunity to advocate for clear information and a reliable perspective for future decisions. For example: It is important to announce when people can expect new information on the return so they can decide what to do.
3. **Listening to the community: the role of the Telephone inquiry centre (TIC)**
   Mainly set up in the Psychosocial Intervention Plan as a tracing tool (Where is my beloved?) the TIC served as an ear to the community: what are the needs, what are the worries, how is a press statement understood, ...
   It was in the TIC that people who were asked to stay indoors reported feeling ill. This info, and the fact that their whereabouts were registered, revealed the sewer problem.
   By registering and clustering the content of other inquiries a quick feedback system was in place. Once this worked well, the info collected by the TIC served guidance for the info delivered to the public.

Care for the responders

Group Debriefings of PS personal:
In the weeks following the emergency, all PS responders, both Red Cross volunteers and local psychosocial responders were invited to take part in a post-crisis group intervention. The focus in this interventions was to offer the people an overview of the complicated situation and the response of which they were part of.
There were 9 group interventions, one for each subteam.

Lessons learned

We limit the number of lessons to those that directly affect our work.

Operational
In the field:

- **Reception centres** set up the first day were located too close to the safety perimeter. Those had to be relocated. Unfortunate a new place didn't turn out sufficient (no privacy, no sleeping arrangements)
- On-site **Information desk** for the public was set up day 4, this was too late.
- There was no plan to process and cluster FAQ's from the TIC, social media and the on-site Information desk.
- **Animal shelters**: No plan is in place to organise animal shelter, especially for dogs. This limited the co-operation from several evacuees that could not count on a social network. By luck one of the shelters neighboured a Dog Training Centre that could host the biggest dogs, neighbours looked after a second group of animals. The time spent on this issue was out of proportion.

Managing human resources in the field
Excellent collaboration does not guarantee good coordination.
Although the collaboration was excellent between Red Cross and local Psychosocial teams, the co-ordination was limited to the quick dispatch of tasks. Hence resources were not used as effective as possible.
For example: The first day of emergency it was agreed among the Psychosocial responders to let the better trained RC people run the reception centres. The local PS network focussed on the TIC as they were familiar with the local situation (street names, locations, ...)
The following days the Red Cross responders took up responsibility in the preparation and the guidance of the returning evacuees as this was seen as an extension of the work in the RC.
It would have been more effective to involve the local psychosocial support team in the return procedure of the inhabitants. The RC people could have taken over the TIC as more and more calls came from worried persons that needed support and the knowledge of the local street map wasn't any longer eminent.
In the future the Psychosocial co-ordination team will be asked to evaluate during the operation this issue. The current Psychosocial co-ordination team was to much operation focused.

Too many tasks carried out by Red Cross responders
As an organisation we took up too many tasks the were carried out by Red Cross volunteers
for example: A tremendous effort was done by the volunteers in the CIP to process data and produce all kinds of lists on the whereabouts of people, day after day. As nobody was reported missing, this effort made little sense as to our tracing role: nobody was missing. Having the names on the whereabouts is of little added value.
In the future we will be more cautious and reluctant in accepting tasks in order not to exhaust our people. This will be a prominent task for our liaison in the coordination committee

After Care
The psychosocial impact on the population, evacuated or not, was underestimated. Hence a plan of action on the longer term was not in place.
There are several explanations to this:

- Key people were exhausted.
  As the crisis lasted that long the coordination committee met on a daily base sitting in a single room for over 12 hours). This key players were relieved when the train was cleared without further incidents, after-care was not a priority.
- Structured assessment
  At his moment any structured tool for the assessment of psychosocial needs is lacking. Little experience on the psychosocial impact of a toxic incident was available.

Still: the inhabitants were worried, the communication from the authorities was distrusted. Due to the vagueness of any evidence on health impact of the specific toxics messages seemed conflicting. "No

need to worry; if you worry lease donate a blood sample". Little sense of safety could be reached, even one year later.

Care for the responders

Lack of a Sense of safety for the responders

As mentioned earlier: nobody was able to install a sense of safety. Information on the risks working in the area remains unclear. Some responders were active for hours in what became later the safety perimeter. Many responders had been in the neighbourhood of the safety perimeter.
The following weeks and months people received letters from the insurance company; were asked to donate a blood sample; ...
Several persons received "positive" results but no clear explanation about what this means.
Al this resulting in people feeling ill at ease, some even questioning their commitment as a volunteer.

Local responders get exhausted

Whereas our Red Cross responders went home once their shift ended, members of the local psychosocial teams returned to their worried families as most of them are part of the affected community. Red Cross responders stayed away some days, local responders worked every day often more than 8 hours. Hence: local responders got exhausted.

Follow up and debrief of personnel

Ad hoc responders; eg. local personnel active in or near the co-ordination team working terrible long shifts. They were not identified as people at risk, they were not offered any after care. Some have showed severe symptoms of burn-out the following months.

Conclusion and recommendations for further programmes

In general the immediate psychosocial response worked as planned. It must be noted that the local psychosocial support networks have played an important role in this response. Only a minority of municipalities have such teams.
The major and unresolved issue was the fact that lots of people felt unsafe, little info could be given on the impact of the toxins as little evidence was available. This fact has had an important impact on the intervention.

- **Be prepared**
  The recommendation of recommendations. In Wetteren both the local ps-teams and the Red Cross were prepared. They received training and had gone through exercises. Boxes for reception centres, TIC and CIP were available. A telephone centre was planned for and operational.

- **Listen to the community: a telephone line, social media, information desk**
  A telephone helpline can serve as a tracing and psychosocial support tool. It can serve as the ear to the community too when one registers FAQ's. A plan needs to be in place to offer the public other interactive ways to communicate (social media, TIC and an Information desk near site). This valuable data needs to be processed to information instantly.

  Information from the authorities to the public should be advocated by Psychosocial experts. Adequate information to the public lowers the pressure on the telephone line and information desk. Which in turn offers more time to offer quality psychosocial support.

- **Use the Hobfoll principles**
  We recommend to use the Hobfoll principles both as a background theory and intervention strategy. Additionally they have proven to be a useful tool to:
  - monitor the psychosocial support during your intervention on several levels
  - motivate and communicate psychosocial measures to the authorities

Trainbombs 2004 in Spain (Madrid train bombings)

Event type: Train bombings
Place of the event: Madrid
Date of the event: March, 11th, 2004
Event characteristics:

- **Casualties: 192**
- **Damage to livelihood : yes**
- **estimaded people affected: 114 surrounding private homes affected and railway installations**
- **aprox. number of people supported:5000**
- **support for helpers: yes (155 FRs)**

Length of the PSS-Interventions: acute and midterm
Experts Organisation: SAMUR-Protección Civil
Experts Position: Psychosocial Crisis Manager

Description

March 11th, 2004 between 7.37 am and 7. 40 am at Atocha, Madrid's main train station: 14 explosive devices had been prepared and put in rucksacks and sports bags which had then been placed inside 4 different commuter trains. A total of 10 bombs detonated during the terrorist attack in Madrid on March 11, 2004. Each bomb contained explosive material and a detonator which was connected to the alarm function of a mobile phone.

The first call concerning the attack was made to the emergency service centre Madrid (112) at 7.39 am on March 11. The alarm was forwarded to the police and SAMUR-PC as well as to other concerned authorities. At about 8.30 am an emergency response regional command centre was set up in Madrid. A little later, at about 10.00 am, the Spanish government established a coordination at a national level.

This incident was the most serious that has occurred in a European country during peacetime. A total of 191 people were killed and more than 1,500 injured. The magnitude of the attack called for the mobilisation of resources from several municipalities in the region. This resulted in the regional and the national command organisations being activated – something which has not happened previously.

The attack occurred inside 4 trains departing from Alcalá de Henares station between 07:01 and 07:14. The explosions took place between 07:37 and 07:40, as described below:

- **Atocha Station** (train number 21431) – Three bombs exploded. Based on the video recording from the station security system, the first bomb exploded at 07:37, and two others exploded within 4 seconds of each other at 07:38.
- **El Pozo Station** (train number 21435) – At approximately 07:38, just as the train was starting to leave the station, two bombs exploded in different carriages.
- **Santa Eugenia Station** (train number 21713) – One bomb exploded at approximately 07:38.
- **Calle Téllez** (train number 17305), approximately 800 meters from Atocha Station – Four bombs exploded in different carriages of the train at approximately 07:39.

Who responded?

Over 70,000 people responded to the disaster

- 460 pre-hospital first medical responders from SAMUR-Civil Protection and SUMMA which is another EMS in Madrid

- 200 Volunteers from SAMUR-Civil Protection
- 235 Ambulances (SAMUR-CP, SUMMA, Red Cross)
- Taxis, urban buses, public buses, anonymous persons
- 320 Psychologists
- 95 Forensics
- 650 Firefighters
- 2.800 Local Police officers
- 1.000 National Police and Civil Guards officers
- 60 Operators from 112 Dispatch Center
- Thousands of blood donors

How was the response organized?

- The team of on duty and volunteer psychologists from SAMUR-CP was activated as per the established procedure.
    - 8:15 - psychologists activation by phone
    - 8:45 - 9: arrival at the scene and distribution of tasks
- Initial psychological assistance at train stations: psychologists and medical personnel dealt mainly with anxiety attacks.
- Around 13:00, authorities of Madrid City Council confirmed that, given the number of casualties, a big fairground in Madrid (IFEMA) was to be enabled as a morgue for reception of corpses and performance of autopsies by the forensics. Also **different rooms for reception and psychological care of relatives of the victims** were set up in this building**.**

Objectives of the intervention:

- Focus on human and material resources
- Focus on the affected persons
- Focus on the First Responders involved

ORGANISATION OF RESOURCES:

- Reception and identification of volunteer psychologists from Spanish Red Cross, Official College of Psychologists of Madrid, Mental Health Services, Social Services, etc.
- Assigning tasks to psychologists from SAMUR-CP and other institutions.
- Assignment of 1 or 2 psychologists to each family, depending on the number of family members.
- Psychologists from SAMUR-CP gave guidelines for psychological intervention in crisis to the professionals from other institutions.
- Rooms were provided to grieve privately.
- Procedures: Corpses, personal belongings, picture recognition, DNA testing, transportation of families to the assigned accommodation (hotels), etc.

INTERVENTION WITH FAMILIES:

- Reception and filiation of families.
- Providing information available so far.
- Facilitatingexpression of thoughts and emotions.
- Prevention of emotional contagion.
- Identification and normalization of symptoms.
- Preparing for a possible communication of bad news.

COLLABORATION WITH THE SCIENTIFIC POLICE IN OBTAINING INFORMATION ABOUT THE VICTIMS FROM THE FAMILY MEMBERS (physical features, clothing, scars, etc.)

REPORT OF THE DEATH delivered to the family by the psychologist assigned to the family, psychologist accompanied a psychologically strong family member during the visual recognition of corpses and when making funeral arrangements.

PSYCHOLOGICAL INTERVENTION AT THE CEMETERY

- A total of 37 unidentified bodies were taken to the cemetery in the morning of March 13th to proceed with the identification via DNA testing. The families staying at IFEMA and in hotels were brought to the cemetery.
- The responsible persons for the cemetery ask for help to organize the assistance of the families. There was no waiting room for families and no personnel to inform the families about the situation.

ORGANISATION OF THE FAMILIES FOR DNA TESTING

- Meeting with the scientific Police
- Establishment of a procedure to inform relatives about the DNA testing result.

INTERVENTION WITH FIRST RESPONDERS

In situ psychological assistance was given at IFEMA with numerous professionals from other institutions.

- After the event, psychological support was given to **fire-fighters** (individual and group therapy)
  - Groups of debriefing were organized
  - Documents with relevant information of symptoms of acute stress, guidelines for coping etc were distributed.
  - Results: 81 fire-fighters attended the scheduled sessions for debriefing. The evaluation carried out so far showed that 4 people had symptoms of acute stress disorder (ASD) symptoms, 5 people had symptoms associated with PTSD (subsyndromal symptoms) and 72 people had no ASD symptoms.
- After the event, psychological support was also given to **SAMUR-CP** first responders (individual and group therapy)
  - A total of 75 people were assisted. According to the acute stress assessment, the most relevant symptoms were:
    - Increased anxiety- activation: 96%
    - Intense feelings of anger and guilt: 92%
    - Re-experiencing symptoms: 84%
    - 6 weeks after the event, no one had ASD symptoms so far.
    - There were psychological interventions during the funerals and memorial services celebrated afterwards.

What were the strong points according to your opinion?

- Quick response
- Appropriate coordination with other institutions
- There was no emotional contagion despite having more than 5000 people in a room (IFEMA).
- New and better procedures of psychological assistance were developed as a result of the lessons learnt.
- The work of the emergency psychologist was considered important and areas aspects needing improvement were detected for further events.

What were the lessons learnt (weak points) according to your opinion?

- Mental Health providers involved in this type of action have to be prepared and trained in crisis intervention and Mass Casualty Incidents. Volunteer psychologists and psychiatrists came to help unprepared and we had to perform many psychological interventions in situ with professionals from other institutions.
- No existing inter-agency emergency planning in the event of a major incident.
- Proper filiations of every assisted person and every mental health provider are very important.
- Communication skills and empathy of the person delivering the bad news plays an important role in the coping abilities of victim's relatives

Conclusion and recommendations for further programmes

- Psychological procedures of performance are definitely necessary not only in big events, but also in daily practice.
- Education and training in crisis intervention are essential to respond to events of great magnitude afterwards.

Tsunami 2004 in South-East Asia_Swedish Perspective

Event type: Tsunami
Place of the event: South-East Asia
Experts Organisation: Swedish Red Cross
Experts Position: Mental Health Professional

Description
The disaster did not only affect south-east Asia, but also influenced many countries far away from its epicentre. Never before had so many Swedish citizens been hit so hard by a disaster, despite the fact that it took place far from their own country. A little more than one year after the disaster it could be con-firmed that 543 Swedes had lost their lifes. Eighteen are still missing. It was a disaster that affected mainly families, 140 children lost their lifes. 66 children lost a parent, 16 children lost both their parents. At the time of the enormous tsunami disaster there were probably more than 20,000 Swedes in south-east Asia. The tsunami hit Thailand's coast just after 10:00 local time; first the island of Phuket and then the islands of Phi Phi. These areas have been established tourist resorts for many years. Fifteen minutes later the wave reached Khao Lak, which lies north of Phuket and is one of the most recently developed tourist areas in the prov-ince of Phang Nga, with hotels and bungalows along a beach about 20 kilo-metres long. Many tourists had gone down to the beach when the wave hit. The wave, which in reality consisted of several waves, carried people for up to one kilometer in some cases. Others were stuck in palm trees and the tops of other trees, while some escaped by climbing to the up-per floors of hotels. Up until 15 January 2005 the police authorities in Sweden registered ap-proximately 19,000 people returning home.

Who responded?
Acute phase: The tsunami disaster put extraordinary demands on the Swedish emergency preparedness; preparedness that was not planned for events outside the country's borders. Thus, for a number of different reasons the measures taken to rescue Swedes involved, above all in Thailand, came to be delayed – which has been analyzed and criticized by the government appointed Tsunami Commission. During the acute phase were many actors involved and especially spontaneous volunteers Swedes on location in Thailand who assisted with first aid on the spot. Swedish authorities organized the action, through the embassy in Bangkok. SRK became invited to participate in the first response team that was sent down to Thailand. Parallel organisation was started in Sweden for the reception at Swedish airports and survivors' home municipalities.
Long term phase: Authorities and more focus

How was the PSS response organized?
Swedish Coordination Council for People Affected by the Tsunami Disaster started their work in January 2005 and closed down … x According to The Directives (Dir. 2005:1) The Council task was to constitute a function where survivors and relatives could turn to for guidance and information. It promoted also good contacts between relatives and survivors and authorities. Furthermore the Council worked coordinating information from authorities. They also identified that children and young people need special attention due to the disaster. The Council's task was also to work closely with government agencies, insurance companies, travel companies, NGOs and religious groups in Sweden.

SRC response. In the acute phase: On site in Thailand, working to organize and provide support to spontaneous volunteers, supporting survivors and screening the area for affected Swedish citizens. The work was coordinated and a part of the Swedish response, working togheter with Swedish authorities, Swedish church, DVI team, and Swedish save the children. In Sweden SRK worked together with other organisations and NGO´s to provide support for homecoming survivors and worried relatives waiting for contact and information about their loved ones. In the long term phase: SRC organisation in Thailand

continued for two years, assisting survivors and bereaved at site and organizing anniversaries. Many Swedish survivors and bereaved return or went to Thailand for "return trips". SRC provided support organizing them. In Sweden:

- SRC organized open meetings for survivors and bereaved in order to establish contact and give information about psychosocial support and provide information about normal reactions and need after potential traumatic events.
- Worked togheter with survivors and bereaved to identify their needs.
- SRC learned how to organize ceremonies together with survivors and bereaved
- Organizing support groups and support weekends
- Coordinated work and set up cooperation with other NGOS, Swedish Church and municipalities
- Payed special attention to children who lost both parents and families who lost children.

What were the strong points according to your opinion

Below are the strong points relating to the Red Cross operation only. For overall assessment see the national evaluation of the concerted efforts during the 22.7 terror attacks (Ministry of Justice, Norway).

- Established good relations and cooperation with other NGO´s with a clear purpose not to not compete for the affected population and to refer to each other so that survivors and bereaved would receive proper and timely support.
- SRC recruited volunteers with a professional background and give them a training in SRC work method.
- Put up a system for guidance for all volunteers
- Interacted with scientists and Swedish Knowledge Centre for Disaster Psychiatry
- Interacted with survivors and bereaved in order to identify needs and develop the programme.
- Part of the evaluation of the programme was made by scientists.

What were the lessons learnt (weak points) according to your opinion

- Support and possibility to access treatment varied a lot in different municipalitie

Conclusion and recommendations for further programmes

Overall conclusion from SRC

SRC discovered a weakness in society, the lack of outreach and long-term support after difficult events. For example there is no such as national guidelines for follow-up of families affected by suicide, even though the majority of these families need to contact support operations or psychiatry.

EVALUATION EXAMPLE: Music festival 2000 in Denmark

Event type: Panic at a Music Festival
Place of the event: Roskilde
Experts Organisation: Swedish Red Cross
Experts Position: Mental Health Professional

Description

The first large disaster intervention carried out by Danish Red Cross (DRC) psychological first aid volunteers was at the **Roskilde Music Festival 2000.**
This information is based on the evaluation report, From human being to human being - an evaluation of psychological first aid, provided by the Red Cross first aiders at the Roskilde Music Festival 2000 by Peter Berliner and Mirjam Höffding Refby, and the article, Psychological first aid as part of disaster response by Peter Berliner and Mette Sonniks and the Best Practices of Psychosocial support – IFRC:
Every year, some 80,000 to 90,000 people attend the music festival in Roskilde, Denmark. In 2000, a tragedy happened. Close to the scene, several people fell and the resulting confusion led to the death of nine individuals; many others were injured. The event had a great impact on all those affected: people at the festival, their families and the relief workers.
As a part of the immediate relief operation, 78 DRC volunteers provided for the first time psychological first aid. They were deeply affected by the tragedy and many were in great need of debriefing after their intervention.

Monitoring and evaluation

In the wake of the Roskilde festival, it was decided to evaluate the psychological first aid given by relief workers and the support they themselves received from the DRC's psychological network. A questionnaire was sent to all the relief workers involved; 30 of them (38 per cent) replied.

The results of the evaluation are as follows:

- Some 90 per cent of the first-aiders provided psychological first aid during or after the disaster.
- In total, approximately 1,500 people were given psychological first aid during and after the event by the volunteers present. (The figure of 1,500 is extrapolated from the numbers given in the returned questionnaires.)
- In general, volunteers spent 15 minutes on psychological first aid with each victim.
- The first aiders spent approximately one-quarter of their time on duty providing psychological first aid. This fraction is probably higher as a form of psychological first aid is a constituent part of physical first aid.
- The first aiders felt that their knowledge of psychological first aid was good. However, they asked that more courses be organized, especially follow-up training with a practical content.
- Sixty per cent of the first aiders experienced adverse psychological reactions in connection with the tasks they carried out, while 40 per cent had none. The reactions consisted mainly of either increased tension (anger, frustration, irritation, confusion, insomnia and restlessness) or intrusive thoughts and feelings (weeping, sense of guilt, fear, shock, shaking, unpleasant dreams, flashbacks and melancholy).
- It appears that the need to give psychological first aid to a large number of people in a very short time frame added to the pressure on the relief workers and may have been a factor triggering the negative reactions they experienced.
- A total of 67 per cent of the volunteers received some sort of psychological first aid after their involvement in the tragedy. On the whole, they were very satisfied with the support. Those most satisfied were relief workers who received help from the psychologists at the DRC's psychological network.

Lessons learned

- By working with volunteers trained in psychological first aid, the DRC is able to provide psychological support to many people affected by a tragic event. One of the most important aspects of psychological support is to raise the awareness of the public at large of what constitutes normal reactions to abnormal events. DRC relief workers have been able to communicate this widely. Another positive factor of psychological first aid is that, by screening victims in the immediate aftermath of a disaster, those in need of more specialized treatment can rapidly be referred to health professionals working with public crisis-intervention services.
- One important advantage that trained psychological first aid volunteers bring to a disaster situation is that they help victims to understand that they are not alone in their suffering and that their reactions are normal. Although some individuals may need further help, the majority benefit from the reinforced social support which is essential in preventing and handling psychological reactions to disasters.
- The sort of psychological support given by the DRC volunteers to victims, and that they themselves receive from the psychological network, has proved highly efficient. However, the society needs to increase the possibilities for psychological support education and training for first aiders.
- It is very important that, in disaster response situations, volunteers should be able to rapidly contact the support system, i.e., in the case of the DRC, the psychological network. This not only means having a telephone number, but also alternative ways of reaching the support system as, in major disasters, telephone systems often break down.
- After a major disaster, it is important to take advantage of the fact that everyone is motivated and wants to learn more. It is, therefore, an ideal time to implement improvements in education, etc.

Practice Examples derived from the literature

In addition to the interviews with stakeholders from different European countries, reports about practice examples have been collected. These practice examples consist of narrations of disaster-affected individuals or groups, or helpers.

Here you can find an overview of these examples from the European and International context.

The examples focus on the target groups as follows:

1. Practice examples focused on the general population
2. Practice examples focused on children/youth
3. Practice examples focused on disabled people
4. Practice examples focused on older people
5. Practice examples focused on helpers
6. Practice examples focused on event types

1. Practice Examples focused on the general population

Organisation(s): 7th July Assistance Centre
Author(s): Stone, C
Year: 2008
Title: Lessons Learned by the 7th July Assistance Centre staff, steering group and partners.
Link: www.gov.uk/government/uploads/system/uploads/attachment_data/file/78999/7july-assistancecentre-lessons-learned.pdf

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Organisation(s): Finnish Red Cross
Author(s): Saari, S.
Year: 2006
Title: Professionally led peer support and coping with the psychological consequences of the tsunami. The Finnish Red Cross psychological peer support work for the relatives of the deceased. Interim report.
Link: Link missing

Organisation(s): Government of Bangladesh
Author(s):
Year: 2008
Title: Cyclone Sidr in Bangladesh. Damage, Loss and Needs Assessment for Disaster Recovery and Reconstruction
Link: http://gfdrr.org/docs/AssessmentReport_Cyclone%20Sidr_Bangladesh_2008.pdf

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Organisation(s): International Federation of Red Cross and Red Crescent Societies (IFRC)
Author(s): -
Year: 2006a
Title: Vulnerability and capacity assessment Lessons learned and recommendations
Link: www.ifrc.org/global/publications/disasters/resources/preparing-disasters/vca/llearned-recommendations-en.pdf

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Organisation(s): International Federation of Red Cross and Red Crescent Societies (IFRC) & Asia Pacific
Author(s): -
How Year: 2010
Title: A Practical Guide to Gender-Sensitive Approaches for Disaster Management
Title Chapter/Tool: Pakistan: Humanitarian Assistance for Internally Displaced Persons (p. 50)
Link: http://www.ifrc.org/pagefiles/96532/a%20guide%20for%20gender-sensitive%20approach%20to%20dm.pdf

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Organisation(s): International Federation of Red Cross and Red Crescent Societies (IFRC) & Asia Pacific
Author(s): -
Year: 2010
Title: A Practical Guide to Gender-Sensitive Approaches for Disaster Management
Title Chapter/Tool: Banladesh: Community-Based Flood Management Programme (p. 60)
Link: http://www.ifrc.org/pagefiles/96532/a%20guide%20for%20gender-sensitive%20approach%20to%20dm.pdf

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Organisation(s): International Federation of Red Cross and Red Crescent Societies (IFRC) & Asia Pacific
Author(s): -
Year: 2010
Title: A Practical Guide to Gender-Sensitive Approaches for Disaster Management
Title Chapter/Tool: Indonesia: Integrated Community-Based Risk Reduction Project (p. 70)
Link: http://www.ifrc.org/pagefiles/96532/a%20guide%20for%20gender-sensitive%20approach%20to%20dm.pdf

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Organisation(s): International Federation of Red Cross and Red Crescent Societies (IFRC) & Asia Pacific Zone
Author(s): -
Year:2010
Title: A Practical Guide to Gender-Sensitive Approaches for Disaster Management.
Title Chapter/Tool: China: Community-Based Disaster Preparedness (p. 65)
Link: http://www.ifrc.org/pagefiles/96532/a%20guide%20for%20gender-sensitive%20approach%20to%20dm.pdf

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Organisation(s): International Federation of Red Cross and Red Crescent Societies (IFRC) & Asia Pacific Zone
Author(s): -
Year:2010
Title: A Practical Guide to Gender-Sensitive Approaches for Disaster Management.
Title Chapter/Tool: Solomon Islands: Working Together for Healthy Communities (p. 75)
Link: http://www.ifrc.org/pagefiles/96532/a%20guide%20for%20gender-sensitive%20approach%20to%20dm.pdf

Organisation(s): International Federation of Red Cross and Red Crescent Societies (IFRC)
Author(s): -
Year: 2007
Title: How to do a VCA. A Practical Step-By-Step Guide for Red Cross Red Crescent staff and volunteers
Title Chapter/Tool: Annex 1: The Caribbean: Flood / Table 1.1: Flood: Example chart (p. 85), Table 1.2: Flood: Vulnerabilities and capacities (p. 86), Table 1.3: Flood: Classing actions as prevention, preparation or mitigation (p. 86), Table 1.4: Flood: What resources are required? (p. 87)
Link: www.ifrc.org/global/publications/disasters/vca/how-to-do-vca-en.pdf

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Organisation(s): International Federation of Red Cross and Red Crescent Societies (IFRC)
Author(s): -
Year: 2007
Title: How to do a VCA. A Practical Step-By-Step Guide for Red Cross Red Crescent staff and volunteers
Title Chapter/Tool: Annex 2: The Caribbean: HIV / Table 2.1: HIV: Example chart (p. 88), Table 2.2: HIV: Vulnerabilities and capacities (p. 88), Table 2.3: HIV: Classing actions as prevention, preparation or mitigation (p. 89), Table 2.4: HIV: What resources are required? (p. 90)
Link: www.ifrc.org/global/publications/disasters/vca/how-to-do-vca-en.pdf

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Organisation(s): International Federation of Red Cross and Red Crescent Societies (IFRC)
Author(s): -
Year: 2001
Title: Psychosocial Support: Best practices from Red Cross Red Crescent Programmes
Link: http://helid.digicollection.org/en/d/Js2902e/

Organisation(s): International Federation of Red Cross and Red Crescent Societies (IFRC) & Asia Pacific
Author(s): -
Year: 2010
Title: A Practical Guide to Gender-Sensitive Approaches for Disaster Management
Title Chapter/Tool: Myanmar: Women´s Participation in Recovery (p. 55)
Link: http://www.ifrc.org/pagefiles/96532/a%20guide%20for%20gender-sensitive%20approach%20to%20dm.pdf

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Organisation(s): Mèdecins Sans Fronieères
Author(s): De Jong, K., Mulhearn, M., Swan, A. & Van der Kam, S.
Year: 2001
Title: Assessing Trauma in Sri Lanka. Psycho-Social Questionnaire. Vavuniya. Survey Outcomes
Link: http://www.msf.org/article/assessing-trauma-sri-lanka-psycho-social-questionnaire

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Organisation(s): Mental Health Task Force in Disaster
Author(s): Danvers, K., Somasundaram, D., Sivayokan, S., & Sivashankar
Year: 2005
Title: Mental Health Task Force in Disaster: Jaffna District. Qualitative Assessment of Psychosocial Issues following the Tsunami
Link: http://www.psychceu.com/DisasterResponse/NCPTSDpdf/Jaffna.pdf

Organisation(s): Queen Elizabeth House International Development Centre University of Oxford & Refugee Studies Centre.
Author(s): Armstrong, M., Boyden, J., Galappatti, A. & Hart, J.
Year: 2004
Title: Piloting Methods for the Evaluation of Psychosocial Programme Impact in Eastern Sri Lanka. Final Report for USAID.
Link: https://www.essex.ac.uk/armedcon/story_id/rrpilotingmethods04.pdf

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Organisation(s): Regional Psychosocial Support Initiative (REPSSI) [Africa], Transcultural Psychosocial Organisation (TPO) [Africa] & Global Psycho-Social Initiatives (GPSI)
Author(s): Baron, N. & Onyango Mangen, P.
Year: 2010
Title: Mainstreaming Psychosocial Care and Support Facilitating Community Support Structures. Lessons learned in Uganda about community-based psychosocial and mental health interventions.
Title Chapter/Tool: Chapter 3 Community Support Structures: Case Examples (p. 20)
Link: http://mhpss.net/wp-content/uploads/group-documents/25/1301657464-facilitatingcommunitysupportstructures.pdf

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Organisation(s): Russian Red Cross, International Federation of Red Cross and Red Crescent Societies & The International Federation. Reference Centre for Psychosocial Support
Author(s): -
Year: 2008
Title: Red Cross Psychosocial Response to the hostage crisis in Beslan, North Ossetia, Russia 2005-2007. Final Assessment Report April 2008
Link: http://www.ukt.cervenykriz.eu/en/wp-content/uploads/2013-11-PSP-Head-of-Operation_Beslan-report-2008.pdf

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Organisation(s): Swayam Shikshan Prayog (SSP) & Covenant Centre for Development (CCD)
Author(s): -
Year: 2005
Title: The Lull after the storm. An assessment report of Tamilnadu Tsunami by community women leaders with previous experience after the Latur and Gujarat earthquakes
Link: http://www.disasterwatch.net/Practice%20links/Lull%20after%20the%20storm.pdf

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Organisation(s): United Nations Children´s Fund (UNICEF) – Unite for children, United Nations Entity for Gender Equality and the Empowerment of Women, CARE International in Viet Nam, Save the Children, Centre for Sustainable Rural Development (SRD), IPS Asia-Pacific Regional Headquarters (IPS), United Nations Development Programm (UNDP), OXFAM, Plan Vietnam, Viet Nam Women's Union, Vietnam Red Cross, ADRA in Vietnam
Author(s): -
Year: 2012
Title: Recognise the strength of women and girls in reducing disaster risks! Stories from Viet Nam.
Link: http://ec.europa.eu/echo/files/policies/sectoral/recognise_strength_en.pdf

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Organisation(s): United Nations Children´s Fund (UNICEF),
Author(s): Ager, A., Ager, W., Stavrou, V. & Boothby, N.
Year: 2011
Title: Inter-Agency Guide to the Evaluation of Psychosocial Programming in Humanitarian Crisis
Title Chapter/Tool: Annex E: Implementing an Evaluation: Case Examples (p. 131)
Link: http://resourcecentre.savethechildren.se/library/inter-agency-guide-evaluation-psychosocial-programmes-humanitarian-crisis

Organisation(s): United Nations Development Programme (UNDP) (Empowered lives. Resilient nations)
Author(s): -
Year: n.d.
Title: Putting Resilience at the Heart of Development. Investing in Prevention and Resilient Recovery
Link:
http://www.undp.org/content/dam/undp/library/crisis%20prevention/disaster/asia_pacific/1206_undp_en_out%20(%20in%20English).pdf

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Organisation(s): World Health Organisation (WHO)
Author(s): -
Year: 2013
Title: Building back better. Sustainable Mental Health Care after Emergencies
Title Chapter/Tool: Part 2: Seizing opportunity in crisis: 10 case examples (p. 25)
Link: http://www.who.int/mental_health/emergencies/building_back_better/en/

Organisation(s): World Health Organisation (WHO)
Author(s): -
Year: 2013
Title: Building back better. Sustainable Mental Health Care after Emergencies
Title Chapter/Tool: Part 3:Spreading opportunity in crisis: Lessons learnt and take home messages (p. 95)
Link: http://www.who.int/mental_health/emergencies/building_back_better/en/

Organisation(s): Kamedo
Author(s): Angantyr, L.-G., Häggström, E., Kulling, P., Sigurdsson, S.
Year: 2009
Title: The Power Failure at Karolinska University Hospital, Huddinge 7 April 2007 Observer Studies. Kamedo Report 93
Link: http://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/8516/2009-126-91_200912692.pdf

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Organisation(s): Kamedo
Author(s): Bolling, R., Brändström, H., Ehrlin, Y., Forsberg, R., Rüter, A., Soest, V. Örtenwall, P., Magnusson, E.
Year: 2007
Title: The Terror Attacks in Madrid, Spain, 2004. Kamedo-report 90
Link: http://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/9210/2007-123-36_200712336.pdf

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Organisation(s): Kamedo
Author(s): Brändström, H., Widman, U. & Lundälv, J.
Year: 2012
Title: The SNAM Mission Following the 2008 Terrorist Attack in Mumbai. KAMEDO report 95
Link: http://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/18799/2012-7-10.pdf

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Organisation(s): Kamedo
Author(s): Brolén, P., Örtenwall, P., Österhed, H., Griggs, W.M., Olsson, M.-L., Brändström, H. & Magnusson, E.
Year: 2007
Title: The Terror Attack on Bali, 2002. Kamedo-report 89.
Link: http://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/9209/2007-123-35_200712335.pdf

Organisation(s): Kamedo
Author(s): Englund, L., Michel, P.-O., Riddez, L., Örtenwall, P./ Eklund, A.
Year: 2012
Title: The bomb attack in Oslo and the shootings at Utøya, 2011. KAMEDO report 97.
Link: http://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/18925/2012-12-23.pdf

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Organisation(s): Kamedo
Author(s): Kulling, P. & Sigurdsson, S.
Year: 2008
Title: Evacuation of Swedes from Lebanon 2006. Studies by observers in connection with the war in Lebanon in summer 2006. Kamedo report 92.
Link: http://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/8788/2008-126-44_200812645.pdf

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Organisation(s): Kamedo
Author(s): Lorin, H.
Year: 2000
Title: Thirty-five Years of Disaster-Medicine Studies Experience from KAMEDO's operations 1963–1998.
Link: http://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/11754/2000-0-81_0000081.pdf

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Organisation(s): Kamedo
Author(s): .
Year: 2008
Title: The 2004 Tsunami Disaster in Asia. Home Transport and Emergency Care in Sweden. KAMEDO-report 91.
Link: http://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/8691/2008-123-5_20081235.pdf

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Organisation(s): Kamedo,
Author(s): Björnstig, U., Albertsson, P.
Year: 2011
Title: Major Bus Crashes in Sweden 1997 – 2007. Kamedo Report No.94.
Link: http://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/18492/2011-11-19.pdf

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Organisation(s):
Author(s): Björnstig, U., Albertsson, P.
Year: 2011
Title: Major Bus Crashes in Sweden 1997 – 2007. Kamedo Report No.94.
Link: http://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/18492/2011-11-19.pdf

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Organisation(s): Council of Europe / The European Federation for Psychologists Associations (EFPA)
Author(s):
Year: 2009
Title: Lessons learned in psychosocial care after disaster.
Link: http://www.recoveryplatform.org/assets/publication/Lessonslearned_psycosocial%20care%20EC_EN.pdf

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Organisation(s):
Author(s): Seidenberg, J.
Year: n.d.
Title: Cultural Competency in Disaster Recovery: Lessons Learned from the Hurricane Katrina Experience for Better Serving Marginalized Communities
Link: https://www.e-education.psu.edu/drupal6/files/sgam/HT_Seidenberg.pdf

Organisation(s): Department for culture, media and sport
Author(s): Eyre, A.
Year: 2006
Title: Literature and Best Practice Review and Assessment: Identifying people´s needs in major emergencies and Best Practice in Humanitarian response.
Link:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/61224/ha_literature_review.pdf

2. Practice Examples focused on children/youth

Organisation(s): Centre for National Operations (CNO)
Author(s): -
Year: 2005
Title: Policy framework and guidelines for the protection and care of children affected by the tsunami disaster.
Link: http://psp.drk.dk/graphics/2003referencecenter/Doc-man/Documents/1Policy%20and%20good%20practice/CNO-Child_policy-SriLanka.pdf

Organisation(s): Participatory Action Research Project (PAR Project),
Author(s): Onyango, G. & Worthen, M.
Year: 2010
Title: Participatory Action Research Project with Young Mothers and their Children in Liberia, Sierra Leone, and Northern Uganda.
Link: http://www.uwyo.edu/girlmotherspar/_files/pubs-handbook.pdf

Organisation(s): Save The Children
Author(s): -
Year: 2009
Title: Guide for setting-up Child Friendly Complaints and Response Mechanisms (CRMs). Lessons Learnt from Save the Children's CRM in Dadaab Refugee Camp.
Link: http://www.hapinternational.org/pool/files/guide-to-a-child-friendly-crm-lessons-from-dadaab-kenya-final-draft.pdf

Organisation(s): Youth Net and Counselling (YONECO), Ecumenical Counselling Centre, Eye of the Child (EYC) & Network of Organisations for Vulnerable and Orphaned Children (NOVOC),
Author(s): Anderson Master Kamwendo A. M. & Kawale-Magela, R.
Year: 2011
Title: Psychosocial Support Source Book for Vulnerable Children in Malawi
Link: http://www.stopaidsnow.org/sites/stopaidsnow.org/files/CABA_Psychosocial-Support-Source-Book.pdf

Organisation(s): Plan
Author(s): Jabry, A.
Year: 2005
Title: After the cameras have gone. Children in disaster.
Title Chapter: Coping in the Aftermath of Calamity. The earthquakes of El Salvador (p. 13)
Link: https://plan-international.org/files/global/publications/emergencies/childrendisasters.pdf

Organisation(s): Plan
Author(s): Jabry, A.
Year: 2005
Title: After the cameras have gone. Children in disaster
Title Chapter: Disasters Preparedness and Safe Villages in Central Vietnam (p. 37)
Link: https://plan-international.org/files/global/publications/emergencies/childrendisasters.pdf

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Organisation(s): International Federation of Red Cross and Red Crescent Societies (IFRC)
Author(s):
Year: 2012
Title: Understanding Childrens Wellbeing
Title Chapter:
Link: http://www.pscentre.org/wp-content/uploads/Understanding-childrens-wellbeing.pdf

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Organisation(s): Save the Children
Author(s):
Year: 2011
Title: Psychological Assessment Report**.** Psychosocial Problems and Needs of Children in Flood Affected Areas in Pakistan
Title Chapter:
Link: http://www.savethechildren.org/atf/cf/%7B9DEF2EBE-10AE-432C-9BD0-DF91D2EBA74A%7D/pakistan-psychological-assessment-2011.pdf

3. Practice Examples focused on disabled people

Organisation(s): Center for Independence of the Disabled in New York
Author(s): -
Year: 2004
Title: LESSONS LEARNED FROM THE WORLD TRADE CENTER DISASTER: Emergency Preparedness for People with Disabilities in New York.
Link:
http://www.nobodyleftbehind2.org/resources/pdf/lessons_learned_from_the_world_trade_center_disaster.pdf

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Organisation(s): Deaf and Hard of Hearing Consumer Advocacy Network (DHHCAN) & Northern Virginia Resource Center for Deaf and Hard of Hearing Persons (NVRC)
Author(s): -
Year: 2004
Title: Emergency Preparedness and Communication Access - Lessons Learned since 9/11 and Recommendations
Link: https://tap.gallaudet.edu/Emergency/Nov05Conference/EmergencyReports/DHHCANEmergencyReport.pdf

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Organisation(s): Council of Europe/European and Mediterranean Major Hazards Agreement (EUR-OPA)
Author(s): Alexander, D. & Sagramola, S.
Year: 2014
Title: Major Hazards and People with Disabilities. Their Involvement in Disaster Preparedness and Response.
Title Chapter/Tool: Examples of good practice (p. 33-37)
Link: http://www.coe.int/T/DG4/MajorHazards/ressources/pub/MajorHazards_Disability_2014_en.pdf

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Organisation(s): Council of Europe/European and Mediterranean Major Hazards Agreement (EUR-OPA)
Author(s): Alexander, D. & Sagramola, S.
Year: 2014
Title: Major Hazards and People with Disabilities. Their Involvement in Disaster Preparedness and Response.
Title Chapter/Tool: Guidelines for assisting people with disabilities during emergencies, crises and disasters (p. 43-50)
Link: http://www.coe.int/T/DG4/MajorHazards/ressources/pub/MajorHazards_Disability_2014_en.pdf

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Organisation(s): Council of Europe/European and Mediterranean Major Hazards Agreement (EUR-OPA)
Author(s): Alexander, D. & Sagramola, S.
Year: 2014
Title: Major Hazards and People with Disabilities. Their Involvement in Disaster Preparedness and Response.
Title Chapter/Tool: Recommendation on the inclusion of people with disabilities in disaster preparedness and response (p. 52-53)
Link: http://www.coe.int/T/DG4/MajorHazards/ressources/pub/MajorHazards_Disability_2014_en.pdf

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4. Practice Examples focused on older people

Organisation(s): HelpAge India, HelpAge Sri Lanka & InResAge in Indonesia
Author(s): -
Year: 2005
Title: The impact of the Indian Ocean tsunami on older people. Issues and recommendations.
Link: http://www.globalaging.org/elderrights/world/2005/emerg.pdf

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Organisation(s): HelpAge International & United Nations High Commissioner for Refugees (UNHCR)
Author(s): -
Year:2012
Title: Protecting older people in emergencies good practice guide.
Title Chapter/Tool: Accessible shelter and latrines: Case study: Kyrgyzstan (p. 2)
Link: http://capacity4dev.ec.europa.eu/dgecho_genderage_wg/document/helpage-international-2012-protecting-older-people-emergencies-good-practice-guide

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Organisation(s): HelpAge International & United Nations High Commissioner for Refugees (UNHCR)
Author(s): -
Year:2012
Title: Protecting older people in emergencies good practice guide.
Title Chapter/Tool: Livelihood support: Case study: northern Uganda (p. 3)
Link: http://capacity4dev.ec.europa.eu/dgecho_genderage_wg/document/helpage-international-2012-protecting-older-people-emergencies-good-practice-guide

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Organisation(s): HelpAge International & United Nations High Commissioner for Refugees (UNHCR)
Author(s): -
Year:2012
Title: Protecting older people in emergencies good practice guide.
Title Chapter/Tool: Access to food and accurate registration: Case study: northern Uganda (p. 4)
Link: http://capacity4dev.ec.europa.eu/dgecho_genderage_wg/document/helpage-international-2012-protecting-older-people-emergencies-good-practice-guide

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Organisation(s): HelpAge International & United Nations High Commissioner for Refugees (UNHCR)
Author(s): -
Year:2012
Title: Protecting older people in emergencies good practice guide.
Title Chapter/Tool: Strengthening family and community structures: Case study: Kenya (p. 5)
Link: http://capacity4dev.ec.europa.eu/dgecho_genderage_wg/document/helpage-international-2012-protecting-older-people-emergencies-good-practice-guide

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Organisation(s): HelpAge International & United Nations High Commissioner for Refugees (UNHCR)
Author(s): -
Year:2012
Title: Protecting older people in emergencies good practice guide.
Title Chapter/Tool: Appropriate healthcare: Case study: West Darfur, Sudan (p. 6)
Link: http://capacity4dev.ec.europa.eu/dgecho_genderage_wg/document/helpage-international-2012-protecting-older-people-emergencies-good-practice-guide

Organisation(s): HelpAge International & United Nations High Commissioner for Refugees (UNHCR)
Author(s): -
Year:2012
Title: Protecting older people in emergencies good practice guide.
Title Chapter/Tool: Mainstreaming age across clusters: Case study: Pakistan (p. 7)
Link: http://capacity4dev.ec.europa.eu/dgecho_genderage_wg/document/helpage-international-2012-protecting-older-people-emergencies-good-practice-guide

Organisation(s): Baylor College of Medicine (BCM), The American Medical Association (AMA), Harris County Hospital District (HCHD) & Care for Elders, American Association of Retired Persons Foundation (AARP)
Author(s): Dyer, C., Festa, N. A., Cloyd, B., Regev, M., Schartzberg, J. G., James, J., Khaine, A., Poythress, L. Vogel, M., Burnett, J., Seaton, E. E., Wilson, N. L., Edwards, J., Mitchell, S. & Dix, M.
Year: 2006
Title: Recommendations for Best Practices in the Management of Elderly Disaster Victims.
Title Chapter/Tool: SWiFT Level tool in the post-disaster phase (p. 10)
Link: https://www.bcm.edu/pdf/bestpractices.pdf

Organisation(s): Baylor College of Medicine (BCM), The American Medical Association (AMA), Harris County Hospital District (HCHD) & Care for Elders, American Association of Retired Persons Foundation (AARP)
Author(s): Dyer, C., Festa, N. A., Cloyd, B., Regev, M., Schartzberg, J. G., James, J., Khaine, A., Poythress, L. Vogel, M., Burnett, J., Seaton, E. E., Wilson, N. L., Edwards, J., Mitchell, S. & Dix, M.
Year: 2006
Title: Recommendations for Best Practices in the Management of Elderly Disaster Victims.
Title Chapter/Tool: SWiFT Screening tool (p. 11)
Link: https://www.bcm.edu/pdf/bestpractices.pdf

Organisation(s): Baylor College of Medicine (BCM), The American Medical Association (AMA), Harris County Hospital District (HCHD) & Care for Elders, American Association of Retired Persons Foundation (AARP)
Author(s): Dyer, C., Festa, N. A., Cloyd, B., Regev, M., Schartzberg, J. G., James, J., Khaine, A., Poythress, L. Vogel, M., Burnett, J., Seaton, E. E., Wilson, N. L., Edwards, J., Mitchell, S. & Dix, M.
Year: 2006
Title: Recommendations for Best Practices in the Management of Elderly Disaster Victims.
Title Chapter/Tool: SWiFT Policies and procedures (p. 12)
Link: https://www.bcm.edu/pdf/bestpractices.pdf

Organisation(s): HelpAge International & United Nations High Commissioner for Refugees (UNHCR)
Author(s):-
Year: n.d
Title: Older people in disasters and humanitarian crisis: Guidelines for best practice
Title Chapter/Tool: Vulnerable individual checklist (p. 22)
Link: http://www.refworld.org/docid/4124b9f44.html

Organisation(s): HelpAge International & United Nations High Commissioner for Refugees (UNHCR)
Author(s):-
Year: n.d
Title: Older people in disasters and humanitarian crisis: Guidelines for best practice
Title Chapter/Tool: Orissa cyclone relief support to older people (p. 23)
Link: http://www.refworld.org/docid/4124b9f44.html

Organisation(s): HelpAge International & United Nations High Commissioner for Refugees (UNHCR)
Author(s):-
Year: n.d
Title: Older people in disasters and humanitarian crisis: Guidelines for best practice
Title Chapter/Tool: Post-disaster village needs assessment (p. 24)
Link: http://www.refworld.org/docid/4124b9f44.html

Organisation(s): HelpAge International
Author(s): Bramucci, G
Year: 2006
Title: Rebuilding lives in longer-term emergencies: Older people's experience in Darfur
Title Chapter/Tool: Rapid vulnerability assessment form (p. 23)
Link: http://www.globalaging.org/armedconflict/countryreports/africa/longerterm.pdf

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Organisation(s): HelpAge International
Author(s): Bramucci, G
Year: 2006
Title: Rebuilding lives in longer-term emergencies: Older people's experience in Darfur
Title Chapter/Tool: Health checklist for older people living in IDP camps (p. 24)
Link: http://www.globalaging.org/armedconflict/countryreports/africa/longerterm.pdf

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Organisation(s): HelpAge International
Author(s): Bramucci, G
Year: 2006
Title: Rebuilding lives in longer-term emergencies: Older people's experience in Darfur
Title Chapter/Tool: Health follow-up monitoring form (p. 25)
Link: http://www.globalaging.org/armedconflict/countryreports/africa/longerterm.pdf

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Organisation(s): HelpAge International
Author(s): Bramucci, G
Year: 2006
Title: Rebuilding lives in longer-term emergencies: Older people's experience in Darfur
Title Chapter/Tool: Nutrition monitoring form (p. 26)
Link: http://www.globalaging.org/armedconflict/countryreports/africa/longerterm.pdf

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Organisation(s): HelpAge International
Author(s): Bramucci, G
Year: 2006
Title: Rebuilding lives in longer-term emergencies: Older people's experience in Darfur
Title Chapter/Tool: Disability assessment form (first home visit interview) (p. 27)
Link: http://www.globalaging.org/armedconflict/countryreports/africa/longerterm.pdf

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Organisation(s): HelpAge International
Author(s): Bramucci, G
Year: 2006
Title: Rebuilding lives in longer-term emergencies: Older people's experience in Darfur
Title Chapter/Tool: Extremely vulnerable individual case card for housebound and cases for regular follow-up (p. 28)
Link: http://www.globalaging.org/armedconflict/countryreports/africa/longerterm.pdf

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Organisation(s): HelpAge International & Inter-Agency Standing Committee (IASC)

Author(s): Day, W., Pirie, A. & Roys, C.
Year: 2007
Title: Strong and fragile: Learning from Older People in Emergencies
Title Chapter/Tool: Displacement , separation and return (p. 9)
Link: http://reliefweb.int/sites/reliefweb.int/files/resources/2DFFE29C6D506325C125740B0038F8BC-HELPAGE_nov2007.pdf

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Organisation(s): Council of Europe/European and Mediterranean Major Hazards Agreement (EUR-OPA)
Author(s): Alexander, D. & Sagramola, S.
Year: 2014
Title: Major Hazards and People with Disabilities. Their Involvement in Disaster Preparedness and Response.
Title Chapter/Tool: Examples of good practice (p. 33-37)
Link: http://www.coe.int/T/DG4/MajorHazards/ressources/pub/MajorHazards_Disability_2014_en.pdf

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Organisation(s): Council of Europe/European and Mediterranean Major Hazards Agreement (EUR-OPA)
Author(s): Alexander, D. & Sagramola, S.
Year: 2014
Title: Major Hazards and People with Disabilities. Their Involvement in Disaster Preparedness and Response.
Title Chapter/Tool: Guidelines for assisting people with disabilities during emergencies, crises and disasters (p. 43-50)
Link: http://www.coe.int/T/DG4/MajorHazards/ressources/pub/MajorHazards_Disability_2014_en.pdf

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Organisation(s): Council of Europe/European and Mediterranean Major Hazards Agreement (EUR-OPA)
Author(s): Alexander, D. & Sagramola, S.
Year: 2014
Title: Major Hazards and People with Disabilities. Their Involvement in Disaster Preparedness and Response.
Title Chapter/Tool: Recommendation on the inclusion of people with disabilities in disaster preparedness and response (p. 52-53)
Link: http://www.coe.int/T/DG4/MajorHazards/ressources/pub/MajorHazards_Disability_2014_en.pdf

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5. Practice Examples focused on helpers

Organisation(s): IFRC Reference Centre for Psychosocial Support
Author(s):
Year: 2012
Title: Caring for volunteers. A Psychosocial Support Toolkit
Title Chapter: Response Cycle and Volunteer Psychosocial Support: Before, During and After
Link: http://pscentre.org/wp-content/uploads/volunteers_EN.pdf

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Organisation(s):
Author(s): Tehrani, N.
Year: 2008
Title: Trauma support for emergency services
Link: http://www.crisis-response.com/

Organisation(s): Volunteers of America
Author(s):
Year: n.d.
Title: Disaster Related Volunteerism. Best Practice Manual Based on Lessons Learned from Hurricanes Katrina and Rita
Link: http://www.handsonnetwork.org/files/best_practices_manual_-_disaster_related_volunteerism-1.pdf

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6. Practice Examples focused on Event types

Terrorist Attacks

- Bomb attack London

Organisation(s): 7th July Assistance Centre
Author(s): Stone, C
Year: 2008
Title: Lessons Learned by the 7th July Assistance Centre staff, steering group and partners.
Link: www.gov.uk/government/uploads/system/uploads/attachment_data/file/78999/7july-assistancecentre-lessons-learned.pdf

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- 9/11

Organisation(s): Deaf and Hard of Hearing Consumer Advocacy Network (DHHCAN) & Northern Virginia Resource Center for Deaf and Hard of Hearing Persons (NVRC)
Author(s):
Year: 2008
Title: Emergency Preparedness and Communication Access - Lessons Learned since 9/11 and Recommendations
Link:https://tap.gallaudet.edu/Emergency/Nov05Conference/EmergencyReports/DHHCANEmergencyReport.pdf

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- Hostage Crises Beslan

Organisation(s): Russian Red Cross, International Federation of Red Cross and Red Crescent Societies & The International Federation. Reference Centre for Psychosocial Support
Author(s): -
Year: 2008

Title: Red Cross Psychosocial Response to the hostage crisis in Beslan, North Ossetia, Russia 2005-2007. Final Assessment Report April 2008

Link: http://www.ukt.cervenykriz.eu/en/wp-content/uploads/2013-11-PSP-Head-of-Operation_Beslan-report-2008.pdf

Bomb attack Madrid

Organisation(s): Kamedo

Author(s): Bolling, R., Brändström, H., Ehrlin, Y., Forsberg, R., Rüter, A., Soest, V. Örtenwall, P., Magnusson, E.

Year: 2007

Title: The Terror Attacks in Madrid, Spain, 2004. Kamedo-report 90

Link: http://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/9210/2007-123-36_200712336.pdf

- Bomb attack Madrid

Organisation(s): Council of Europe / EFPA

Author(s): Scherdel, C. P.

Year: 2010

Title: Lessons learned in psychosocial care after disasters

Title Chapter/Tool: Spain - Terrorist attack in Madrid, March 2004 (p. 50)

Link: http://www.recoveryplatform.org/assets/publication/Lessonslearned_psycosocial%20care%20EC_EN.pdf

- Bomb attack Mumbai

Organisation(s): Kamedo

Author(s): Brändström, H., Widman, U. & Lundälv, J.

Year: 2012

Title: The SNAM Mission Following the 2008 Terrorist Attack in Mumbai. KAMEDO report 95

Link: http://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/18799/2012-7-10.pdf

- Bomb attack Bali

Organisation(s): Kamedo

Author(s): Brolén, P., Örtenwall, P., Österhed, H., Griggs, W.M., Olsson, M.-L., Brändström, H. & Magnusson, E.

Year: 2007

Title: The Terror Attack on Bali, 2002. Kamedo-report 89.

Link: http://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/9209/2007-123-35_200712335.pdf

- Bomb attack Oslo

Organisation(s): Kamedo

Author(s): Englund, L., Michel, P.-O., Riddez, L., Örtenwall, P./ Eklund, A.

Year: 2012

Title: The bomb attack in Oslo and the shootings at Utøya, 2011. KAMEDO report 97.

Link: http://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/18925/2012-12-23.pdf

Natural Disaster

- *Cyclone Sidr in Bangladesh*

Organisation(s): Government of Bangladesh

Author(s): -

Year: 2008

Title: Cyclone Sidr in Bangladesh. Damage, Loss and Needs Assessment for Disaster Recovery and Reconstruction

Link: http://reliefweb.int/sites/reliefweb.int/files/resources/F2FDFF067EF49C8DC12574DC00455142-Full_Report.pdf

- Hurricane Katrina

Organisation(s):

Author(s): Seidenberg, J.

Year: n.d.

Title: Cultural Competency in Disaster Recovery: Lessons Learned from the Hurricane Katrina Experience for Better Serving Marginalized Communities

Link: https://www.e-education.psu.edu/drupal6/files/sgam/HT_Seidenberg.pdf

- Earthquake and tsunami Indian Ocean

Organisation(s): International Federation of Red Cross and Red Crescent Societies (IFRC)

Author(s): -

Year: 2013

Title: Stronger together. The global Red Cross Red Crescent response to the 2004 Indian Ocean earthquake and tsunami

Title Chapter:

Link: http://www.ifrc.org/PageFiles/136957/1255200-Stronger%20Together-EN-HR.pdf

- Earthquake Haiti

Organisation(s): International Federation of Red Cross and Red Crescent Societies (IFRC)

Author(s): -

Year: 2014

Title: Haiti earthquake. Five-years progress report

Title Chapter:

Link: http://www.ifrc.org/Global/Publications/general/1287600-IFRC-Haiti%205-year%20progress%20report-EN-LR.pdf

- Earthquake Greece

Organisation(s): Council of Europe / EFPA

Author(s): Boukouvala, V.

Year: 2010

Title: Lessons learned in psychosocial care after disasters

Title Chapter: Greece - Earthquake in Attica, September 1999 (p. 26)

Link: http://www.recoveryplatform.org/assets/publication/Lessonslearned_psycosocial%20care%20EC_EN.pdf

- Earthquake Italy

Organisation(s): Council of Europe / EFPA

Author(s): Fernandez, I.

Year: 2010

Title: Lessons learned in psychosocial care after disasters

Title Chapter: Italy - Earthquake in central Italy, October 2002 (p. 30)

Link: http://www.recoveryplatform.org/assets/publication/Lessonslearned_psycosocial%20care%20EC_EN.pdf

- Earthquake L´Aquila

Organisation(s): Council of Europe / EFPA

Author(s): Palma, G. L., Baldassarre, G. & Fernandez, I.

Year: 2010

Title: Lessons learned in psychosocial care after disasters

Title Chapter: Psychological support in the aftermath of the 2009 L´Aquila earthquake (p. 33)

Link: http://www.recoveryplatform.org/assets/publication/Lessonslearned_psycosocial%20care%20EC_EN.pdf

- Earthquake Marmara

Organisation(s): Council of Europe / EFPA

Author(s): Karanci, A N.

Year: 2010

Title: Lessons learned in psychosocial care after disasters

Title Chapter: Turkey - Earthquake in Marmara, August 1999 (p. 61)

Link: http://www.recoveryplatform.org/assets/publication/Lessonslearned_psycosocial%20care%20EC_EN.pdf

- Flood in Lower Austria

Organisation(s): Council of Europe / EFPA

Author(s): Münker-Kramer, E.

Year: 2010

Title: Lessons learned in psychosocial care after disasters

Title Chapter: Austria - Flood in Lower Austria, August 2002 (p. 7)

Link: http://www.recoveryplatform.org/assets/publication/Lessonslearned_psycosocial%20care%20EC_EN.pdf

- Landslide in Log pod Mangartom

Organisation(s): Council of Europe / EFPA

Author(s): Polic, M.

Year: 2010

Title: Lessons learned in psychosocial care after disasters

Title Chapter: Slovenia - Landslide in Log pod Mangartom, November 2000 (p. 48)

Link: http://www.recoveryplatform.org/assets/publication/Lessonslearned_psycosocial%20care%20EC_EN.pdf

- Hurricane Katrina

Organisation(s):

Author(s): Seidenberg, J.

Year: n.d.

Title: Cultural Competency in Disaster Recovery: Lessons Learned from the Hurricane Katrina Experience for Better Serving Marginalized Communities

Title Chapter:

Link: https://www.e-education.psu.edu/drupal6/files/sgam/HT_Seidenberg.pdf

- Earthquake and tsunami Indian Ocean

Organisation(s): International Federation of Red Cross and Red Crescent Societies

Author(s):

Year: 2013.

Title: Stronger together. The global Red Cross Red Crescent response to the 2004 Indian Ocean earthquake and tsunami

Title Chapter:

Link: http://www.ifrc.org/PageFiles/136957/1255200-Stronger%20Together-EN-HR.pdf

- Earthquake Haiti

Organisation(s): International Federation of Red Cross and Red Crescent Societies

Author(s):

Year: 2014.

Title: Haiti earthquake. Five-years progress report

Title Chapter:

Link: http://www.ifrc.org/Global/Publications/general/1287600-IFRC-Haiti%205-year%20progress%20report-EN-LR.pdf

Tsunami

- Tsunami Jaffna District-South Asia

Organisation(s): Mental Health Task Force in Disaster
Author(s): Danvers, K., Somasundaram, D., Sivayokan, S., & Sivashankar
Year: 2005
Title: Mental Health Task Force in Disaster: Jaffna District. Qualitative Assessment of Psychosocial Issues following the Tsunami
Link: http://www.psychceu.com/DisasterResponse/NCPTSDpdf/Jaffna.pdf

- Tsunami Asia

Organisation(s): Kamedo
Author(s): .
Year: 2008
Title: The 2004 Tsunami Disaster in Asia. Home Transport and Emergency Care in Sweden. KAMEDO-report 91.
Link: http://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/8691/2008-123-5_20081235.pdf

- Tsunami in South-East Asia

Organisation(s): Council of Europe / EFPA
Author(s): Malikova, J.
Year: 2010
Title: Lessons learned in psychosocial care after disasters
Title Chapter: Czech Republic - Tsunami in South-East Asia, December 2004 (p. 13)
Link: http://www.recoveryplatform.org/assets/publication/Lessonslearned_psycosocial%20care%20EC_EN.pdf

- Tsunami in South-East Asia

Organisation(s): Council of Europe / EFPA
Author(s): Korsgaard, A.
Year: 2010
Title: Lessons learned in psychosocial care after disasters
Title Chapter: Denmark - Tsunami in South-East Asia, December 2004 (p. 16)
Link: http://www.recoveryplatform.org/assets/publication/Lessonslearned_psycosocial%20care%20EC_EN.pdf

- Tsunami in South-East Asia

Organisation(s): Council of Europe / EFPA
Author(s): Hakanson, E.
Year: 2010
Title: Lessons learned in psychosocial care after disasters
Title Chapter: Sweden - Tsunami in South-East Asia, December 2004 (p. 57)
Link: http://www.recoveryplatform.org/assets/publication/Lessonslearned_psycosocial%20care%20EC_EN.pdf

- Tsunami Tamilnadu

Organisation(s): Swayam Shikshan Prayog (SSP) & Covenant Centre for Development (CCD)

Author(s): Hakanson, E.

Year: 2005

Title: The Lull after the storm. An assessment report of Tamilnadu Tsunami by community women leaders with previous experience after the Latur and Gujarat earthquakes

Title Chapter: Sweden - Tsunami in South-East Asia, December 2004

Link: http://www.recoveryplatform.org/assets/publication/Lessonslearned_psycosocial%20care%20EC_EN.pdf

Mass Emergency

- Bus Crash in Sweden

Organisation(s): Kamedo

Author(s): Björnstig, U., Albertsson, P.

Year: 2011

Title: Major Bus Crashes in Sweden 1997 – 2007. Kamedo Report No.94.

Link: http://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/18492/2011-11-19.pdf

- Firework disaster in Enschede

Organisation(s): Council of Europe / EFPA

Author(s): Rooze, M.

Year: 2010

Title: Lessons learned in psychosocial care after disasters

Title Chapter: The Netherlands - Firework disaster in Enschede (p. 41)

Link: http://www.recoveryplatform.org/assets/publication/Lessonslearned_psycosocial%20care%20EC_EN.pdf

- Maritime disaster Norwegian Coast

Organisation(s): Council of Europe / EFPA

Author(s): Dyregrov, A. & Gfestad, R.

Year: 2010

Title: Lessons learned in psychosocial care after disasters

Title Chapter: Norway - Maritime disaster on Norwegian coast, November 1999 (p. 45)

Link: http://www.recoveryplatform.org/assets/publication/Lessonslearned_psycosocial%20care%20EC_EN.pdf

- Plane crash Luxembourg

Organisation(s): Council of Europe / EFPA

Author(s): Marc Stein, M.

Year: 2010

Title: Lessons learned in psychosocial care after disasters

Title Chapter: Luxembourg - Plane crash, November 2002 (p. 38)

Link: http://www.recoveryplatform.org/assets/publication/Lessonslearned_psycosocial%20care%20EC_EN.pdf

- Rail crash Belgium

Organisation(s): Council of Europe / EFPA
Author(s): Semiclaes, O.
Year: 2010
Title: Lessons learned in psychosocial care after disasters
Title Chapter/Tool: Belgium - Rail crash, March 2001 (p. 10)
Link: http://www.recoveryplatform.org/assets/publication/Lessonslearned_psycosocial%20care%20EC_EN.pdf

- Rail crash Belgium

Organisation(s): Council of Europe / EFPA
Author(s): Saari, S.
Year: 2010
Title: Lessons learned in psychosocial care after disasters
Title Chapter: Finland - Road accident in Konginkangas, March 2004 (p. 19)
Link: http://www.recoveryplatform.org/assets/publication/Lessonslearned_psycosocial%20care%20EC_EN.pdf

CBRN

- AFZ disaster in Toulousse

Organisation(s): Council of Europe / EFPA
Author(s): Szepielak, D.
Year: 2010
Title: Lessons learned in psychosocial care after disasters
Title Chapter: France - AZF disaster in Toulouse, September 2001 (p. 21)
Link: http://www.recoveryplatform.org/assets/publication/Lessonslearned_psycosocial%20care%20EC_EN.pdf

School shooting

- School shooting in Erfurt

Organisation(s): Council of Europe / EFPA
Author(s): Gewepieper, G.
Year: 2010
Title: Lessons learned in psychosocial care after disasters
Title Chapter: Germany - School shooting in Erfurt, April 2002 (p. 24)
Link: http://www.recoveryplatform.org/assets/publication/Lessonslearned_psycosocial%20care%20EC_EN.pdf

- School shooting Finland Kauhajoki

Organisation(s): Finnish ministry of the Interior
Author(s):
Year: 2010
Title: Kauhajoki School shooting: report of the investigation commission
Title Chapter:
Link:
http://oikeusministerio.fi/fi/index/julkaisut/julkaisuarkisto/392010kauhajokischoolshootingon23september2008-reportoftheinvestigationcommission/Files/OMSO_39_2010_Kauhajoki_School_Shooting_194_s.pdf

- School shooting Finland Kauhajoki (FInland), Jokela (Finland), Omaha (USA) and Virginia Tech (USA)

Organisation(s): University of Turku
Author(s): Hawdon, J, Oksanen, A., Räsänen, P, Ryan, J
Year: 2012
Title: School shooting and local communities an international comparison
Title Chapter:
Link: http://www.utu.fi/en/units/soc/units/econsoc/Documents/SchoolShootings.pdf

Lebanon Evacuation

- Lebanon Evacuation

Organisation(s): Kamedo
Author(s): Kulling, P. & Sigurdsson, S.
Year: 2008
Title: Evacuation of Swedes from Lebanon 2006. Studies by observers in connection with the war in Lebanon in summer 2006. Kamedo report 92.

Link: http://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/8788/2008-126-44_200812645.pdf

An overview of Standardised Instruments most frequently used in the Assessment of Mental Health Problems after Disasters and Major Incidents

PTSD diagnoses

Scale	©/Reference	Interrater agreement	Self-report (SR) and/or clinician administered (CA)	Freely available	DSM-5 based
CAPS-5 *(Clinician-Administered PTSD Scale for DSM-5)*	*Weathers, F. W., Blake, D. D., Schnurr, P. P., Kaloupek, D. G., Marx, B. P., & Keane, T. M. (2013). The Clinician-Administered PTSD Scale for DSM-5 (CAPS-5). Interview available from the National Center for PTSD at www.ptsd.va.gov.* ***To obtain:*** *http://www.ptsd.va.gov/professional/assessment/adult-int/caps.asp*	Unpublished	CA	Yes	Yes
SCID-I *(Structured Clinical Interview for the DSM-IV Axis I Disorders)*	*First, M. B., Spitzer, R. L., Gibbon, M., & Williams, J. B. W. (1996). Structured Clinical Interview for DSM-IV Axis I Disorders, Clinician Version (SCID-CV). Washington, DC: American Psychiatric Press.* ***To obtain:*** *http://www.scid4.org/info/refscid.html*	Good	CA	No	Yes[1]
M.I.N.I. *(The Mini-International Neuropsychiatric Interview)*	*Sheehan, D. V. et al. (1998). The Mini-International Neuropsychiatric Interview (M.I.N.I.): The development and validation of a structured diagnostic psychiatric interview for DSM-IV and ICD-10, The Journal of Clinical Psychiatry; 59 Suppl 20:22-33;quiz 34-57.* ***To obtain:*** *http://www.medical-outcomes.com/index/mini*	Excellent	CA	No	No[2]

1=The SCID development team has completed only a final draft of the SCID for DSM-5
2=DSM-IVbased

Depression diagnoses

Scale	©/Reference	Interrater agreement	Self-report (SR) and/or clinician administered (CA)	Freely available	DSM-5 based
SCID-I *(Structured Clinical Interview for the DSM-IV Axis I Disorders)*	*First, M. B., Spitzer, R. L., Gibbon, M., & Williams, J. B. W. (1996). Structured Clinical Interview for DSM-IV Axis I Disorders, Clinician Version (SCID-CV). Washington, DC: American Psychiatric Press.* ***To obtain:*** *http://www.scid4.org/info/refscid.html*	Good	CA	No	NA
M.I.N.I. *(The Mini-International Neuropsychiatric Interview)*	*Sheehan, D. V. et al. (1998). The Mini-International Neuropsychiatric Interview (M.I.N.I.): The development and validation of a structured diagnostic psychiatric interview for DSM-IV and ICD-10, The Journal of Clinical Psychiatry; 59 Suppl 20:22-33;quiz 34-57.* ***To obtain:*** *http://www.medical-outcomes.com/index/mini*	Excellent	CA	No	NA

Posttraumatic stress symptoms / probable PTSD

Scale	©/Reference	Internal consistency	Self-report (SR) and/or clinician administered (CA)	Freely available	DSM-5 based	Recommended cut-off
DTS *(Davidson Trauma Scale)*	*Davidson, J. R. et al. (1997). Assessment of a new self-rating scale for post-traumatic stress disorder, Psychological Medicine, 27, 153-160.* ***To obtain:*** http://www.mhs.com/product.aspx?gr=cli&id=overview&prod=dts	Excellent	SR	No	No	≥40 probable PTSD
IES-R *(Impact of Event Scale – Revised)*	*Weiss, D. S. (2007). The Impact of Event Scale: Revised. In J. P. Wilson & C. S.-k. Tang (Eds.), International and Cultural Psychology Series. Cross-Cultural Assessment of Psychological Trauma and PTSD (pp. 219–238). Boston, MA: Springer US.* ***To obtain:*** http://www.ptsd.va.gov/professional/assessment/adult-sr/ies-r.asp	Excellent	SR	No	No	≥33 probable PTSD
PCL *(PTSD Checklist)*	*Weathers, F. W., Litz, B. T., Keane, T. M., Palmieri, P. A., Marx, B. P., & Schnurr, P. P. (2013). The PTSD Checklist for DSM-5 (PCL-5), Scale available from the National Center for PTSD at www.ptsd.va.gov.* ***To obtain:*** http://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp	Excellent	SR	Yes	Yes	≥44 probable PTSD

Scale	©/Reference	Internal consistency	Self-report (SR) and/or clinician administered (CA)	Freely available	DSM-5 based	Recommended cut-off
PC-PTSD *(Primary Care-PTSD)*	*Prins, A., Ouimette, P., Kimerling, R., Cameron, R. P., Hugelshofer, D. S., Shaw-Hegwer, J., Thrailkill, A., Gusman, F. D., & Sheikh, J. I. (2003). The primary care PTSD screen (PC-PTSD): development and operating characteristics, 1, 9-14.* ***To obtain:*** *http://www.ptsd.va.gov/professional/assessment/screens/pc-ptsd.asp*	Excellent	SR	Yes	Yes	≥3 probable PTSD
PTCI *(Posttraumatic Cognitions Inventory)*	*Foa, E. B., Ehlers, A., Clark, D. M., Tolin, D. F., & Orsillo, S. M. (1999). The posttraumatic cognitions inventory (PTCI): Development and validation. Psychological Assessment, 11, 303-314.* ***To obtain scale:*** *http://www.fortrefuge.com/quiz-PTCI.php*	Excellent	SR	Yes	Yes	x
SAM *(Smart Assessment on your Mobile)*	*AMC (2014). An efficient assessment of resilience and stress responses in the face of adversity. Being validated.*	Being validated	SR	Yes	No	x
CMS *(The Mississippi Scale for Civilian PTSD)*	*Keane, T. M., Caddell, J. M., & Taylor, K. L. (1988). Mississippi scale for combat related posttraumatic stress disorder: Three studies in reliability and validity. Journal of Consulting and Clinical Psychology, 56(1), 85-90.* ***To obtain:*** *http://www.ptsd.va.gov/professional/assessment/adult-sr/mississippi-scale-m-ptsd.asp*	Excellent	SR	-	NA	>107 probable PTSD

Depression symptoms / probable depression

Scale	©/Reference	Internal consistency	Self-report (SR) and/or clinician administered (CA)	Freely available	DSM-5 based	Recommended cut-off
BDI-II *(Beck Depression Inventory)*	*Beck, A. T., Steer, R. A., Brown, G. K., (None), & (None). (1996). Manual for the Beck Depression Inventory-II (Vol. 4). San Antonio, TX: Psychological Corporation.* ***To obtain:*** *http://www.beckinstitute.org/beck-inventory-and-scales/*	Excellent	SR	No	NA	≥20 probable depression
CES-D *(Center for Epidemiologic Studies Depression Scale)*	*Radloff, L. S. (1977). The CES-D Scale: A Self-Report Depression Scale for Research in the General Population. Applied Psychological Measurement, 1(3), 385–401.* ***To obtain:*** *http://cesd-r.com/*	Excellent	SR	Yes	NA	≥23 probable depression
HDS *(Hamilton depression scale)*	*Hamilton, M. (1960). A rating scale for depression. Journal of Neurology, Neurosurgery & Psychiatry, 23(1), 56–62.* ***To obtain:*** *http://healthnet.umassmed.edu/mhealth/HAMD.pdf*	Excellent	SR and CA	Yes	NA	≥20 probable depression
BSI *(Brief Symptom Inventory – depression subscale)*	*Derogatis, L.R. & Savitz, K.L. (2000). The SCL-90-R and the Brief Symptom Inventory (BSI) in Primary Care. In M. E. Maruish (Ed.), Handbook of psychological assessment. Volume 236 Mahwah, NJ: Lawrence Erlbaum Associates, pp 297-334.* ***To obtain:*** *http://www.pearsonclinical.com/psychology/products/100000450/brief-symptom-inventory-bsi.html*	Good	SR	No	NA	males ≥0.66; females ≥1.07 probable depression

Scale	©/Reference	Internal consistency	Self-report (SR) and/or clinician administered (CA)	Freely available	DSM-5 based	Recommended cut-off
SCL-90-R *(Symptom Checklist 90 Revised – depression subscale)*	*Derogatis, L.R. & Savitz, K.L. (2000). The SCL-90-R and the Brief Symptom Inventory (BSI) in Primary Care. In M. E. Maruish (Ed.), Handbook of psychological assessment. Volume 236 Mahwah, NJ: Lawrence Erlbaum Associates, pp 297-334.* ***To obtain:*** *http://www.pearsonclinical.com/psychology/products/100000645/symptom-checklist-90-revised-scl-90-r.html*	Excellent	SR	No	NA	males ≥0.72; females ≥1.13 probable depression
SAM *(Smart Assessment on your Mobile)*	*AMC (2014). An efficient assessment of resilience and stress responses in the face of adversity. Being validated.*	Being validated	SR	Yes	-	x
DASS *(Depression Anxiety Stress Scale)*	*Henry, J. D., & Crawford, J. R. (2005). The 21-item version of the Depression Anxiety Stress Scales (DASS–21): Normative data and psychometric evaluation in a large non-clinical sample. British Journal of Clinical Psychology, 44, 227–239.* ***To obtain:*** *http://www2.psy.unsw.edu.au/dass/*	Excellent	SR	Yes	-	x

Substance abuse symptoms and diagnoses

Scale	©/Reference	Internal consistency/ Interrater agreement	Self-report (SR) and/or clinician administered (CA)	Copyright free	DSM-5 based	Recommended cut-off
AUDIT-C *(Alcohol Use Disorders Identification Test)*	*Bush, K., Kivlahan, D. R., McDonell, M. B., Fihn, S. D., & Bradley, K. A. (1998). The AUDIT alcohol consumption questions (AUDIT-C): an effective brief screening test for problem drinking. Internal Medicine, 158, 1789-1795.* ***To obtain:*** *http://www.hepatitis.va.gov/provider/tools/audit-c.asp*	Excellent	SR	Yes	NA	Heavy users: > 14 drinks a week
SAM *(Smart Assessment on your Mobile)*	*AMC (2014). An efficient assessment of resilience and stress responses in the face of adversity. Being validated.*	Being validated	SR	Yes	NA	X
SCID-I *(Structured Clinical Interview for the DSM-IV Axis I Disorders)*	*First, M. B., Spitzer, R. L., Gibbon, M., & Williams, J. B. W. (1996). Structured Clinical Interview for DSM-IV Axis I Disorders, Clinician Version (SCID-CV). Washington, DC: American Psychiatric Press.* ***To obtain:*** *http://www.scid4.org/info/refscid.html*	Good	CA	No	NA	X
M.I.N.I. *(The Mini-International Neuropsychiatric Interview)*	*Sheehan, D. V. et al. (1998). The Mini-International Neuropsychiatric Interview (M.I.N.I.): The development and validation of a structured diagnostic psychiatric interview for DSM-IV and ICD-10, The Journal of Clinical Psychiatry; 59 Suppl 20:22-33;quiz 34-57.* ***To obtain:*** *http://www.medical-outcomes.com/index/mini*	Excellent	CA	No	NA	X

General mental health

Scale	©/Reference	Internal consistency	Self-report (SR) and/or clinician administered (CA)	Freely available	DSM-5 based	Recommended cut-off
BSI *(Brief Symptom Inventory – global severity index score)*	*Derogatis, L.R. & Savitz, K.L. (2000). The SCL-90-R and the Brief Symptom Inventory (BSI) in Primary Care. In M.E.Maruish(Ed.) Handbook of psychological assessment. Volume 236 Mahwah, NJ: Lawrence Erlbaum Associates, pp 297-334.* ***To obtain:*** *http://www.pearsonclinical.com/psychology/products/100000450/brief-symptom-inventory-bsi.html*	Excellent	SR	No	No	*males ≥0.58; females ≥0.83 poor mental health*
GHQ *(General Health Questionnaire)*	*Goldberg, D. P., & Williams, P. (1988). A users guide to the General Health Questionnaire. Slough: NFER-Nelson.* *Versions: GHQ-12; GHQ-28; GHQ-30; GHQ-60.* ***To obtain:*** *http://www.gl-assessment.co.uk/products/general-health-questionnaire-0*	Excellent	SR	No	No	*When scored 0-0-1-1:* *GHQ-12 ≥2;* *GHQ-20 ≥4;* *GHQ-28 ≥5* *GHQ-30 ≥5* *GHQ-60 ≥12* *poor mental health*
SCL-90-R *(Symptom Checklist 90 Revised – global severity index score)*	*Derogatis, L.R. & Savitz, K.L. (2000). The SCL-90-R and the Brief Symptom Inventory (BSI) in Primary Care. In M.E.Maruish (Ed.), Handbook of psychological assessment. Volume 236 Mahwah, NJ: Lawrence Erlbaum Associates, pp 297-334.* ***To obtain:*** *http://www.pearsonclinical.com/psychology/products/100000645/symptom-checklist-90-revised-scl-90-r.html*	Excellent	SR	No	No	*males ≥0.58; females ≥0.78 poor mental health*

Scale	©/Reference	Internal consistency	Self-report (SR) and/or clinician administered (CA)	Freely available	DSM-5 based	Recommended cut-off
WHOQoL-BREF *(WHO Quality of Life scale – abbreviated)*	*Development of the World Health Organisation WHOQOL-BREF quality of life assessment. The WHOQOL Group. (1998) Psychol Med, 28(3), 551-558.* ***To obtain:*** http://www.who.int/mental_health/media/en/76.pdf	Good	SR	Yes	NA	

Traumatic stress inventories

Scale	©/Reference	Internal consistency	Self-report (SR) and/or clinician administered (CA)	Freely available	DSM-5 based
LEC *(Life Events Checklist)*	*Gray, M. J., Litz, B. T., Hsu, J. L., & Lombardo, T. W. (2004). Psychometric Properties of the Life Events Checklist. Assessment11, 330.* ***To obtain:*** *http://www.ptsd.va.gov/professional/assessment/te-measures/life_events_checklist.asp*	Good	CA	Yes	No
PDI *(Peritraumatic Distress Inventory)*	*Brunet A., Weiss D. S., Metzler T. J., Best S. R., Neylan T. C., Rogers C., Fagan J., Marmar C. R. (2001). The Peritraumatic Distress Inventory: a proposed measure of PTSD criterion A2. American Journal of Psychiatry, 158 (9), 1480-5.* ***To obtain:*** *http://www.info-trauma.org/flash/media-e/triageToolkit.pdf*	Good	SR	Yes	Yes

Scale	©/Reference	Internal consistency	Self-report (SR) and/or clinician administered (CA)	Freely available	DSM-5 based
PDEQ *(Peritraumatic Dissociative Experiences Questionnaire)*	*Marmar, C. R., Weiss, D. S., & Metzler, T. J. (1997). The peritraumatic dissociative experiences questionnaire. In Wilson J. P., Marmar C. R. (Eds.). Assessing psychological trauma and posttraumatic stress disorder (p. 412-428). New York: The Guilford Press.* ***To obtain:*** *http://www.info-trauma.org/flash/media-e/triageToolkit.pdf*	Excellent	SR	Yes	Yes
TESS *(Traumatic Exposure Severity Scale)*	*Elal, G., & Slade, P. (2005). Traumatic Exposure Severity Scale (TESS): A measure of exposure to major disasters. Journal of Traumatic Stress, 18 (3), 213–220.* ***To obtain:*** *http://onlinelibrary.wiley.com/doi/10.1002/jts.20030/abstract*	Good	SR	No	No
SAM *(Smart Assessment on your Mobile)*	*AMC (2014). An efficient assessment of resilience and stress responses in the face of adversity. Being validated.*	Being validated	SR	Yes	No

Resilience

Scale	©/Reference	Internal consistency	Self-report (SR) and/or clinician administered (CA)	Freely available	DSM-5 based
CART *(Communities Advancing Resilience Toolkit)*	*Pfefferbaum RL, Pfefferbaum B, & Van Horn RL (2011). Communities Advancing Resilience Toolkit (CART): The CART Integrated System. Oklahoma City, OK: Terrorism and Disaster Center at the University of Oklahoma Health Sciences Center.* ***To obtain:*** *http://tdc.missouri.edu/doc/cart_online-final_042012.pdf*	Good/Excellent	SR	Yes	NA
RES (*Resilience Evaluation Scale)*	*AMC & Arq (2013) Van der Meer, Te Brake, Bakker & Olff. Assessment of psychological resilience: validation of the new 10-item Resilience Evaluation Scale (RES) - AMC & Arq Internal report, article in prep. 2015)* ***To obtain:*** *Christianne van der Meer, c.a.meervander@amc.uva.nl* *Hans te Brake h.te.brake@arq.impact.org*	Being validated	SR	Yes	NA
SAM *(Smart Assessment on your Mobile)*	*AMC (2014). An efficient assessment of resilience and stress responses in the face of adversity. Being validated.*	Being validated	SR	Yes	NA
MIRROR part I	*IMPACT (2014). Under construction.*	Being validated	SR	Yes[1]	NA
MRM *(Military Resilience Monitor)*	*TNO (2014). Being validated.*	Being validated	SR	No	NA
PRM *(Police Resilience Monitor)*	*TNO (2014). Being validated.*	Being validated	SR	No	NA

[1] Copyright free for at least the first 5 years after its release.

Social support

Scale	©/Reference	Internal consistency	Self-report (SR) and/or clinician administered (CA)	Freely available	DSM-5 based
MSPSS *(Multidimensional Scale of Perceived Social Support)*	*Zimet, G. D., Dahlem, N. W., Zimet, S. G., & Farley, G. K. (1988). The multidimensional scale of perceived social support.* Journal of personality assessment*, 52(1), 30-41.* ***To obtain:*** *http://www.yorku.ca/rokada/psyctest/socsupp.pdf*	Excellent	SR	Yes	NA
SSL *(Social Support List)*	*Bridges, K.R., Sanderman, R. & Sonderen, E. van. (2002) An English language version of the social support list: preliminary reliability. Psychosocial reports, 90, 1055-1058.*	Excellent	SR	Yes	NA

Functioning

Scale	©/Reference	Internal consistency	Self-report (SR) and/or clinician administered (CA)	Freely available	DSM-5 based
SF-36 *(Short-Form Health Survey)*	*Ware Jr, J. E., & Sherbourne, C. D. (1992). The MOS 36-item short-form health survey (SF-36): I. Conceptual framework and item selection.* Medical care*, 473-483.* ***To obtain:*** *http://www.rand.org/health/surveys_tools/mos/mos_core_36item.html*	Good/Excellent	SR	Yes	NA

Scales for children and adolescents

Scale	©/Reference	Internal consistency	Self-report (SR) and/or clinician administered (CA)	Freely available	DSM-5 based	Recommended cut-off
CDI 2 *(Children's Depression inventory 2nd edition)*	*Kovacs, M. (2011). Children's Depression Inventory 2™ (CDI 2). North Tonawanda, NY: Multi-Health Systems Inc* ***To obtain:*** *http://www.mhs.com/product.aspx?gr=edu&id=overview&prod=cdi2*	Excellent	SR	No	NA	x
CRIES *(Children's Revised Impact of Event Scale)*	*Perrin, S., Meiser-Stedman, R. & Smith, P. (2005). The Children's Revised Impact of Event Scale (CRIES): Validity as a screening instrument for PTSD. Behavioural and Cognitive Psychotherapy, 33, 487‑498.* ***To obtain:*** *http://www.childrenandwar.org/measures/children%E2%80%99s-revised-impact-of-event-scale-8-%E2%80%93-cries-8/*	Excellent	SR	Yes	No	8 item version ≥ 17 13 item version ≥ 23 probable PTSD
PTSD-RI *(PTSD Reaction Index)*	*Pynoos, R., Rodriguez, N., Steinberg, A., Stuber, M., & Frederick, C. (1998). UCLA PTSD Index for DSM-IV.* ***To obtain:*** http://www.ptsd.va.gov/professional/assessment/child/ucla-ptsd-dsm-iv.asp	Excellent	SR	No	No	≥ 38 probable PTSD
READ *(Resilience Scale for Adolescents)*	*Hjemdal, O., Friborg, O., Stiles, T. C., Martinussen, M., & Rosenvinge, J. H. (2006). A New Scale for Adolescent Resilience: Grasping the Central Protective Resources Behind Healthy Development. Measurement and Evaluation in Counseling and Development, 84-96.* ***To obtain:*** *http://www.redalyc.org/articulo.oa?id=282235731002*	Good/ Excellent	SR	Yes	NA	x

Suggested 'golden standard' mental health instruments for use after crises

per domain, freely available, relatively short, validated
Miranda Olff – 16 September 2015

Topic	Scale	Freely availble	To obtain scale	©/Reference
Potential Traumatic Events Checklist (17 items)	***Life Events Checklist for DSM-5*** (LEC-5)	Yes	http://www.ptsd.va.gov/professional/assessment/te-measures/life_events_checklist.asp	©Weathers, Litz, Keane, Palmieri, Marx, & Schnurr - National Center for PTSD (2013)
Posttraumatic Stress Quick screener (5 items)	***The Primary Care PTSD Screen for DSM-5*** (PC-PTSD 5)	Yes	The scale is being validated, see: http://www.ptsd.va.gov/professional/assessment/screens/pc-ptsd.asp and http://www.ptsd.va.gov/professional/assessment/DSM_5_Validated_Measures.asp	©Prins et al. - National Center for PTSD (2013)
Posttraumatic Stress Questionnaire PTSD symptoms (20 items)	***PTSD checklist for the DSM-5*** (PCL-5)	Yes	Request form: http://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp	©Weathers, Litz, Keane, Palmieri, Marx, & Schnurr - National Center for PTSD (2013)
Posttraumatic Stress Interview	***Clinician-Administered PTSD scale for DSM-5*** (CAPS-5)	Yes	Request form: http://www.ptsd.va.gov/professional/assessment/adult-int/caps.asp	©Weathers, Blake, Schnurr, Kaloupek, Marx, & Keane - National Center for PTSD (2013)
Psychological Resilience Brief questionnaire (10 items)	***Resilience Evaluation Scale*** (RES)	Yes	E-mail: Christianne van der Meer, c.a.meervander@amc.uva.nl Hans te Brake, h.te.brake@arq.impact.org	© AMC & Arq (2013) Van der Meer, Te Brake, Bakker & Olff. Assessment of psychological resilience: validation of the new 10-item Resilience Evaluation Scale (RES) - AMC & Arq Internal report, article in prep. 2015)
Depression, Anxiety, Stress Questionnaire (21 items)	***Depression Anxiety Stress Scales-21*** (DASS-21)	Yes	http://www2.psy.unsw.edu.au/dass/down_W6.htm	©Lovibond, School of Psychology, University of New South Wales, Sydney

Depression Questionnaire (20 items)	***The Center for Epidemiologic Studies Depression Scale Revised*** (CESD-R)	Yes	http://cesd-r.com/	Eaton, W. W., Smith, C., Ybarra, M., Muntaner, C., & Tien, A. (2004). Center for Epidemiologic Studies Depression Scale: review and revision (CESD and CESD-R). In M. E. Maruish (Ed.). , *The Use of Psychological Testing for Treatment Planning and Outcomes Assessment* (363-377). Mahwah, NJ: Lawrence Erlbaum.
Alcohol abuse or dependence Questionnaire (3 items)	***The Alcohol Use Disorders Identification Test*** (AUDIT-C)	Yes	http://www.hepatitis.va.gov/provider/tools/audit-c.asp	© WHO (1990)
Peritraumatic Distress Questionnaire (13 items)	***Peritraumatic Distress Inventory*** (PDI)	Yes	http://www.info-trauma.org/flash/media-e/triageToolkit.pdf	Brunet, A., Weiss, D.S., Metzler, T.J., et al. (2001). The Peritraumatic Distress Inventory: A proposed Measure of PTSD criterion A2. American Journal of Psychiatry, 158, 1480-1485.
Peritraumatic Dissociation Questionnaire (10 items)	***Peritraumatic Dissociative Experiences Questionnaire*** (PDEQ)	Yes	http://www.info-trauma.org/flash/media-e/triageToolkit.pdf	Marmar, C.R., Weiss, D.S., & Metzler, T.J. (1997). The Peritraumatic Dissociative Experiences Questionnaire. In Wilson J.P., Marmar C.R., (Eds.). Assessing psychological trauma and posttraumatic stress disorder (p. 412-428). New York : The Guilford Press.