The Need for a Systematic Approach to Disaster Psychosocial Response: A Suggested Competency Framework

Robin S. Cox, PhD; Taryn Danford, MA

Royal Roads University, Victoria, British Columbia, Canada

Correspondence:
Robin S. Cox, PhD
Royal Roads University
Building 28
2005 Sooke Road
Victoria, BC V9B 5Y2
E-mail: robin.cox@royalroads.ca

Conflicts of interest: The authors have no disclosures or conflicts of interest to report.

Keywords: competency frameworks; disasters; psychosocial competencies; public health emergencies; resilience

Abbreviations:
CISM: Critical Incident Stress Management
PFA: Psychological First Aid
SARS: Severe Acute Respiratory Syndrome

Received: June 4, 2013
Revised: October 27, 2013
Accepted: October 14, 2013

Online publication: March 17, 2014

doi:10.1017/S1049023X14000259

Abstract

Competency models attempt to define what makes expert performers "experts." Successful disaster psychosocial planning and the institutionalizing of psychosocial response within emergency management require clearly-defined skill sets. This necessitates anticipating both the short- and long-term psychosocial implications of a disaster or health emergency (ie, pandemic) by developing effective and sustained working relationships among psychosocial providers, programs, and other planning partners. The following article outlines recommended competencies for psychosocial responders to enable communities and organizations to prepare for and effectively manage a disaster response.

Competency-based models are founded on observable performance or behavioral indicators, attitudes, traits, or personalities related to effective performance in a specific role or job. After analyzing the literature regarding competency-based frameworks, a proposed competency framework that details 13 competency domains is suggested. Each domain describes a series of competencies and suggests behavioral indicators for each competency and, where relevant, associated training expectations. These domains have been organized under three distinct categories or types of competencies: general competency domains; disaster psychosocial intervention competency domains; and disaster psychosocial program leadership and coordination competency domains.

Competencies do not replace job descriptions nor should they be confused with performance assessments. What they can do is update and revise job descriptions; orient existing and new employees to their disaster/emergency roles and responsibilities; target training needs; provide the basis for ongoing self-assessment by agencies and individuals as they evaluate their readiness to respond; and provide a job- or role-relevant basis for performance appraisal dimensions or standards and review discussions.

Using a modular approach to psychosocial planning, service providers can improve their response capacity by utilizing differences in levels of expertise and training. The competencies outlined in this paper can thus be used to standardize expectations about levels of psychosocial support interventions. In addition this approach provides an adaptable framework that can be adjusted for various contexts.

Cox RS, Danford T. The need for a systematic approach to disaster psychosocial response: a suggested competency framework. ***Prehosp Disaster Med.*** **2014;29(2):183-189.**

Introduction

There is a growing global recognition of and consensus on the need to provide "psychosocial support," to those exposed to extreme stressors as a result of disasters, public health emergencies, terrorism, and war.[1-3] Globally, various governmental, nongovernmental, and professional bodies are working to develop a standard of care in the provision of disaster psychosocial services. This requires articulating shared values and principles of psychosocial care, and developing competency guidelines for the planning, delivery, and evaluation of psychosocial services.[4,5]

A variety of terms are used to describe approaches to assessing and meeting the psychological, emotional, and spiritual needs of those affected by disasters and complex emergencies. These terms include "disaster psychological support," "disaster mental health," "disaster behavioral health," and "disaster psychosocial support." However, these terms must not be taken to be seamlessly interchangeable. Each term implies not only theoretical and conceptual differences in the understanding of what support those affected

https://doi.org/10.1017/S1049023X14000259 Published online by Cambridge University Press

Category	Domain
General Psychosocial Competencies	**Domain 1 – Personal Attributes** These competencies are based on some of the critical personal attributes associated with compassion and self-awareness; active listening, effective communication; professional and ethical conduct; effective performance as a team member; cultural competence.
	Domain 2 – General Disaster and Emergency Psychosocial Preparedness These competencies demonstrate an understanding of the disaster context and the psychosocial implications of disasters; the role and responsibilities of psychosocial services within the emergency management system; and an orientation to resilience and empowerment in the care of self and others.

Cox © 2014 Prehospital and Disaster Medicine

Table 1. General Disaster Psychosocial Competency Domains

by extreme stressors need, but also professional and jurisdictional differences in defining and determining what competencies, training, and expertise is required to deliver those services. Therefore, the term "psychosocial" will be used throughout this document to denote the interplay between social, cognitive, emotional, and spiritual needs and interventions. (ie, providing shelter has psychosocial implications; providing emotional support can include addressing functional needs). This "psychosocial" support incorporates the basic psychological, social, and cultural aspects of human interactions that impact wellbeing. Recognizing that these factors are interlinked and inclusive of one another, rarely acting in isolation, is essential.[6]

Disaster and emergency response systems function best when all aspects are coordinated, coherent, and consistent. There remain differences in the interpretation and standards of psychosocial response in disasters.[7] However, this type of support is best envisioned at local and regional levels as a flexible, coordinated, and carefully considered program of activities and interventions designed to meet the assessed needs of the population and responders. This may include those directly or indirectly impacted by a disaster, as well as volunteer or paid response staff.

The definition and coordination of psychosocial support requires a collaborative and consultative approach amongst governmental and nongovernmental organizations working with affected populations. It also requires acknowledgement of intraorganizational and interorganizational differences in access to resources, training, expertise, and mandates. This article proposes a modular competency framework, complete with various levels of skills and knowledge of responders that is adaptable to the complex environment of disasters and health emergencies such as pandemics.

The rationale for engaging in systematic, psychosocial planning is based in the research on the psychosocial consequences for survivors and responders in recent and not so recent disasters.[8,9] The size of the psychosocial "footprint" of a disaster is often much larger than the "medical" footprint.[10] Research on the mental health outcomes of disasters indicates that such events are associated with increases in stress-related disorders, anxiety, depression, adjustment issues, alcohol and substance abuse and absenteeism related to recovery activities, fear, and increased caregiving responsibilities.[11] Responders are also at increased health risks associated with stress, trauma, and grief. Research on the Severe Acute Respiratory Syndrome (SARS) outbreak in Toronto, Canada in 2003, for example, indicates that front line responders, in this case health care providers, experienced high levels of stress and distress.[12-14]

Maximizing personal and social resilience and professional performance has short- and longer-term benefits and requires a multi-sectoral, collaborative, and holistic approach to the provision of psychosocial support. Ideally, the competencies required by psychosocial responders would be outlined clearly so that communities and organizations can prepare for and effectively manage such a response in a disaster event.

Competence generally can be understood as the ability to integrate and apply the knowledge, understanding, skills, attitudes, and values required to practice effectively, safely, and ethically in a designated role and practice setting.[15] Competency-based models are based on observable performance or behavioral indicators and attitudes, traits, or personalities that are related to effective or superior performance in a specific role or job. In other words, competency models attempt to define what makes expert performers "experts." However, competencies do not replace job descriptions nor should they be confused with performance assessments.

Report

Disaster Psychosocial Competency Domains

The proposed framework outlines a modular approach to psychosocial competencies. This addresses the need for flexibility in response to differences in availability of resources, needs, and endorsement of specific support models and interventions. The competencies outlined in this paper can be used to standardize expectations regarding levels of care and specific psychosocial support interventions. This also will provide a flexible, adaptable framework for use in multiple disaster scenarios and contexts.

Category A: General Psychosocial Competencies—General Psychosocial Competencies include core competencies that are the foundation for all higher-level competencies in the framework. These are outlined in Table 1. Domain 1 in this category, Personal Attributes, includes competencies related to the ability to function in a high-stress environment while maintaining one's own wellbeing and supporting the wellbeing of others. Domain 2, General Disaster and Emergency Psychosocial Preparedness, includes competencies related to the required basic knowledge of disaster systems and disaster psychosocial impacts that would be expected of all those working in a disaster psychosocial function. With minimal training, all those working in a response environment should be able to understand the psychosocial implications of the disaster for survivors and responders, and recognize the relevance and function of disaster psychosocial services within emergency management. This includes demonstrating the value of personal, family and work-

https://doi.org/10.1017/S1049023X14000259 Published online by Cambridge University Press

Category	Domain
Psychosocial Intervention Competencies	**Domain 3 – Supportive Presence** Includes competencies associated with the foundation of all psychosocial support including understanding the role of being a supportive presence, and an ability to engage in respectful, supportive relationships with disaster affected individuals and groups.
	Domain 4 – Psychological First Aid – PFA These competencies relate to the provision of Psychological First Aid including demonstrating an understanding of the rationale and goals of PFA, the 8 functions and their related methods and strategies, and the ethical and practice standards of the PFA model
	Domain 5 – Workforce Resiliency Includes competencies that demonstrate an understanding of the unique nature and demands of participating in a disaster response; understanding of trauma and stress management; and capacity to work effectively with individuals and their families to address the effects of stress and trauma.
	Domain 6 – Critical Incident Stress Management – CISM This domain includes competencies associated with an understanding of the theories and principles of CISM, the role of demobilization, defusing, debriefing, and stress management; and the associated skills.
	Domain 7 – Crisis Intervention These competencies include demonstrating an understanding of the theories, principles, and intervention strategies of crisis intervention; demonstration of relevant skills including applying the principles and strategies of suicide assessment and treatment planning.
	Domain 8 – Community and Family Outreach These competencies reflect the outreach focus of disaster psychosocial services and include demonstrating skill and comfort working in a community-based or outreach capacity; knowledge and skill of a range of disaster psychosocial topics and disaster related mental health issues; ability to deliver psycho-educational sessions. May include community- and individual-level support and outreach such as outlined in Skills for Psychological Recovery (National Center for PTSD and National Child Traumatic Stress Network)
	Domain 9 Mental/Behavioral Health Triage Competencies in this domain include demonstrating expertise in knowledge domains relevant to Psychological Triage and an ability to work with extreme emotions and ethical decisions.
	Domain 10 – Multi-faith Spiritual Care These competencies are adapted from the Ontario Multifaith Council on Spiritual and Religious Care. Those providing spiritual care should be trained and certified leaders in their faith communities.
	Domain 11 – Death Notification, Bereavement and Grief Support. Death notification can be a very challenging task within disaster psychosocial support services. For those who have lost a loved one, the notification itself is often the traumatic event.

Cox © 2014 Prehospital and Disaster Medicine

Table 2. Psychosocial Support Competency Domains
Abbreviations: CISM, Critical Incident Stress Management; PFA, Psychological First Aid.

life preparedness and resiliency, individual and group empowerment, and the value and role of support networks.

Category B: Psychosocial Intervention Competencies—The second category, Psychosocial Intervention Competencies, refers to the general and specific knowledge and skills associated with the delivery of specific psychosocial interventions (eg, psychosocial first aid, critical incident stress management, crisis and suicide intervention, community and family outreach, mental health triage, spiritual care and death notification, or bereavement and grief support). This category, outlined in Table 2, includes nine domains, each of which describes the competencies associated with a specific intervention strategy or related set of strategies. These domains range from the very basic, core psychosocial intervention (that of being a supportive presence to survivors, their families and peers, and fellow responders) to interventions requiring a higher level of skill and training such as mental health triage, bereavement support, and spiritual care.

Domain 3, Supportive Presence, includes competencies such as active listening and engaging others with empathy, respect, compassion, and self-awareness. As with those competencies described in the first category, these are considered foundation skills and knowledge (eg, building trust and a sense of safety) necessary for all subsequent domains.

Domain 4, Psychological First Aid, describes a systematic, evidence-informed approach to providing basic psychosocial support. The primary goal of psychological first aid or basic disaster psychosocial support is to reduce initial distress, enhance immediate and longer-term adaptive functioning, and foster self-efficacy and resilience. Psychological First Aid training can be delivered to a wide range of individuals including community members and responders in order to encourage both peer-to-peer and mutual support.

https://doi.org/10.1017/S1049023X14000259 Published online by Cambridge University Press

Category	Domain
Psychosocial Leadership and Coordination	**Domain 12 – Disaster Psychosocial Organizational Consulting, Coordination, Program Development and Evaluation** Competencies associated with developing and leading a disaster psychosocial program including skill in organizational consulting, strategic planning, human resource management, coordination, multi-stakeholder process facilitation, and ability to mentor and lead.
	Domain 13 – Disaster Psychosocial Education and Training. Demonstrates expertise in relevant knowledge and skill domains associated with developing training and delivering to mental health professionals and para-professionals; possesses expertise in wide range of psychosocial topics and interventions and demonstrates ability to assess training needs and adapt training programs to a range of organizational contexts.

Cox © 2014 Prehospital and Disaster Medicine

Table 3. Psychosocial Leadership and Coordination Competency Domains

Domain 5, Workforce Resiliency, describes competencies associated with specific psychosocial and mental health interventions. Many of these interventions require specific training, and all require an understanding of the unique nature and demands of a disaster or public health crisis, as well as the potential impacts on individual workers and their families. In many cases, they also require an extensive clinical background with exposure to and experience working with multiple presenting issues and client populations in a variety of organizational contexts. The demands and culture of response can make it extremely challenging for psychosocial support workers to engage responders. For this reason, it is suggested that, those working to establish and enhance workforce resilience have more advanced levels of clinical skills and judgment.

This likely will include specific knowledge of simple and complex stress reactions, the signs and symptoms of acute and posttraumatic stress disorder, skills related to crisis intervention, suicide assessment, stress management, organizational consulting, outreach, and other very specific crisis intervention protocols. Those providing response worker support must be able to translate their clinical skills for use in the context of a hierarchical, structured disaster response system. This is also necessary to address the unique cultural expectations of diverse responder groups (eg, nurses, police, emergency social services). For these reasons, those providing workforce resiliency interventions typically will have a recognized academic degree in an applied mental health discipline (eg, clinical social work, counseling psychology, clinical psychology, psychiatric nursing) or the equivalent in experience and training.

Domain 6, Critical Incident Stress Management (CISM), focuses on a specific and systematic set of interventions. This includes precrisis education designed to increase awareness, enhance crisis and stress management coping skills, and organizational resilience, postcrisis assessment, and a range of highly-structured post interventions. Single-session or "one-off" critical incident debriefings are not recommended and should not be confused with CISM. Critical Incident Stress Management requires specific training and an ability to work proactively and sensitively within a range of organization, community, and cultural contexts.

Domain 7, Crisis Intervention, describes support activities related to the provision of immediate, short-term support to individuals experiencing acute distress as a result of a crisis. This moves beyond psychological first aid. It may include the capacity to recognize signs and symptoms of a range of mental health disorders and the ability to screen for and address suicidality. The goal in the latter case is to keep the individual alive until stabilized (in other words, survives the crisis) in order to explore alternatives to suicide and seek other avenues of support. As with the previous domain, Domain 7 requires specialized knowledge and training.

Domain 8 focuses on Community and Family Outreach. This domain includes a range of competencies associated with outreach and working in a multidisciplinary team. Despite years of clinical experience, some providers may be very unfamiliar and uncomfortable with the challenges of outreach work. This kind of work requires providing support in nontraditional settings with diverse populations, and an ability to engage from a community development approach (ie, working with rather than for, in order to build capacity). It often includes the provision of psychoeducation to individuals and groups (eg, community town halls) on a wide range of topics. This in turn requires a depth and breadth of knowledge about the psychosocial and other health-related dimensions of the specific type of disaster or public health emergency (eg, symptoms and progression of influenza) and a demonstrated ability to work in diverse cultural, ethnic, and economic contexts.

Domain 9, Mental/Behavioral Health Triage, describes competencies associated with assessment and the triaging of limited resources in a crisis. Similar to medical triaging, mental health triaging may be required during a large-scale disaster or public health emergency where the demand for psychosocial services exceeds the availability of resources. The goal of triaging is to distinguish clients on the basis of the severity and nature of their symptoms, and the urgency of intervention, in ways that optimize the use of resources and recovery outcomes. This requires skill in mental health assessment, in order to effectively sort, stage, distinguish, and manage direct and indirect psychosocial casualties (eg, families searching for their missing loved ones). Triaging also requires distinguishing psychological from medical symptoms in situations where these may have a similar presentation or where one may mask the other. Both individuals and teams may undertake triaging activities. However, the assumption in this framework is that whoever leads the triaging process would have extensive clinical and clinical assessment experience and training (ie, be a senior, professional provider).

Domain 10, Multi-faith Spiritual Care, defines competencies relevant to trained and certified leaders from recognized faith communities (eg, professional chaplains, imams, rabbis, priests, trained lay chaplains), indigenous spiritual leaders, and/or those with specialized training and certification in multifaith spiritual

https://doi.org/10.1017/S1049023X14000259 Published online by Cambridge University Press

Level	Roles	Competency Domains
Level I Minimally-trained volunteers	General supportive presence providing: • Contact and engagement • Active listening • Initial assessment of needs and referral to other levels of care	1. Personal Attributes 2. General Disaster and Emergency Psychosocial Preparedness 3. Supportive Presence
Level II Para-professionals and professional mental health workers without graduate degrees	Supportive presence plus: • Emotional support • Psychological First Aid	Domains 1 through 3 plus: 4. Psychological First Aid
Level III Professional mental health workers with graduate degrees and/or extensive experience, and preferably members of relevant professional associations	Supportive presence plus basic and more advanced emotional support including: • Psychological first aid • Delivery of specific psychosocial interventions • Worker care • Assessment and referral	Domains 1 through 4 plus some combination of: 5. Workforce Resilience 6. CISM 7. Crisis Intervention 8. Community and Family outreach 9. Mental Health Triage 10. Spiritual Care 11. Death Notification support, bereavement and grief support
Level IV Professional mental health workers with graduate degrees and/or extensive experience, management experience, members of relevant professional associations, and preferably previous disaster psychosocial response training and experience	All the support and intervention strategies from previous levels. In addition, program development, coordination, education and training plus: • Leadership • Evaluation • Supervision	Domains 1 through 11 plus: 12. Disaster Psychosocial Organizational Consulting, Coordination, Program Development & Evaluation 13. Disaster Psychosocial Education and Training

Cox © 2014 Prehospital and Disaster Medicine

Table 4. Levels of Psychosocial Care and Related Competency Domains
Abbreviation: CISM, Critical Incident Stress Management.

care. The provision of spiritual care requires an ability to assess the specific needs and faith orientations of survivors, while also responding sensitively to those needs in ways that respect and are consistent with the faith/spiritual traditions or orientations of those receiving services.

Domain 11, Death Notification, Bereavement and Grief Support, describes competencies necessary for working with those who have recently lost a loved one. Death certification is legislatively determined in each jurisdiction and death notification practices vary across these jurisdictions. For those who have lost a loved one, the notification itself is often a traumatic event and the provision of psychosocial support during or following notification requires skill, sensitivity and familiarity with grief and bereavement responses. Many factors can influence the experience, nature, and trajectory of the grieving process and those providing support need to be aware and sensitive to the influence of those factors. Grief support, whether in relation to a death notification or not, may be provided by an individual or a multidisciplinary team. Those involved should have training and experience in providing grief support and counseling and/or spiritual care, generally and more specifically, experience with traumatic and multicasualty loss.

Category C: Psychosocial Program Leadership and Coordination Competencies—As outlined in Table 3, the final category of competencies relates to the development and maintenance of disaster psychosocial programs, their integration into emergency management systems, and their implementation in the event of a disaster. This category will typically involve someone with significant experience as a mental health professional working in disaster response, as well as the personal and organizational authority to implement psychosocial programs and interventions.

The first domain in this category, Domain 12, Disaster Psychosocial Organizational Consulting, Coordination, Program Development and Evaluation, describes the competencies associated with establishing and maintaining a psychosocial program. Those leading the psychosocial response should have a firm grasp of the organizational context in which they will be working and of the local disaster management system.

Domain 13, Disaster Psychosocial Education and Training, refers to competencies related to the ongoing and emergent training and education needs of those providing psychosocial support. This should include a consideration of the educational requirements of command and/or management positions within the response. Leaders will need to acquire an understanding of psychosocial implications of disasters for responders and survivors, and the roles and responsibilities of disaster psychosocial providers. This domain includes competencies associated with the delivery of effective training in multiple psychosocial intervention approaches to multiple client populations. This also includes ensuring those being trained understand the organizational, procedural, emotional, and environmental aspects of disaster response work and how these influence the delivery of services. Because disaster psychosocial training may be delivered in advance or as just-in-time training, competencies in this domain require an ability to adapt, synthesize and manage

https://doi.org/10.1017/S1049023X14000259 Published online by Cambridge University Press

training modules and delivery methods to address different training contexts and learning styles. At a minimum, those developing programs would either have the competencies to provide training or to evaluate the relevance of external training.

Levels of Psychosocial Care and Providers

Given the outlined competencies, and the range of knowledge and skills, the proposed framework supports the inclusion of a range of disaster psychosocial providers, from minimally trained volunteers offering a supportive presence to disaster mental health experts who can triage and manage survivors who may be highly traumatized and/or actively psychotic. In order to easily determine how and where to deploy psychosocial support workers, it may be useful to organize teams in terms of levels of support that are linked to levels of competency. The British Columbia Disaster Psychosocial Program,[15] for example, divides providers into four levels of psychosocial response that align with specific competency domains. These levels, described in Table 4, are not meant to be proscriptive, but rather to provide a flexible guideline for those organizing a response. All levels are valuable and, in large disasters, necessary. They are intended to allow for a range of skills and knowledge and the ability to adapt the response to available resources and to specific disaster contexts.

At Level I, a provider would be expected to be able to be a supportive presence with survivors and their families. Those meeting the required competencies for Level II would be able to be a supportive presence but would also have the skills and knowledge to engage in Psychological First Aid Strategies. Psychosocial providers in Level III would meet these aforementioned competencies, and a range of competencies associated with other specific psychosocial interventions such as Critical Incident Stress Management, Crisis Intervention and Death Notification. Those tasked with the development, management, and evaluation of psychosocial programs, or Level IV, would be expected to meet all or most of the required competencies for the previous levels. They will also have substantive clinical and supervisory or management experience, and preferably, working experience as a psychosocial provider in a disaster context. Finally, those developing and delivering training in psychosocial disaster response would meet the criteria for Level IV and, additionally, have experience and expertise in training.

Discussion

A competency framework, such as the one suggested in this paper, is best thought of as a flexible, adaptable, but systematic means of assessing levels of skill and training in order to maximize the efficient and effective use of limited resources in a disaster scenario. The proposed framework is designed to support the development of local and regional psychosocial response programs and capacity. As such, it serves as an entry point for collaboration between psychosocial service providers and the larger emergency response organization by providing a systematic approach to addressing the social, emotional, psychological, and physical needs of responders and survivors.

By adapting this proposed tiered approach to the provision of psychosocial support, emergency response systems and the psychosocial service providers who work within and alongside them, can acknowledge, prioritize and match the range of emotional and psychological support needs to the abilities, capacity, and competency of those tasked with meeting those needs. This can improve the efficiency of such a response. It also will allow for more comprehensive coverage of needs, and simultaneously identify the various degrees of authority and responsibility required for particular tasks and activities relevant to psychosocial planning and crisis management.

During emergency situations, organizational leaders and managers need to be able to use any and all human resources available to ensure adequate response and recovery. One aspect of building this capacity is ensuring that responders are psychologically prepared for their work and have the skills and knowledge to support each other. Employing a systematic, competency-based approach to developing support teams allows the response system to proactively identify and address potential gaps in their capacity. Training and education needs and priorities can then be established to address these gaps and ensure that competencies are systematically evaluated and updated.

The provision of relevant training and education programs can enhance not only the resilience of the response system but also that of the general public. Psychological First Aid (PFA) training was designed as an intervention to be delivered by a range of response workers providing immediate assistance in the aftermath of disasters.[16] As a basic training in supportive listening, it would be possible to adapt this training to ensure that citizens, who are often the first responders in any disaster,[17] have basic supportive listening skills. In this way, PFA might be rolled out in much the same manner as basic medical first aid and cardiopulmonary resuscitation (CPR) have been rolled out to the general public. Citizens who are prepared to provide basic first aid and psychological first aid make for a more resilient community and increase the overall disaster response capacity of communities and organizations. In Joplin, Missouri, for example, Freeman Health trained a corps of citizens as outreach crisis workers (V. Miesler, personal communication, January 16, 2013). These workers, known colloquially as the "blue shirts," provided much-needed psychological first aid outreach in their community for months following the tornado.

The Joplin blue-shirts example is indicative of the kind of creative and flexible response to psychosocial needs that is necessary in disaster psychosocial response. The cultural, social, and resource context of each disaster is unique. The challenges to the psychological and emotional wellbeing of citizens and responders will also vary depending on the nature and duration of the event and how these impact such things as workforce shortages, supply chain disruption, the likelihood of workers having to take on new roles or responsibilities in a disaster, and the potential of working in non-traditional work environments. A competency-based framework approach to the provision of psychosocial support allows governments, disaster response and relief organizations, and health care institutions and providers to develop flexible plans that account for a range of disaster scenarios and psychosocial issues. This includes meeting the anticipated and emergent needs of responders from various responder groups (eg, first responders, emergency service volunteers, incident commanders, and other leaders) and those of survivors. It also includes planning for how and where the response will provide on-site support to both groups (ie, responders, survivors) and to the families of workers. Finally, plans should ensure that relevant and timely psychosocial support is available and accessible to psychosocial responders during and following deployment.

As with all disaster management plans and planning processes, collaboration and resource sharing are crucial to building capacity and resilience. Procedures and protocols should

https://doi.org/10.1017/S1049023X14000259 Published online by Cambridge University Press

be established to ensure the timely and effective deployment, integration, collaboration, and management of psychosocial teams at the local, regional, and national levels.

Conclusion

Successful disaster psychosocial planning and the institutionalizing of psychosocial response within emergency management requires anticipating both the short- and long-term psychosocial implications of a disaster or health emergency (ie, pandemic). This necessitates developing effective and sustained working relationships amongst psychosocial providers, programs, and other planning partners. The capacity and resources of a system and the roles, responsibilities, and accountability structures for various stakeholders in the system (including shared leadership roles) need to be clearly defined. By using a modular approach to psychosocial planning, service providers are able to improve their response capacity by utilizing different levels of expertise and training. The competencies outlined in this paper can thus be used to standardize expectations regarding levels of psychosocial support interventions in addition to providing an adaptable framework capable of adjustment in various contexts.

By planning for and adopting a competency-based approach to disaster relief, organizations can increase professional performance and accountability. Ultimately, by clearly defining disaster psychosocial response competencies, those systems, organizations, and agencies tasked with managing disasters and emergency will be able to: build on existing capacity, anticipate and address issues related to the wellbeing of citizens and responders, and contribute to the disaster resilience of communities and states.

References

1. Burkle FM. Acute-phase mental health consequences of disasters: implications for triage and Emergency Medical Services. *Ann Emerg Med*. 1996;28:119-128.
2. Leon GR. Overview of the psychosocial impact of disasters. *Prehosp Disaster Med*. 2004;19(1):4-9.
3. Rao K. Lessons learnt in mental health and psychosocial care in India after disasters. *Int Rev Psychiatry*. 2006;18(6):547-552.
4. Everly GS, Beaton RD, Pfefferbaum B, et al. Training for disaster response personnel: The development of proposed core competencies in disaster mental health. *Public Health Rep*. 2008;123(4):539-542.
5. Hsu EB, Thomas TL, Bass EB, et al. Healthcare worker competencies for disaster training. *BMC Med Educ*. 2006;6:19-27.
6. Addressing psychosocial factors through capacity building: A guide for managers of contaminated sites, Ottawa, ON. *Health Canada*. 2005: 1–22.
7. Core competencies for public health professionals, Washington, DC: the council on linkages between academia and public health practice; 2010:1–21.
8. Nickell LA, Crighton EJ, Tracy CS, et al. Psychosocial effects of SAES on hospital staff: Survey of a large tertiary care institution. *Canadian Medical Association Journal*. 2004;170:793-798.
9. Robertson E, Hershenfield K, Grace SL, et al. The psychosocial effects of being quarantined following exposure to SARS: A qualitative study of Toronto health care workers. *Can J Psychiatry*. 2004;49(6):403-407.
10. Shultz JM, Espinel Z, et al: Deep prep: all hazards disaster behavioral health training. Miami, FL. DEEP Center; 2003.
11. Norris FH, Friedman MJ, Watson PJ. 60,000 disaster victims speak: Part II. Summary and implications of the disaster mental health research. *Psychiatry*. 2002;65(3):240-260.
12. Fikensbaum L, Marjanovik Z, Greenglass ER, Coffey S. Emotional exhaustion and state anger in nurses who worked during SARS outbreak: The role of perceived threat and organizational support. *Canadian Journal of Community Mental Health*. 2006;25(2):89-103.
13. Maunder RG, Lancee WJ, Rourke S, et al. Factors associated with the psychological impact of severe acute respiratory syndrome on nurses and other hospital workers in Toronto. *Psychosomatic Medicine*. 2004;66(6):938-942.
14. Chapter 5: SARS: lessons from a new disease, the world health report 2003 – shaping the future. Geneva, Switzerland: World Health Organization; 2003.
15. Knowles M. *Self-directed Learning*. New York, NY: Association Press; 1975.
16. Psychological first aid: guide for field workers. Geneva, Switzerland: World Health Organization; 2011.
17. Perry RW, Lindell MK. Understanding citizen response to disasters with implications for terrorism. *Journal of Contingencies and Crisis Management*. 2003;11(2).

https://doi.org/10.1017/S1049023X14000259 Published online by Cambridge University Press