Stronger Canterbury

Earthquake Recovery.

Strategic Planning Framework

To support individual recovery and community wellbeing, and to build community resilience

Following the 2010 Canterbury and 2011 Christchurch earthquakes

18 May 2011

New Zealand Government

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Introduction to the Strategic Planning Framework

Who is it for?

The Strategic Planning Framework is primarily to assist those responsible for planning the psychosocial response to the earthquakes in Canterbury and Christchurch City. It is specifically for the Christchurch Psychosocial Response subgroup and relevant Community Wellbeing subgroups.

It provides information, advice and guidance on the key factors which need to be considered when developing a psychosocial recovery plan. These considerations include the principles that should guide the response, evidence about the expected impact on individuals and groups, and the expected duration of those impacts.

The Framework's intention is to provide an overarching context to assist the development of regional operational plans.

How was it developed?

This Framework has been developed through the National Psychosocial Response Subgroup with the support of the Psychosocial Recovery Advisory Group, established to provide advice on the development of the psychosocial response.[1]

It was also informed by the *Recovery and Wellbeing Implementation Plan* developed by the Christchurch Psychosocial Response Subgroup. The Framework will in turn inform the ongoing development of the Christchurch Plan.

A number of other documents have informed and assisted the development of this Framework. These are outlined in the Reference section contained in Appendix D and include the 2007 Ministry of Health's *Planning for Individual and Community Recovery in an Emergency Event: Principles for Psychosocial Support: National Health Emergency Plan.* Where this Framework differs from the latter and other documents is in its specific focus on the Christchurch and Canterbury situation and its emphasis on the broader social aspects of a psychosocial recovery.

The Framework will be reviewed and revised, as necessary, to ensure that it remains useful as the recovery progresses.

What is its scope?

The Framework is concerned with the psychosocial response only, although it recognises that this sits within the context of the wider welfare and overall responses and recovery for the earthquakes. It aims to be consistent with, and support, the psychosocial recovery activities that are already underway following the Canterbury earthquake (i.e. in those areas not directly affected by the second event).

It can also support the provision of psychosocial recovery assistance outside Canterbury and Christchurch City.

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[1] Memberships of the National and Christchurch Psychosocial Response Subgroups and the Psychosocial Recovery Advisory Group are contained in the Acknowledgements Section of this document.

What does it contain?

The Framework is divided into three sections with supporting appendices. The three sections are:

- the overarching strategy[2]
- developing a psychosocial recovery plan
- a framework for monitoring and evaluation.

The supporting appendices provide:

- background information on the Canterbury and Christchurch earthquakes, definitions and principles of psychosocial support, information on priority population groups and levels of community engagement (Appendices A and B)
- an intervention pyramid for mental health and psychosocial support in emergencies, taken from the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (Appendix C).
- template headings around planning psychosocial interventions (Appendix D) with an example
- some possible actions (Appendix E)
- references (Appendix F).

[2] The Strategy builds on an earlier draft strategy "Supporting Individual Recovery and Community Wellbeing, and Building Community Resilience following the Canterbury Earthquake".

The strategy

The strategy is underpinned by the principles for a psychosocial recovery process, the context of the Canterbury and Christchurch earthquakes and evidence-based learning around emergency events including identifying and addressing the needs of high risk or vulnerable populations. This background information is contained in Appendix A of the document.

This strategy builds on an earlier Ministry of Social Development draft strategy document "Supporting Individual Recovery and Community Wellbeing, and Building Community Resilience following the Canterbury Earthquake".

The strategy seeks to provide an overarching framework to planning within which local actions and local approaches can be developed. There are two distinct components in this strategy – each with long-term goals, medium-term objectives and short-term outcomes. Component One supports the psychological recovery of individuals and their wellbeing. Component Two provides for building community resilience and supporting wellbeing. Overarching these components sits the overall vision: A Stronger Canterbury.

Actions to achieve the short-term outcomes, the medium-term objectives and finally the long-term goals will need to be developed and finalised through individual regional psychosocial recovery plans. As discussed in the next section on planning, some of these actions will be focused on the short term, some on the medium term and some on the longer term. Actions will need to be monitored, evaluated and revised to meet evolving needs. Some possible actions are outlined in Appendix E.

Component One is of more significance during the earlier phases of response and recovery although, as with any disaster, there will always be some people that will require intervention some months, and even years, after the event. Long term, Component Two will ensure a real, sustainable response for Christchurch communities and their resilience.

Component One: Individual recovery and wellbeing

This stream focuses on individual recovery – it is most relevant in the short to medium term and recognises that strategies need to be put in place to minimise and mitigate the effect of stress and other psychological reactions on the Christchurch population subsequent to the event on 22 February 2011. Note that the majority of individuals will recover from the event in time as long as their basic needs are met, social networks are maintained or restored, and they feel informed, engaged, and have a sense of ownership of the recovery.

For Christchurch City, the event on the 22 February 2011, on top of the experience of the Canterbury earthquake in September 2010, means that the impact of the Christchurch earthquake on its population may be significantly higher than in September 2010 and subsequent months. Alternately, the solidarity and coping that has come to the fore in the months after the September quake may counterbalance this effect. The manner in which the community is consulted, engaged and included in the rebuilding/recovery will be important in mitigating the impact of the two events on psychosocial functioning and the subsequent level of demand for psychosocial support.

Long-term goal

Stress-related responses following the earthquakes are minimised for Christchurch City and Canterbury individuals, families and whānau, and wellbeing and functioning communities are enhanced and promoted.

Medium-term objectives

1. Individuals, families, whānau and caregivers are able to support themselves, children, youth and older people through the stress resulting directly and indirectly from the event.

2. Individuals are personally supported to reduce psychological stress and distress while promoting coping strategies, and their sense of control, self-efficacy, ownership and empowerment are enhanced.

3. Causes and effects of secondary risk factors[3] on stress are minimised.

Short-term outcomes

Each outcome, or series of outcomes, relates to a specific medium-term objective and has a number of resulting actions that can be implemented. The actions are not shown as they would need to be developed at the local level. The numbers below specify which objective the outcome belongs to:

1.1 Parents and caregivers have basic skills to support children, youth and older people to cope with stress related to the immediate disaster.

1.2 Individuals have basic skills to cope with the direct and indirect psychological stress, and distress, post-disaster.

1.3 Individuals can recognise the signs and symptoms of unusual levels of stress in others and can distinguish between normal responses to a stressful event and those which require referral to specialised services.

2.1 Early childhood education, school-based support, or private support for children, youth and older people is accessible (including for those children and students that have temporarily relocated to other schools or the elderly that have been relocated to retirement homes outside of Canterbury).

2.2 Individuals are able to access assessments to assist them to receive support if, and when, appropriate (including those who have temporarily relocated outside Christchurch/Canterbury).

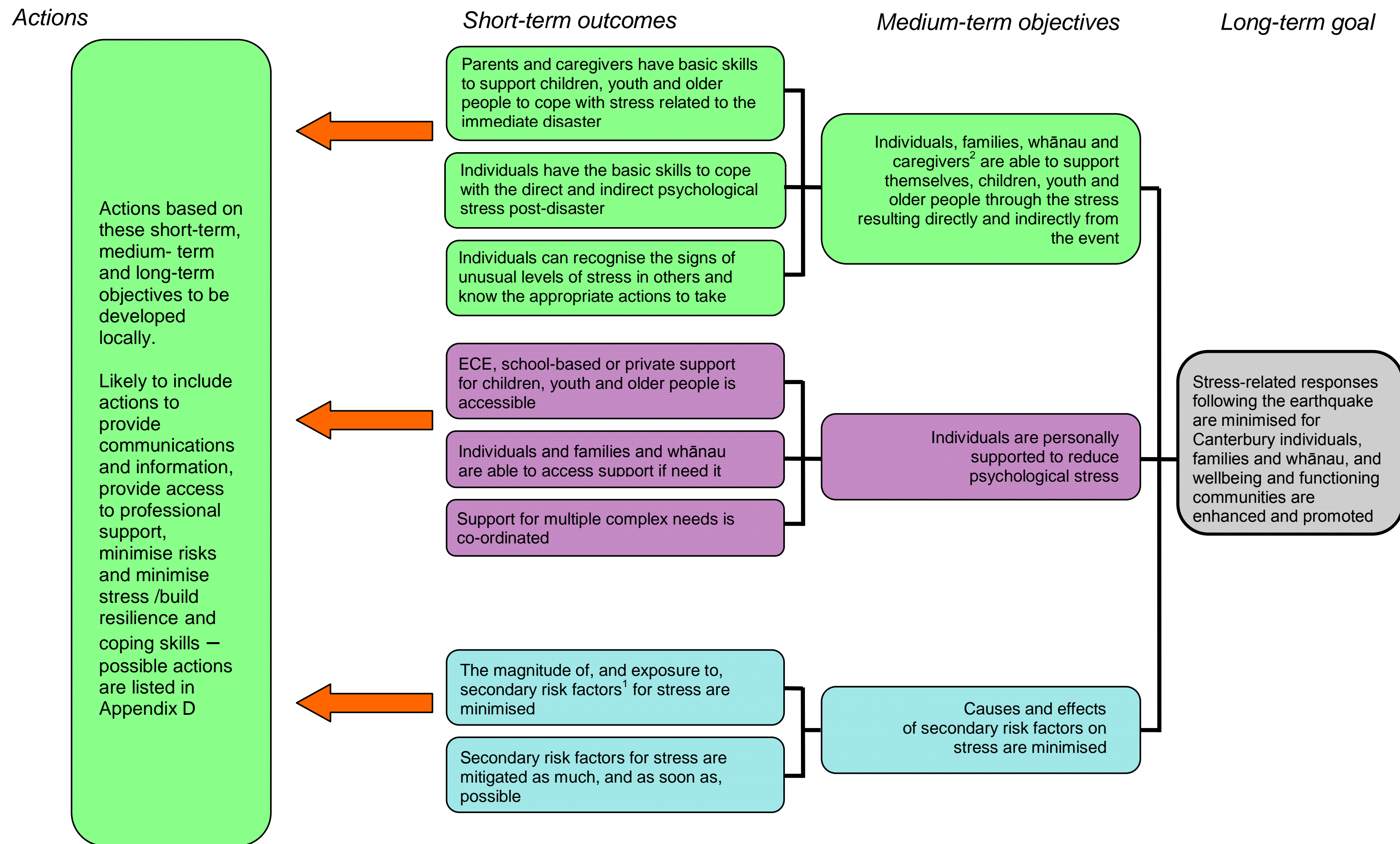
2.3 Support for individuals, families and whānau with multiple and/or complex needs are co-ordinated and seamless, including children in potentially harmful environments and those whose injuries have long and debilitating consequences.

3.1 The magnitude of, and exposure to, secondary risk factors for stress are minimised.

3.2 Secondary risk factors for stress are mitigated as much, and as soon, as possible.

[3] For example, accommodation, employment, insurance claims.

Figure 1: Overview of outcomes for individual recovery and wellbeing following the Canterbury and Christchurch earthquakes



[1] Secondary risk factors are causes of stress that arise subsequent to an earthquake (e.g. lack of resolution from material property loss, loss of employment, relationship problems).
[2] Caregivers include primary (e.g. foster parents) and secondary (e.g. schools).

Component Two: Building community resilience and supporting psychosocial wellbeing

This stream focuses on community level psychosocial recovery and wellbeing. It deals with the social implications of a disaster on the community as a whole, is long term and is underpinned by the concept of community resilience – physically and socially. The strategy highlights the need to regularly engage with affected communities, listen to them, hear and integrate their suggestions, organise with them, advocate on their behalf and fully support them in their psychosocial recovery.

Building community resilience, and the principles of effective community engagement, cross all four disaster recovery environments. Community wellbeing relies on rebuilding across the social, built, economic and natural environments with resilience a critical component. However, for the social rebuild and psychosocial recovery, community resilience is critical as it plays an integral role in an individual's wellbeing.

The goals, objectives and outcomes set out below relate to the psychosocial response alone. However, they can inform the development of community engagement and resilience in a broader recovery strategy (when developed) and may need to be reviewed and adapted once that broader recovery strategy is place.

Long-term goal

Develop strong and resilient Christchurch City and Canterbury communities.

Medium-term objectives

1. Community action to address psychosocial wellbeing is sustainable.
2. Community action to address psychosocial wellbeing is undertaken in an organised manner.
3. All sectors of the community participate in action, are active in the planning of their community recovery, and feel ownership of results.[4]

Short-term outcomes

As with stream one, each outcome or series of outcomes relates to a specific medium-term objective and has a number of resulting actions that can be implemented. Again, the numbers below specify which objective the outcome belongs to:

1.1 Communities have the capacity to build psychosocial resiliency and wellbeing.

1.2 Communities have skills to build psychosocial resiliency and wellbeing.

2.1 Communities are listened to for their needs, their ideas, and mobilised to take action to build their local community recovery as well as their psychosocial resiliency and wellbeing.

2.2 Communities are well informed – including community members who have temporarily relocated outside their Christchurch City or Canterbury community.

[4] See Appendix B for community engagement hierarchy, where collaborative participation and community empowerment participation are seen as optimum styles.

2.3 A shared vision for the community on fostering wellbeing and resilience.

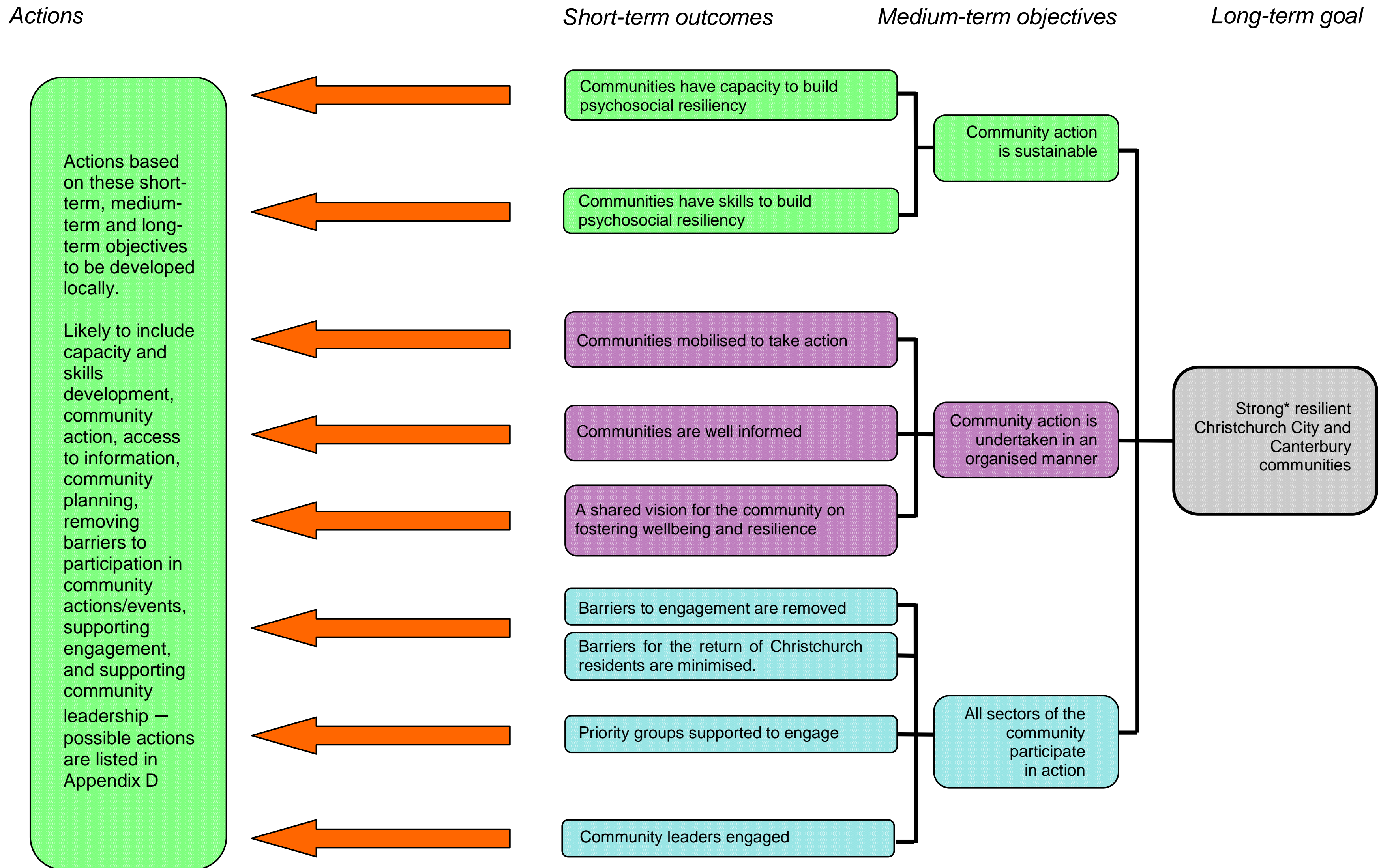
3.1 Barriers to engagement in community action are removed – including for those temporarily relocated outside their Christchurch City or Canterbury community.

3.2 Barriers to the return of Christchurch residents are minimised.

3.3 Priority groups are supported to engage – the Waimakariri Council's approach to rebuilding Kaiapoi is an example of good practice in this area.

3.4 Community leaders are engaged.

Figure 2. Overview of outcomes to build community resilience following the Canterbury and Christchurch earthquakes



* emotional, spiritual, cultural, psychological and social strength.

Psychosocial recovery plan

This section provides advice on the development of a psychosocial recovery plan. It highlights some of the key issues that need to be considered and how this links to the principles around recovery, impacts and priority groups (outlined in Appendix A). It looks at the critical components which need to be addressed and some short, medium and long-term responses (months to years).

Regions can use this advice to develop their own psychosocial recovery plans; thus ensuring national consistency whilst also being able to customise to meet the needs of local environments and differing priority groups. A *Recovery and Wellbeing Implementation Plan* has been developed by the Christchurch Psychosocial Response Subgroup.

Key considerations for a psychosocial recovery plan

1. It must be consistent with best practice and principle driven.

   Some key resources which outline best practice and principle driven approaches are attached at Appendix F. Some of these resources have informed the development of this framework and others provide useful background information.

2. It must build on the psychosocial intervention pyramid – the right interventions to the right people at the right time – starting with the provision of basic services.

   Timing of activities is important for both individuals and communities and needs to be taken into account when planning. This is explained further in Appendix C.

3. A continuum of services from self-help to more specialised services needs to be provided within a clear referral and assessment framework.

   The continuum of psychosocial support and Mental Health Services is dynamic – symptoms and responses can happen across time and distance. Recovery commences with the requirements of food, shelter, basic services, and safety being met in a supportive, efficient way.

   Some individuals, families and whānau have high and complex needs. These needs may be around bereavement, homelessness, loss of income and severe health issues as well as mental health and other social issues, for example, alcohol and drug abuse and an escalation of violence within the family. For some these will be pre-existing conditions while for others the behaviours have emerged as a response to the earthquake(s). These individuals, families and whānau may require a case management approach and intensive wrap around services. Collaboration and co-ordination across these services, including those from NGOs, is very important and needs to be addressed in psychosocial planning.

4. It must be built on co-operative and co-ordinated relationships across agencies and with the local community.

Co-ordination among government and NGOs is vital for effective planning for both individual and community recovery. This includes: co-ordination around information on movements of people within the Canterbury area and around New Zealand; information on emerging psychosocial needs and interventions; co-ordination with the Ministry of Education, Ministry of Health, local council and local community initiatives, co-ordination to ensure consistency of messaging and linked to this, co-ordination and co-operation with the media.

5. The needs of priority populations, including vulnerable populations, must be addressed.

   Severe disaster events tend to increase any existing inequalities. This means that certain population groups may be more likely to need support and services. Also, some population groups such as adolescents might fall through the gaps of provision. This can be allayed in part by well thought out communication and overall community involvement in programmes, for example, listening to local people and their analysis of needs, asking members of the older population who are able to help in extra tuition programmes and/or encouraging and supporting youth to be active in helping some activities for younger children.

   A psychosocial plan needs to address the requirements of vulnerable population groups while noting that prioritising these groups may cause anger and resentment among non-priority population groups if the rationales for the prioritisation are not known, understood, or generally accepted.

6. Addressing the needs of internally displaced people.

   The number of internally displaced people from the Christchurch earthquake, whether voluntarily or involuntarily, has been significant. Within those internally displaced there will be substantial variance in existing resilience including resource capability. However, some will require psychosocial support which will need to be met in the areas to which they have relocated, or on their return. Issues could include:

   - the stress for families and individuals of moving into a new community and required responses
   - appropriate transition arrangements for psychosocial support for families returning to Christchurch
   - effective co-ordination among servicing providers and agencies to achieve streamlined services for Christchurch residents either relocating to other cities or returning to Christchurch
   - following up on child protection cases for those who have relocated or are transient
   - adequate co-ordination and integration of new temporary accommodation for families with the surrounding established neighbourhood and the provision of all social aspects of this “new” neighbourhood.

7. The duration of the planning period is likely to be years.

   The planning period is dynamic and will range from before the event, in terms of preparedness planning, to years after the event.

8. Organisations need to plan to support frontline staff.

   Waves of frustration and anger from those experiencing the event are to be expected – particularly if people perceive that their basic needs are not being met. Frontline staff themselves may be in vulnerable and insecure circumstances. Organisations need to plan to support staff, for example by developing and offering induction training and adequate and supportive supervision. This includes those who return from Christchurch after being deployed from other regions to assist with the response.

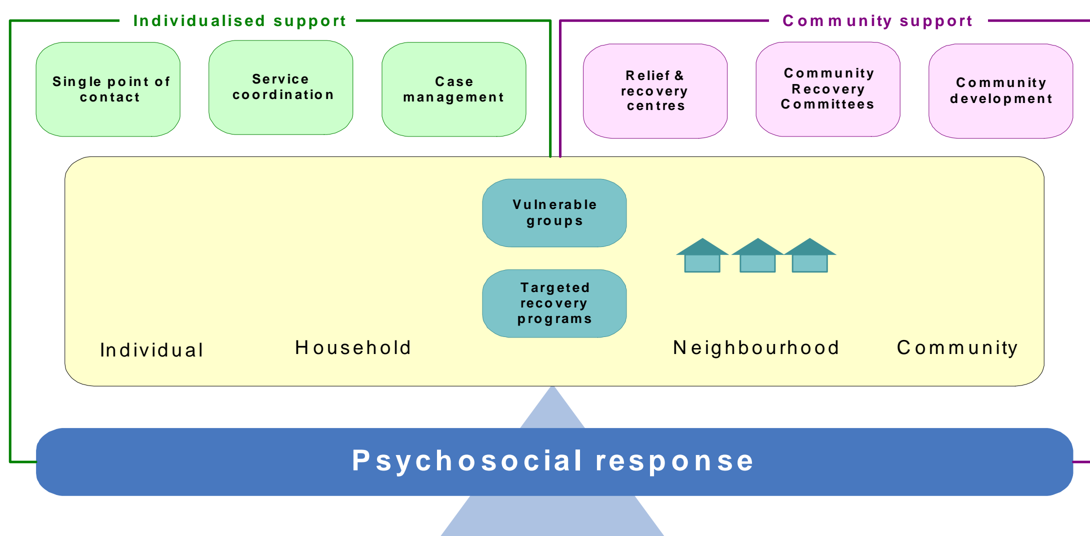
9. It needs to build on the existing strengths within communities and build on the basis of a community led recovery supported by agency/NGO provision as, and when, appropriate.

   Active community participation and involvement is important in initial and ongoing planning as well as implementation and monitoring and evaluation. This will assist in ensuring that the knowledge held by local communities is part of, and built into, the recovery process and more effective strategies developed.

Structuring a psychosocial plan

A psychosocial plan needs to focus on the two interconnected components discussed previously in the document: individual recovery and wellbeing; and building community resilience and supporting wellbeing. The relationship between individualised support and community support within the psychosocial response is illustrated in Figure 3 below.

Figure 3: Psychosocial recovery – individuals, households, neighbourhoods and communities[5]



[5] Taken from B. Raphael (1986).

Component One: Individual recovery and wellbeing

Component One focuses on individual recovery. Individuals, families and whānau have and will continue to have a range of psychosocial related responses to the Christchurch and Canterbury earthquakes. These responses will be influenced by such factors as the requirements for food, shelter and safety being satisfactorily addressed, the rate of economic recovery and the rebuilding of social capital for communities in which residents live.

This needs to be provided in a supportive way. It is helpful if staff and volunteers are sensitised around giving this basic support; on how to provide these vital, basic services in a psychosocial way, including also how to protect themselves.

The psychosocial needs of individuals, families and whānau relocated from Christchurch, either temporarily or permanently, need to be addressed in this component. However, actions around assisting in their re-engagement in the Christchurch City and Canterbury communities need to be included in the second component.

Particular groups with psychosocial needs may include:

- young people who have relocated to other schools
- the elderly who have been relocated to retirement homes outside of Canterbury
- ethnic groups with limited English and resources
- those that have been injured and/or who have developed disabilities from the earthquake
- children in precarious situations
- people who have lost their jobs.

GPs and schools may pick up vulnerabilities and we will need to coordinate with and raise psychosocial awareness in these domains.

Short term – up to three months

For large numbers of people, basic support and information helping them to make sense of their own response and people around them will probably be both necessary and sufficient in the first instance. Many people will benefit from a conversation, information, financial assistance and where appropriate (which will be the majority of the time), basic reassurance that their responses are normal. It is also crucial for people to be able to return to normal routines including social activities and religious observances. Often people will have multiple needs at this time and may benefit from 'one-stop shop' and/or community information services and outreach services.

The need for formal face to face counselling is likely to be low to minimal. Counselling should only be accessed via a formal psychosocial needs assessment. A few presentations to health services may need these formal assessments and primary or secondary service provision.

Medium term – up to one year

During this time, psychosocial support services need to be able to continue to address ongoing needs as well as identify and assist those who have coped less well and who are moving away from the 'normal' trajectory. There may be more presentations requiring formal mental health assessments and primary or secondary service provision.

Practical experience and surrounding literature suggests there can be a peak in psychosocial needs around the mid-year mark – when the population realises that insurance, house repair and employment issues will take longer to resolve than initially expected. With the present Christchurch situation, the ongoing presence of aftershocks may slow down recovery trajectories for some as their vigilance levels remain high. Beverley Raphael's community recovery model may be of interest here.[6]

Long term – two to four years

Presentations may continue for some time, although in the majority of cases people will be stable on a new (post-event) path. There may also be people who managed to cope initially, but for whom life has become more challenging and who are now in need of assistance. It is important that there is a rolling programme of assessments for community members. It is also important that such a programme is non-stigmatising for those who wish to come forward for assistance.

Component Two: Building community resilience and supporting psychosocial wellbeing

Component Two focuses on contributing towards the longer term development of strong and resilient communities – physically and socially – by actively working with local community groups, promoting and advocating for psychosocial needs and resilience. Additionally it is important that psychosocial concerns are considered in all sectors of the recovery work because the way the recovery process is implemented (e.g. utilising community engagement processes and promoting community led recoveries) can affect psychosocial wellbeing.[7]

Encouraging active participation of the community has positive outcomes for coping and resilience. Allowing people or community membership of steering committees for projects encourages a feeling of self-efficacy, some control and empowerment that evidence has shown will promote coping and wellbeing.[8] This concept also applies to communities. For the community, there is a concept of collective efficacy – a sense that one belongs to a group that is likely to experience positive outcomes.[9]

Considerations for planning around a psychosocial response and community support include:

- identifying new barriers to community building that have emerged as a result of the Canterbury and Christchurch earthquakes, for example, the destruction of community meeting spaces such as neighborhood centres, cafes, sporting venues or pubs
- indepth knowledge about the psychosocial needs and resources within existing communities and new communities established through relocation
- sharing of information between key recovery stakeholders including information around those who have relocated and any emerging psychosocial needs or trends and accepting/encouraging community participation in activities

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[6] Raphael (1986).
[7] This point is made in the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings in relation to how aid is implemented but can also apply to the recovery process.
[8] Hobfoll, et al. (2007).
[9] Benight (2004).

- engagement with affected local communities around assessment of their psychosocial needs, supporting their initiatives and working with them on recovery
- identifying new social structures and networks forming within communities as members and social dynamics change.

Essential foundations for community resilience building are an indepth knowledge of local communities and meaningful community engagement (a hierarchy of styles of participatory engagement in community programs is included in the glossary at Appendix A). Local government and local communities, including those which emerge as a result of the earthquake(s) and may not be formally recognised as such, play a critical role here.

Building an indepth knowledge could include the development of a community profile similar to that proposed by the Queensland Department of Communities for their draft Flood Recovery Community Plan.[10] Mapping the needs of communities is also based on effective co-ordination of information across the range of organisations working in the area at the national, regional and local levels. For example, information on the differing capacities of local community support services to continue to provide support when they too are disrupted by the earthquake(s). An example of this in Christchurch is the Outbound Calling Campaign where community support services were each phoned to find out their capacity after the earthquake and the support they needed or could provide. This information was entered into a database and will be updated on a regular basis to inform the level of support required.

Plans need to include strategies around co-ordination at all levels, and strategies to encourage collaboration among agencies and providers who may not usually work together. A first step to effective co-ordination could include the development of a database and mapping of where the various social support services are working and roles and responsibilities. Effective monitoring, feedback and reporting mechanisms need to be in place as well as systems to analyse this emerging data. This can assist in testing whether strategies are making a positive difference and also in ensuring that learning around the earthquake recovery is fed back to improve processes and strategies for the future. As with the individual component, plans will need to include short, medium and longer term actions.

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[10] This was seen as an initial building block and aimed to gather and analyse information and knowledge to support flood-affected communities when they undertook their more detailed Flood Recovery Community Development Action Plans.

Framework for monitoring and evaluation

[A framework to support the monitoring of progress against plans for psychosocial support and to assess the impact of the plans, and to identify any necessary changes in direction is being developed with input from the Psychosocial Response Advisory Group – it will be included in a later version of this document.]

Monitoring and evaluation

As Canterbury and Christchurch City moves from the emergency response to the recovery phases, monitoring and evaluation will play an important role in ensuring that psychosocial actions being undertaken or proposed are being effective and remain relevant.

Monitoring

The Red Cross Handbook on Psychosocial Interventions describes monitoring as:

> *"the regular and continuous process of collecting and analyzing data to assess progress and development… it is a way of keeping a regular check on the planned inputs, outputs and outcomes of a response."*

Two types of monitoring are described in the Handbook, the first of which is *process monitoring*, that has as its purpose to identify:

- whether actions are being implemented as planned
- emerging problems and how they could be addressed
- opportunities for improvement
- effective or ineffective use of resources.

The second is around measuring the results of the actions undertaken. Are the responses still relevant and useful? Have there been changes which affect the planned activities? Is there new information that will increase our understanding of what is occurring?

Issues to be aware of around monitoring activities are the importance of co-ordinating monitoring activities, if possible, across government and non-government agencies. There will also be a need to ensure that people who are affected by the Christchurch and Canterbury earthquakes do not feel overwhelmed and that the information collected is integrated.

Evaluation

An evaluation is defined in the Red Cross Handbook as:

> *"an objective assessment that aims to find out if the implemented activities or programme has succeeded in doing what it aimed to do."*

Appendix A: Psychosocial recovery in the context of the Canterbury and Christchurch earthquakes

Background

On Saturday 4 September 2010 at 4.35 am, the Canterbury region was hit by an earthquake measuring 7.1 on the Richter Scale. The earthquake was centred northwest of Christchurch city in Darfield and was originally referred to as the Darfield earthquake. It is now known as the Canterbury earthquake. Despite the magnitude of the earthquake there were no fatalities. However, a number of people were injured, a few seriously, and significant damage was experienced to public buildings, businesses and private properties throughout the Canterbury region. In the weeks following the main earthquake, hundreds of aftershocks were experienced in the Canterbury region causing significant distress to some people.

On Tuesday 22 February 2011 at 12.52 pm, another earthquake measuring 6.3 on the Richter Scale struck Christchurch City and surrounding areas causing significant damage to Christchurch, particularly the CBD, the eastern and southern suburbs, the Port Hills, and Lyttelton.

The 22 February earthquake was centred southeast of Christchurch and was part of the aftershock sequence that had been occurring since the September 7.1 quake. However, due to a number of factors,[11] the quake on 22 February resulted in impacts that were greater than those experienced on 4 September 2010 – the fatalities and injuries which resulted, the number of buildings which collapsed, the widespread infrastructure outages (e.g. power, waste-water, water) and the liquefaction in some areas (e.g. eastern suburbs). Significant damage occurred in public buildings, businesses and private properties throughout Christchurch and Lyttelton.

A state of national emergency was declared at 10.30 am on Wednesday 23 February 2011.

In the weeks following the February earthquake, aftershocks continued to be felt in Christchurch causing further damage and disrupting infrastructural services. It has been noted that the earthquake on 22 February has been followed by a higher-than-usual number of aftershocks. On 16 April 2011 a 5.3 aftershock caused further rock falls around the Port Hills, liquefaction in the eastern suburbs and some damage to buildings. This pattern of aftershocks has caused significant distress to some people, communities, and businesses – especially on top of the event that occurred on 4 September 2010.

The state of national emergency was lifted on 30 April 2011. Christchurch and the Canterbury region are now on the path to recovery but it is expected that this process will take years, even decades, to achieve.

[11] These include the high amount of energy released in the rupture of the fault, the direction the energy was released, trampolining of the geological layers underneath the city and the close proximity of the earthquake to the city.

Definitions of Psychosocial response

A common term used in relation to social recovery following a disaster is *psychosocial support*. Psychosocial refers to the psychological and social needs of individuals as part of wider communities. The International Federation of Red Cross, in the *Psychosocial Framework of 2005–2007*, defines psychosocial support as:

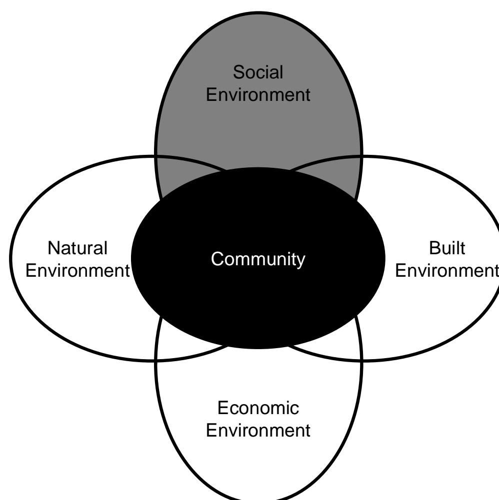
> *"a process of facilitating resilience within individuals, families and communities" [enabling families to bounce back from the impact of crisis and helping them to deal with such events in the future]. By respecting the independence, dignity and coping mechanisms of individuals and communities, psychosocial support promotes the restoration of social cohesion and infrastructure."* [12]

Another definition of psychosocial is "actions that address psychological and social needs of individuals, families and communities to promote well-being."[13]

Community disaster recovery – what is it?

In New Zealand, disaster recovery for communities focuses on four main environments: social, built, economic and natural (figure 4). These environments are interdependent. A lack of recovery activity in one environment can affect the way a community recovers as a whole. The concept of holistic recovery has therefore been introduced, which highlights the importance of all four environments working together. Social environment strategies need to link with recovery efforts in the built, economic and natural environments. At the centre of all four environments sits the community.

Figure 4. Connection between the social, built, economic and natural environments for community recovery



Source: Ministry of Civil Defence & Emergency Management (2005)

[12] This definition appears in the Red Cross's *Psychosocial Interventions: A Handbook*, page 25.
[13] This definition appears in the Red Cross psychosocial training manual.

Four distinct stages have been identified by New Zealand recovery agencies in relation to preserving or rebuilding individual and community wellbeing following disasters. These stages can be characterised as:

i. Interagency and community planning before a disaster (readiness).[14]
ii. The immediate aftermath of a disaster where rescuing people who have been injured and making sure people are safe is of paramount concern (response).
iii. Helping people deal with stress and the causes of stress in the aftermath of disaster (acute recovery).
iv. Supporting communities to rebuild and strengthen their resilience and to use any learnings from the earthquake to face any future adversity (medium to long-term recovery). These learnings will be cycled back into stage one and will lead to efforts to reduce vulnerabilities and mitigate future events.

This document is not concerned with readiness but with the next three stages, which typically overlap.

Principles

The underlying principles[15] for any psychosocial recovery process are as follows:

1. Many people will experience some psychosocial reaction. It will usually be manageable with basic comfort and support. However, 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 and advice, participation of survivors in decision-making, facilitation of social networks and social supports are important principles.
3. There is a direct relationship between the psychosocial element of recovery and other elements of recovery.
4. Support in an emergency event should initially be geared toward meeting basic needs (e.g. food, shelter, safety).[16]
5. A continuum from self-help to more specialist 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.

[14] Readiness includes psychosocial planning and training, co-ordination of bodies involved and ideally, exercises in working together pre-events. From a psychosocial perspective, this phase is characterised by sensitising emergency response teams as to how to deliver basics in a psychosocial manner, setting up information and tracing centres.
[15] Adapted from *Planning for Individual and Community Recovery in an Emergency Event* (Ministry of Health, 2007).
[16] This support should be delivered with psychosocial needs in mind.

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.

The Wellbeing and Resilience Forum in Canterbury, held after the Canterbury earthquake in 2010, agreed the following principles for action on psychosocial recovery:

Social Recovery should:

1. Build on the surviving infrastructure[17] of the community

2. Be spatially, temporally and culturally close to the community

3. Match actions to the phase of recovery of the community

4. Provide a range of tools to reach many people simultaneously

5. Be tailored to the needs of priority populations i.e. vulnerable people, elderly.[18]

[17] This phrase is taken to mean the existing community organisations, the community's strengths and existing activities, and infrastructure.
[18] Source: Canterbury Wellbeing and Resilience Forum 2010.

Psychosocial impacts of the Canterbury and Christchurch earthquakes

Many Christchurch residents will have experienced at least some level of stress during and after the earthquake on February 22. These effects are likely to be greater for many than the effects of the 4 September 2010 earthquake.

After an emergency event, psychosocial recovery is closely tied to having basic needs met (including safety, shelter, and appropriate medical intervention). As the seriousness of the consequences increases (e.g. property damage, financial loss, injuries, deaths, and other disruption), so too will the demand for basic needs become more apparent (e.g. food, water, clothing). As the physical impacts and lack of resources to meet basic needs continue, social and emotional consequences will most likely follow.[19]

The Ministry of Health's *Planning for Individual and Community Recovery in an Emergency Event: Principles for Psychosocial Support* (2007) suggests that promoting basic forms of assistance and normalising the recovery process should be preferred over providing intensive forms of assistance, particularly in the immediate aftermath. Early psychological intervention in the form of debriefings can prevent the normal recovery process taking place.[20] For most people, specialist mental health intervention following an emergency event is not required and for others, inappropriate intervention, particularly when it is not warranted, has been shown in some cases to actually exacerbate difficulties.[21]

Over time, most residents are expected to be able to cope with event-related stress through their own personal and social resources. Factors that may affect the time it takes for people to recover include the resolution of issues related to property damage (in particular homes), access to permanent and satisfactory housing arrangements, the impact on livelihoods (e.g. employment) and their sense of control in being able to influence the resolution of any of these factors. These factors are significant in much of Christchurch and this suggests a longer term recovery. Having basic social support needs and other needs met also promotes coping in the population.

A small minority of those directly affected by the earthquake (e.g. via the actual experience or as a result of anxieties created by their post-quake experiences such as loss of homes or livelihoods) will experience distress that may require specialist support. Over time the number of people experiencing significant distress will lessen.

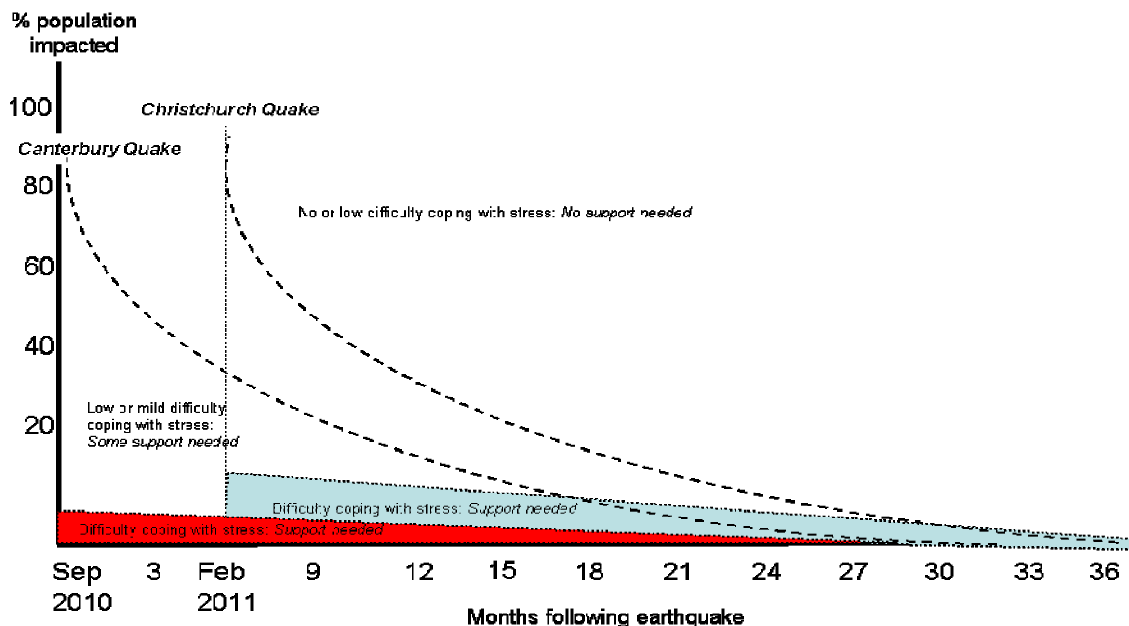
Predicting the level of demand for professional support in the medium to longer term is not straightforward. While it may be expected that the combined effect of the two earthquakes and their impacts may increase the level of need, and previous trauma is well established as a risk factor in the literature, some studies show an inoculation effect.[22] That is, that going through the first earthquake provides people with coping skills

[19] Freedy, Kilpattrick, and Resnick (1993). Hobfoll et al. (2007).
[20] Hobfoll et al. (2007).
[21] Expertise in delivering services is vital. A number of interventions – including large-scale education, early forms of support, and more specialist mental health interventions – 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. Intervention should be based on evidence-based practices. The use of ineffective or unsafe techniques should be discouraged.
[22] Bland, O'Leary, Farinaro, Jossa and Trevisan (1996) on survivors of the Italian earthquake (those who did not experience prior quake damage showed higher distress, and Knight et al (2000) demonstrated a similar result for depression in survivors of the Northridge quake.

and resilience that helps them to deal better with the second earthquake. It is, however, important to note that this 'inoculation' effect may not be seen to the same extent in Canterbury as the two earthquake events were very different from one another.

Figure 1 illustrates the expected demand for psychosocial support. A minority will need to access professional support in the longer term. The majority will manage via their own social networks (e.g. family, friends) supported by self-help resources and key messages on how to manage. It is important to note that the figure is illustrative rather than a definitive projection of demand. There are likely to be peaks and troughs in actual demand over the time period, for example at the one year anniversary point, and severe reactions often take time to emerge and may not be seen until three to six months after the event.

Figure 5. Coping with stress related to the Christchurch earthquake

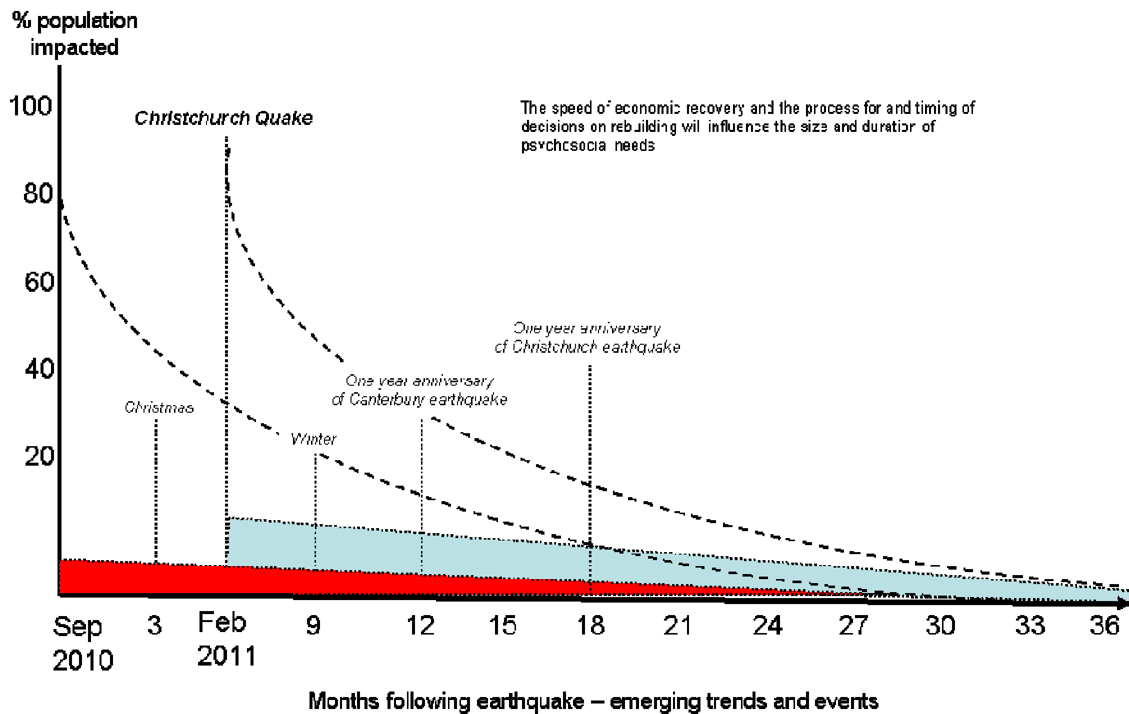


Specific events following the earthquake may also increase vulnerability to stress reactions. These events include:

- funerals and memorial services (short term)
- displaced persons returning to Christchurch, the time when subsidisation of temporary housing by insurance companies ceases, and decisions on rebuilding (medium term)
- the rebuilding itself (which may require the relocation of families and communities), economic impacts, and the one year anniversaries of the earthquakes (medium to longer term).

Other stressors may include the duration and size of aftershocks and medium and long-term impacts on the local economy and employment. Such potential sources are likely to cause fluctuations in the level of need for psychosocial support. This is illustrated in figure 6.

Figure 6. Additional sources of stress relating to the Christchurch and Canterbury earthquakes



Canterbury v Christchurch impacts

It is important to acknowledge the different impacts that the earthquake of 22 February had on Canterbury communities, i.e. that they will be primarily focused on one or other of these streams. Canterbury communities outside Christchurch were already focusing on building and supporting community resilience before the quake on 22 February. While these communities were not directly impacted by the earthquake of 22 February, making progress on this stream will continue to be a priority for them. They will however have within them displaced residents of Christchurch for which they will need to plan to provide individual support (stream one).

Before the earthquake of 22 February, Christchurch's recovery was moving to focus on building and supporting community resilience. However, post-22 February, the priority for Christchurch reverted back to supporting the immediate psychosocial support needs of individuals, families and whānau.

Displaced people

In addition, with the displacement of Christchurch City residents to other regions, those regions are now required to plan how they will support individual recovery and wellbeing. In some instances, they may also need to consider longer-term community resilience building measures in communities where Christchurch residents are resettling permanently.

Priority groups for the psychosocial response and recovery following the Canterbury and Christchurch earthquakes

The impacts set out above will be felt differently by different groups and sub-populations of the Christchurch community. Some individuals and groups are more vulnerable to these impacts and/or have fewer resources, lower levels of resilience and fewer coping skills. Often they were generally more vulnerable before the earthquake events. The vulnerability faced by a family or individual can increase in relation to the multiplicity of risk groups to which the individual/family belongs. While the psychosocial response should have a focus on the whole community, these more vulnerable groups can be seen to be in need of particular attention in the provision of psychosocial support.

The following information explains the rationale for identifying the priority groups for the Canterbury and Christchurch earthquakes. Risk and vulnerability are seen at both an individual and community level and there is overlap between the two. The priority groups may differ, however, for the individual counselling and support component and the community wellbeing and resilience component.

Priority groups are sectors in the population that have the potential to become marginalised during the community revitalisation process. Priority groups will be defined by pre-existing demographic factors (e.g. socioeconomic status). While these groups can not be forced to take part in revitalisation they should have at least equal access to community planning forums and resources as part of building stronger and more resilient communities.

While priority groups are defined, it is important that all people, not only those defined as vulnerable, receive some attention. This prevents the build up of opposing groups or the creation of divisions within the same community which in turn can lead to a break down in community identify or solidarity.

Risk and protective factors

While anybody within Canterbury or Christchurch may need professional support to help them cope, there are specific populations that may be more vulnerable to the effects of the earthquakes or their aftermath. Vulnerability, for the purposes of this document, is defined as either:

> *"Individuals and families who, due to pre-existing conditions, are at a greater risk of developing stress related responses following the earthquakes."*

or

> *"Individuals and families who, due to a pre-existing condition, or as a result of the earthquake, have more barriers to accessing support to help deal with stress."*

It is important to note that there is a group of people who have suffered severe effects from both earthquakes (e.g. property damage, severe anxiety, injury, or the death of a family member).

At the individual level, *Planning for Individual and Community Recovery in an Emergency Event: Principles for Psychosocial Support* identifies a number of risk or protective factors for psychosocial recovery. Protective factors can include stable, functioning, social and family networks, feelings of control, self-efficacy, self-esteem and having a competent problem-solving approach to difficult situations. It suggests that at

the community level, when the following factors occur, the risk for psychosocial problems is raised:

- emergency events
- major property damage
- ongoing physical injury
- financial problems
- human factors related to the emergency event (e.g. 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).

An important feature for building resilience and supporting wellbeing within communities is that it is shared amongst all members. For many communities, access to key resources is often not uniformly available and as a result some groups may have lower levels of wellbeing and resilience to adversity. When building resilience and supporting wellbeing, it is important that barriers are removed to enable all community groups to participate in community action activities.

With these factors and definitions in mind, the population groups listed below may be considered more at risk of experiencing stress-related responses to the Canterbury or Christchurch earthquakes. However responses to stress will not be uniform amongst these population groups as some individuals will cope well while others who are more isolated may show more stress and distress.

Pre-existing conditions:

- children and youth
- older people
- disabled people
- single parents with dependants
- people with pre-existing / concurrent psychiatric illness
- people who have experienced previous traumatic events or stress (e.g. family violence victims)
- lower socioeconomic status
- Māori, who are over-represented in most of the vulnerable groups
- Pacifica
- refugees and migrants – including temporary residents from overseas.

Disaster-related conditions:

- people with housing-related needs, including those:
  - who have had to move out of their homes
  - who are living in damaged homes
  - in over-crowded households
- people under financial stress, including:
  - those living in damaged homes without insurance
  - low-income earners whose employment has been affected
- people living in worst hit areas.

Some people will experience both pre-existing conditions and disaster-related conditions; this is likely to exacerbate the pre-existing conditions and increase vulnerability. Some people who will be included in these priority groups are likely to have

not experienced this level of adversity previously. For some, the earthquakes will have significantly changed their circumstances in the short to medium term.

In addition, for the Christchurch earthquake the following additional priority groups have been identified:

- those who have already been significantly affected by the Canterbury earthquake (as being already impacted by the Canterbury earthquake can be considered a 'pre-existing condition')
- those who have experienced significant injuries
- family/friends/colleagues of those who have died.

Appendix B: Community Engagement

The table below describes a hierarchy of styles of participatory engagement in community programs.

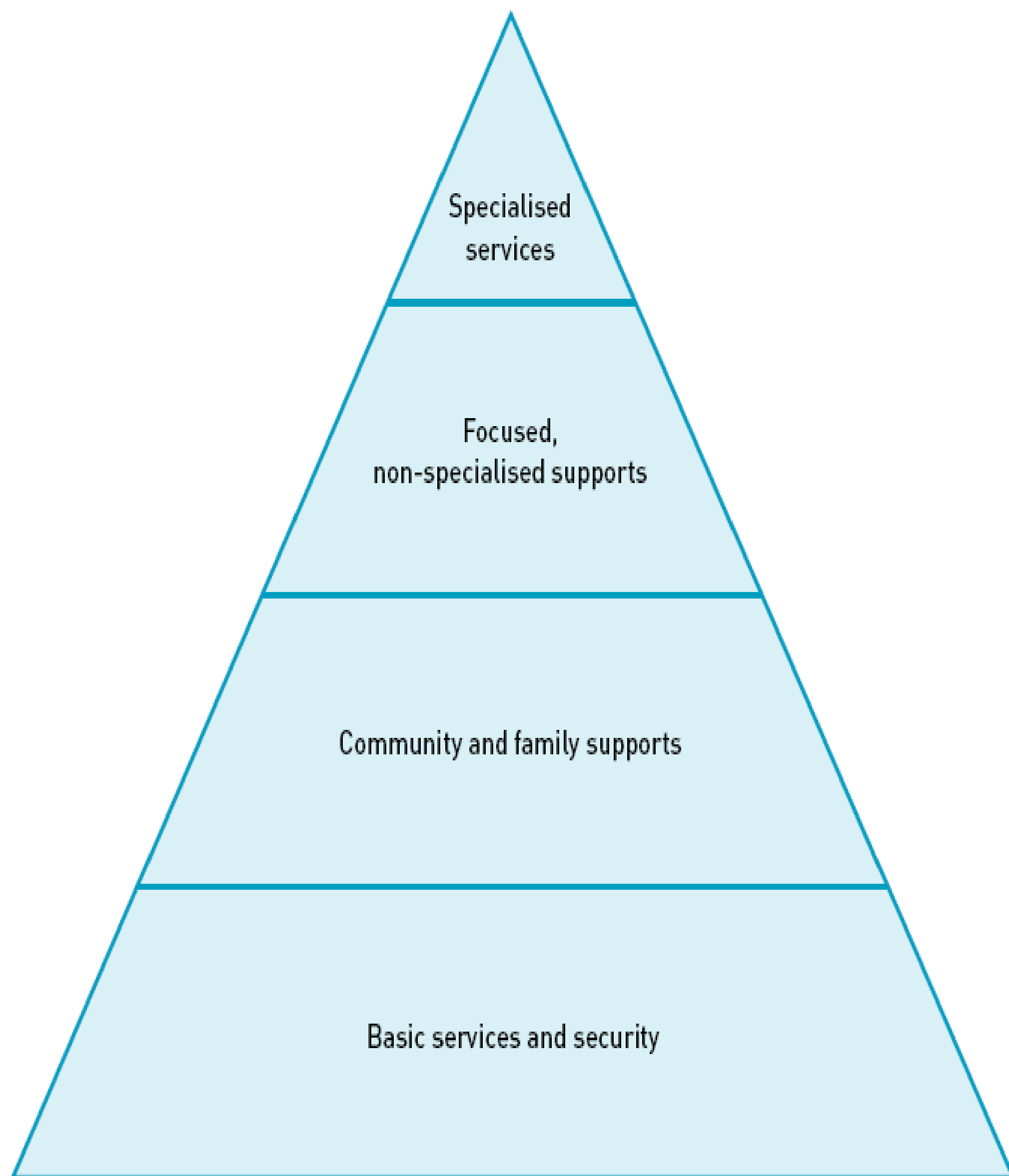
• Community empowerment participation	Community members are actively engaged in all aspects of the project or program; skills and knowledge are appreciated and maximised. Empowering the community is a key outcome.
• Collaborative participation	Engagement of the wider community; collaborative community engagement and consultation process.
• Facilitated participation	Independent facilitation, which promotes effective dialogue between stakeholders. Value and understanding of stakeholder input.
• Functional with limited engagement participation	Steps taken to recognise the diversity of community needs; attempts to incorporate community engagement strategies.
• Informative participation	Providing an opportunity for community members to participate in an intervention trial. Ongoing, passive and limited interactive feedback is requested.
• Functional participation	Closed consultation with selected stakeholders, non-collaborative consultative committee and community input is not valued (perceived or real).
• Passive participation	Pre- and post-survey data collection; requires passive interaction with community members to provide feedback on intervention.
• Information dissemination or non-participation	Information dissemination: passive learning and no physical interaction from agency to community

Adapted from Figure 17:2 A hierarchy of styles of participatory engagement in community EAE programs for natural hazards.[23]

[23] Elsworth, Gilbert, Stevens, Robinson, and Rowe (2010).

Appendix C: Intervention pyramid for mental health and psychosocial support in emergencies

Figure 7. Intervention pyramid for mental health and psychosocial support in emergencies[24]



Each layer of Figure 7 is described below.[25]

[24] Taken from *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*, p.13.

i. Basic services and security

The wellbeing of all people should be protected through the (re)establishment of security, adequate governance and services that address basic physical needs (food, shelter, water, basic health care, control of communicable diseases). In most emergencies, specialists in sectors such as food, health and shelter provide basic services. An MHPSS response to the need for basic services and security may include: advocating that these services are put in place with responsible actors[26]; documenting their impact on mental health and psychosocial wellbeing; and influencing humanitarian actors to deliver them in a way that promotes mental health and psychosocial wellbeing. These basic services should be established in participatory, safe and socially appropriate.

ii. Community and family supports

The second layer represents the emergency response for a smaller number of people who are able to maintain their mental health and psychosocial wellbeing if they receive help in accessing key community and family supports. In most emergencies, there are significant disruptions of family and community networks due to loss, displacement, family separation, community fears and distrust. Moreover, even when family and community networks remain intact, people in emergencies will benefit from help in accessing greater community and family supports. Useful responses in this layer include family tracing and reunification, assisted mourning and communal healing ceremonies, mass communication on constructive coping methods, supportive parenting programmes, formal and non-formal educational activities, livelihood activities and the activation of social networks, such as through women's groups and youth clubs.

iii. Focused, non-specialised supports

The third layer represents the supports necessary for the still smaller number of people who additionally require more focused individual, family or group interventions by trained and supervised workers (but who may not have had years of training in specialised care). For example, survivors of gender-based violence might need a mixture of emotional and livelihood support from community workers. This layer also includes psychological first aid (PFA) and basic mental health care by primary health care workers.

iv. Specialised services

The top layer of the pyramid represents the additional support required for the small percentage of the population whose suffering, despite the supports already mentioned, is intolerable and who may have significant difficulties in basic daily functioning. This assistance should include psychological or psychiatric supports for people with severe mental disorders whenever their needs exceed the capacities of existing primary/general health services. Such problems require either (a) referral to specialised services if they exist, or (b) initiation of longer-term training and supervision of primary/general health care providers. Although specialised services are needed only for a small percentage of the population, in most large emergencies this group amounts to thousands of individuals.

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[25] These descriptors are quoted from IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, p.13.

[26] "Actors" are interpreted as those who are sensitised to possible reactions in the population and who have a grasp of basic psychosocial first aid skills (for example, active listening, staying close, accompanying not advising, giving practical information).

Appendix D: Planning psychosocial interventions – template headings

Good planning for psychosocial interventions starts with asking:

- what is the aim or goal?
- what are the desired outputs and outcomes of the interventions?
- what activities will produce these desired outputs and outcomes?
- why are we doing this?
- how will be know that the activities are achieving their purpose and are still relevant for the next phase, for example when we move from emergency response to recovery?
- how will we know that we have achieved our goals?[27]

The Red Cross Handbook on Psychosocial interventions puts forward a *logical framework* (also described as a logframe) as a useful tool for planning an intervention. This is:

> *"based on the idea that certain inputs will lead to specific outputs and outcomes or results, which will eventually bring about the expected change. A logframe is often used as the core reference document throughout the whole implementation period of a response: planning and design, implementation and monitoring, and evaluation of the intervention".*[28]

The Handbook provides the following headings as the typical components of a logical framework which can be adapted depending on local circumstances:

- Goal /Overall objective
- Outcome/Immediate objective
- Output/Results
- Examples of activities
- Indicators
- Selected indicators.

An example, using these headings with minor adaptations for the Christchurch City and Canterbury communities, is provided on the next page.

[27] Adapted from The International Reference Centre for Psychosocial Support (2009) *Psychosocial Interventions: A handbook*, p. 109.
[28] Ibid. pp. 110 & 111.

The example below uses the higher levels of Component One of the strategic framework around individual recovery and wellbeing contained on pages 4–6 of this document.

Component 1	**Timeframe**	**Goal /Overall objective**	**Medium-term objectives**	**Outcome/ Immediate objective**	**Actions**	**Agencies responsible**	**Indicators**
Stress-related responses following the earthquake are minimised for Christchurch City and Canterbury. Individuals and families and wellbeing and functioning communities are enhanced.	Response phase up to three months.	Stress-related responses following the earthquake are minimised for Christchurch City and Canterbury individuals and families, and wellbeing and functioning communities are enhanced.	Individuals are personally supported to reduce psychological stress and distress while promoting coping strategies and their sense of control, self-efficacy, ownership and empowerment are enhanced.	Individuals are able to access assessments and services for the provision of support if, and when, appropriate (including those who have temporarily relocated out of Christchurch/ Canterbury).	Select and contract NGOs to provide telephone and face to face assessment for the provision of appropriate support. Develop a standardised assessment form distributed to relevant NGOs Communicate messages on the availability of quake counselling support throughout New Zealand through print and web media.	National PS subgroup Christchurch PS subgroup Welfare Advisory Groups.	Number of assessments undertaken benchmarked against requests Number of standardised assessment forms used by NGOs and the indicator behaviours designated in their programmes Volumes of calls to Helplines and visits to RACs and referrals from Work and Income Assistance Centres Number of people seeking reassessment around support Increased knowledge in the community on ways of obtaining support.

Example of a Logframe approach for one of the immediate objectives in the Christchurch City/Canterbury situation

Appendix E: Possible actions

Individual recovery and wellbeing

Mass communications on psychosocial education

- Provide basic information on strategies to cope with earthquake-related stress and where to get support.
- Develop and make easily accessible resources on how to cope with earthquake-related stress and access services.
- Provide tailored information for parents and caregivers on
  - how to support children and young people
  - how to support older people
  - how to support themselves.

Provide access to professional support

- Use best practice assessment and screening tools to systematically identify those experiencing significant earthquake-related distress.
- Refer those identified to appropriate support.
- Provide counselling, therapy and support according to best practice.
- Trained professionals are available to help affected families, children, youth and the elderly across the country.

Minimising risk factors

- Create and maintain a sense of engagement and self-control: People affected by the earthquake are actively engaged in decision-making.
- Those dislocated or whose homes have suffered significant damage are supported to have safe, secure and healthy living environments.
- Those dislocated from their homes are supported to maintain connections with key institutions within their communities.
- Ensure decision-making and work is carried out in a timely and effective manner, with no unnecessary delays.

Mitigating stress

- People dislocated from their homes receive support to get them back into permanent homes.
- Those whose homes have significant damage are kept informed regarding the process for getting them repaired.
- Ongoing information is provided on what to expect after quakes in relation to their frequency and magnitude.

Building community resilience and supporting psychosocial wellbeing

Capacity

- Existing physical and social infrastructure is used to build capacity.
- Identify the resources required to mobilise communities and support community participation.

- Identify gaps in the physical or social infrastructure needed for community action and take steps to address them.
- Make resource for developing capacity available.
- Develop internal and external partnerships to support action.

Skills

- Skilled people from outside the communities support community mobilisation process as requested.
- Community members are up-skilled to maintain community action.

Community action

- Engage community leaders to lead the mobilisation.
- Provide expert facilitation, where requested, to support the mobilisation process.
- Ensure all community members have opportunities to contribute to decisions on the selection of key issues for the community.

Access to information

- Keep communities fully informed on issues affecting their revitalisation/development.
- Share information between key agencies and communities.

Developing community plans

- Support communities to develop plans that build resilience and foster wellbeing.
- Facilitate access to resources that aid the implementation of community plans.

Removal of barriers

- Hold activities at times and places that are accessible for the whole community.
- Minimise any costs for participation in any activities.
- Ensure that the location and content of activities are appropriate for diverse community members.

Support for engagement and community centres when appropriate

- Systematic and active engagement with priority groups.
- Listen to the needs or concerns of groups who may have difficulty fully participating in planning and engaging in community action. Ensure their needs are incorporated into any plans.

Leadership

- Engage formal and informal leaders of community groups when strengthening community resilience and wellbeing.
- Support these community leaders.

Appendix F: References and additional resources

Benight, C.C. (2004). Collective efficacy following a set of natural disasters. *Anxiety Stress and Coping*: *An International Journal*, Volume 17(4), 401–420.

Bland, S. H., O'Leary, E. S., Faninaro, E., Jossa, F., & Trevisan, M. (1996). Long-term psychological effects of natural disasters. *Psychosomatic Medicine, 58,* 18–24.

Brewin, C.R., Rose, S., Andrews, B., Green, J., Tata, P., McEvedy, C., et al. (2002). Brief screening instrument for post-traumatic stress disorder. *British Journal of Psychiatry*, *181*, 158–162.

Caniglia, F. & Trotman, A. (2011). *A Siver Lining: Community development, crisis and belonging. Exploring the role of community development in Queensland's recovery from the January 2011 floods.* Under 1 Roof, Brisbane.

Department of Human Services (2009). *After the Bushfires; Victoria's psychosocial recovery framework.* Victorian Government Department of Human Services, Melbourne.

Devilly, J.G., Gist. R., & Cotton, P. (2006). Ready! Fire! Aim! The status of psychological debriefing and therapeutic interventions: In the workplace and after disasters. *Review of General Psychology*, 10 (4), 318–345.

Elsworth, G., Gilbert, J., Stevens, K., Robinson. P., & Rowe, C. (2010). *Guidelines for the Development of Community Education, Awareness & Engagement Programs – Australian Emergency Manuals Series*. Commonwealth Attorney-General's Department, Australia.

Freedy, J., Kilpatrick, D., & Resnick, H. (1993). Natural disasters and mental health: Theory, assessment, and intervention. In R. Allen (Ed.) *Handbook of Postdisaster* Interventions (special issue of the *Journal of Social Behavior and Personality,* 8, 49–104).

Galea, S., Vlahov, D., Resnick, H., Ahern, J., Susser, E., et al.(2003). Trends of probable post-traumatic stress disorder in New York City after the September 11 terrorist attacks. *American Journal of Epidemiology*, 158(6), 514–524.

Galea, S., Nandi, A., & Vlahov, D. (2005). The Epidemiology of Post-Traumatic Stress Disorder after Disasters. *Epidemiologic Reviews*, 27(1), 78–91.

Galea, S., Tracy, M., Norris, F., & Coffey, S.F. (2008). Financial and social circumstances and the incidence and course of PTSD in Mississippi during the first two years after Hurricane Katrina. *Journal of Traumatic Stress*, 21(4), 357–368.

Gordon, R. (2007). *A "social biopsy" of social processes and personal responses in recovery from natural disaster: A case study from the 2005 Matata debris flow*. GNS Science, Lower Hutt.

Hobfoll, S.E., Watson, P., Bell, C.C., Bryant, R.A., Brymer, M.J., Friedman, M.J., Friedman, M., et al. (2007). Five essential elements of immediate and mid-term mass trauma intervention: Empirical evidence. *Psychiatry*, 70(4), 283–315.

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

The International Reference Centre for Psychosocial Support. (2009) *Psychosocial Interventions: A handbook*. International Federation of Red Cross and Red Crescent Societies. Denmark.

Knight, Bob G., Gatz, Margaret, Heller, Kenneth, & Bengtson, Vern L., (2000) Age and emotional response to the Northridge earthquake: A longitudinal analysis. *Psychology and Aging*, Vol 15(4), 627–634.

Mayunga, J.S. (2007) *Understanding and applying the concept of community disaster resilience: A capital-based approach.* Presentation at the 2007 Summer Academy on Megacities: Social vulnerability and resilience building. Germany.

Ministry of Civil Defence and Emergency Management. (2009). *The Guide to the National Civil Defence Emergency Management Plan*. Ministry of Civil Defence and Emergency Management. Wellington.

Ministry of Civil Defence. (2005). *Focus on Recovery: A holistic framework for recovery in New Zealand.* Ministry of Civil Defence. Wellington.

Ministry of Civil Defence and Emergency Management. (2010). *Community engagement in the CDEM context: Best practice guideline for civil defence emergency management sector [BPG 4/10].* Ministry of Civil Defence and Emergency Management. Wellington.

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

National Institutes of Health. (2005). *Theory at a glance: A guide for health promotion practice.* US Department of Health and Human Services. United States.

Queensland Department of Communities (draft). Community Capacity and Vulnerability Mapping version 0.01 27.01.2011 – to inform the development of the Queensland Flood Recovery Community Development Plan.

Raja, M., Onofri, A., Azzoni, A., Borzellino, B., & Melchiorre, N. (2008). Post-traumatic stress disorder among people exposed to the Ventotene street disaster in Rome. *Clinical Practice and Epidemiology in Mental Health,* 4:5.

Raphael, B. (1986). *When Disaster Strikes: How Communities and Individuals Cope with Catastrophe.* Basic Books.

van Griensven, F., Chakkraband, S., Thienkrua, W., Pengjuntr, W., Cardozo B.L., Tantipiwatanaskul, P., et al. (2006). Mental health problems among adults in tsunami-affected areas in Southern Thailand. *Journal of the American Medical Association*, 296(5), 537–548.

Additional resources

The Ministry of Health has developed the following draft documents which are presently in consultation stage. The Ministry have updated their Integrated Recovery Planning Guide created in response to the 4 September quake and have invited feedback. The document is accessible from their website (see link below).
Integrated Recovery Guide V01.1 - Draft For Review.
Please send information or comment for the final version to IRGFeedback@cdhb.govt.nz.

Long Term Planning for Recovery After Disasters: ensuring health in all policies has been drafted by Christchurch Public Health staff. The document discusses some of the findings from previous disasters around people’s wellbeing during the recovery period. It is currently being peer reviewed.

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Christchurch Psychosocial Response Subgroup

Association of Guidance Counsellors

Christchurch City Council

Christchurch District Health Board – Public Health CDHB – Mental Health CDHB – Primary Health; Pegasus Health CDHB – Funding and Planning Ministry of Health

Department of Corrections (Community Probation)

Department of Internal Affairs

Ministry of Education

Ministry of Social Development – Family and Community Services; Child, Youth and Family

National Disaster Relief Forum

Ngai Tahu

Public Health, Primary Health, Secondary Care, and the CDHB Funding and Planning – (in the role of co-ordinator for the health-funded NGOs)

Te Puni Kōkiri Welfare Planning Committee Representative

University of Canterbury

National Psychosocial Response Subgroup

ACC

Ministry of Civil Defence and Emergency Planning

Ministry of Education

Ministry of Health

Ministry of Social Development

Red Cross

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Salvation Army

Te Puni Kōkiri

Victim Support

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MINISTRY OF
SOCIAL DEVELOPMENT
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