

Planning for Individual and Community Recovery in an Emergency Event

Principles for Psychosocial Support

National Health Emergency Plan

Citation: Ministry of Health. 2007. *Planning for Individual and Community Recovery in an Emergency Event: Principles for Psychosocial Support. National Health Emergency Plan*. Wellington: Ministry of Health.

Published in September 2007 by the
Ministry of Health
PO Box 5013, Wellington, New Zealand

ISBN 978-0-478-1917-1 (Print)
ISBN 978-0-478-1913-8 (Online)
HP4431

This document is available on the Ministry of Health's website:
<http://www.moh.govt.nz>



Contents

Acknowledgements	v
Executive Summary	vi
Introduction	1
Overview	1
Structure	1
Scope	3
Future development of these guidelines	4
Part A: Evidence-based Principles and Good Practice for Psychosocial Recovery	5
Principles of the psychosocial recovery process	5
How people react to emergency	5
Risk and protective factors	8
Addressing potential disparities	10
Promoting psychosocial recovery	11
Operational principles	15
Part B: Operational Planning	17
Key aspects of planning for psychosocial recovery	17
Ministry of Health roles	18
District Health Board roles	18
National inter-agency links	19
Operationalising the psychosocial recovery principles: a summary of agency actions	21
Pre-event: risk reduction	23
Pre-event: readiness	24
Response and recovery	24
An example of emergency management: pandemic influenza	33
Glossary	39
Abbreviations	41
References	42
Further reading	43

List of Tables

Table 1:	Survivor responses in emergency situations	6
Table 2:	Planning for psychosocial recovery in the readiness phase of an emergency event	25
Table 3:	Psychosocial recovery in the response phase	30
Table 4:	Planning for psychosocial recovery in the recovery phase	31
Table 5:	Possible psychosocial effects of a pandemic	34
Table 6:	Suggested planning activities to address psychosocial effects in a pandemic	36

List of Figures

Figure 1:	Considering psychosocial support	2
Figure 2:	Structure of the New Zealand health and disability sector for emergency management	20
Figure 3:	Recovery pathway for those experiencing the emergency event and professionals responding to the event	23

Acknowledgements

The Ministry of Health would like to thank the members of the Psychosocial Recovery Advisory Group for their contribution and commitment to the development of this document.

The members are:

- Gay Puketapu Andrews, NZ Association of Counsellors
- Bruce Parkes, St John – Northern
- Liz Prior, Waikato District Health Board
- Adriaan Engelbrecht, Bay of Plenty District Health Board
- Barbara Wilson, Canterbury District Health Board
- Dr Tim Harvey, Pegasus Health
- Mathew Keen, MidCentral District Health Board
- Mr Nigel Fairley, Capital and Coast District Health Board
- Marion Blake, Platform
- Professor Peter Ellis, Capital and Coast District Health Board.

The Ministry of Health would like to thank Emeritus Professor Tony Taylor for his particular contribution to the draft and final versions of this document.

Others who have contributed their expertise include:

- Dr Frances Hughes, Ministry of Health
- Dr Sarbjit Johal, Ministry of Health
- Pauline Cook, Ministry of Health
- Fiona Julian, Ministry of Health
- Wi Keelan, Ministry of Health
- Justine Canning, Ministry of Health
- Professor Kevin Ronan, Central Queensland University
- National Welfare Recovery Co-ordination Group.

Executive Summary

This document outlines the importance of psychosocial recovery when planning how to respond to and recover from an emergency event.

Our awareness of vulnerability to emergency events, and the difficulties of assisting those who survive them, has been heightened by events such as the terrorist attack on the World Trade Centre in 2001, the Indian Ocean tsunami in 2004, Hurricane Katrina in 2005, and a number of civil defence emergencies in New Zealand since 2004. Public and government expectations have been raised for all aspects of response and recovery from emergency events.

This document is aimed primarily at a health sector audience, but should also be useful for other agencies, organisations, providers and non-governmental organisations (NGOs). The purpose of these Principles is to help orient organisations towards good practice principles for providing psychosocial support to promote recovery in an emergency event.

Part A of this document outlines key evidence-based principles and good practice for psychosocial recovery. Part B gives suggestions for operational planning actions – how to translate the principles into practice.

It is important that everyone involved in emergency planning has a shared understanding of what is meant by the term 'psychosocial recovery'. In the past, psychosocial recovery has been understood and implemented in different ways by different organisations, both in New Zealand and overseas. Recovery encompasses the psychological and social dimensions that are part of the regeneration of a community. The process of psychosocial recovery from emergencies involves easing the physical and psychological difficulties for individuals, families/whānau and communities, as well as building and bolstering social and psychological wellbeing.

Many components of psychosocial recovery will not be delivered by the health and disability system, but by individuals and families; community organisations such as church groups; welfare agencies; or other groups convened for recovery purposes under the umbrella of the regionally based Civil Defence Emergency Management (CDEM) groups. Most people affected by an emergency event will not need a psychiatrist or psychologist, but they will need food, shelter, security, family reunion and related social interventions. By meeting these needs, agencies and organisations are contributing to psychosocial recovery.

The challenges for all agencies are to:

- be aware of the principles of psychosocial recovery
- recognise the breadth of the interventions required
- identify what your agency can deliver that will contribute to psychosocial recovery
- work out how to deliver that particular intervention in a way that co-ordinates with the efforts of other agencies involved with emergency management through the CDEM group governance structure.

This might mean service delivery practices such as:

- a District Health Board (DHB) mental health service working as part of a CDEM group welfare advisory group to identify staff with specialist skills who can assist with screening for higher-risk people at recovery centres
- a mental health service working with other partner agencies such as Work and Income, Child Youth and Family, local authorities and Victim Support to help provide information for community groups
- a DHB mental health service contributing to the training of Victim Support or other psychological outreach community workers to assist with the appropriate delivery of social and psychological interventions.

However, these functions might also be provided by other agencies or individuals who have the requisite skills and links.

The evidence indicates that most people will recover without the need for specific psychosocial interventions, but organisations with a mandate for psychosocial recovery will need to plan for access to outreach services, psychological first aid, screening and referral to assist those who may need other interventions to help in their recovery.

Another aspect of psychosocial recovery that has become increasingly important to health care agencies and other organisations engaged in responding to emergency events is the need to plan for the psychosocial welfare of staff working in emergency situations. The Severe Acute Respiratory Syndrome (SARS) outbreak in 2003/04 provided critical research evidence for agencies to factor into their psychosocial recovery planning. The education of workers about expected stress reactions and the importance of stress management can help these workers to anticipate and manage their own response to the emergency event. During the emergency event, consistent adherence to administrative controls is essential. For example, health worker shifts should be limited to no more than 12 hours, and staff should be rotated between high-, medium- and low-stress areas.

This document summarises the principles derived from the evidence base, and covers:

- incidence and course
- risk and protective factors
- practice principles
- organisational principles.

These principles are drawn from an evolving knowledge base on the process of psychosocial recovery following a range of natural, technological and mass casualty emergency events. They also align with international best practice guidelines, including outcomes from an international consensus conference of experts in 2002 (National Institute of Mental Health 2002), as well as recent guidelines provided by WHO (World Health Organization 2003).

This document summarises the principles of psychosocial recovery at both the social and community level, and aims to promote increased awareness of the process of psychosocial recovery by government agencies, community organisations, NGOs and the public.

Introduction

Overview

This document outlines the importance of psychosocial recovery when planning how to respond to and recover from an emergency event. Recovery in this context is defined as ‘the co-ordinated efforts and processes to effect the immediate, medium and long-term holistic regeneration of a community following an emergency event’ (MCDEM 2005a). It is part of an overall structure used by civil defence emergency planners that encompasses four phases (also known as the ‘4 Rs’): reduction, readiness, response and recovery.

Recovery encompasses the psychological and social dimensions that are part of the regeneration of a community. The process of psychosocial recovery from emergencies involves easing the physical and psychological difficulties for individuals, families/whānau and communities, as well as building and bolstering social and psychological wellbeing.

A key World Health Organization (WHO) approach is to note that ‘social intervention’ is used for activities that primarily aim to have social effects, while ‘psychological intervention’ is used for activities that primarily aim to have psychological (or psychiatric) effects. In this document, the term ‘psychosocial’ refers to aspects of both psychological and wider social behaviour.

This is a high-level principles document aimed at helping organisations to determine their approach to supporting social and community recovery after an emergency event. It is primarily aimed at the health sector, but should also be useful for all organisations participating in the CDEM group governance structure, including Ministry of Social Development regional commissioners, District Health Board emergency planners, local government co-ordinating executive group (CEG) representatives, public health departments, mental health service managers, primary health organisations and general practitioner services, Māori health providers, community service providers, and non-governmental organisations (NGOs). Its purpose is to help orient these organisations towards good practice principles for providing psychosocial support to promote recovery in an emergency event.

Structure

Part A of this document outlines the principles identified from a review of the existing literature to describe the most probable reactions of individuals and communities in emergency events. It also provides guidance on the levels of intervention that have proven most useful for people who experience reactions that are outside the expected range, in terms of intensity or duration. These principles are as follows.

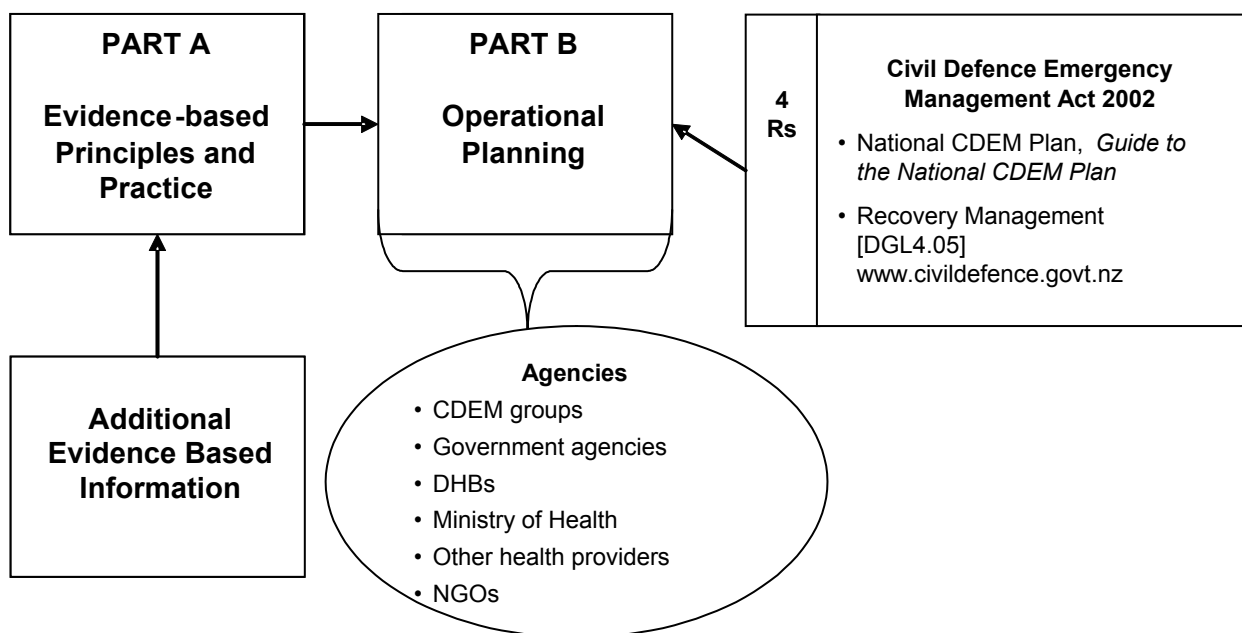
1. Most people will experience some psychosocial reaction, usually within a manageable range. Some may exhibit more extreme reactions in the short, medium or long term.
2. Most people will recover from an emergency event with time and basic support.

3. There is a relationship between the psychosocial element of recovery and other elements of recovery.
4. Support in an emergency event should be geared towards meeting basic needs.
5. A continuum from self-help to more intensive forms of support should be provided within a clear referral and assessment framework.
6. Those at high risk in an emergency event can be identified and offered follow-up services provided by trained and approved community-level providers.
7. Outreach, screening and intervention programmes for trauma or related problems should conform to current professional practice and ethical standards.
8. Readiness activity is an important component in creating effective psychosocial recovery planning.
9. Co-operative relationships across agencies, sound planning and agreement on psychosocial response and recovery functions are vital.

Part B is a guide to operational planning for issues relating to psychosocial recovery. An understanding of the Civil Defence Emergency Management (CDEM) group governance structure is helpful in appreciating how the health sector can work in partnership with other central government agencies, local government, NGOs, and community agencies to plan and deliver interventions to promote recovery in emergency events. Further information about the CDEM group governance structure can be found in *The Guide to National CDEM Plan* (MCDEM 2006).

Part B provides guidance for agencies on how to organise and use the principles described in Part A, and how to co-ordinate their efforts with others. Figure 1 outlines the links between the parts of this document and the resources that contribute to the planning for psychosocial recovery.

Figure 1: Considering psychosocial support



Part B focuses on the organisational aspects of the principles. It is intended to provide information to agencies to inform their own planning and to promote multi-agency collaboration at local, regional and national levels. Given the need for flexibility in decision-making during an emergency, the aim is not to give instructions on what to do, but to provide evidence-based principles that can enhance planning. This is done by enhancing the welfare arrangements in sections 40 to 44 of the National Civil Defence Emergency Management Plan 2005.

Scope

Psychosocial recovery is not limited to the recovery phase of an emergency event, and is not synonymous with the concepts of 'recovery' that feature in mental health service delivery. Psychosocial recovery in the field of emergency management begins at the level of prevention through risk reduction.

Thus psychosocial recovery spans the 4 Rs of civil defence emergency management planning, with most emphasis on the readiness, response and recovery phases. It is just one element of wider social recovery, and also links to the other three components of recovery, namely of the economic, natural and built environments.

The wide-ranging nature of psychosocial recovery means that agencies need to incorporate the principles and organisational planning for it into all aspects of their emergency management planning. In this way, the document seeks to *build on your organisation's existing planning processes* rather than create new processes. The idea is to build on the broad focus of community considerations embedded within these plans and enhance arrangements to support the psychosocial aspects of recovery.

Overall, this document aims to:

- act as a guide for DHB emergency planners, primary health organisation (PHO) providers, NGO managers, regional council planners, residential care managers, community organisation liaison officers, private providers, and other groups and individuals
- provide information on national planning for psychosocial recovery
- provide information on how to contribute to the psychosocial recovery component of regional plans.

Before beginning any planning, consider the following questions:

- Which organisations are responsible for co-ordinating psychosocial recovery planning and response in your region?
- Do you know who to contact to find out more about psychosocial recovery plans in your region?
- When and how will you contact agencies involved in psychosocial recovery following an emergency event?
- What are your goals in participating in the psychosocial recovery process?
- What guidance or training are you receiving to help you reach your goals?

- Are you planning, or is your organisation planning, to provide a function to support psychosocial recovery, and if so, to whom?
- Who will be co-ordinating the function that you wish to provide, and how will this fit into other services that may be supplied?

Incorporated in Part B is a section concerning pandemic influenza. This explores some of the psychosocial issues that an influenza pandemic (and the associated public health measures) might trigger in New Zealand, and some of the actions that might be taken to deal with them.

Future development of these guidelines

As a result of consultation meetings held between June and September 2006, changes have been made to this document to address a number of issues.

- The title of the document has been changed to try to clarify the meaning of 'recovery' in an emergency management context.
- The intent and purpose of the document has been brought to the beginning of the document in an attempt to make this clearer – particularly highlighting the governance structure of regional CDEM groups, which act as a hub to co-ordinate recovery activities.
- An executive summary has been provided.

Although these Principles are designed to provide high-level assistance in planning for emergency events, the consultation process also identified a need for further resource development, including:

- reference to case studies that provide details on what has worked in recovering from previous emergency events in New Zealand and in international contexts
- developing templates and checklists to help organisations to develop their own plans to meet their goals, and to facilitate audit after emergency events
- bolstering the section on 'Reducing inequalities' to include more on Māori community strengths, in terms of both qualities and practices
- providing more information on social interventions, because the document is weighted towards individual-based psychological interventions.

Although these needs cannot be met within the timeframe to produce this version of the Principles, these issues have been noted and planners within the Ministry of Health are aware of the work that needs to be done.

In the meantime, an excellent interim resource is the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (Inter-Agency Standing Committee 2006). Although this is a generic document aimed at international contexts, it is a helpful interim measure to meet the need for templates that will help planners to decide how to plan to provide psychosocial support to facilitate social and community recovery.

Part A: Evidence-based Principles and Good Practice for Psychosocial Recovery

Principles of the psychosocial recovery process

In this section the following principles of the psychosocial recovery process are discussed.

1. Most people will experience some psychosocial reaction, usually within a manageable range. Some may exhibit more extreme reactions in the short, medium or long term.
2. Most people will recover from an emergency event with time and basic support.
3. There is a relationship between the psychosocial element of recovery and other elements of recovery.
4. Support in an emergency event should be geared toward meeting basic needs.
5. A continuum from self-help to more intensive forms of support should be provided within a clear referral and assessment framework.
6. Those at high risk in an emergency event can be identified and offered follow-up services provided by trained and approved community-level providers.
7. Outreach, screening and intervention programmes for trauma or related problems should conform to current professional practice and ethical standards.
8. Readiness activity is an important component in creating effective psychosocial recovery planning.
9. Co-operative relationships across agencies, sound planning and agreement on psychosocial response and recovery functions are vital.

How people react to emergency

Key principle 1

Most people will experience some psychosocial reaction, usually within a manageable range. Some may exhibit more extreme reactions in the short, medium or long term.

Most people will be affected in some way by the experience of an emergency event, either directly or indirectly. However, research indicates that most people who experience an emergency event tend to recover with time. Consequently, a sensible working principle in the phase immediately following such an event is to expect a manageable 'trajectory of recovery' for those involved, although it must be emphasised that the post-emergency life circumstances will not be as they were before the emergency event.

Following an emergency event there is a range of common transitory reactions, as outlined in Table 1.

Table 1: Survivor responses in emergency situations

<p>Physical</p> <ul style="list-style-type: none"> • Faintness and dizziness • Hot or cold sensations • Tightness in throat and chest • Agitation, nervousness, hyper-arousal • Fatigue and exhaustion • Gastrointestinal distress and nausea • Appetite decrease or increase • Headaches • Exacerbation of pre-existing conditions 	<p>Behavioural</p> <ul style="list-style-type: none"> • Sleep disturbances and nightmares • Jumpiness – easily startled • Hyper-vigilance – scanning for danger • Crying and tearfulness • Conflicts with family and co-workers • Avoidance of reminders of trauma • Inability to express feelings • Isolation or withdrawal from others • Increased use of alcohol or drugs
<p>Emotional</p> <ul style="list-style-type: none"> • Shock, disbelief • Anxiety, fear, worry about safety • Numbness • Sadness, grief • Longing and pining for deceased • Helplessness • Powerlessness and vulnerability • Dissociation (disconnected, dream-like) • Anger, rage, desire for revenge • Irritability, short temper • Hopelessness and despair • Blame of self and others • Survivor guilt • Unpredictable mood swings • Re-experiencing pain associated with previous trauma 	<p>Cognitive</p> <ul style="list-style-type: none"> • Confusion and disorientation • Poor concentration and memory problems • Impaired thinking and decision-making • Complete or partial amnesia • Repeated flashbacks, intrusive thoughts and images • Obsessive self-criticism and self-doubt • Preoccupation with protecting loved ones • Questioning of spiritual or religious beliefs

Source: US Department of Health and Human Services 2005.

Initial reactions to emergency events are not only appropriate but, for some, might actually be adaptive. These reactions need to be recognised as fairly typical. A large proportion of people will have some sort of short-term reaction to an emergency event, such as shock and grief, followed by distress and anxiety about the future. Emergency workers and recovery agencies need to be mindful of this fundamental first principle. It reinforces the need to be aware of potential reactions, and to promote basic forms of support and self-help strategies in the immediate post-incident phase, such as ensuring safety, re-connection with communities, and the provision of comfort, care, information and advice about the meaning of such reactions to those experiencing them.

A minority of people experience longer-term problems. However, it is generally inappropriate to make any assumptions about clinically significant psychological disorder in the early post-incident phase: immediate distress (such as heightened anxiety or sleeping difficulties) does not mean there will be enduring problems. Risk is increased if someone has a pre-existing condition and/or a previous trauma experience, or if there are multiple risk factors. Delayed reactions, including diagnosable mental health difficulties, have been found to be rare.

The problems that people experience tend to cluster around identifiable themes. The most common are anxiety, depression, prolonged grief and general distress, but may also include:

- anxiety-based symptoms, including acute stress disorder and post-traumatic stress disorder (PTSD)¹
- grief reactions and depression
- general forms of distress (eg, increased stress levels, sleep disruption)
- physical health problems
- secondary stressors (ie, new problems that emerge following the emergency event, such as loss of employment or relationship changes)
- loss of psychosocial resources (including usual patterns of coping and social support networks)
- problems relating to specific parts of the population; for example:
 - children, who may exhibit clinginess, tantrums or disruptive behaviour
 - pre-existing mental health consumers whose current medication is not controlling their symptoms
 - health and response workers who have had extensive exposure to survivors while also coping with their own personal losses.²

Key principle 2

Most people will recover from an emergency event with time and basic social support.

Time helps. Most people recover with time and basic support. Even with a condition like post-traumatic stress disorder, research has shown that prevalence drops, sometimes relatively quickly (eg, there was a reduction of approximately two-thirds in prevalence after four months following the 9/11 disaster).

¹ More information on post-traumatic stress disorder can be found in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association 2006).

² More information on this overall list of common sequelae, along with associated risk factors, can be found in Norris et al 2002a.

While most people tend to recover with time, the natural process may include fluctuations, particularly in the first year following an emergency event. In other words, recovery may not be a linear process. Anniversaries or similar events might be problematic for some, which could result in an increased need for services.

Risk and protective factors

Key principle 3

There is a relationship between the psychosocial element of recovery and other elements of recovery.

The link between physical wellbeing and psychosocial recovery

After an emergency event, psychosocial recovery is closely tied to having basic needs met (including safety, shelter and appropriate medical intervention). Even in an event that does not include major disruption or loss of life, immediate basic needs are likely to be most pressing.

As the seriousness of the consequences increases (eg, property damage, financial loss, injuries, deaths, other disruption), so too will the demand for basic needs become more apparent (eg, food, water, clothing). As the physical impacts and lack of resources to meet basic needs continue, social and emotional consequences will most likely follow. These can include a sense of uncertainty about the future and a reduced sense of control. Within a Western framework of psychosocial response, a reduced sense of control and various emotional and behavioural correlates can reduce a person's ability to carry out physical recovery tasks (eg, through reduced motivation, lack of energy, or a sense of being overwhelmed).

There is good evidence for a reciprocal relationship between social recovery and the other components of recovery. When psychosocial and emotional functioning is adaptive (eg, when people feel more in control, have reduced arousal and increased energy, and support is available), people's ability to participate in their own recovery is increased. When people are able to participate in their own recovery, they tend to feel better, more in control and less overwhelmed.

Community-level risk and protection

When the following occur in a community, the risk for psychosocial problems is raised:

- emergency events
- major property damage
- physical injury
- ongoing financial problems

- human factors related to the emergency event (eg, neglect, perceived corporate responsibilities and attribution of blame)
- breakdown in the availability of emotional and social support within a community (including social networks and social support).

Individual and family factors

A number of factors have been identified as increasing the risk for problems with psychosocial recovery:

- being female
- being young
- being middle-aged (between 40 and 60 years)
- belonging to an ethnic or cultural minority
- socioeconomic factors
- family or relationship status (eg, being married and/or with a family versus being single and without a family or a partner) – risk is increased with increased distress or conflict in the family
- the presence of children (see also next section)
- for females, having a partner/spouse (which increases risk)
- low levels of support (both actual and perceived emotional and social support and sense of connectedness) – high levels would be considered to be protective factors (sources include various groups, including family/whānau, friends, social, cultural and community-based groups and networks)
- exposure to mass violence
- being a primary victim (versus secondary, such as emergency workers)
- increased exposure severity (eg, life threat, loss, severe initial reactions, including health care workers in the context of infectious disease exposure)
- past and current psychiatric problems
- minimal experience coping with an emergency event
- additional stressors following the emergency event
- unhelpful forms of coping (eg, avoidance coping, blaming) and particular thoughts or beliefs (eg, low sense of control) versus more helpful forms (eg, self-help strategies), increased hope and optimism, and a sense of control, which are protective factors.

It is impossible at this stage to predict which combination of risk factors may play a part in increasing vulnerability to psychosocial effects in the face of any particular emergency event.

Vulnerable groups

Children are a particularly vulnerable group. For children and youth, a number of risk and protective factors, including those identified in the previous section, have been found to be important. However, what appear to be most crucial for children are features of the family. New Zealand and overseas research shows a relationship between parents' and children's emergency-related distress. In general, parental difficulties, including distress, are a primary risk factor, but a number of other family factors also increase risk (eg, distress in another family member, marital and family conflict). By contrast, effective parenting and healthy family functioning are protective factors. This group may also include children who become orphans as a result of an emergency event.

Health workers and other response workers working in emergency situations are at risk of experiencing significant psychosocial impact, especially if they have a high level of exposure to traumatic stimuli.

Older adults are at risk because they may become isolated from their usual networks and supports. *Disabled and/or dependent people* living alone or in supported accommodation are at risk because they may be dependent on others and lack access to their basic care and support. *Mental health consumers* are at risk because their medications may not be as well monitored, and their illness may be exacerbated or their physical health needs unmet.

Migrants or those for whom English is not a primary language are at risk because they may not understand public information and may be isolated from their community and family networks.

Addressing potential disparities

Particular communities within the population may be at increased risk for poor psychosocial recovery. These potential disparities require the planning of a strategy to address the risks of inequalities in wellbeing. Reducing health inequalities is a key policy of the Government, as outlined in the *New Zealand Health Strategy* (Minister of Health 2000). These inequalities are defined as differences in health that are unnecessary, avoidable and unjust.

Such inequalities are determined by many factors, both individual (such as age, sex and heritable differences) and wider issues (such as social, cultural and economic contexts). These individual and broader factors also map on to each other to produce additional areas of vulnerability (or, less commonly, resilience). Evidence indicates that people from lower socioeconomic groups have correspondingly poorer health and access to health providers, and greater exposure to risks. In particular, Māori and Pacific peoples have consistently poorer health in comparison with the rest of the New Zealand population. They also have less access to health services and utilise health services less frequently.

However, not all differences between Māori and non-Māori can be explained by disparities in socioeconomic status. Analysis of health outcomes by ethnicity and deprivation indicates that Māori have poorer health outcomes than non-Māori within the same deprivation deciles.

Past experience suggests that an emergency event, such as pandemic influenza, could have an especially severe impact on Māori communities, particularly because it seems likely that the impact of pandemic influenza on Māori in 1918 has been significantly underestimated. The Ministry of Health has used data from the 1918 New Zealand pandemic to develop a planning model that invites Māori participation in building community resilience and psychosocial recovery capacity in the face of emergency events such as pandemic influenza. The success of this planning relies on collaboration and partnership between government agencies, service providers and community groups.

To achieve this aim, the Ministry of Health recognises the guidance of *He Korowai Oranga: Māori Health Strategy* (Ministry of Health 2002) as a framework for the special relationship between iwi and the Crown, recognising that health and wellbeing are influenced by the collective as well as the individual, and the importance of working with people in their social contexts, not just their physical symptoms. This special relationship is underpinned by the principles of partnership, participation and protection in order to meet the aims of strengthening community and individual physical and mental wellbeing through culturally appropriate interventions aligned with kaupapa and tikanga Māori.

In considering psychosocial recovery from emergency events, it is vital to understand the perspective of the many people and groups affected by the event and those who may be responsible for providing psychosocial recovery services. Modern New Zealand is developing into an increasingly diverse nation with many different constituent communities of varying ethnicities, cultures and interests. It is the aim of the Ministry of Health to facilitate engagement at national and local levels with groups who may also be at particular risk of poor psychosocial outcome after an emergency event because of individual factors and/or social, cultural and economic determinants.

Promoting psychosocial recovery

The main focus in this document is on principles of practice during and following an emergency event (ie, during the response and recovery phases). However, a key principle in prevention (the readiness phase) is for communities to prepare effectively in advance of an emergency event (see 'Operational principles' (below) and 'Part B: Operational Planning' for more information on readiness).

Key principle 4

Support in an emergency event should be geared towards meeting basic needs.

When a major incident occurs, the dual process of facilitating psychosocial recovery for the majority while identifying those who need more intensive assistance should underpin the support provided within an affected community. Social support systems for several vulnerable groups, such as older adults and ethnic minorities (especially refugee groups), may be adversely affected. Such communities may need to plan at an early stage to access the additional resources they need to assist them during an emergency event. Similarly, service providers should plan how to target these vulnerable communities in order to address potential disparities in support.

In line with the first principle of psychosocial recovery, promoting basic forms of support (ie, safety, food, water and shelter) and normalising the recovery process should be preferred over providing intensive forms of assistance, particularly in the immediate aftermath of an emergency event. Research has shown that some interventions, if they occur too early in the psychosocial recovery process, have the potential to worsen distress and physical functioning through over-burdening the survivor. Early interventions for those immediately affected, including critical incident stress debriefing, have not been found to reduce risk of later post-traumatic stress disorder or related adjustment difficulties. Research has shown that formally intervening during some specific processes, such as grieving, may be inappropriate. In fact, for most people following an emergency event, specialist mental health intervention is not required. For others, inappropriate intervention, particularly when it is not warranted (eg, during grieving), has been shown in some cases to increase difficulties.

Given the potential for some interventions to make matters worse, the principle of helping at the level of basic needs to avoid inadvertent harm is paramount in early interventions. This highlights the need to ensure that appropriately trained personnel make assessments of whether individuals or families require further intervention.

Also, given the link between the different components of recovery, the first forms of assistance and support should be geared towards: meeting basic needs (safety, food, water, shelter), family reunification, community connections and other recovery requirements. Psychosocial assistance should emphasise and provide access to fundamental forms of social, emotional and informational support through information and educational material disseminated to the public, psychological first aid, one-stop shops (which may include drop-in services), and other settings (eg, primary health services/clinics and social service agencies). The assistance should aim to foster – but not force – social interaction and the facilitation of networks to help individuals and communities process the experience of their involvement in the incident (eg, peer support networks), and enable outreach services for those in greater need.

The primary focus is on helping communities and people to help themselves through basic support and normalisation of the variety of responses that will occur. It is therefore crucial that consideration of psychosocial recovery begins during the readiness phase, *before* an emergency event happens.

Key principle 5

A continuum from self-help to more intensive forms of support should be provided within a clear referral and assessment framework.

For those who do require further assistance, a gradient from self-help through to more intensive forms of support assumes a stepped-care and community-based approach, encompassing all aspects of need. The first step of care involves assistance aimed at improving people's ability to help themselves and their families, while the most intensive step will involve formal psychological/psychiatric interventions.

The way these steps of support are put into practice depends very much on local community resources. However, certain universal features should be considered, including the means used for promoting wellbeing and psychosocial support. This can be done through a variety of strategies that incorporate:

- revitalising a community's own support networks
- providing outreach and screening capacity
- making formal services available for those who require more intensive support.

This can be achieved by using multiple providers and collaborating with media networks. Outreach services will be a crucial ingredient of any response formula, given that those most in need of help are often also least likely to present in traditional ways.

To encourage self-help, pre-event public education should be aimed at increasing knowledge and the public's capacity to cope effectively. Post-event public information distributed through various means – fact sheets, press releases and interviews, websites, one-stop shops, educational evenings, free phone lines, victim and peer support agencies, and so on – is important. This may include information about the range of expected responses to an emergency event, how to facilitate the psychosocial recovery process for oneself and one's family, and when and where to seek further help if required. Information could be provided to parents and caregivers to help them understand their vital role in their child's ability to cope. Appropriate systems to facilitate public information messages and information about self-help should be considered.

It is important that there be a balance between acknowledging the problems the emergency event has caused, and assisting individuals and communities to generate helpful solutions to these problems. A solution-focused approach that builds on previous experience of establishing a sense of control over seemingly unmanageable situations in order to respond to current problems is likely to facilitate both physical wellbeing and psychosocial recovery.

Provision of these resources should be co-ordinated through the response and recovery process.

Key principle 6

Those at high risk in an emergency event can be identified and offered follow-up services provided by trained and approved community-level providers.

Through outreach and support services, those at high risk can be identified and offered follow-up services from trained and approved community-level providers. This may include those who have:

- acute stress disorder or post-traumatic stress disorder
- unusually intense and/or prolonged bereavement
- a pre-existing psychological condition
- exposure that is particularly intense and drawn-out
- an accumulation of risk factors.

Note that research indicates that some of those who may be most in need of assistance may be least likely to seek it.

In terms of more formalised specialist interventions, the evidence supports the following approaches.

- Brief and focused information-based and/or psychological intervention can reduce distress and assist coping.
- Selected cognitive behavioural therapy approaches may reduce the incidence, duration and severity of acute stress disorder, post-traumatic stress disorder, depression and complicated grieving in victims and survivors. For longer-term reactions to emergency events, cognitive behavioural therapy approaches have the most evidence-based support for both adults and children.
- Other evidence-based intervention approaches may have potential and be preferred by affected people in need of formal assistance (eg, emotion-focused therapies have documented efficacy for traumatic reactions and depression, and appear to be preferred by some people).

Key principle 7

Outreach, screening and intervention programmes for trauma or related problems should conform to current professional practice and ethical standards.

Participation in any form of outreach or intervention programmes – from early forms of social support and psychological first aid to later, more intensive interventions, whether administered to a group or individually – should be voluntary. Outreach, screening and intervention programmes for trauma or related problems should conform to current professional practice and ethical standards.

Expertise in delivering services is vital. A number of interventions – including large-scale education, early forms of support and more specialist mental health interventions – all have the potential to do unintended harm. Thus, choosing specialist providers who are well trained and have expertise and accountability for their practice is essential.

Some geographic areas may not have the specialist and trained providers to deliver appropriate interventions, so those who will become involved in response and recovery efforts will need training in preparedness for an emergency event. This could include a range of providers; for instance, local counselling and therapy collectives and other support-based agencies, at both the local and national level.

Intervention should be based on evidence-based practices. The use of ineffective or unsafe techniques should be discouraged. In addition, research at both the overall programme and individual service level is needed to establish the effectiveness of local response and psychosocial recovery programmes and services.

Operational principles

Key principle 8

Readiness activity is an important component in creating effective psychosocial recovery planning.

Effective planning and readiness

A key principle of operational effectiveness in psychosocial recovery is effective planning and readiness. This is consistent with section 40 of the National Civil Defence and Emergency Management Plan Order 2005 and research findings. Co-ordination, multidisciplinary relationships and effective communication are all necessary.

The development of co-operative relationships across agencies, along with sound planning and agreement on psychosocial response and recovery functions, is vital when it comes to assisting affected communities. Planning and preparation help to establish a solid framework for effective psychosocial intervention during response and recovery activities, and should include community participation in planning, and local support.

Readiness to respond

Readiness to respond to an emergency event includes engaging in planning, training and exercises. It should include organisational preparation and planning, as well as promoting readiness activities in the community. Research has identified various ways to increase organisational and public readiness.

Key principle 9

Co-operative relationships across agencies, sound planning and agreement on psychosocial response and recovery functions are vital.

Leadership and co-ordination

Response to an emergency event requires leadership and co-ordination across agencies. It is especially valuable to work collaboratively at a readiness stage with existing community organisations, such as local neighbourhood watch groups, church groups and local and national ethnic group associations. The regional CDEM group acts as a hub for the co-ordination of recovery activities.

Response and recovery

This involves the co-ordination of trained personnel to re-establish community structure, foster community support, increase family and individual resilience, and safeguard the community.

Ongoing needs assessment and monitoring

An emergency event will require agencies to engage in co-ordinated and ongoing needs assessment and monitoring of psychosocial recovery over an extended period. A range of issues may need to be addressed, including:

- How well are ongoing needs being addressed within the recovery environment?
- What services are being provided effectively, and what additional services are required?
- What monitoring is there for ongoing and additional threats and stressors?
- What monitoring is there for correcting inaccurate media coverage and dispelling public rumours?

Operationalising the best practice principles

This document is a resource to inform and guide decisions about how best to implement psychosocial recovery. Part A has worked through the best practice principles. Part B of these guidelines now gives more focus to the organisational aspects of the principles. The intention is to provide guidance to relevant agencies to inform their own planning, with the ultimate aim of promoting collaboration across agencies at local, regional and national levels.

However, it is important to allow for flexibility in decision-making in the response and recovery environment, and agency planning should take this into account.

Part B: Operational Planning

Key aspects of planning for psychosocial recovery

Psychosocial recovery planning aims to develop the maximum potential for individual and community resilience and recovery from an emergency event. Psychosocial recovery focuses on the communities affected by an emergency event, so it is important that all agencies with community responsibilities for delivering health and welfare services engage in planning for psychosocial recovery.

Operational planning for psychosocial recovery is informed by the legislative and strategic environment, as well as the evidence-based principles and practices outlined in Part A. Psychosocial recovery is an element of wider social recovery and links to three other components of recovery: the economic, natural and built environments. Goal 4 of the Ministry of Civil Defence and Emergency Management's *Focus on Recovery* summarises the overall strategic direction for recovery (MCDEM 2005a). Psychosocial recovery is considered in a holistic context, but must ensure that the particular social and psychological needs of individuals are met appropriately. The Part A principles and practices provide guidance for meeting these needs within the overall strategic psychosocial recovery goal.

Planning for psychosocial recovery requires agencies to work together to ensure that, in an emergency event, the people whose social and psychological needs are not sufficiently addressed with a basic level of support can be identified and helped through the provision of, or referral to, other types of support. Welfare and health agencies have a key role in emergency events in terms of both providing support and setting up systems that will work locally and nationally to ensure that people's psychosocial needs are addressed.

Social support is the first level of support in psychosocial recovery, in conjunction with establishing safety from the emergency event. Social reconnection, and a focus on helping people to help themselves, is a key aspect of social support and may require advance planning for a suitable facility in which such activities can be conducted. This involves acknowledging problems while helping people to find solutions based on their own experience of recovering from previous challenges. This could be in addition to freephone services that provide information on what services are available, along with some capacity for identifying those who may need more specialised types of psychosocial support.

In an emergency event, psychological support may need to be provided to people who are experiencing severe impacts, such as grief over the death of loved ones or loss of their homes. People with pre-existing social and psychological vulnerabilities, whether socioeconomic deprivation or mental illness, may also need an extra level of support. Factors that need to be covered in psychosocial recovery plans should include processes for referral – either to primary care or via DHB community or inpatient services – in situations where people are experiencing psychological difficulties that are not resolving.

Planning at the local level includes CDEM groups and DHB emergency management planners. By integrating welfare and health provision, the principles outlined in Part A can be achieved more appropriately than they could if planning was done independently. Planning at a national level models this integration of welfare and health planning. The National Welfare Recovery Co-ordination Group (NWRCG) is convened by the Ministry of Social Development, with a variety of agencies contributing to the development of policies and co-ordination of national-level recovery activity when national-level assistance to support local CDEM capacity is needed. The planning process should include appropriate training, exercising, and identifying the lessons learnt from the activation of plans, which will improve arrangements for future emergencies.

Ministry of Health roles

The primary Ministry of Health roles will be to:

- promote evidence-based best practice and principles of psychosocial recovery interventions, including planning for psychosocial recovery – refer to the Ministry of Health's *National Health Emergency Plan: Guiding principles for emergency management planning in the health and disability sector* (Ministry of Health 2005)
- liaise with DHB service providers (including DHB mental health services), and other health and disability sector providers (eg, PHOs, general practitioners, NGOs) to facilitate the co-ordination of planning and interventions during the reduction, readiness, response and recovery phases of psychosocial recovery.

Other Ministry of Health responsibilities include discussing what information needs to be provided and when, as well as what information should come from the national, local and regional levels, and supplying information to the public, primary health service providers and DHBs.

Additional planning considerations include:

- public education on mental wellbeing
- consultation with helpline providers
- consultation with professional and regulatory bodies (eg, capacity building)
- after the emergency event occurs, careful reinforcement of messages outlining the difference between appropriate adjustment responses and more concerning symptoms that may require active interventions (other than providing basic support).

District Health Board roles

Where appropriate, DHB actions have been specified in this part of the document to assist DHB emergency management planners and other DHB service providers to focus on the role of the health and disability sector in providing psychosocial interventions in the event of an emergency.

DHB emergency management planning also needs to take into account the responsiveness of the primary care sector to provide psychosocial interventions. In an emergency event, general practitioners (GPs) and other primary health care service providers may be the first point of contact for many people in need of psychological interventions. Primary health care providers can also provide health services for those who may need higher-level interventions. People with acute and severe psychological needs, where their safety or the safety of others is an issue, may also need direct referral to DHB mental health services.

In all these scenarios, the role of DHB emergency management planners is critical to ensure health and disability sector responsiveness at the community level is co-ordinated with the range of interventions required and planned for via CDEM groups, and is linked into national-level arrangements to:

- provide district annual plans to the Ministry of Health that include information on emergency planning for their service users
- work within their regional structure to provide timely information for people in their geographical area
- contribute to assessment systems at a local level to assess the needs of those affected by the emergency event and to provide appropriate mental health and/or other services according to local arrangements
- provide staff support for health and other response workers, including appropriate management support, structure, a regular routine, social support, psychosocial support and training.

National inter-agency links

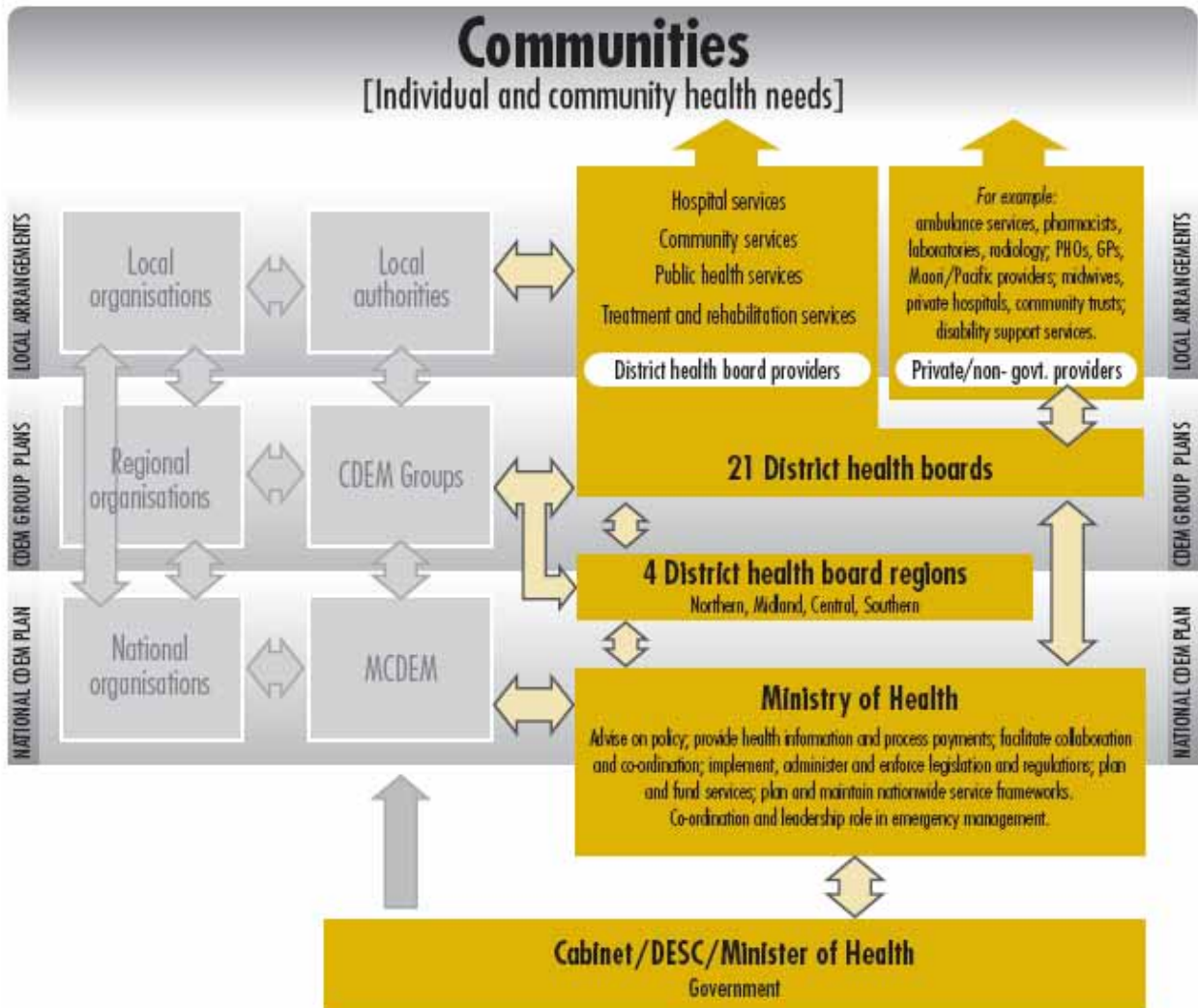
In July 2003 the Ministry of Civil Defence and Emergency Management requested that the Ministry of Social Development undertake the role of lead agency and chair the NWRCG. The NWRCG includes a number of welfare groups, with a lead agency responsible for developing the direction and work programmes for each group. It has an explicit welfare focus and is responsible for planning the delivery of national welfare when assistance or support is required to be co-ordinated at a national level. It may also bring together government and NGO sector agencies in order to provide welfare assistance when CDEM groups are unable to meet local or regional welfare needs.

The specific roles of the NWRCG are to:

- liaise with all agencies providing welfare and ensure their logistical and other needs are met
- monitor welfare provision against rising needs, identify gaps, and monitor support agencies to ensure needs are met
- provide information (in summary form) on welfare issues and activities during an emergency
- report on welfare provision
- develop, or support the development of, social and community components of recovery programmes

- co-ordinate financial assistance, accommodation, inquiry and identity, domestic animal welfare and psychosocial support.

Figure 2: Structure of the New Zealand health and disability sector for emergency management



CDEM groups and others might also find it useful to access the Ministry of Health’s *National Health Emergency Plan: Guiding principles for emergency management planning in the health and disability sector* (Ministry of Health 2005). This plan outlines four principles that agencies should keep in mind when planning for emergency management:

- activating and co-ordinating a response
- managing service delivery
- setting up a safe and appropriate environment
- organisational management and structure.

These principles intersect with the psychosocial recovery principles because health and disability service providers, and similar organisations, factor them into their overall emergency management plans. The *National Health Emergency Plan* includes useful

examples and complementary sections on governance, external relationships and training.

Emergency services, including Police and Fire and those based in the health and disability sector, also need to factor in psychosocial recovery planning and delivery to their Co-ordinated Incident Management System (CIMS) approach to emergency management. Other agencies need to be aware of the CIMS approach as an organisational tool so that they can better understand how key agencies are interlinked, especially during the response phase of an emergency event.

Operationalising the psychosocial recovery principles: a summary of agency actions

The summary that follows is based on the Civil Defence Emergency Management Act 2002 and related key documents for psychosocial recovery.

Agencies contributing to the CDEM group welfare planning may include any community-based groups that can deliver psychosocial recovery interventions and meet appropriate national benchmarks for quality and training. Co-ordination is required to identify the agencies that will be able to deliver psychosocial interventions. Figure 3 outlines the structure for providing psychosocial support to those affected by an emergency.

Our awareness of vulnerability to emergency events, and the difficulties of assisting those who survive them, has been heightened by events such as the terrorist attack on the World Trade Centre in 2001, the Indian Ocean tsunami in 2004, Hurricane Katrina in 2005, and a number of civil defence emergencies in New Zealand since 2004. Public and government expectations have been raised for all aspects of response and recovery from emergency events.

It is important that everyone involved in emergency planning has a shared understanding of what is meant by the term 'psychosocial recovery'. In the past, psychosocial recovery has been understood and implemented in different ways by different organisations, both in New Zealand and overseas. Recovery encompasses the psychological and social dimensions that are part of the regeneration of a community. The process of psychosocial recovery from emergencies involves easing the physical and psychological difficulties for individuals, families/whānau and communities, as well as building and bolstering social and psychological wellbeing.

Many components of psychosocial recovery will not be delivered by the health and disability system, but by individuals and families, community organisations such as church groups, welfare agencies, or other groups convened for recovery purposes under the umbrella of the regionally based CDEM groups. Most people affected by an emergency event will not need a psychiatrist or psychologist, but they will need food, shelter, security, family reunion and related social interventions. By meeting these needs, agencies and organisations are contributing to psychosocial recovery.

The challenges for all agencies are to:

- be aware of the principles of psychosocial recovery
- recognise the breadth of the interventions required

- identify what your agency can deliver that will contribute to psychosocial recovery
- work out how to deliver that particular intervention in a way that co-ordinates with the efforts of other agencies involved with emergency management through the CDEM group governance structure.

This might mean service delivery practices such as:

- a DHB mental health service working as part of a CDEM group welfare advisory group to identify staff with specialist skills who can assist with screening for higher-risk people at recovery centres
- a mental health service working with other partner agencies such as Work and Income; Child, Youth and Family; local authorities and Victim Support to help provide information for community groups
- a DHB mental health service contributing to the training of Victim Support or other psychological outreach community workers to assist with the appropriate delivery of social and psychological interventions.

However, these functions might also be provided by other agencies or individuals who have the requisite skills and links.

The evidence indicates that most people will recover without the need for specific psychosocial interventions, but organisations with a mandate for psychosocial recovery will need to plan for access to outreach services, psychological first aid, screening and referral to assist those who may need other interventions to help in their recovery.

Another aspect of psychosocial recovery that has become increasingly important to health care agencies and other organisations engaged in responding to emergency events is the need to plan for the psychosocial welfare of staff working in emergency situations. The SARS outbreak in 2003/04 provided critical research evidence for agencies to factor into their psychosocial recovery planning. The education of workers about expected stress reactions and the importance of stress management can help these workers to anticipate and manage their own response to the emergency event. During the emergency event, consistent adherence to administrative controls is essential. For example, health worker shifts should be limited to no more than 12 hours, and staff should be rotated between high-, medium- and low-stress areas.

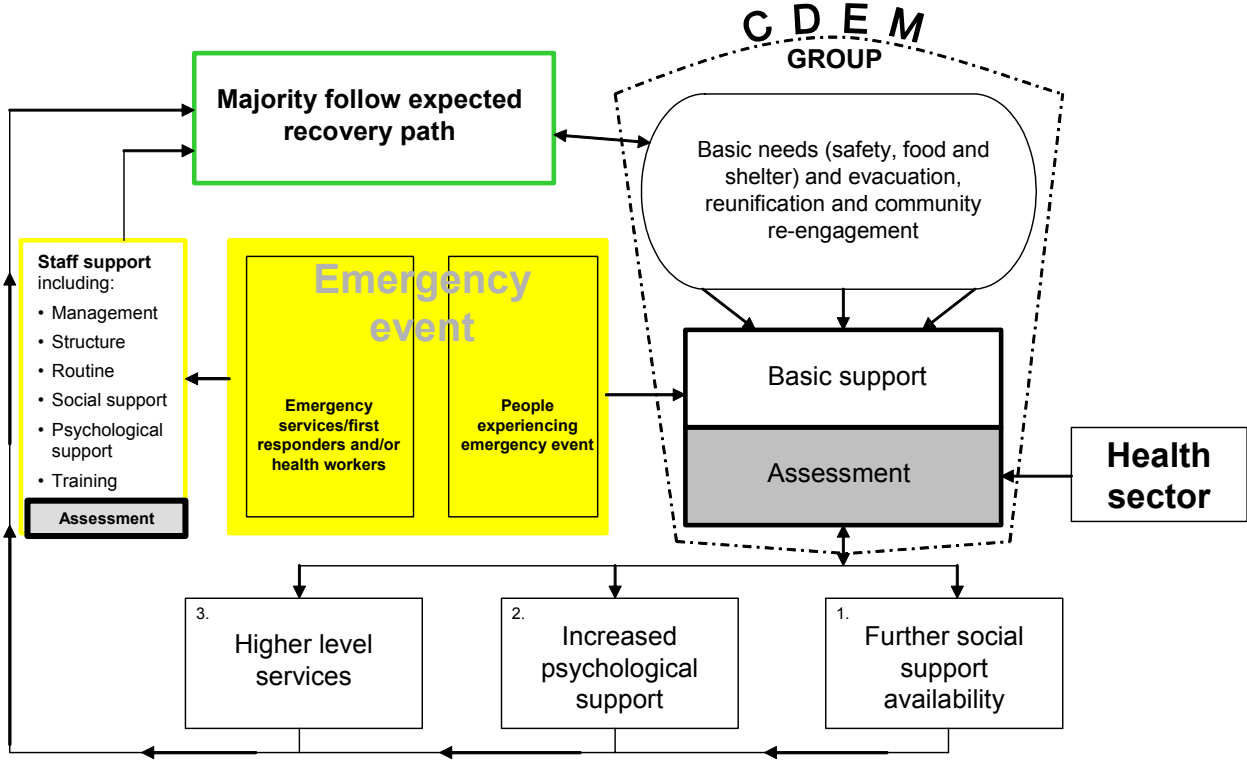
Starting in the central area of Figure 3 (labelled 'Emergency event' in the background), those experiencing the emergency event will have basic support available, co-ordinated by the CDEM group. This support should aim to ensure basic needs are met, such as adequate nutrition, safety, shelter for all, as well as co-ordinating appropriate evacuation, family reunification and community re-engagement and communication processes.

Simultaneously, those workers and volunteers who are responders to the emergency, either initially or later in the process, should be supported by appropriate management that seeks to maximise routine, clear structure in work processes, clear and timely communication of information, and access to social and psychological support and ongoing training.

The majority of people can be expected to follow a distressing but manageable recovery path (see Table 1: Survivor responses in emergency situations). Those that do not follow the expected recovery path should have their social and psychological needs assessed by appropriately trained personnel. Care should then be provided at the appropriate level by trained and approved service providers, with regular reassessment of the person’s needs. DHBs will take a central role in providing expertise in these areas.

The following sections provide both pre- and post-event planning implications for psychosocial recovery for stakeholders. It is expected that providers will work with a range of agencies to address psychosocial recovery planning for their communities.

Figure 3: Recovery pathway for those experiencing the emergency event and professionals responding to the event



Pre-event: risk reduction

For psychosocial recovery, risk reduction is related to the lessening of overall community risk. The combined activities of many agencies contribute to the resilience of a community. For health and disability and social service agencies, the broad agenda of strengthening the social, physical and mental wellbeing of communities will prove the best strategy for creating community resilience.

Post-recovery evaluation is a specific strategy to effect risk reduction: learning from events will help to provide more effective psychosocial recovery interventions in future emergencies. Local and regional agencies should consider how best to evaluate the psychosocial recovery responses to particular emergencies. Evaluation can range from

inter-agency workshops and organisational debriefing, to formal scientific or other academic audit or research.

Risk reduction can also be approached at an agency level. For DHBs, for example, there are accountability mechanisms (such as contract monitoring by the Ministry of Health and district annual reporting to the Ministry) that allow for fine-tuning of DHB responsiveness to emergency management planning, including psychosocial recovery planning.

Pre-event: readiness

Readiness is similar to primary prevention in health promotion, and is aimed at preventing physical or psychosocial problems. In broad terms, agencies should be focusing on:

- psychosocial recovery planning
- training and exercising
- public education and information
- business continuity planning
- increasing community capacity.

Response and recovery

Psychosocial recovery planning activities aim to facilitate community recovery by providing information and guidance to those affected by the emergency event, and to those who support them. As discussed in *Focus on Recovery* (MCDEM 2005a), recovery from an emergency event is most effective when planning for it is embedded in the reduction, readiness and response phases of emergency management. The report also notes:

Response planning includes a range of provisions relevant to recovery planning. The most significant is the allocation of functions and tasks for response activities. The facilities and co-ordination arrangements set up for response may also be available for recovery use. In most cases, agencies will carry their response roles over into recovery, changing only the reporting arrangements and the level of resource commitment. As response agencies are involved in recovery activities it is vital that they are included in recovery planning and coordination arrangements pre-event (MCDEM 2005a).

The following tables contain some suggested activities agencies can engage in to prepare for the readiness, response and recovery phases of a psychosocial recovery scenario. Please note that these relate to an ideal scenario and aim to describe what it might look like if going well.

The tables are designed to assist DHBs and other health providers to clarify how they would develop their own plans to support psychosocial recovery and how these plans would fit into the wider landscape of regional and national emergency planning.

It should be noted that this is an interim guide for suggested activities only. Other agencies with responsibility for psychosocial recovery will also be developing their own guidelines in parallel with this document.

Table 2: Planning for psychosocial recovery in the readiness phase of an emergency event

		Suggested local and regional actions	Suggested other agency actions	Suggested national actions
Readiness phase	Communication and liaison	<p>Link with and engage in training with other stakeholder agencies to develop community and organisational readiness.</p> <p>Public education can include:</p> <ul style="list-style-type: none"> • media campaigns • web-based information • school education programmes • other information. <p>Local iwi and hapū should be consulted and invited to link in.</p> <p>Representatives of groups that may be considered vulnerable (ie, children, elderly, the remotely located, and those that provide services to them) should be invited to link into the CDEM group. These could be community organisations, DHB providers, NGOs or others.</p>	<p>Identify extra resources that may be required by at-risk client groups during an emergency.</p> <p>Aim to work in synergy with the CDEM group.</p> <p>Have input to the CDEM group via the Health Advisory Group, as appropriate.</p>	<p>Develop and distribute information (including via websites and fact sheets) on a variety of reactions and recovery timelines that can be expected, where to go for further help, etc.</p> <p>Liaise and co-ordinate with stakeholders (eg, Earthquake Commission, Institute of Geological and Nuclear Sciences, Insurance Council) to develop relationships in anticipation of an event.</p>

		Suggested local and regional actions	Suggested other agency actions	Suggested national actions
Readiness phase	Identifying resources	<p>Develop a social map of your community to identify groups that might be able to deliver outreach or other social services, or that might be appropriate to target for educational purposes, such as:</p> <ul style="list-style-type: none"> • local service groups (eg, Lions and Rotary) • local business organisations • church groups: <ul style="list-style-type: none"> – Catholic Social Services – Presbyterian Support – Salvation Army – local church organisations – other social resources. • senior citizens' groups • education sector groups: <ul style="list-style-type: none"> – kōhanga reo – kindergartens – primary schools – secondary schools – tertiary institutes. 	<p>Develop a social map of your community to identify groups that might be able to deliver outreach or other social services, or that might be appropriate to target for educational purposes such as:</p> <ul style="list-style-type: none"> • local service groups • church groups: • other social resources • sporting groups • cultural groups • local business organisations • senior citizens' groups • education sector groups: <ul style="list-style-type: none"> – kōhanga reo – kindergartens – primary schools – secondary schools – tertiary institutes. 	<p>Identify national agencies that can provide social, psychological and higher-level support needs.</p> <p>Identify the roles and responsibilities of member agencies and additional roles that can be undertaken in an emergency/recovery period.</p> <p>Ensure that 'live information' and responder pathways can be set up quickly (eg, freephone lines).</p> <p>Establish links with other agencies (eg, Victim Support, Healthline, Plunket, Youthline, Samaritans) that can provide support to people who are experiencing reactions within the expected range.</p> <p>Develop leadership and co-ordination across all relevant agencies.</p> <p>Draft a psychosocial support contract and agree on the principles, to be ready for activation when required.</p>

		Suggested local and regional actions	Suggested other agency actions	Suggested national actions
Readiness phase	Vulnerable groups	<p>Identify at-risk groups in your community. These may include:</p> <ul style="list-style-type: none"> • children and young people • mental health consumers • people with physical and other disabilities • immigrant and refugee groups • families and others who are at higher risk. <p>Identify agencies in the local community that can provide:</p> <ul style="list-style-type: none"> • social support • psychological support • higher-level support (eg, DHB mental health services may be able to provide contact information for local alcohol and drug counsellors). <p>Identify and liaise with local providers of outreach services (eg, Victim Support or a similar local organisation).</p> <p>Other such agencies may also be national, such as Barnardos, Plunket, Healthline, Youthline, Samaritans, Salvation Army, Presbyterian Support Services, Catholic Social Services, Women’s Refuge, Disabled Persons Assembly, Relationship Services, and Lifeline.</p>	<p>Maximise care for your own at-risk client groups.</p> <p>Develop emergency management plans, as follows:</p> <ul style="list-style-type: none"> • DHB hospital providers – for all client groups • DHB mental health services – for service users • Child, Youth and Family (CYFS) – for clients • disability support services – for clients • PHOs – for service users • Independent Practitioner Associations and other primary health care providers. <p>Ensure that client contact details are up-to-date and can be accessed in emergency situations.</p> <p>Develop leadership and co-ordination across all relevant agencies.</p> <p>Liaise with relevant CDEM group committees.</p> <p>Set up networks with other groups operating in your area.</p> <p>Learn about CIMS and other aspects of local and national emergency management planning.</p>	<p>Ensure networks are in place (as per the Communications section of this table) to ensure that support is readily accessible if needed.</p> <p>Ensure planning includes the identification of vulnerable groups and agencies’ responsibilities to respond.</p> <p>Identify funding requirements and the process for obtaining additional resources.</p>

		Suggested local and regional actions	Suggested other agency actions	Suggested national actions
Readiness phase	Vulnerable groups	<p>Identify an agency, professional person or group that can identify those with higher-level needs. This may be a combination of local Victim Support and local trained mental health service providers, including those in the community and within various agencies (eg, DHBs).</p> <p>Identify trained and approved community-level providers who can supply higher-level services for those with higher-level needs.</p> <p>Undertake workshops and training.</p> <p>Develop a schedule of Exercises to practice and test emergency planning.</p> <p>Develop leadership and co-ordination across all relevant agencies.</p>	<p>DHB-contracted providers should ensure there are plans in place for their service users:</p> <ul style="list-style-type: none"> • aged care • intellectual disability • mental health • other clients. 	

		Suggested local and regional actions	Suggested other agency actions	Suggested national actions
Readiness phase	Communication	<p>Develop arrangements that incorporate evidence-based principles and practices.</p> <p>Include a communications plan that will identify media, such as radio stations and community newspapers.</p> <p>Where possible, identify synergies so that communicating and planning for one group (eg, families) will link with other groups (such as educational institutions), and encourage these synergies in emergency management planning, to develop resilience and an active approach to recovery.</p> <p>Access information from the Ministry of Civil Defence and Emergency Management / NWRCG on recovery that can be distributed to groups identified in your community 'social and organisational map'.</p> <p>Develop 'key messages' for educating community groups.</p> <p>Encourage psychosocial recovery planning.</p>		<p>Include psychosocial considerations in across-agency communications strategy.</p> <p>Ensure psychosocial support is incorporated into flier/ note-taking for 0800 line/ads etc.</p>

Table 3: Psychosocial recovery in the response phase

		Suggested local and regional actions	Suggested other agency actions	Suggested national actions
Response phase	Communication and liaison	<p>Co-ordinate various support services, including:</p> <ul style="list-style-type: none"> • support of communities through information dissemination and education • outreach/psychological first aid • screening/referrals • therapeutic interventions by registered and trained health professionals. <p>Activate the recovery plan (including outreach/ psychological first aid and screening for higher-level needs) while maintaining appropriate links to other aspects of the response.</p> <p>Aim to increase personal control and decrease uncertainty as much as possible.</p>	<p>Contact clients and respond to the needs of your client group.</p> <p>Liaise with the CDEM group.</p>	<p>Address multi-agency responses, based on the National CDEM plan and the <i>Guide to National CDEM Plan</i>.</p> <p>Psychosocial recovery may require liaison with other national-level agencies (to facilitate assistance from their supporting agencies/ provider services), CDEM groups, and the Ministry of Civil Defence and Emergency management or another lead agency (eg, the Ministry of Health in a pandemic).</p> <p>Individual agencies support requirements of the NWRCG and provide the lead/co-ordinating agency with timely information.</p> <p>Ensure the decision-makers of each agency have adequate decision-making capacity for their agency.</p> <p>Finalise a contract detailing the psychosocial response, and request further funding if required.</p> <p>Receive information on local needs from CDEM groups and regional teams.</p> <p>The Ministry of Social of Development will take the lead agency role for welfare to ensure provision of these services.</p>

Table 4: Planning for psychosocial recovery in the recovery phase

		Suggested local and regional actions	Suggested other agency actions	Suggested national actions
Recovery phase	Communication and liaison	<p>Provide local information, and social, psychological and higher-level support using the principles of psychosocial recovery.</p> <p>Safety, evacuation, sheltering, reunification and basic physical and social needs should continue to be assessed by recovery agencies.</p> <p>Outreach services should continue to identify members of the community who may not already have been contacted or who may be avoiding contact.</p> <p>Provide information on coping skills, including encouraging the seeking of social supports, and the value of engaging in approach- versus avoidance-related coping.</p> <p>Continually assess local recovery capability, and escalate to the NWRCG if a local/regional group cannot provide sufficient resources to deliver effective psychosocial recovery.</p> <p>Monitor for ongoing threats and stressors.</p> <p>Liaise with local and national media to get messages across and to inform the media if any inappropriate messages are being delivered.</p>	<p>Provide extra social, psychological and higher-level support as required to your own client groups.</p> <p>Primary health care providers such as GPs, nurses, iwi and NGO health and disability service providers can expect an increased demand for services as more people present with physical illness, as well as illness related to psychosocial stressors.</p> <p>All such agencies should apply psychosocial recovery principles, including screening and referral to higher-level support services such as DHB mental health services, where relevant clinical criteria are met for such referrals.</p>	<p>National-level assistance with welfare will be required when a CDEM group cannot meet the demand for welfare assistance and requires help from the responsible national agency.</p> <p>The level of assistance required will depend on the resources of the affected areas and the consequences that have to be managed.</p> <p>Hold ongoing and regular meetings to assess the situation, manage the issues as they arise and ensure the right support is getting to the right people/communities in a timely and appropriate way.</p>

		Suggested local and regional actions	Suggested other agency actions	Suggested national actions
Recovery phase	Communication and liaison	<p>Review the map of local social groupings, such as schools, marae, religious and other cultural and community interest organisations, to reach wider community groupings and people who might have extra vulnerabilities.</p> <p>Less intensive actions include informal information dissemination, outreach/ psychological first aid and screening.</p> <p>More intensive actions include formal assessments and individualised interventions.</p> <p>Provide resources that help recovery while identifying those who require more intensive assistance, including:</p> <ul style="list-style-type: none"> • basic support • psychological support (including psychological first aid and education) • needs assessment • monitoring the recovery environment • public outreach and information • organisational co-ordination, roles, training. <p>Continue liaison with other agencies/CDEM group.</p>	<p>Liaise with the CDEM group/s to advise of any capacity to assist others, or of need to access extra support for your own client group/s.</p>	<p>Assess the situation reports of the recovery phase, and use them to identify gaps and extra resourcing needs.</p> <p>Prepare Cabinet briefing papers (if required) to request government funding for extra support services that have been identified as necessary to supplement CDEM group resources. The most probable immediate resource needs will be for outreach/ psychological support and screening services, but, depending on the degree of trauma experienced by a community may extend to funding or other resourcing for formal assessments and individualised interventions.</p> <p>Government agency actions should be aligned with the particular psychosocial intervention that needs to be strengthened. For example, social interventions should be organised by a social sector agency at the national level and provided at a local level.</p>

An example of emergency management: pandemic influenza

Introduction

The background context for this section of the document can be found in the *New Zealand Influenza Pandemic Action Plan*, which can be accessed on the Ministry of Health website (<http://www.moh.govt.nz/moh.nsf/indexmh/nz-influenza-pandemic-action-plan-2006>). This section focuses on the psychosocial effects of a pandemic of infectious disease in New Zealand and the possible effects of management measures.

Psychosocial effects of an outbreak of infectious disease

There is almost no data on the mental health impacts of outbreaks of disease.
(Center for the Study of Traumatic Stress, 2006: 1)

There is abundant data on the mental health impacts of geological or weather-related events (eg, the 2004 Asian tsunami and the impact of Hurricane Katrina on New Orleans and its environs in 2005). Severe stress reactions may be widespread, front-line health workers may be at high risk for post-traumatic stress disorder (PTSD), and there may be severe strain on mental health services, even in areas that are relatively developed.³ However, there is very little information available on the mental health impacts of outbreaks of infectious disease, largely because there have been few pandemic health threats in the last century.

The outbreak of SARS has had a unique and complex social impact. There has been global alarm and concern at recent localised outbreaks of SARS in Asia and Canada, but these did not turn out to be pandemic outbreaks. Information from the areas affected by SARS indicates that more than 40 percent of local communities experienced increased stress in family and work settings, 16 percent showed signs of traumatic stress, and high percentages of the population felt horrified, apprehensive and helpless in the face of the outbreak (McAlonan et al 2005).

Although the actual survival rate of SARS infection was upwards of 80 percent, another community survey showed that 30 percent of those surveyed thought that they would contract SARS, with only a quarter believing they would survive if they contracted the disease (Lau et al 2005). This heightened level of perceived risk of death was much higher than the actual mortality rate.

The anxiety that can be associated with such high perceived risk (as well as anxiety associated with other factors) can affect further psychological, emotional and behavioural responses. For example, person-to-person infection control precautions were adopted differentially during the SARS outbreak according to anxiety levels and perceived risk of contracting the disease (Lau et al 2005). This reinforces the importance of taking stress, anxiety and baseline mental health status into account when implementing a public health programme of risk assessment and communication, prevention and consequence management. Although much of public health planning assumes that measures to prevent an outbreak will be successful, it is crucial to manage the behavioural responses to failure to control an outbreak, including failure to

³ More on these aspects can be found in Part A.

deliver support and services, failure to develop a vaccine and failure of therapies (eg, Tamiflu) to work.

Table 5 below presents a summary of the possible psychosocial effects of an infectious disease such as influenza. The table identifies effects on the wider population, community and individual family/whānau.

Table 5: Possible psychosocial effects of a pandemic

Consequence	Wider population effects	Community effects	Individual/family/whānau
Social distancing	<ul style="list-style-type: none"> • Surge of anxiety • Fear of every human encounter • Reinforces discrimination and prejudice 	<ul style="list-style-type: none"> • Stigma • Anxiety • Isolation and possible lack of adequate care • Adverse effects on community mental health 	<ul style="list-style-type: none"> • Alienation • Reduced self-esteem • Loss of networks • Rejection • Loss of personal closeness • Reduced sense of security
Restriction of movement	<ul style="list-style-type: none"> • Transport/travel cancelled • Increased demand for basic supplies • Anger • Lack of trust in political leaders 	<ul style="list-style-type: none"> • Difficulty ensuring basic supplies • Anger • Frustration • Resentment 	<ul style="list-style-type: none"> • Anger • Isolation • Powerlessness • Loss of independence and mobility • Limitations • Reduced access to services
Isolation and quarantine	<ul style="list-style-type: none"> • Disruption of lifestyle • Uncertainty • Restricted workforce capacity • Hyper-vigilance for threat 	<ul style="list-style-type: none"> • Support agencies overwhelmed • Community support networks required • Community reserves stretched • Vulnerable groups disadvantaged • Racial and ethnic discrimination • Stigma of those quarantined or in isolation 	<ul style="list-style-type: none"> • Isolation and withdrawal from others • Anger/fear/helplessness • Rejection • Stress • Frustration • Uncertainty/stigma • Disorientation • Boredom • Increased use of alcohol and/or drugs • Hyper-vigilance • Family/whānau conflict • Concern for others

Consequence	Wider population effects	Community effects	Individual/family/whānau
Closure of educational institutions and restriction on gatherings, including funerals	<ul style="list-style-type: none"> • Cancelling events • Closing buildings • Avoiding crowding • Closing schools • Closing childcare centres • Banning public gatherings • Funeral/tangi ceremonies restricted • Anger • Fear 	<ul style="list-style-type: none"> • Children at home that need to be cared for – parents away from workforce as a consequence • People confined to specific communities • Restricted workforce capacity • Lack of alternative activity 	<ul style="list-style-type: none"> • Frustration • Reduced self-esteem • Irritability • Relationship breakdown • Loss of networks • Unresolved grief • Guilt • Possible loss of employment and income concerns • Boredom
Use of personal protective equipment (PPE); eg, masks	<ul style="list-style-type: none"> • Surge of use of PPE • Fear • Avoidance of public activities, including work attendance 	<ul style="list-style-type: none"> • Demand for free PPE • Fear • Unrealistic reliance on PPE as a means of protection • Overuse of PPE • Poor handling of PPE 	<ul style="list-style-type: none"> • Fear for personal safety • Restricted communication • Infection control issues • Frustration • Obsessive behaviour • Unrealistic confidence and risk-taking behaviours
Not going to work	<ul style="list-style-type: none"> • Reduced availability of goods and services • Businesses in 'stand still' mode or frozen • Loss of income and profits 	<ul style="list-style-type: none"> • Workplaces closed or restricted • Workers available to help in the community – need to be managed • Reduced available income 	<ul style="list-style-type: none"> • Possible loss of: <ul style="list-style-type: none"> – job – income – self-esteem – networks – security • Boredom
The challenge of being ill	<ul style="list-style-type: none"> • Social discrimination against infected people and their family members 	<ul style="list-style-type: none"> • Community discrimination • Fear • Stigma 	<ul style="list-style-type: none"> • Depression • Anxiety and fear of outcome of illness • Dealing with physical symptoms • Fear of infecting other family members • Weakness, recovery fatigue • Worry about basic needs • Fear of stigma • Survivor guilt

Consequence	Wider population effects	Community effects	Individual/family/whānau
Keeping going in the face of 'waves' of new challenges	<ul style="list-style-type: none"> • Uncertainty about returning to normal in case there is a recurrence of the disease 	<ul style="list-style-type: none"> • Uncertainty • Preparation for next wave • Community resources stretched • Compassion fatigue 	<ul style="list-style-type: none"> • Anxiety about the disease recurring • Trying to keep positive • Easy to lose sight of ability to manage

Table 6: Suggested planning activities to address psychosocial effects in a pandemic

Consequence	Wider population effects	Community	Individual/family/whānau
Social distancing	<ul style="list-style-type: none"> • Model leadership and appropriate behaviour. • Provide broad population information. • Conduct media and web-based campaigns. • Emphasise social distancing at the appropriate time in the preparedness and response phases. • Revise advice on social distancing as more information becomes available. • Acknowledge tension between social distancing and community support. • Be honest about uncertainties. 	<ul style="list-style-type: none"> • Communities support their members by: <ul style="list-style-type: none"> – increased community networks – telephone contacts – updating web-based information frequently – distributing basic supplies. • This includes: <ul style="list-style-type: none"> – church and volunteer groups – other groups with suitable training. • Support identified vulnerable groups in order to enhance sense of community cohesion. 	<ul style="list-style-type: none"> • Provide education on: <ul style="list-style-type: none"> – managing infection – protecting yourself and your family – care for sick family members – keeping in contact with family and friends – use of email – internet chat groups – dealing with depression and low self-esteem – identifying and supporting vulnerable individuals.
Restriction of movement	<ul style="list-style-type: none"> • Minimise transport use and travel. • Increase supply of basic goods at local outlets. 	<ul style="list-style-type: none"> • Provide information on safe travel. • Community distribution of basic needs. • Community leaders find out who is vulnerable in the community. 	<ul style="list-style-type: none"> • Provide advice on: <ul style="list-style-type: none"> – obtaining supplies of basic goods – positive activities at home – schooling at home.

Consequence	Wider population effects	Community	Individual/family/whānau
Isolation and quarantine	<ul style="list-style-type: none"> Supply education to prevent stigma. 	<ul style="list-style-type: none"> Use alternative ways for community communication, eg: <ul style="list-style-type: none"> email telephone text messaging agreed signals on doors signifying need for help. 	<ul style="list-style-type: none"> Provide education on: <ul style="list-style-type: none"> email communication telephone networks internet chat rooms how to maintain and connect to social support networks positive activities at home.
Closure of educational institutions and restriction on gatherings including funerals/tangi	<ul style="list-style-type: none"> Provide information about home education. Provide guidelines for managing the deceased. 	<ul style="list-style-type: none"> Provide home education programme via the internet. Suggest people use home-based forms of entertainment. 	<ul style="list-style-type: none"> Advice on keeping children entertained at home. Protecting children and family health and well-being. Dealing with death of family and friends. Setting up and maintaining existing support networks.
Use of personal protective equipment (PPE), eg, masks	<ul style="list-style-type: none"> Provide education on the use of PPE. 	<ul style="list-style-type: none"> Provide education on the use of PPE. 	<ul style="list-style-type: none"> Provide education on the application and use of PPE and infection control. Explain PPE for children and other vulnerable groups.
Not going to work	<ul style="list-style-type: none"> Management of unoccupied property from security and infection control perspectives. 	<ul style="list-style-type: none"> More people in residential community during working hours, but fewer in commercial districts. Community support potential increased. Potential for property crime in commercial areas. 	<ul style="list-style-type: none"> Information on working from home. Advice on activities (home-based). Provide advice and information on suitable community support activities. Income support processes via Ministry of Social Development advice to be disseminated.

Consequence	Wider population effects	Community	Individual/family/whānau
The challenge of being ill	<ul style="list-style-type: none"> • Media messages about recovery through various channels. 	<ul style="list-style-type: none"> • Compassion for the sick. • Community support. • Social cohesion. 	<ul style="list-style-type: none"> • Provide info on helpful coping strategies – supporting self and others. • Planning to survive crises – plan to get through. • Promote message that recovery will be to a different level from where you started. • Relieve pressure to return to work – time to recuperate, balanced with messages of enhanced immunity once recovered. • Possible enhanced appreciation of life in the face of illness. • Appreciation of home and family.
Keeping going in the face of 'waves' of new challenges	<ul style="list-style-type: none"> • Maintain positive but realistic media messages. • Highly visible pandemic management and leadership. 	<ul style="list-style-type: none"> • Enhance sense of community support and cohesion – 'all in this together'. 	<ul style="list-style-type: none"> • Provide information on ways of managing anxiety. • Raise awareness of the importance of continuing good personal hygiene practices. • Prepare for the next wave with increased knowledge.

Although most of the consequences listed in these tables are short term, it is imperative to plan for psychosocial recovery over the medium to long term.

Glossary

Term	Definition/meaning
4 Rs	Reduction, readiness, response, recovery. ⁴
Basic needs	These include safety, food, water and shelter.
Emergency	A situation that: <ul style="list-style-type: none"> (a) is the result of a happening, whether natural or otherwise, including, without limitation, any explosion, earthquake, eruption, tsunami, land movement, flood, storm, tornado, cyclone, serious fire, leakage or spillage of any dangerous gas or substance, technological failure, infestation, plague, epidemic, failure of or disruption to an emergency service or a lifeline utility, or actual or imminent attack or warlike act; and (b) causes or may cause loss of life or injury or illness or distress or in any way endangers the safety of the public or property in New Zealand; and (c) cannot be dealt with by emergency services, or otherwise requires a significant and co-ordinated approach under the CDEM Act 2002
Evidence based	The conscientious, explicit and judicious use of current best evidence in making decisions.
Emergency worker	A help agency or worker responding to the emergency situation.
Hapū	The sub-tribe component of a tribe to which a family/whānau may indicate their connection or affiliation.
Iwi	A tribe or common ancestor, canoe or region(s).
Kaupapa	A strategy or theme.
Mental health	How an individual thinks, feels and acts when faced with life's situations.
Needs assessment	A method of identifying a person's support needs
Pandemic	An epidemic that becomes very widespread and affects a whole region, a continent or the world. ⁵
Psychological first aid	Support for people early after the emergency event to reduce initial distress and foster short- and long-term adaptive functioning.
Psychological support	Support for people who experience increased levels of stress or are more severely affected by the emergency event than others. These people require a greater level of support, which needs to be provided by a trained person. This is not a mental health intervention, but a listening and problem-solving approach.
Psychosocial	The dynamic relationship that exists between psychological and social effects, each continually interacting with and influencing the other.
Psychosocial recovery planning	Psychosocial recovery planning is focused on the social and psychological interventions that will help a community recover.
Self-help strategies	Self-help groups include people with a common bond who voluntarily come together to share, reach out and learn from each other in a trusting, supportive and open environment.

⁴ National CDEM Plan Order 2005.

⁵ National Health Emergency Plan: Infectious Diseases 2004.

Term	Definition/meaning
Social effects	Altered relationships, family and community networks and economic status.
Social support	The involvement of activities such as conversation, peer support, providing opportunities for people to discuss experiences in a supportive environment, bringing communities together and sharing experiences.
Tikanga Māori	Māori custom or meaning

Abbreviations

4 Rs	Reduction, readiness, response, recovery – the fundamental organisational approach to civil defence emergency management
CEG	Local Government Co-ordinating Executive Group
CDEM	Civil Defence Emergency Management
CDEM group	Civil Defence Emergency Management (CDEM) group. A group established under section 12 of the Civil Defence Emergency Management Act 2002.
CIMS	Co-ordinated Incident Management System
CYFS	Child, Youth and Family Services
DESC	Domestic and External Security Group
DHB	District Health Board
GP	General Practitioner
MCDEM	Ministry of Civil Defence and Emergency Management
NGO	Non-Governmental Organisation
NWRCCG	National Welfare Recovery Coordination Group
ODESC	Committee of Officials for Domestic and External Security Co-ordination
PHO	Primary Health Organisation
PPE	Personal Protective Equipment
PTSD	Post-Traumatic Stress Disorder
SARS	Severe Acute Respiratory Syndrome
WHO	World Health Organization

References

- American Psychiatric Association. 2006. *Diagnostic and Statistical Manual of Mental Disorders*. 4th ed. Washington DC: American Psychiatric Association.
- Center for the Study of Traumatic Stress. 2006. *Mental Health and Behavioral Guidelines for Response to a Pandemic Flu Outbreak: Background on the mental health impact of natural disasters, including epidemics*. URL: http://www.centerforthestudyoftraumaticstress.org/downloads/CSTS_Pandemic_flu.pdf. Accessed 16 June 2006.
- Inter-Agency Standing Committee (IASC). 2006. *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*. Geneva: IASC. URL: <http://www.humanitarianinfo.org>. Accessed 11 September 2006.
- Lau JT, Yang X, Yang P, et al. 2005. Psychological distress of nurses in Taiwan during the outbreak of SARS. *Psychiatric Services* 56(1): 76–9.
- McAlonan GM, Lee AM, Cheung V, et al. 2005. Psychological morbidity related to the SARS outbreak in Hong Kong. *Psychological Medicine* 35(3): 417–24.
- MCDEM (Ministry of Civil Defence and Emergency Management). 2005a. *Focus on Recovery: A holistic framework for recovery in New Zealand: information for the CDEM sector [IS5/05]*. Wellington: MCDEM.
- MCDEM (Ministry of Civil Defence and Emergency Management). 2006. *The Guide to National CDEM Plan*. Wellington: MCDEM.
- Minister of Health. 2000. *New Zealand Health Strategy*. Wellington: Ministry of Health.
- Ministry of Health. 2002. *He Korowai Oranga: Māori Health Strategy*. Wellington: Ministry of Health.
- Ministry of Health. 2005. *National Health Emergency Plan: Guiding principles for emergency management planning in the health and disability sector*. Wellington: Ministry of Health. URL: <http://www.moh.govt.nz/moh>. Accessed 10 May 2006.
- National Institute of Mental Health. 2002. *Mental Health and Mass Violence: Evidence-based early psychological intervention for victims/survivors of mass violence. A workshop to reach consensus on best practices*. NIH Publication No. 02-5138. Washington DC: US Government Printing Office.
- Norris FH, Friedman MJ, Watson PJ. 2002a. 60,000 disaster victims speak: Part 1: an empirical review of the empirical literature, 1998–2001. *Psychiatry* 65(3): 207–40.
- World Health Organization. 2003. *Mental Health in Emergencies*. Geneva: Department of Mental Health and Substance Dependence, World Health Organization.
- US Department of Health and Human Services (2005). *Mental health response to mass violence and terrorism: A field guide* (DHHS Publication No. SMA 4025). Rockville MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

Further reading

- Dirkzwager A, Grievink L, Van Der Velden P, et al. 2006. Risk factors for psychological and physical health problems after a man-made disaster. *British Journal of Psychiatry* 189: 144–7.
- Greenhaigh T, Robert G, MacFarlane F, et al. 2004. Diffusion of innovations in service organizations: systematic review and recommendations. *Millbank Quarterly* 82(4): 581.
- Hughes F, Grigg M, Fritsch K, et al. 2007. Psychosocial response in emergency situations: the nurse's role. *International Nursing Review* 54: 19–27.
- Koh T, Plant A, Eng HE. 2003. *The New Global Threat*. London: World Scientific Publishing Company.
- MCDEM (Ministry of Civil Defence and Emergency Management). 2005b. *Recovery Management: Director's guide for CDEM groups* [DGL4/05]. Wellington: MCDEM.
- Ministry of Health. 2004. *National Health Emergency Plan: Infectious diseases*. Wellington: Ministry of Health. URL: <http://www.moh.govt.nz>. Accessed 20 June 2006.
- Ministry of Health. 2006. *New Zealand Influenza Pandemic Action Plan*. Wellington: Ministry of Health.
- Norman S (ed). 2004. *NZ Recovery Symposium Proceedings*. Wellington: MCDEM.
- Norris FH, Friedman MJ, Watson PJ. 2002b. 60,000 disaster victims speak: Part II: summary and implications of the disaster mental health research. *Psychiatry* 65(3): 241–60.
- Rice GW. 2005. *Black November: The 1918 influenza pandemic in New Zealand*. 2nd ed. Christchurch: Canterbury University Press.
- Rogers E. 1995. *Diffusion of Innovations*. 4th ed. New York NY: The Free Press.
- Ronan KR, Johnson DM. 2005. *Community Resilience to Disasters: The role for schools, youth, and families*. New York: Springer.
- Sijbrandij M, Olf M, Reijtsma J, et al. 2006. Emotional or educational debriefing after psychological trauma. *British Journal of Psychiatry* 189: 150–5.
- Sphere Project. 2004. *Sphere Handbook: Humanitarian charter and minimum standards in disaster response*. Geneva: WHO. URL: <http://www.sphereproject.org/handbook/index.htm>. Accessed 10 May 2006.
- The Working Group On 'Governance Dilemmas' In Bioterrorism Response. 2004. Leading During Bioattacks and Epidemics with the Public's Trust and Help. *Biosecurity and Bioterrorism: Biodefense Strategy, Practice, and Science* 2(1): 25–40.
- Watson PJ, Friedman MJ, Gibson LE, et al. 2003. Early intervention for trauma-related problems. In: RJ Ursano, AE Norwood (eds). *Trauma and Disaster: Responses and management*. Washington DC: American Psychiatric Publishing.