



The Psychosocial Special Interest Group (SIG) aims to pursue didactic, research, policy, and operational excellence in international disaster preparedness, response, and recovery, including the prevention and mitigation of psychological stress, and the promotion of resilience.

Psychosocial Special Interest Group Newsletter

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Issue Theme: *Applied Disaster Mental Health and Psychosocial Research*
- Principles, Status, and Exemplary Examples

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Introduction

This is the fourth newsletter issued by WADEM's Psychosocial Special Interest Group. The newsletter has been developed as a medium to provide WADEM members and other interested academics, professionals, students, and organizations useful information relevant to international psychosocial work. Please feel free to forward this newsletter to other people who may be interested.

Purpose of the Psychosocial Newsletter

Each issue has a theme, with this issue's being that of ***Applied Disaster Mental Health and Psychosocial Research – Principles, Status, and Exemplary Examples***. This theme is consistent with one of WADEM's main purposes, that of bringing academic and applied endeavors together for the benefit of the peoples we have a responsibility to serve. It is a pleasure to have had [Cecilie Dinesen](#) of [IFRC's Reference Centre and the Red Cross and Red Crescent Research Network](#) take leadership in pulling together the guest editorial, articles, and journal references addressing this issue's theme.

In addition, each issue briefly identifies a different graduate school program or institute having a disaster mental health or psychosocial graduate level track, organizations providing a variety of psychosocial research

information, identification of a journal or other publications with psychosocial emphasis, and upcoming conferences or events of likely interest.

Psychosocial Centre



This edition of the WADEM newsletter focuses on applied research on mental health and psychosocial support and linkages to practice. The contributions to this newsletter are written by members of the Red Cross Red Crescent Research Network on Mental Health and Psychosocial Support.

The research network is a space for collaboration and shared learning that was established in June 2016 with the vision to provide effective humanitarian action through a strengthened evidence-base in the Red Cross Red Crescent Movement for MHPSS for affected populations, volunteers and staff.

The research network is always interested in connecting with academics and practitioners who are interested in research partnerships on mental health and psychosocial support. The research network is hosted by the IFRC Reference Centre for Psychosocial Support, and if you want to know more about the network, please read more here:

<http://pscentre.org/what-we-do/research-network/> or write us at - psychosocial.centre@ifrc.org

Applied Research in the Fields of Disaster Mental Health and Psychosocial Support

Joseph O. Prewitt Diaz¹, PhD

Guest Editor

Background

Mental health and psychosocial support (MHPSS) has become an integral part of the humanitarian response in disasters. This is the result of (1) care in developing a field-based tool, (2) interest in the humanitarian community in addressing the mental health and psychosocial support needs after a humanitarian crisis, and (3) the opportunity to field test the MHPSS tool in recent humanitarian crises around the world.

In 2006, the Inter-Agency Standing Committee tasked a group of partners with developing guidelines that would allow humanitarian actors to plan, establish, and coordinate a set of minimum multi-sectoral responses to protect and improve the mental health and psychosocial well-being of people during an emergency.

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Mental health and psychosocial support was designed to provide interventions that improve the emotional, mental, and social well-being of beneficiaries by providing a space for affected people to react to the event, identify their resilience capacities, and respond.² Guidance for MHPSS has become an important component of humanitarian responses.³ It was meant to begin with community-wide supportive interventions then move on to focused individual interventions provided by local resources, and finally to professional assistance in a clinical setting if needed.

Research Priorities

Together with the efforts of an interdisciplinary group of academics, policy makers, and practitioners representing regions where humanitarian crises occur, Tol et al. developed a consensus-based research agenda for the next ten years.⁴ It emphasizes the generation of practical knowledge that could translate to immediate tangible benefits for programming in humanitarian settings rather than addressing the key debates that have dominated the academic literature.

The study yielded four points of interest for future research: (1) research questions favoring practical initiatives with strong potential for translation of knowledge into mental health and psychosocial support programming have priority, (2) perspectives from affected people must be included, and promoting sensitivity to the sociocultural context is of importance in any research on the impact of MHPSS, (3) problem analysis research is of interest, particularly when addressing concerns about major stressors, mental health, psychosocial problems as defined by populations affected by humanitarian crises, protective factors, and common mental health and psychosocial problems in humanitarian settings, and (4) as it applies to specific interventions, the effectiveness of family- and school-based preventive interventions and those for children and adolescents should be investigated.⁵

Tol et al. conducted a subsequent study, exploring the issue of relevance in placing MHPSS research priorities in humanitarian settings.⁶ Given both ideological and knowledge gaps in MHPSS practice in the existing literature, empirical research would guide these debates with greater evidence. Establishing a consensus-based research agenda would make a specific contribution to such research activities in a more coordinated, coherent, and cost-effective manner.

The study found that overall, participants placed strong emphasis on research questions assessing the prevalence and burden associated with mental health and psychosocial problems. Other themes included: (1) how to improve the implementation of MHPSS as it relates to community participation and building on existing supports, strengthening coordination, sustainability, selection, and training of human resources and policy frameworks, (2) evaluation of the effectiveness of MHPSS interventions, intervention mechanisms, and the wider impact of interventions on families and communities; (3) identification and prioritization of individual and community risk and protective factors for mental health and psychosocial well-being, and (4) improvements in

²O'Hanlon, K. P., Budosan, B. Access to community based mental healthcare and psychosocial support within a disaster context. *B J Psych Int* 2015, 12(2): 44-47.

³Meyer, S., Morand, M. Mental health and psychosocial support in humanitarian settings: Reflections on a review of UNHCR's approach and activities. *Intervention* 2015, 13(3): 235-247.

⁴Tol, W. A., Patel, V., Tomlinson, M., Baingana, F., Galappatti, A., Panter-Brick, C., et al. Research priorities for mental health and psychosocial support in humanitarian settings. *PLoS Med* 2011, 8(9): e1001096. <https://doi.org/10.1371/journal.pmed.1001096>

⁵ Same as 5 above

⁶Tol, W. A., Patel, V., Tomlinson, M., Baingana, F., Galappatti, A., Silove, D., et al. Relevance or excellence? Setting research priorities for mental health and psychosocial support in humanitarian settings. *Harvard Review of Psychiatry* 2012, 20(1): 25-36.

<http://doi.org/10.3109/10673229.2012.64911>

measuring mental health and psychosocial well-being as well as questions addressing how to improve MHPSS evaluation.⁷

Moving forward, applied research in MHPSS should address at least three research standards as part of the research strategies: (1) a scoping review of terminology and focus on MHPSS programs,⁸ (2) a study of the impact of culture and context in humanitarian responses,⁹ and (3) strict adherence to ethical standards.¹⁰

In the outset of a major disaster, the external organization that arrives in the affected area to provide psychosocial support could lack community consultation, coordination with local groups, and qualified providers. One way to reduce community distress is to provide cultural and contextual information that enhances the design of MHPSS program development. A desk review of existing knowledge about the target geographic area provides at least three knowledge bases: they synthesize existing literature, provide high quality materials prepared by experts, and reduce the need for practitioners on the ground for collecting background information.¹¹

Developing a common language for MHPSS monitoring and evaluation has been identified as a priority in a recent consensus-based setting of a research agenda.¹² A real issue, as practitioners in the field, is to develop a common language with the target community. Much of the information obtained as programs are developed is qualitative in nature. It is important for the applied researcher to gather qualitative and quantitative data and make them integral parts of the monitoring and evaluation procedures.

Finally, all the work conducted using the MHPSS framework must be performed in such a way that the recipient of those services are protected from additional harm caused by interventions or applied research. All types of research such as operational needs assessment, program monitoring and evaluation, and formal academic research must be conducted ethically.¹³ The preferred ethical approach in conducting applied research in MHPSS is to acknowledge that each disaster and disaster-affected peoples are unique, that context is important, and that the application of ethical standards promotes and protects the rights of the affected people while making valuable contributions to the evidence base. We are called upon to strengthen the ethical foundation of MHPSS research.¹⁴

This editorial note is accompanied by the contribution of two scholars: (1) Dr. Barbara Juen discusses in her article the importance of disability integration in applied research in MHPSS and (2) Dr. Sigríður Björk Pormar makes the case for improving helpful practices that reduce the occurrence and impact of traumatic stress and the decrease in Post-Traumatic Stress Disorder (PTSD) symptoms over time. Finally, Sarah Harrison and Cecilie Dinesen compare and contrast two monitoring and evaluation (M&E) framework for psychosocial support for MHPSS developed by the IFRC Reference Centre for Psychosocial Support and the IASC Reference Group on

⁷ Same as 7 above

⁸ Augustinavicius, J. L., Greene, M. C., Lakin, D. P., Tol, W. A. Monitoring and evaluation of mental health and psychosocial support programs in humanitarian settings: A scoping review of terminology and focus. *Conflict and Health* 2018, 12: 9. DOI 10.1186/s13031-018-0146-0

⁹ Greene, M. C., Jordans, M. J. D., Kohrt, B. A., Ventevogel, P., et al. Addressing culture and context in humanitarian response: Preparing desk reviews to inform mental health and psychosocial support. *Conflict and Health* 2017, 11: 21. <https://doi.org/10.1186/s13031-017-0123-z>

¹⁰ Chiumento, A., Rahman, A., Frith, L., Snider, L., Tol, W. A. Ethical standards for mental health and psychosocial support research in emergencies: Review of literature and current debates. *Globalization and Health* 2017, 13: 41. <https://doi.org/10.1186/s12992-017-0231-y>

¹¹ Same as 10 above

¹² Same as 5 above

¹³ Same as 11 above

¹⁴ Same as 11 above

MHPSS in Emergency Settings. Both frameworks are essential in program development and provide a good foundation for organisations to strengthen their M&E systems, which in turn can position them better to engage in research partnerships with academic institutions.

Enhancing the Resilience of Vulnerable Groups in Disasters

Dr. Barbara Juen, University of Innsbruck

During the last decade the view on vulnerability and resilience in disasters has changed remarkably. Whereas some decades ago vulnerability and resilience have been seen as two concepts that exclude each other, in the meantime vulnerability and resilience are seen as interlinked (1,2,3). Thus vulnerable groups who have formerly been seen as passive receivers of support and care, come into focus as an active partner in disaster prevention, response and recovery. Furthermore intersectionality has become a topic in disaster research and management. Thus vulnerability indicators have to be conceptualized as interlinked. One single characteristic like for example age or gender does not suffice when deciding about the vulnerability of an individual or group (4). A combination of characteristics instead, like for example age, gender, education and social status may very well characterize an individual or group as being more vulnerable. In spite of this, poverty, proximity to the event and marginalisation are seen as universal vulnerability indicators by the IFRC. In research, a lack or loss of resources is seen as a central factor of vulnerability (5). But still a combination of aspects is needed to define vulnerability. The same applies for resilience. After traumatic events the resilient outcome is the result of a complex coalescence of several risk and resilience factors. Some of these factors are personal others are social. Some of these factors are stable while others might fluctuate across the lifespan (3,5).

In the following, two EU projects are presented where specific groups and their special needs in disaster contexts were analysed. The first project PrepAge which was co-funded by the European Commission's DG ECHO aimed at developing specific recommendations for older people in emergency and disaster preparedness and prevention programmes. The PrepAGE-project identified the needs, structures and measures to find out how to prepare and reach the target group of older people in case of emergencies and disasters. The project also took into account the resources and resilience of older people and brought together experts from the health and social sector and the field of disaster management. The project was implemented in Austria, Bulgaria, Croatia, Latvia and the United Kingdom from 1 April 2014 to 31 May 2016 (<http://prepage.eu/at/>). Amongst the outcomes are an exercise guide that shows how to prepare exercises together with older people in a community and an empirical as well as a desk research report focusing on the status quo of research on the topic. As could be shown, older people cannot be seen as a vulnerable group per se. Other aspects like socioeconomic factors, education, gender and ethnicity also play an important role. Regarding the strengths of older people in disasters, specific and general aspects have to be taken into account. General aspects are their life experience whereas specific aspects address their previous disaster experience. Both can be of great use in disasters.

In the empirical research, expert interviews from all over Europe showed that some of the lower resource countries like Croatia or Bulgaria tend to involve older people more actively into disaster prevention, response and recovery. This is due to the fact that in many villages the average age is far above 60 because young people have left the countryside. Thus it can be seen how a risk factor may evolve into a resilience building factor. Higher resource countries like Austria or Germany for example do not involve older people to the same extent. Another important aspect was the mapping and identification of (vulnerable) older people and their special

needs which could successfully be addressed by a closer networking between disaster managing organisations and organisations involved in the care for older people.

This leads to the second EU project Eunad IP (<http://eunad-info.eu/home.html>) which focused on people with disabilities in disasters. Within the project various qualitative and quantitative studies were done on people with sensory disabilities, people with mental disabilities and people with physical disabilities. In general, this research showed that in emergencies and disasters people with disabilities have the same needs as people without disabilities. Nevertheless there is a great variation in how they perceive emergencies and disasters and what additional means they require to have their needs fulfilled. People with visual disabilities for example experience emergencies on an everyday basis and have to learn to trust in strangers in order to manage everyday life. The desire to be self-reliant and to avoid accidents is prominent in this group. The Norwegian project partners presented additional articles on two topics that arose during the interviews, sexual assault and bullying (6,7). People with hearing impairment were a special group insofar as they perceive the in-group as a distinct culture. Diagnosis as well as therapy requires specific communication measures, namely translation into sign languages as well as adaptation to the specificities of this group. Deaf people often report fear and mistrust in healthcare settings, they appreciate efforts to improve communication and make use of sign languages (8). People with mental disabilities (in the project we focused upon intellectual disabilities, autism and dementia) often have a high dependence on normalcy and predictability of their environment and depend on well-known caregivers.

Similar to all other groups they have a high need for self-reliance and self-efficacy and want to be actively involved and informed in case of emergencies and disasters. The main obstacle for all groups in emergencies and disasters is an environment that is not well prepared to adapt to the special communication requirements of the given group. Legal framework, trainings, exercises and tools shall help to overcome these obstacles and enhance the participation of people with disabilities in disasters. The Sendai Framework for Disaster Risk Reduction explicitly mentions the inclusion of people with disabilities. Contrary to previous conferences the 2015 World Conference on Disaster Risk Reduction gave explicit recommendations toward a disability-accessible and inclusive environment. Accessibility, inclusion, and universal design are some of the main concepts that have been included (9). In the project recommendations, training materials and tools have been developed that can be downloaded from the project website (<http://eunad-info.eu/home.html>).

Summarizing, we can state that although the necessity of inclusion and disability accessibility are seen as important there are some steps to be taken towards an inclusion of these groups as equal partners with their own rights. One step in this direction may be the re-conceptualization of vulnerability. Thus persons with disabilities may be perceived differently. Instead of viewing them as a vulnerable group that is dependent on support we can view them as a group with some risks that enhance vulnerability that have to be addressed. At the same time persons with disabilities can be seen as a resilient group that can be actively involved into disaster prevention, response and recovery. Furthermore, healthcare personnel have to be trained for communicating and interacting with these groups in a way that allows for participation and inclusion. As has been shown in the two EU projects mentioned above, starting a communication with the people themselves about their needs and perceptions can lead to intriguing insights and perhaps add to a change in the old paradigm of vulnerability excluding resilience.

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Mental Health and Psychosocial Support for Disaster Volunteers - A Group that Needs Greater Attention

Dr. Sigríður Björk Pormar, University of Reykjavík

When a disaster strikes, communities are reliant on speedy responses in order to prevent further loss of lives, livelihood and resources. With good disaster preparedness in place, professional rescuers are quick to respond but where disaster preparedness is not highly developed the response time can be long and professional resources may be scarce. Volunteers are a valuable resource in providing a timely response, and are particularly important in less developed communities where they may even be the main source of rescue and recovery. Although the humanitarian aid community can respond quickly (within 48 hours) with Emergency Response Units (ERU’s) that, for example, set up field hospitals, and water and sanitation stations as well as distributing relief; the local immediate response time can be critical in terms of lives saved or reduction in morbid injury and resources lost. Volunteers are therefore a valuable resource

The European Volunteer Centre has chosen to define volunteerism as: “ all forms of voluntary activity, whether formal or informal, full-time or part-time, at home or abroad. It is undertaken of a person's own free will, choice and motivation, and is without concern for financial gain. It benefits the individual volunteer, communities and society as a whole. It is also a vehicle for individuals and associations to address human, social or environmental needs and concerns. Formal voluntary activities add value, but do not replace, professional, paid employees” (European Volunteer Centre, 2014).

One of the largest volunteer networks is the International Society for Red Cross and Red Crescent or IFRC who annually responds with around 20 million volunteers where around two million work solely in crises and disasters. Although people volunteer all over the world, no satisfactory registry of worldwide volunteers exists.

Volunteers have a natural credibility with beneficiaries, donors, government officials, and others for the mere reason that they are not paid staff and thus hold no financial interest in what they may be advocating. They vary greatly in terms of age, ethnicity, social background, income, educational level, etc. which gives an even greater distinction to their individual motives. They increase the feeling of community ownership of solutions by being directly involved in some of the decision making processes on behalf of the individuals most impacted. When working on tasks that affect people's quality of life, volunteers empower themselves by improving their own neighborhood, which can create a motivation for them to contribute in a time when they may otherwise feel overwhelmed and helpless due to external circumstances. From being passive members of society, they at least started becoming active actors (Gillette, 2003).

One of the largest steps taken to make international recommendations about mental health and psychosocial support in emergency settings is the Inter-Agency Standing Committee Guidelines (IASC) (Inter-Agency Standing Committee, 2007). These guidelines reflect the insights of mental health experts (evidence informed) from different geographic regions, disciplines and sectors; and reflect an emerging consensus on good practice among practitioners. The core idea behind them is that, in the early phase of an emergency, social support is essential to protect and support mental health and psychosocial well-being (Inter-Agency Standing Committee, 2007). They identify potentially harmful practices and clarify how differing approaches may complement each other. They cover a broad spectrum of needs ranging from practical sides such as coordination, assessment, monitoring and evaluation and human rights, as well as the personal needs of beneficiaries and humanitarian workers. Recommendations for caring for the mental health of staff are proposed on action sheet 4.4 in the guidelines (pp. 87). Although including volunteers in the definition of staff, the word 'staff' in this action sheet refers to paid and volunteer, national and international workers, including drivers and translators, affiliated with an aid organization. Thus, no clear distinction is made between the needs of volunteers and staff.

However, the guidelines overlook the fact that volunteers are often not registered and often do not work under any terms of reference. They often do ad hoc assignments and are often not supervised by one particular person. Many of them are not insured, vaccinated or enjoy any term of organization follow up once the disaster is over. In future recommendations a clear distinction needs to be made between staff and volunteers. Recently, the IFRC Reference Center for Psychosocial Support published a much needed and long overdue operational framework or a model that can guide psychosocial support interventions directed at volunteers presented in the manual "Caring for volunteers" (International Federation of Red Cross and Red Crescent Societies Reference Centre for Psychosocial Support, 2012).

In the past decade, the IFRC has put efforts into creating a good policy for volunteer management that states that volunteers should have the right to receive the necessary information, training, supervision, and personal and technical support for the discharge of their duties. They should be insured against the risk of accidents and illnesses related to the volunteer activity and have the right to work in safe, secure and healthy conditions. Moreover, they should have the right to be reimbursed for reasonable expenses related to the volunteer activity, as well as be provided with basic subsistence support for food and accommodation whenever the volunteer assignment so requires; and have appropriate accreditation describing the nature and length of time of the volunteer activity, as well as certification acknowledging the volunteer's contribution at the end of the service. Equally, the volunteers are expected to conform to the objectives and observe the regulations of the

organization in which they are involved, respect the rights, beliefs and opinions of beneficiaries and to participate in any necessary training courses provided by the host organization (Volunteering Policy, 2002). Despite volunteers' key role in emergency and disaster response, their role and legal protection often lacks clarity. Even though the past decade has seen an increase in legislation relating to volunteering in general, specific issues may arise in the context of emergencies, for example exposure to contamination or exploitation (The Legal Framework for Volunteering in Emergencies, 2011). This may reflect volunteers' sense of safety; and this lack of safety has been shown to influence mental health and exacerbate post-traumatic stress disorder (PTSD) symptoms in people having experienced critical events (Dückers, 2013; Hobfoll et al., 2007).

In general, volunteers fall into two main categories, core and non-core volunteers. The former have volunteered in non-disaster times and received appropriate preparation and training. The latter, are new to this type of work and have simply responded ad hoc to an urgent need within their community. Core-volunteers will be more familiar with the organization's structure, support system and internal network.

Apart from the daily tasks assigned to them as a non-professional resource, such as assisting with administration and packing of food or non-food items, volunteers also carry out tasks that professionals will respond to in non-disaster times. This can include evacuation of bodies and burials; limb amputations of community members stuck under rubble; basic and advanced first aid to the severely injured; evacuation from unsafe buildings; clean-up of rubble, and provision and setting up of shelter as well as distribution of food and water. These tasks are often highly emotionally impactful like tracing lost family members, providing psychosocial support to the affected, and distribution of relief to those unable to reach aid. Due to the nature of disaster settings - being mostly sudden, unpredictable and chaotic - the volunteers may have to work within unclear task descriptions and attend to ad hoc requests triaged by team leaders or operational managers. They may work for varying amounts of time, some for weeks or months and may at the end of mission never return back to the organization, and thus never receive any follow up or support (Inter-Agency Standing Committee, 2007). Typically about half of the volunteers come from the affected community. This also means that they and their families are often unable to leave the affected area, even if the security situation worsens. Thus, quality volunteer management is required in order to look after and follow up on their health, both physical and mental.

More recently we have scaled up to study mental health and in particular the incidence of Post-Traumatic Stress Symptoms (PTSD) in volunteers. Also, a closer look has been taken at factors within the organization that could influence complaints as well as exploring differences in complaints between core and non-core volunteers.

In a review published in 2010 it was shown that volunteers vary from considerable to high levels of mental health complaints, in particular PTSD, with levels ranging from 24-46% risk of developing the disorder. Compared to professional workers they tend to have higher complaint levels more similar to those of direct survivors (Thormar et al., 2010).

Studies have also shown high levels of PTSD and subjective health complaints up to 18 months post disaster, while anxiety and depression levels remained in the normal range. Higher levels of exposure as well as certain tasks (e.g. provision of psychosocial support to beneficiaries, handling administration or handing out food aid) made volunteers more vulnerable. Sense of safety, expressed general need for support at six months, and a lack of perceived support from team leaders and the organization were also related to greater psychopathology at 18 months (Thormar et al., 2012). Quality of sleep has been shown to be related to both outcomes but resource loss only to PTSD symptoms. Studies have shown that characteristics of disaster work e.g. low quality of sleep, may be an important contributor to PTSD symptoms and subjective health complaints in volunteers (Thormar et

al., 2014). Non-Core volunteers have also been found to have higher levels of PTSD symptoms than Core volunteers. Core volunteers with high symptoms of PTSD were characterized by having sought prior mental health help, reported lower levels of self-efficacy and perceived social acknowledgment, and were more likely to have provided psychosocial support to beneficiaries. The results emphasize the importance of providing adequate support especially to the large number of non-core volunteers involved in disaster recovery operations. (Thomar et al., 2016).

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Monitoring and Evaluation of Psychosocial Interventions

Sarah Harrison, IFRC Reference Centre for Psychosocial Support and Co-Chair IASC MHPSS RG and Cecilie Dinesen, IFRC Reference Centre for Psychosocial Support

Monitoring and evaluation (M&E) of mental health and psychosocial support (MHPSS) programs is important, not only for facilitating learning but also for providing accountability to stakeholders. In addition, strong M&E systems can also contribute to bridging the gap between practice and research because implementing agencies who build their capacity in data collection, management and analysis will be better placed to engage in research partnerships with academic institutions.¹⁵

Box 1: Definitions

Monitoring is a continuous process of collecting and analyzing information to compare how well a project or program is being implemented against expected results. Monitoring aims at providing managers and other stakeholders with regular feedback and early indications of progress (or lack of progress) in the achievement of intended results. It generally involves collecting and analyzing data on implementation processes, strategies and results, and recommending corrective measures.

Evaluation is the systematic and objective assessment of an ongoing or completed project or program, its design, implementation and results. Evaluation determines the relevance and fulfilment of objectives, efficiency, effectiveness, impact and sustainability. An evaluation should provide information that is credible and useful, leading to the incorporation of lessons learned into the decision-making process of both recipients and donors.

Source: International Federation of Red Cross and Red Crescent Societies Reference Centre for Psychosocial Support (2017): IFRC Monitoring and evaluation framework for psychosocial support interventions. Guidance Note. Copenhagen, 2017

The Inter-Agency Standing Committee Reference Group on Mental Health and Psychosocial Support in Emergency Settings has developed a M&E framework because the field of mental health and psychosocial support in humanitarian settings is advancing rapidly, with various MHPSS activities now forming a part of standard humanitarian responses. In 2007, the Inter-Agency Standing Committee released the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*, which have been widely used to guide MHPSS programmes in many humanitarian contexts. At the same time, rigorous research that evaluates the effectiveness of specific MHPSS activities is increasingly being published. However, the wide variation of goals, outcomes and indicators for the many MHPSS projects being implemented in different humanitarian settings has led to difficulties in demonstrating their value or impact.¹⁶ To address this challenge, a common monitoring and evaluation (M&E) framework has been developed to supplement the IASC guidelines.

Parallel to this, the International Federation of Red Cross and Red Crescent Societies Reference Centre for Psychosocial Support (IFRC PS centre) has developed a M&E framework for Psychosocial Support Interventions in order to identify and ensure best practices throughout IFRC global psychosocial (PS) programmes, contributing to quality PS interventions and strengthen advocacy for PS programmes. The framework aims to support Red Cross Red Crescent National Societies and other organisations to design relevant M&E systems for PS programmes and to help in programme planning and development of PS strategies.

The IFRC PS Centre, who is currently the co-chair of the IASC Reference group for mental health and psychosocial support in emergency settings as well as active members, has closely followed the development of the IASC MHPSS M&E framework. The IFRC PS Centre has where ever it was possible tried to align content from

¹⁵ Augustinavicius, Jura L., et al. "Monitoring and evaluation of mental health and psychosocial support programs in humanitarian settings: a scoping review of terminology and focus." *Conflict and health* 12.1 (2018): 9.

¹⁶ Tol, Wietse A., et al., 'Research Priorities for Mental Health and Psychosocial Support in Humanitarian Settings', *PLoS Medicine*, vol. 8, no. 9, 2011, e1001096.

the IASC MHPSS framework in the IFRC PS Centre framework (e.g. using the same indicators where appropriate) as well as aligning all content to follow international standards and guidelines, but at the same time acknowledging that there are apparent differences between the two frameworks and hence having both frameworks are useful as they also cover different areas.

The two M&E Frameworks are publicly available and can be downloaded from the two websites:

- [IFRC M&E Framework for PSS Interventions](#) (available in English)
- [IASC MHPSS RG: Common M&E framework for MHPSS in emergency settings](#) (Available in English and Arabic)

Below is a table that provides an overview of the main differences between the two frameworks. This is to avoid confusion about possible duplication work and to illustrate the different areas that are covered in the two frameworks.

IFRC M&E Framework for PSS Interventions	IASC MHPSS RG: Common M&E framework for MHPSS in emergency settings
Focuses on psychosocial interventions both in emergencies and non-emergencies	Focuses on mental health and psychosocial support interventions in emergency settings
Based on Red Cross/ Red Crescent (National Societies’) programming and on Hobfoll’s five principles: <ul style="list-style-type: none"> ■ Promote a sense of safety, ■ Promote calming, ■ Promote sense of self and collective efficacy, ■ Promote connectedness and, ■ Promote hope. 	Based on the IASC MHPSS Guidelines, including the 6 Core Principles, which underpin the framework: <ul style="list-style-type: none"> ■ Human rights and equity of affected persons, ■ Participation of local affected populations, ■ Do No Harm, ■ Building on available resources and capacities, ■ Integrated support systems and, ■ Multi-layered supports
Goal statement: <b style="color: red;">Improved psychosocial well-being, resilience and capacity to alleviate human suffering (emerged through a combination of the IASC MHPSS common M&E framework goal statement and the IFRC 2020 strategy)	Goal statement: <b style="color: blue;">Reduced suffering and improved mental health and psychosocial support (emerged through a 3-year consultative process with IASC MHPSS RG members)
Has two ‘key’ headers for outcomes; <ul style="list-style-type: none"> ■ PS wellbeing for beneficiaries (which includes outcomes related to PS service provision and community engagement) 	Has two headers for outcomes; <ul style="list-style-type: none"> ■ Community focused ■ Person focused.

<ul style="list-style-type: none"> ■ Quality PS programmes (which includes outcomes related to “training and supervision” and “care for volunteers”) 	These are based on the IASC MHPSS intervention pyramid and the focus for interventions across the 4 layers.
Has two intermediate outcomes related to “training and supervision” and “caring for volunteers	There are indicators covering training and supervision under Outcomes 1 and Outcomes 5. Staff and volunteer care is not specifically covered
Has outcome objective statements with corresponding indicators	Has outcome statements with corresponding indicators
Has output objective statements with corresponding indicators	Output level is not included in the framework
Uses neutral indicators ¹⁷ (which should then be defined in the IFRC M&E plan).	Uses neutral indicators. Definitions of key words or phrases within the five outcomes are explained in Chapter 5 of the Framework.
Has suggested MoV for all indicators at outcome level and output level	Does not include Means of Verification for any indicators. Reasons for this include diversity in MoVs across MHPSS actors and a lack of evidence-base in which to judge efficacy and validity of MOVs at this stage. MoVs will be further developed during the field testing phase.
Includes data collection tools for all suggested MoVs at outcome level and some at output level	Does not include data collection tools. Evidence-based MoVs will be developed in the field testing phase.
Refers to IFRC’s templates on ‘Plan of Action’, Log frames and ‘M&E plan’, which are used by all Red Cross/ Red Crescent National Societies.	Designed to be used by all MHPSS actors and flexible enough for information to fit different donor proposal and reporting templates. No specific log frame template suggested.

¹⁷ Neutral indicators do not specify specific numbers, nor do they include words such as ‘increase’ or ‘decrease’. Rather, these neutral statements are worded in such a way to provide evidence of change (whether positive or negative), rather than targets to be achieved.

Traditional indicator: 80% of PS programme recipients report an improvement in skills and knowledge through participation in the programme.

Neutral indicator: % of PS programme recipients reporting a change in skills and knowledge through participation in the programme

Featured Graduate Program

Bloomberg School of Public Health at Johns Hopkins



The Bloomberg School of Public Health at Johns Hopkins in Baltimore, Maryland has a Mental Health Department that offers masters and doctorate tracks. It has a Global Mental Health Faculty for one of its academic resources, and provides a unique opportunity for integrating disaster mental health with a public health focus. A quote from their website reads as follows, “The Department of Mental Health conducts research to advance the understanding of mental and behavioural disorders, develops, implements and evaluates methods to prevent and control these disorders; and promote mental health in the population.”

Featured Publications

The Bloomberg School of Public Health publishes *Center for Humanitarian Health Weekly Newsletter* that contains considerable information of value to our readers. Of special note for our readers is the very recent book edited by Joseph O. Prewitt Diaz the guest editor for this Psychosocial SIG’s current newsletter. In addition to several chapter contributions by Joe, it has other contributors’ chapters describing community-based disaster response programs. Its title is [Disaster Recovery: Community-Based Psychosocial Support in the Aftermath](#), published by Apple Academic Press, Waretown New Jersey, 2018.

N.B. Readers are encouraged to submit mental health and psychosocial support article manuscripts for review and possible publication in WADEM’s journal *Prehospital and Disaster Medicine*. For further information, please see the journal’s submission instructions.

Upcoming Events

- [Promoting Social Change](#), I.S.T.S.S, 8-10 November, Washington DC, USA
- [WADEM Congress on Disaster and Emergency Medicine](#), 7-10, May 2019 Brisbane, Australia*

*Readers are encouraged to submit abstracts for review and possible presentation at this congress. For further information, please visit - wadem2019.org.

Organizational and Informational Resources

This issue's featured informational resource that has free publications and training materials for academic, professional, and lay persons who are interested in disaster psychosocial matters is:

- War Trauma Foundation - www.wartrauma.nl.

Reader Comment

Comment from our newsletter readers is welcomed. The primary purpose of reader comment is to briefly address the issue's theme writings (guest editorial and abstracts). Please include your name and email address.

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