Community in Mind

Hei Puāwai Waitaha – a flourishing Waitaha

Background Document

What is needed for effective psychosocial recovery of individuals and communities in greater Christchurch?

Executive summary

Purpose

In 2013, the Canterbury Earthquake Recovery Authority began research for the purpose of developing this Background Document to inform the Greater Christchurch Psychosocial Recovery Strategy. This report, *Community in Mind: Greater Christchurch Psychosocial Recovery Background Document*, identifies what individuals and communities in greater Christchurch need for effective psychosocial recovery, as a guide to organisations (both government and non-government) and community groups in their planning, coordinating, funding and delivery of psychosocial recovery activities in greater Christchurch.

The research involved a qualitative approach. First, semi-structured focus groups were conducted with a range of participants and their feedback was examined with inductive thematic analysis to identify key priorities in effective psychosocial recovery. Semi-structured interviews were then conducted with key informants experienced in psychosocial research and/or recovery. Key informant responses were analysed using a confirmatory qualitative approach, which validated the hypotheses from the focus groups. A literature review was also undertaken using a confirmatory qualitative approach and included peer-reviewed, published information as well as grey (informally published) literature.

Community in Mind fits within the wider recovery work guided by the Canterbury Earthquake Recovery Authority's (2012b) *Recovery Strategy for Greater Christchurch: Mahere Haumanutanga o Waitaha*.

Findings

The earthquakes and aftershocks in greater Canterbury in 2010 and 2011 have had psychosocial effects: some of those effects have been psychological, affecting how individuals feel; others have been social, affecting how people relate to each other. The significant size and scale of the natural disaster and the associated stressors have caused major disruptions for individuals, families, whānau and communities.

Local research undertaken since the earthquakes initially identified significant increases in reported distress and anxiety. While subsequent research indicates anxiety associated with the earthquakes and aftershocks has now diminished, secondary stressors (such as dealing

with insurance issues, making decisions over repairs and other indirect consequences of the disaster) are reportedly having an increasing impact on the population and particular population groups within the community. Research suggests that in the longer term, most people can be expected to recover from the distress and anxiety but that a small group will develop chronic traumatic conditions. In local research, significant numbers of people have reported a deterioration in their quality of life, and for some people, social connectedness has been weakened as a result of the earthquakes. While there has been a significant uptake in psychosocial services since the earthquakes, particular population groups have little or no awareness of the services available. Consistent with previous research, three groups of vulnerable people have been identified since the earthquakes: those with pre-existing vulnerabilities; those who become vulnerable as a direct result of the earthquakes; and those who become vulnerable as recovery proceeds.

Psychosocial recovery will have been achieved when the people and communities of greater Christchurch have established a relatively stable pattern of functioning, regained a sense of control and are oriented towards their future. Psychosocial recovery takes between five and ten years.

Research identifies that psychosocial recovery has several phases which individuals and communities progress through at different times. In greater Christchurch, the nature and number of aftershocks exposed people to significant stress while the various continuing human, social and economic impacts of the disaster contribute to chronic, ongoing stress for many. These unique factors complicate the phases of recovery for people and communities.

Community in Mind acknowledges the importance of both:
- supporting the majority of the population who need some psychosocial support through their neighbourhoods and networks
- responding appropriately to the minority who are significantly affected.

Principles to guide recovery responses

The following six principles provide a useful guide to recovery responses although it is acknowledged that some principles become less relevant as recovery progresses while others become more relevant. Responses should promote:
- a sense of safety
- calming

- a sense of self-efficacy
- community efficacy
- connectedness
- hope.

Priority areas for recovery

There are three priorities for effective psychosocial recovery, and specific goals within each priority area.

Priority One: Community-led recovery *(Mō te hapori, mā te hapori)*

Effective psychosocial recovery involves positive, inclusive, self-organising, diverse, satisfying and often spontaneous responses at neighbourhood and community levels. The specific goals recommended for this priority area are that:

- communities have the capacity to lead their own recovery
- existing and emergent community groups and networks have information and support
- volunteers and volunteerism are actively encouraged
- positive and inclusive community action and activities connect people and build resilience
- community-based planning is successful
- spaces are available for communities to be, meet and do
- community building tools and resources are available and accessed
- opportunities for collaborative leadership development and joint learning are available and well used.

Priority Two: Innovative service provision *(Ratonga hapori)*

Effective psychosocial recovery involves an innovative service response that is strengths-based, collaborative, coordinated, reliable, accessible and adaptable. The specific goals recommended for this priority area are that:

- service planning, delivery and funding work from collaborative and innovative models that are coordinated, accessible and adaptable, and build on strengths
- data and trends are actively monitored to inform understanding, planning and responses and this information is shared with communities
- targeted responses to emergent trends and to those population groups most in need are provided

- successful initiatives for individuals and communities are identified and supported
- a strengths-based practice model promotes self-efficacy
- organisations and communities gather information and share it with each other
- workforce resilience is maintained
- performance and outcomes are regularly evaluated.

Priority Three: Engagement and communication *(Taumata kōrero*)

Effective psychosocial recovery involves communication, interaction and engagement between service responses and community-led responses, between individuals and communities and with the broader recovery efforts. The specific goals recommended for this priority area are:

- recovery planners/decision makers and communities participate in effective two-way engagement
- clear and accessible information about referral pathways to psychosocial services and community supports is available
- coordination mechanisms are in place between community groups, and local and central government and non-governmental organisations
- individual and community stories of hope and overcoming adversity are regularly identified and communicated
- collaborative planning for future emergencies and building community resilience takes place
- information is provided to assist communities to understand psychosocial recovery and find ways to care for each other and meet members' needs.

The three priorities are connected and interact in complex and dynamic ways. All three are necessary for effective psychosocial recovery of individuals and communities in greater Christchurch.

Although the psychosocial recovery process may be difficult for many individuals and communities, the potential exists for an improved sense of wellbeing and resilience across greater Christchurch as a result. Identifying what is needed is an important step in this direction.

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Acknowledgements

It is acknowledged that a broad range of community members, community leaders and community organisations have committed a significant amount of time and energy to Canterbury's psychosocial recovery and have achieved some outstanding results through dedication, skill, kindness and humanity.

Many central and local government organisations and non-governmental organisations have implemented many worthwhile responses and initiatives over this period.

Inclusiveness, collaboration and partnerships are all features of the psychosocial recovery to date.

Through the Psychosocial Sub-Committee and the CERA Wellbeing Planners Group, a broad range of central and local government agencies, tertiary institutions and community organisations have been working hard to deliver an effective cross-sectoral programme of work that has had a collective impact on the psychosocial recovery of greater Christchurch since September 2010.

He mihi

E hara taku toa, i te toa takitahi, engari he toa takitini …
Success is not the work of one but the work of many …

Introductory statement

Community in Mind: Greater Christchurch Psychosocial Recovery Background Document has been informed by a series of focus groups, key informant interviews, a literature review and consultation.

This report has been developed as the recommended background document to the Greater Christchurch Psychosocial Strategy and Programme of Action and the associated CERA Community Resilience Work Programme.

Community in Mind provides a framework for identifying what is needed for effective psychosocial recovery in greater Christchurch as a guide to organisations (both government and non-government) and community groups in their planning, coordinating, funding and delivery of psychosocial recovery activities in greater Christchurch.

Section 1: Introduction

Community in Mind: Greater Christchurch Psychosocial Recovery Background Document informs a Strategy and a Programme of Action. *Community in Mind* is part of the broader recovery work guided by the Canterbury Earthquake Recovery Authority's (2012b) *Recovery Strategy for Greater Christchurch: Mahere Haumanutanga o Waitaha*. The Recovery Strategy identified social recovery as one of the key components of recovery, which is the domain within which *Community in Mind* fits.

The psychosocial effects of a disaster have the potential to cause as much damage as any infrastructure loss. For most people the Canterbury earthquakes and aftershocks have had psychosocial effects: some of those effects have been psychological, affecting how individuals feel; others have been social, affecting how people relate to each other. The nature of the Canterbury aftershocks exposed people to acute stress while the various continuing human, social and economic impacts of the disaster have contributed to chronic and ongoing stress for many. Effective psychosocial recovery, which takes between five and ten years, is essential to the overall recovery of greater Christchurch.

Community in Mind provides the framework for a Strategy and Programme of Action to meet the recommendations of Professor Sir Peter Gluckman of the Office of the Prime Minister's Science Advisory Committee. Gluckman recommended a comprehensive and effective psychosocial recovery programme in response to the Canterbury earthquakes.

Qualitative research has been the primary research method for this report. An inductive thematic analysis has drawn on data from a series of focus groups, using an exploratory approach. This analysis, which examined priorities within and relationships between data, identified three key priorities for achieving effective psychosocial recovery. Understanding of these priorities has been extended by a literature review of peer-reviewed research and grey (informally published) literature as well as interviews with key informants, with the results of both methods analysed using a confirmatory approach.

Community in Mind identifies, describes and develops the three key priorities for effective psychosocial recovery and recommends specific goals in relation to each of them.

Section 2: Psychosocial impacts of the earthquakes

This section describes the psychosocial impacts of the earthquakes, drawing on both local and international research. It includes analysis of the results from the CERA Wellbeing Surveys and the Canterbury Wellbeing Index. This section also draws on findings about the effects of other disasters from research around the world that may help to better understand the situation in greater Christchurch and to work constructively towards psychosocial recovery.

> Since the magnitude 7.1 earthquake on 4 September 2010, greater Christchurch has experienced a series of damaging earthquakes and aftershocks. The most significant, of magnitude 6.3, was on 22 February 2011. This earthquake has been described as New Zealand's most deadly peacetime disaster, resulting in the deaths of 185 people. The quake and the soil liquefaction that accompanied it caused widespread damage across Christchurch, especially in the central city and eastern suburbs (CERA 2012c).

The earthquakes and aftershocks (numbering more than 12,000 as at May 2013) caused major disruptions to the lives of people throughout greater Christchurch, in both the short and longer term. Among the notable effects:

- many thousands of homes and businesses, along with core infrastructure such as water and sewage systems, were damaged
- a significant number of residents of Christchurch city moved to alternative accommodation
- schools were wholly or partially relocated or shared sites with other schools
- more than 60% of the 5,000 businesses in the CBD and their 50,000 employees were displaced
- many swimming pools, historic buildings, community halls, community organisation premises, museums, churches, sports clubs and grounds were closed either permanently or temporarily
- the marae in the marae network became emergency response centres. Many newly displaced services – including fire, ambulance and social workers – based themselves at the local marae.

Gluckman (2011) recommended a comprehensive and effective psychosocial recovery programme in response to the Canterbury earthquakes. He identified two primary areas of focus:

1. support the majority of the population who need some psychosocial support within the community so that their innate psychological resilience and coping mechanisms could take over

2. address the most severely affected minority by efficient referral systems and sufficient specialised care. (Gluckman 2011, p 2)

Gluckman determined that, if the first group does not receive sufficient attention, the number of those in the more severely affected group is likely to grow. He recommended an emphasis on resilience, community participation and wellbeing. He also noted that particular groups and populations are likely to be more vulnerable and to require targeted approaches.

Phases of recovery

The timeframe for psychosocial recovery is at least five to ten years. Figure 1 illustrates how people tend to respond differently to a disaster over time. As the experience of Cantabrians and research evidence (Mooney et al 2011; Thornley et al 2013) have shown, community wellbeing rises sharply after an adverse event – the honeymoon phase, when people initially pull together and deal with the immediate concerns – but this later declines into a disillusionment phase when people realise the full impact of the event. Over time, between five and ten years, wellbeing improves gradually and typically reaches a new plateau at a higher level than the pre-disaster level of wellbeing.

In Christchurch city and Waimakariri and Selwyn districts, this pattern was complicated by the extent and size of the aftershocks and the widespread and diverse impacts on different geographical areas and populations. Due to the significant aftershocks in Canterbury, the disillusionment dip occurred on several occasions. In addition, different communities and individuals had quite different experiences on each occasion.

In the future, the experiences of people and communities will differentiate further. People and communities will also progressively cycle between phases of recovery and response. These trends increase the complexity of recovery and have the potential to create divisions within these groups.

Figure 1: Phases of response to a disaster over time

Source: California Department of Mental Health (2012, reproduced by Britt et al 2012, p 33).

One phase in recovery that Klinterberg (1979, cited in Gordon 2004d) has noted is the "developing conflict" phase in which people are generally disoriented over the recovery. This occurs some time after the initial disaster response. It is a time when innovation is lacking as agencies try to return to or stay with their pre-disaster ways of doing things and leaders and recovery organisations fail to respond effectively to needs. Communities too can be weakened as people find their traditional groupings and interpersonal loyalties disrupted, and struggle to plan for the future.

Impacts of primary and secondary stressors

Any disaster brings both:

- primary stressors, which come directly from the disaster and include the earthquakes and aftershocks in greater Christchurch
- secondary stressors, which are the circumstances and events that are indirectly related to the disaster (the primary stressor).

Primary stressors cause deaths, injuries and distress and can lead some people to develop mental disorders after a disaster (Lock et al 2012). Secondary stressors are recognised for their major impact on psychosocial recovery for both individuals and communities.

Secondary stressors typically persist for longer and make it more difficult for people to re-establish routines and return to a sense of normality following the disaster.

From a literature review, Lock et al (2012) have identified the following as common categories of secondary stressors:

- economic stressors such as problems with compensation and rebuilding homes, and loss of physical possessions and resources
- health-related stressors
- stressors related to education and schooling
- media reporting
- family and social stressors
- loss of leisure and recreation
- changes in people's views of the world or themselves.

Primary and secondary stressors interact in complex ways. As time goes on, it becomes difficult, if not impossible, to separate the impact of the primary stressors from the secondary stressors of normal life events. Where primary and secondary stressors are more intense and persistent, people are more likely to become distressed or develop a mental disorder.

Vulnerable groups

The World Health Organization's definition of vulnerability is "the degree to which a population, individual or organisation is unable to anticipate, cope with, resist and recover from the impacts of disasters" (World Health Organization, 2002). This definition is a useful tool to identify vulnerable populations who would benefit from targeted responses.

Different parts of the community will experience impacts at different times following a disaster. Particular population groups are more likely to experience stress, anxiety and other poor outcomes. Although it is difficult to generalise about groups likely to be most vulnerable or at greatest risk, disasters tend to exacerbate existing inequalities. Populations that were vulnerable before the earthquake will continue to be vulnerable afterwards. General factors that determine levels of vulnerability include income, gender, race, ethnicity, culture and age.

The initial Strategic Planning Framework (Ministry of Social Development 2011) identified the following groups as likely to be particularly vulnerable:

Young people, the elderly, different ethnic groups, children, people who have lost their jobs, people who were injured or developed disabilities as a result of the earthquakes.

It also identified the following groups as more susceptible to stress and distress, particularly if they are isolated:

Children, youth, older persons, disabled people, single parents with children, people with pre-existing mental health issues, people who have previously experienced significant traumatic events or stress, those with lower socio-economic status, Maori, Pacific and refugee and migrants groups, as well as people who have experienced significant impact from the earthquakes.

In addition, it suggested people who lost their jobs, were injured or developed disabilities as a result of the earthquakes were likely to be vulnerable (Ministry of Social Development 2011).

Other vulnerable groups that Gluckman (2011) has identified include mothers of young children, people with a prior history of or unresolved mental illness or poor social adjustment, and families that have suffered bereavement or a personal crisis (which may be unrelated to the disaster).

It is also possible for new vulnerable groups to emerge after a disaster (Sety 2012; All Right? Research 2013). Gluckman (2011) notes the need to monitor for such groups, for example, through non-clinical interventions at schools and 'check-ins' with people with a prior history of mental illness.

Some protective factors for vulnerable groups (making them less vulnerable to psychosocial effects) are support from families, colleagues, teachers and peers, and exposure to positive news stories (Gluckman 2011). Psychosocial services need to reach out to vulnerable populations and target the different groups with appropriate responses. Gordon (2004a) emphasises the importance of identifying people who may become isolated, such as the elderly, poor, infirm and disabled.

Mooney et al (2011) highlight that a strengths-based perspective focusing on resilience and empowerment with community participation is especially effective when practical and

psychological support is also provided. Focusing on strengths does not mean ignoring the need to respond to particular vulnerable groups. Rather, it is an important part of working with vulnerable populations.

Trying to predict vulnerable groups based on other countries' disaster experiences is problematic because the task is so complex. As identified above based on previous research, there is a significant number of groups that have the potential to be vulnerable. The reality is that some members of 'vulnerable' groups do fine while others struggle with recovery for a variety of complex reasons based on other aspects of people's circumstances. What this means, however, is that the impact on different groups is likely to be quite dynamic over the different phases of this particular recovery, and different vulnerable groups may emerge at different times.

Disaster highlights three broad groups of vulnerable: those with pre-existing vulnerabilities; those who become vulnerable as a direct result of the disaster; and those who become vulnerable as recovery proceeds.

From the latest CERA Wellbeing Survey (April 2013), the following population groups were identified as vulnerable and most likely to have identified themselves as experiencing stress always or most of the time:

- people living in temporary accommodation (38%)
- people with a health condition or disability (33%)
- Māori (29%)
- people aged 35–49 years (28%).

Quality of life

The CERA Wellbeing Survey of April 2013 identified three-quarters (76%) of greater Christchurch residents rated their overall quality of life positively (15% rated it as extremely good while 61% rated it as being good). Just 5% indicated that their quality of life is poor. Figure 2 shows these results broken down by the three local authority areas of greater Christchurch.
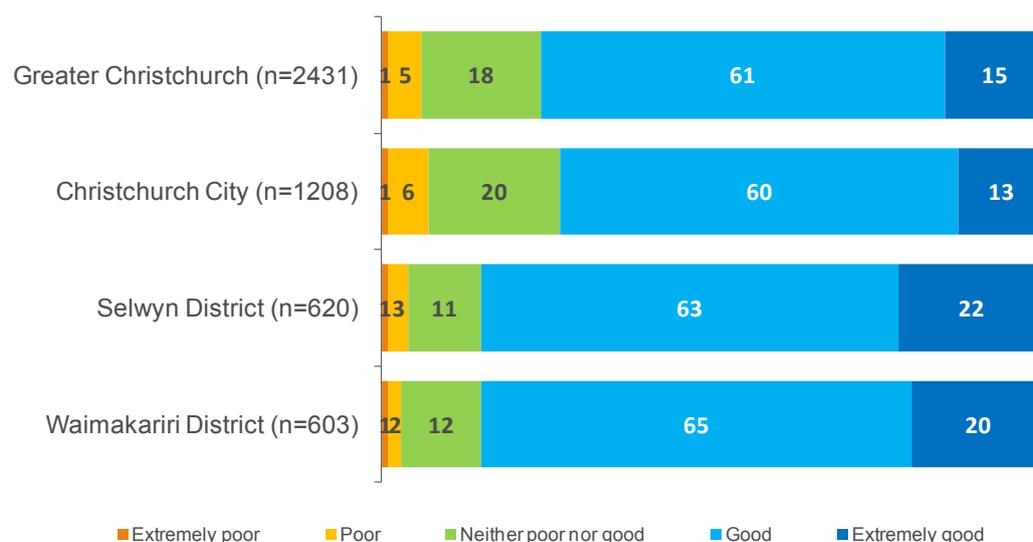
Those *less* likely to rate their overall quality of life positively were:

- of Pacific, Asian or Indian ethnicity (52%)

- living in temporary housing (54%)

- experiencing a physical health condition or disability (56%)

- from a household with an income of less than $30,000 (60%) or $30,001 to $60,000 (66%)

- renting the dwelling that they usually live in (69%)

- aged 65 years or over (70%).

Figure 2: Quality of life of residents in greater Christchurch and by city/district (%)

	Extremely poor	Poor	Neither poor nor good	Good	Extremely good
Greater Christchurch (n=2431)	1	5	18	61	15
Christchurch City (n=1208)	1	6	20	60	13
Selwyn District (n=620)	1	3	11	63	22
Waimakariri District (n=603)	1	2	12	65	20

Base: All respondents, excluding not answered

When asked whether their quality of life has changed over the last year, a quarter (25%) believed that their quality of life has deteriorated while 19% indicated that there has been an improvement. Those more likely to say that their quality of life had deteriorated were:

- living in temporary accommodation (44%)

- experiencing a physical health condition or disability (40%)

- from a household with an income of less than $30,000 (31%).

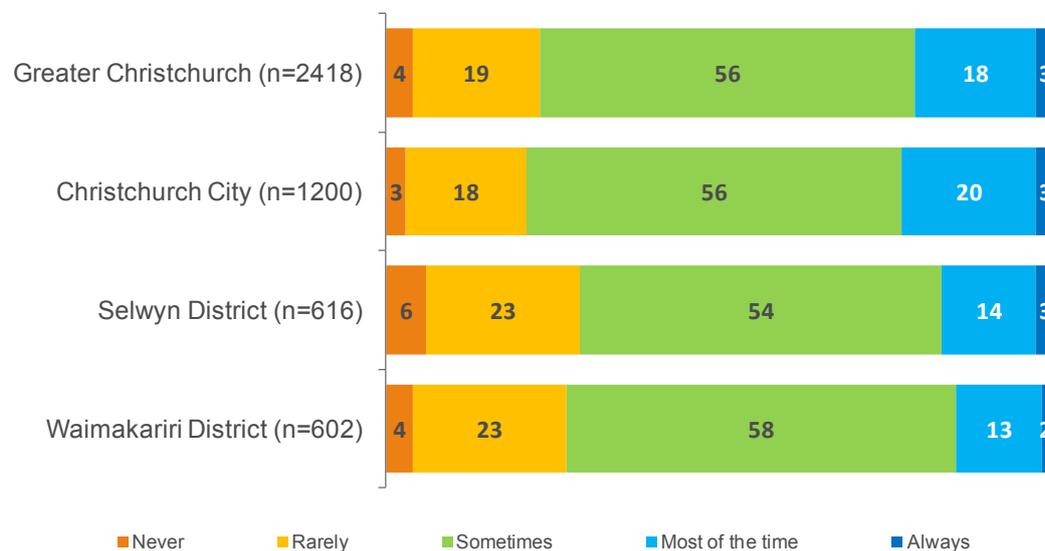## Impacts on mental wellbeing including anxiety and stress

Anxiety and stress are features of many people's lives for a long time after a major disaster. Continued anxiety means the acute stress response may continue for prolonged periods. This can lead people to feel exhausted or tired much of the time, be more irritable, have

difficulty concentrating (known locally as 'earthquake brain') and experience negative health impacts.

Stress continues to be a factor in many people's lives. In the April 2013 CERA Wellbeing Survey, 77 percent of greater Christchurch residents stated that they were negatively affected by experiences of stress in the previous 12 months. About one in five (21%) participants indicated they experienced stress always or most of the time during this period (Figure 3). Many respondents indicated that they had taken advantage of the support services available.

Figure 3: Experience of stress with a negative impact, in the past 12 months, among residents of greater Christchurch and by city/district (%)

	Never	Rarely	Sometimes	Most of the time	Always
Greater Christchurch (n=2418)	4	19	56	18	3
Christchurch City (n=1200)	3	18	56	20	3
Selwyn District (n=616)	6	23	54	14	3
Waimakariri District (n=602)	4	23	58	13	2

Base: All respondents, excluding not answered

A significant number of residents experienced stress in the short term following the earthquakes. However, it is often not until two to three years a disaster that longer term mental health and relationship issues begin to emerge. After two years, many people and communities are only just entering the window where meaningful recovery begins. Five years after the earthquake in Kobe, Japan, mental health issues were still paramount.

Gordon (2013) suggests that the following features may appear to different degrees in the second to fourth years following a significant natural disaster:

- physical health problems result from not taking care of self; having maintained rigid perseverance or focus on particular things
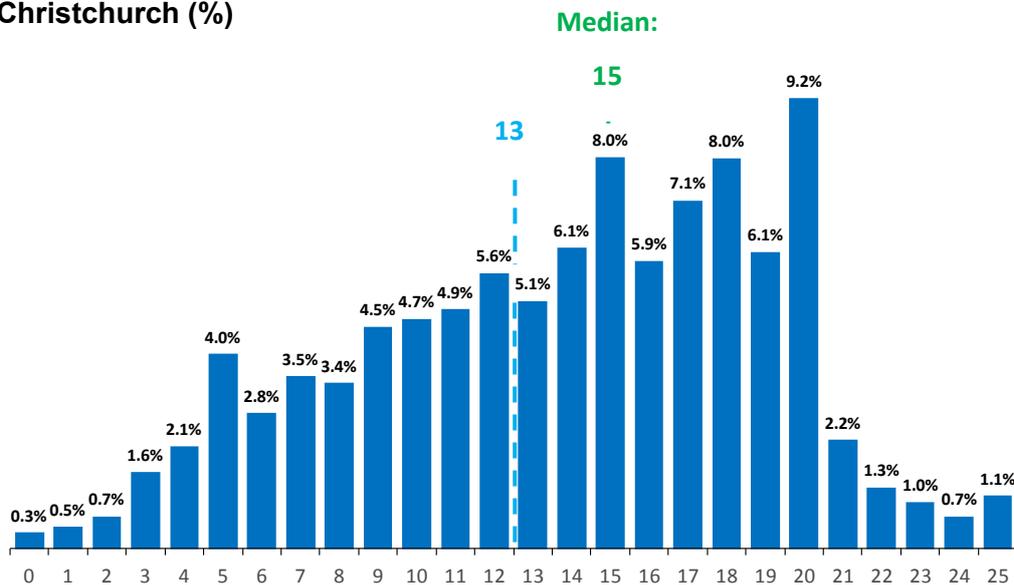
- decision making is impulsive or poor
- people accept a new lifestyle with degraded quality of life
- relationships reach a crisis point as partners run out of patience
- developmental problems appear in children
- the affected community that felt together now has people at different points of recovery
- people become more judgemental and critical of others as differences emerge
- conflict, frustration, hostility and rivalry feature, reflecting the differences in experiences, losses, geographical locations, insurance arrangements, tolerances and so on.

The WHO-5 (Bech et al 1996) is a self-rated measure of emotional wellbeing scored out of a total of 25, as the highest level of emotional wellbeing. Scores between 0 and 12 are considered to indicate poor emotional wellbeing and a risk of poor mental health.

Figure 4 shows the WHO-5 scores of greater Christchurch residents from the April 2013 CERA Wellbeing Survey. The median score is 15, and 38 percent of respondents have a score of below 13.

Figure 4: Raw scores on WHO-5 measure of emotional well-being for greater Christchurch (%)

Base: All respondents, excluding not answered on any statement (n=2343)

Those living in Waimakariri district have the highest median WHO-5 score of 16, followed by Selwyn district on 15 and Christchurch city on 14. However, these results should be

interpreted with caution given there is no New Zealand norm and no pre-quake data for greater Christchurch.

In the longer term, most people who experience traumatic stress in the period after the earthquakes can be expected to recover. However, a small group will develop chronic traumatic conditions that may not be easily identified (Silove et al 2006). Much of the literature on disaster recovery suggests that mental health issues after a traumatic event on the scale that greater Christchurch has experienced can last several decades if not appropriately addressed.

It is widely accepted in academic and medical literature that trauma in childhood continues to have an impact throughout a person's life, including on their general health and wellbeing in autoimmune and inflammatory conditions and diseases (Perry 2006). Early childhood trauma has also been linked to crime, mental illness and un-employability (New Zealand Federation of Graduate Women 2009). Taking a "life-course view of child development", Jacobsen et al (2002, p18) note how a child's individual, family and communal experiences can affect that child's wellbeing and resilience throughout life.

Understanding how trauma affects children over time is important for policy makers, mental health services, parents and caregivers (Perry 2006). Commenting on the impact of Hurricane Katrina, Perry (2006) notes that mental health services need to provide appropriate interventions and responses.

Mental health issues for individuals also affect the wider community, society and economy. The economic cost of child abuse and neglect in New Zealand, for example, was estimated in 2009 at between $1 billion and $2 billion per year (New Zealand Federation of Graduate Women 2009, p 4). The economic impacts of Canterbury earthquake trauma across the region's population can also be measured, by estimating the cost-burden to society that would from not treating mental health issues. This cost could be considerable for the New Zealand economy over many generations.

For many, however, the experience of a disaster may not have a negative impact in the long term. From their research on survivors of natural disaster, Joseph et al (2004, cited in Paton 2000) conclude that while some remained traumatised three years after the event, most reported overcoming the victimising aspects of the experience. Many actually reported
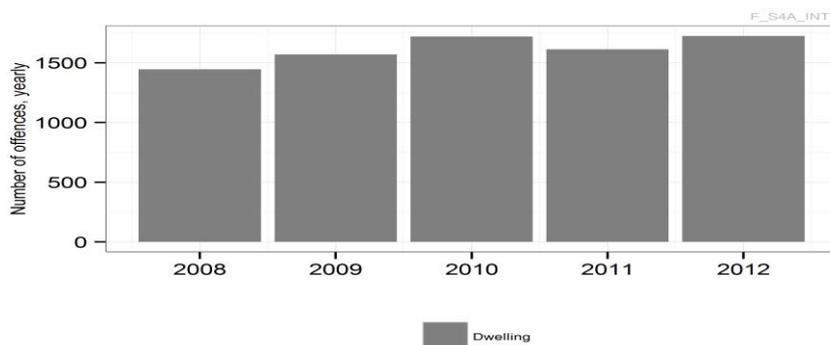
strong positive changes in their outlook on life, and over half rated their life as having changed for the better. Paton (2000) describes similar changes at a community level.

Impacts on relationships

The April 2013 CERA Wellbeing Survey found some evidence that the earthquakes affected relationships: 19% of participants reported "relationship problems (arguing with partner/friends)" and for 9% these problems had a strong negative impact. Other experiences reported were "dealing with frightened, upset or unsettled children" for 14% (with a strong negative impact for 7%) and "dealing with barriers around disabilities (own or other people's)" for 14% (with a strong negative impact for 8%).

Assaults in dwellings, as one way of measuring family violence, fluctuated over the post-disaster period. In 2011 they fell by 6.2% but in 2012 they increased by 7% (Figure 5).

Figure 5: Assaults in dwellings in greater Christchurch, 2008–2012

Impacts in the workplace

Workplace stress and fatigue have also been identified as issues related to the earthquakes (Healthy Christchurch 2011). The CERA Wellbeing Survey of April 2013 found that 26% of respondents continue to be impacted by additional work pressures, such as workplace relocation and an increase in workload as a result of the earthquakes. For 16%, these pressures are having a moderate or major negative impact on them. Impacts are felt most by higher income earners.
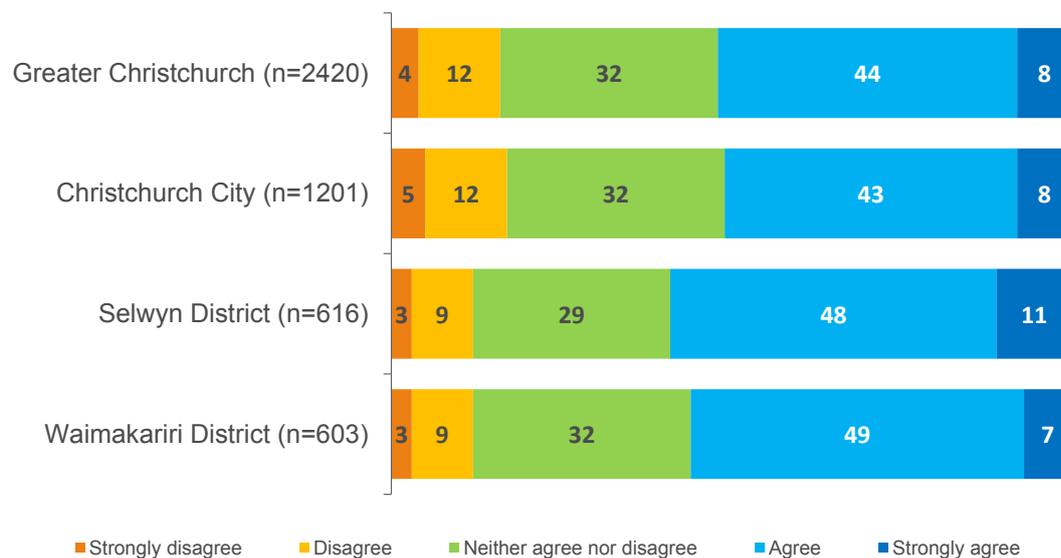
Impacts on social connectedness

The Canterbury Wellbeing Index defines social connectedness as including relationships with family, friends, colleagues and neighbours, as well as the connections people make through paid work, sport and other leisure activities, voluntary work or community service. For disabled people, the earthquakes may reduce their social connectedness to an even greater extent than usual. Providing adequate access to the built environment allows disabled people to be included in the economic and social life of the community, to make social connections and to contribute to society.

One way of measuring social connectedness is to ask whether people feel a sense of community. In April 2013, just over half (52%) of those living in greater Christchurch stated that they feel a sense of community with others in their neighbourhood (Figure 6). This proportion has fallen slightly from September 2012 when 55% agreed that they felt a sense of community with others in their neighbourhood.

Figure 6: Sense of community among residents in greater Christchurch and by city/district (%)

Base: All respondents, excluding not answered

1. For some communities, the earthquakes have weakened social connectedness. Whole communities were uprooted as people left due to damage to their homes or concerns about aftershocks. Some people felt their social networks had developed 'holes' due to people leaving (Torstonson and Whitaker 2011). Children's social networks were disturbed, with

some travelling to schools in other parts of town. Some people, particularly in the hard-hit eastern suburbs, had their lives and social connections severely disrupted (Canterbury Wellbeing Index, 2012).

Many facilities, where people used to meet and connect, were damaged and have been closed down. In the April 2013 CERA Wellbeing Survey, 43% of respondents reported they had lost recreational, cultural and leisure-time facilities (cafés, restaurants, libraries, marae, arts and cultural centres). Places for people to be, meet and do things together are important in achieving community connectedness and therefore effective psychosocial recovery.

Impacts on volunteering

Following the February 2011 earthquake, the reported proportion of greater Christchurch residents who had spent time volunteering rose to 35%. The rate has fluctuated since then but has generally remained below the rate for New Zealand as a whole (Figure 7).

Figure 7: Volunteering rate in greater Christchurch and New Zealand, 2009–2012

When comparing the rates for Canterbury and New Zealand as a whole, please note that people in Canterbury have taken part in a lot of informal volunteering since the earthquakes, which research will not have recorded.

Uptake and awareness of psychosocial services

A programme of psychosocial services has been in place to support people since the September 2010 earthquake. Both government and non-government agencies provide these

services. Many are focused on community-based early intervention to give people help and support that will prevent them from developing severe mental health conditions.

The April 2013 CERA Wellbeing Survey asked whether respondents were aware of these psychosocial services. Among the services available, the highest proportion (57%) of residents was aware of the free counselling service. Over half of residents are aware of the Canterbury Earthquake Temporary Accommodation Service and the 0800 Canterbury Support Line. The lowest level of awareness (among only 29% of residents) was for the Earthquake Support Coordination Service.

Awareness of the psychosocial services available is lowest among:
• people living in rented homes
• younger people aged 18–24 years and 25–34 years
• people of Pacific, Asian or Indian ethnicity.

The number of residents actually using these services is significant. Over 51,000 sessions of free counselling have been provided and more than 13,000 calls made to the Canterbury Support Line. Moreover, the number of people having Brief Intervention Counselling has doubled and over 7,000 households have accessed the Earthquake Support Coordination Service.

By late 2012, the demand for the mental health services had not increased significantly, in contrast to predictions. This trend indicates that the community-based psychosocial services were effective in supporting people to deal with their mental health needs at the early stage of recovery and in this way had prevented needs for more specialist services from developing. One emerging exception to this trend is that young people (0–17 years) are increasingly accessing specialist mental health services. In September 2012 there were 875 admissions of young people, up 18% from September 2011.

Positive and negative impacts

The Canterbury earthquakes have had both positive and negative impacts. According to the CERA Wellbeing Survey of 2012/2013, the three issues that have a strong negative impact on the daily lives of the greatest number of residents are: dealing with the Earthquake Commission (EQC) and other personal property and house insurance issues; making

decisions relating to house damage, repairs and relocation; and loss of recreational, cultural or leisure-time facilities (Table 1). All three of these issues are secondary stressors (refer Page 8).

In September 2012 the issue causing the greatest negative impact (on 42% of residents) was "distress or anxiety associated with ongoing aftershocks". The impact of this primary stressor has decreased significantly as the aftershocks have eased: by April 2013 only 16% of the population reported that the aftershocks had a strong impact on their lives.

On the other hand, some positive impacts have also diminished over time. Compared with April 2013, more respondents in September 2012 reported a renewed appreciation of life, more time spent together with family and pride in their ability to cope as positive impacts of the earthquakes. Similarly, in September 2012 a third of respondents reported feeling a stronger sense of community but in the April 2013 survey the proportion had dropped to one in five.

Table 1: Positive and negative outcomes of the earthquakes that have the strongest impact

Negative outcome	% who reported moderate or major negative impact	
	Sept 2012	April 2013
Dealing with EQC/insurance issues in relation to personal property and house	37	26
Making decisions about house damage, repairs and relocation	29	22
Loss of other* recreational, cultural and leisure time facilities (cafes, restaurants, libraries etc)	34	21
Being in a damaged environment and/or surrounded by construction work	30	21
Positive outcome	**% who reported moderate or major positive impact**	
	Sept 2012	April 2013
Renewed appreciation of life	45	33
Spending more time together as a family	36	27
Pride in ability to cope under difficult circumstances	41	26
Family's increased resilience	36	23

Note: * Additional questions were asked about the loss of indoor and outdoor sports facilities etc.

Section 3: Overarching framework for psychosocial recovery

Community in Mind has evolved from the initial responses of psychosocial services to the earthquakes. It fits within the broader effort focused on the recovery of greater Christchurch.

Initial responses

The National Civil Defence Emergency Management Background Document Order (2005/295) prescribed that, following a civil emergency, a Welfare Advisory Group has the role of advising the Group Welfare Manager on developing the welfare strategy and managing welfare functions in the emergency operations centre. After a civil emergency was declared in Canterbury, the Regional Commissioner for Ministry of Social Development chaired the local Welfare Advisory Group over the period of the earthquakes and the associated response.

In the civil emergency, welfare delivery operated under the following principles.

- All welfare agencies work together in readiness, response and recovery to ensure services provided are integrated to achieve the best outcomes for communities.
- The nationally coordinated welfare response must take into account local needs and processes.
- Welfare provision succeeds when it supports local arrangements and networks, restoring self-reliance as the foundation for individual and community recovery.
- Welfare agencies have pre-event continuity planning to ensure they can deliver services.
- During and following an emergency, agencies support their own staff.

The Ministry of Social Development at the time of the earthquakes was the lead agency responsible for planning the delivery of psychosocial support when assistance or support needs to be coordinated. The 2005 National Civil Defence Emergency Management Background Document Order (2005/295) stated psychosocial support involves both social support and psychological support. Particular support agencies the Order identified were district health boards, Child, Youth and Family, Victim Support, Iwi and Māori providers, voluntary service organisations and church groups. In addition, it recognised that a broader range of agencies and providers also provide support.

It is understood that, following the earthquakes in Canterbury, the civil defence responsibilities and activities are the subject of review.

CERA and the Recovery Strategy

The Canterbury Earthquake Recovery Act 2011 was passed by the New Zealand Parliament in response to the 2010 and 2011 earthquakes. The Act established the Canterbury Earthquake Recovery Authority (CERA) as a public service organisation to lead and coordinate the rebuilding of three territorial authorities – Christchurch, Waimakariri and Selwyn.

CERA developed the *Recovery Strategy for Greater Christchurch: Mahere Haumanutanga o Waitaha* (the Recovery Strategy) as a long-term strategy to guide the reconstruction, rebuilding and recovery of greater Christchurch (CERA 2012b).

The principles of the Recovery Strategy, listed below, are intended to inform all planning and implementation activities associated with the recovery.

- **Work together:** Recovery is a collaborative effort. It is essential to have constructive relationships between the private sector, NGOs, local and central government agencies, and the wider community.
- **Take an integrated approach:** Links between different recovery initiatives will be identified so that together they achieve the greatest benefits.
- **Look to the future:** Development and recovery initiatives will be undertaken in a sustainable manner. They will ensure community safety and wellbeing now and in the future. If the process of repair reveals a way of enriching people's quality of life, that opportunity will be taken.
- **Promote efficiency:** Resources will be used wisely so that the recovery is timely and affordable, and delivers value for money. A wide range of information will be collected, shared and used to help decision making, improve transparency, promote best practices and enable the public to participate in the recovery effectively.
- **Care about each other:** Recovery initiatives will take account of people's psychological, physical, spiritual and social needs. They will promote equitable outcomes and connected communities and recognise diversity.
- **Innovate:** Creative, cultural and resourceful solutions to recovery issues will be encouraged.

- **Aim for balanced decision making:** Decisions will balance action and certainty with risk. They will consider the need for positive, speedy responses and certainty; and the risk of short-term economic, environmental and social hardship and of compromising long-term objectives.
- **Keep it simple:** Communication must be clear and stick to the facts. It must give land owners, residents and businesses the information they need.

Within the Recovery Strategy are a number of Recovery Programmes focused on the different components of recovery: leadership and integration, built environment, natural environment, economic, cultural and social recovery. *Community in Mind* fits within the overarching purpose and principles of the Recovery Strategy within the social recovery domain.

The goal and objectives of social recovery that directly influence *Community in Mind* are:
- To strengthen community resilience, safety and wellbeing and enhance quality of life for residents and visitors by:
  o enabling and empowering local communities to shape and lead their own recovery;
  o growing capacity, knowledge and skills within the community to build resilience;
  o delivering community, health, education and social services that are collaborative, accessible, innovative and inclusive;
  o supporting communities as they go through the processes of resettlement.

A fifth objective, "supporting people, in particular those facing hardship and uncertainty, by providing quality housing, education and health services", will be a focus for a number of social recovery programmes within the Recovery Strategy. Specific programmes that will lead and contribute most directly to achieving this objective include: the Residential Rebuild Programme (by providing quality housing), the Education Renewal Programme (by delivering collaborative, accessible, innovative and inclusive education services) and the Health Recovery Programme (by delivering collaborative, accessible, innovative and inclusive health services).

Like psychosocial recovery, the broader recovery efforts also need to change over time (Quarantelli 1999, cited in Bidwell 2011). Phases tend to include:

- the emergency response, focused on survival and restoring essential services
- restoration and reconstruction, focused on repairing housing and infrastructure
- long-term betterment, as communities are rebuilt and the area is improved.

The significance of the psychosocial response

In considering the psychosocial response as part of the wider recovery effort, Chief Science Advisor Professor Sir Peter Gluckman declared the psychosocial wellbeing of Cantabrians to be as important for the recovery as the demolition and reconstruction of buildings, roads and infrastructure. He notes that, where conditions such as post-traumatic stress syndrome are left unresolved, the effects can continue for generations (Gluckman 2011).

The primary goal of *Community in Mind* is to identify what individuals and communities in greater Christchurch need for effective psychosocial recovery over the next three to six years.

Psychosocial principles and priority responses

This section sets out various principles of psychosocial services and responses to recovery that have been supported by research. These principles are useful in shaping an approach to psychosocial recovery, although their relevance may grow or lessen over different phases of recovery.

The Ministry of Health's principles for the response phase

In a review of the literature, the Ministry of Health (2007, p 6) identified the most probable reactions of individuals and communities to a disaster along with a set of principles to guide psychosocial responses to those individuals and communities in the response phase. The following is a summary of its findings.

- Most people will experience some psychosocial reaction, usually within a manageable range. Some may exhibit more extreme reactions in the short, medium or long term.
- Most people will recover from an emergency event with time and basic support.
- There is a relationship between the psychosocial element of recovery and other elements of recovery.
- Support in an emergency event should be geared towards meeting basic needs.
- A continuum from self-help to more intensive forms of support should be provided within a clear referral and assessment framework.
- Those at high risk in an emergency event can be identified and offered follow-up services from trained and approved community-level providers.

- Outreach, screening and intervention programmes for trauma or related problems should conform to current professional practice and ethical standards.
- Readiness activity is an important component in creating effective psychosocial recovery planning.
- Cooperative relationships across agencies, sound planning and agreement on psychosocial response and recovery functions are vital.

IASC's guidelines for psychosocial services

Now that greater Christchurch has moved from the response to the recovery phase, the guidelines developed by the Inter-Agency Standing Committee (IASC) are relevant to agencies providing psychosocial services. These guidelines set minimum standards for responses from a range of different sectors to protect and improve people's psychosocial wellbeing (Inter-Agency Standing Committee 2007). The fundamental components of these guidelines are:
- human rights and equity
- participation
- do no harm
- build on available resources and capacities
- integrate support systems
- provide multi-layered supports.

Multi-layered support, as described by IASC, consists of the following four layers of necessary service support (Figure 8).

- **Basic services and security** services, aimed at the whole of the population, generally provide information about support services and resources. They establish (or re-establish) safety and services that address basic needs.
  Canterbury examples of this type of support include the 0800 Canterbury Support Line (funded by the Ministry of Social Development) and the "All Right?" social marketing campaign (funded by the Ministry of Health) to provide self-care tools and tips to encourage wellbeing.
- **Community and family supports** are aimed at the people who are able to maintain their mental health and psychosocial wellbeing if they receive some level of support from family, neighbourhood or community contacts. Useful responses include mass communication about constructive coping methods, and starting and extending social networks such as through support groups and youth groups.

A Canterbury example is the Earthquake Support Coordination Service (funded by the Ministry of Social Development).
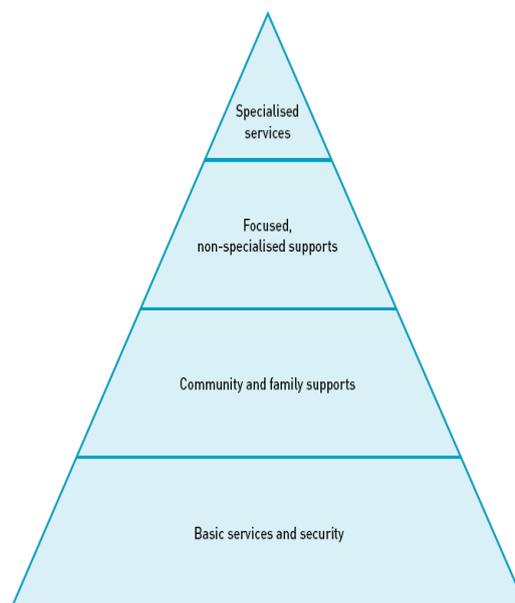
- **Focused, non-specialised supports** are necessary for a smaller number of people who require more focused interventions, at the individual, family or group level, by trained, supervised workers (ideally from within the culture or affected community).

  A Canterbury example is Relationships Aotearoa's free counselling services (funded by the Ministry of Social Development).

- **Specialised services** (psychological or psychiatric) target the small subset of people whose suffering, despite the supports at the other levels, is severe and who may have significant difficulties in basic daily functioning. This assistance includes psychological or psychiatric supports for people with severe mental disorders when needs exceed the capacities of primary or general health services.

  Canterbury examples include a range of specialised mental health services implemented in response to the earthquakes by the Canterbury District Health Board.

Figure 8: Pyramid of psychosocial support

Source: Inter-Agency Standing Committee (2007)

Principles of psychosocial recovery

In recovery, the principles of psychosocial recovery can be put to work in a variety of ways. International experts (Hobfall et al 2007) have agreed on six principles as the most useful to guide responses at the early to mid-term stages of recovery. Specifically, responses should promote:

- **a sense of safety** – providing a sense that no harm will occur and any risks are mitigated or managed
- **calming** – overcoming any sense of mistrust or animosity to achieve some composure, recognising that some anxiety continues to be a normal response
- **a sense of self-efficacy** – understanding and having confidence in one's ability to influence and effect change
- **community efficacy** – having a sense of belonging and of being an active participant in a competent, collaborative, inclusive community
- **connectedness** – feeling part of something bigger, taking a joined-up approach in which many individuals and organisations work together in a coordinated way
- **hope** – having a sense of optimism and a future orientation.

Community in Mind supports the principles of Hobfall et al (2007) as a general guide to achieving effective psychosocial recovery in greater Christchurch. At the same time, it acknowledges that as recovery progresses some of these principles become less relevant while others become more relevant. Additionally, within each of the three priorities of *Community in Mind* are contemporary good practice features of psychosocial recovery that are of particular relevance to that priority.

The Recovery Strategy principles that fit most closely with those described above are "caring about each other", "working together" and "taking an integrated approach".

Defining psychosocial recovery

Psychosocial recovery is concerned with both the psychological and social needs of individuals as part of wider communities. The psychological needs are concerned with how individuals feel, while the social needs focus on how people relate to each other (Gluckman 2011).

The International Federation of Red Cross and Red Crescent Societies define psychosocial recovery 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. (cited in New Zealand Red Cross 2012, p 21)

As Gluckman (2011) describes it, "Recovery is primarily judged in terms of people feeling that they are coping with their lives and livelihood" (p 1).

For Gordon (2013), the underlying concept of recovery is when people once again get to the point where the disaster is no longer an active focus in their lives and instead they are looking towards the goals for their future that they have chosen:

Recovery is not only about the replacement of losses but for many the disaster is a life changing experience which will mean they can never go back to exactly the life they had before so an important focus of recovery is the establishment of the basis for a new future. It is important to emphasise the idea that recovery is, in the end, the resumption of a meaningful life, as one bushfire resident said "the life you want to lead".

The above and other descriptions of psychosocial recovery have key features in common. First, achieving recovery depends on the way individual feelings, thoughts, feelings and behaviours are interrelated with a range of social factors. In addition, common characteristics of recovery include coping, regaining agency, establishing new life patterns and having a future orientation.

This report defines psychosocial recovery as being **when people and communities have established a relatively stable pattern of functioning, regained a sense of control and are oriented towards their future**.

Related documents

In May 2011, a high-level Strategic Planning Framework was provided to assist those responsible for implementing key service aspects of the psychosocial response to the Canterbury earthquakes (Ministry of Social Development 2011). It was developed through the National Psychosocial Response Subgroup with the support of the Christchurch Psychosocial Response Subcommittee and with input from a National Psychosocial Recovery Advisory. Building on some initial work undertaken post-September 2010, this framework focused on two main areas: individual recovery and wellbeing; and building

community resilience and psychosocial wellbeing. The 2011 framework provided a useful starting point for *Community in Mind*.

The associated "Strategy for rebuilding health and wellbeing in greater Christchurch" is based on *Community in Mind*. It is intended as a guide for a broad range of central and local government organisations, non-governmental organisations and community groups across the region to develop, target and coordinate their work programmes for the psychosocial recovery of greater Christchurch.

The Programme of Action will further develop the priority actions identified in the Strategy.

The Strategy and Programme of Action will directly influence the Community Resilience Programme of Work.

The six-monthly CERA Wellbeing Survey and the annual Canterbury Wellbeing Index will inform regular reviews of both the Psychosocial Programme of Action and the CERA Community Resilience Programme of Work.

Section 4: Three priorities for effective psychosocial recovery

This section describes three priorities for effective psychosocial recovery of individuals and communities in greater Christchurch:

- a community-led response in which community leaders and communities plan and initiate actions for recovery
- innovative service provision in which innovative support services are available for those who need them, with targeted services for those most in need
- communication and engagement between the service response, the self-organising responses and individuals and communities.

The development of these priorities began with a series of semi-structured focus groups, where people from a range of backgrounds discussed issues related to psychosocial recovery. Their responses were then examined using emergent inductive analysis to identify the three priorities set out in this section. Semi-structured, in-depth interviews with informants experienced in psychosocial research and/or recovery helped to add to and refine understanding of each priority, with their responses incorporated where relevant. Another important source of information was a literature review on the priority areas identified, which covered both peer-reviewed publications and informally published 'grey' literature. (See Appendix 1 for more information on the methodology and design of this research.)

In combination, these methods developed the understanding of what is needed in addressing each of these priorities to achieve an effective psychosocial recovery. This understanding is explained in this section.

Priority One: Community-led response

Kaupapa 1: Mō te hapori, mā te hapori

Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed it is the only thing that ever has.

- Margaret Mead.

Effective psychosocial recovery of individual and communities in greater Christchurch involves positive, inclusive, self-organising, diverse, satisfying and often spontaneous responses at neighbourhood and community levels.

Localised, community-led responses are an important part of achieving psychosocial recovery. In a recovery environment, the best comfort comes from people who survivors know and who share their culture, beliefs and values (Silove et al 2006).

People get a sense of community from bonding with other members of their group or local area, from having a shared concern for community issues, and from having a sense of connection with and concern for others (Norris 2005). Immediately after a disaster, as communications are disrupted, people focus on the immediate problems and their family connections, which can lead to social "de-bonding" (Gordon 2004d). This phase does not usually last long, unless many people have been dislocated from their communities, such as when they leave the area temporarily or permanently.

> *"In Kobe, people died from broken hearts; a phenomenon known as Kodoku shi or lonely deaths, as a result of losing their social connections."*
> Daniel Aldrich

A natural disaster can also have positive effects on communities. Gordon (2006) describes how spontaneous altruistic behaviour, as was seen in the weeks and months after the earthquakes, helps to strengthen pre-existing social networks and to break down barriers between groups and individuals. Communities (and neighbourhoods) that were functioning well before the earthquakes have generally responded and recovered more quickly than those with few previous social connections (Thornley et al 2013). Communities can be encouraged to build their resilience through:

- supporting people to work together
- fostering positive community action
- promoting activities that support people to volunteer and encourage communities to become more connected and neighbourly.

> *"Sense of hope is really important for people's recovery."*
> Extract from Focus Group, 2013

Neighbourhoods can influence residents' health and wellbeing positively or negatively. Social fragmentation in a neighbourhood is a risk factor for poor mental health. Some of the factors that can contribute to neighbourhood fragmentation are: limited means of communication (which generally happens through interaction); low levels of attachment (through lack of involvement in social networks and ties); and few social resources that foster social interaction (Ivory et al 2012).

Conversely, as Diers (2006) has observed, "neighbourhoods and communities are not simply places with needs but also communities of people with tremendous resources". Moreover, disasters and their aftermath commonly bring out the very best in people and communities: generosity, resourcefulness and a desire for social engagement (Solnit 2009). As Stone (2008, cited in Solnit 2009, p 197) describes it, for most people altruism is "a two-way street; a giving and receiving at the same time". Helping gives the helper a sense of connection with other people, a sense of being part of something larger than themselves and a sense of purpose. Communities are restored in a context of possibility, generosity and gifts, rather than fear, mistakes and self-interest (Block 2008).

> *"The best things are when cohorts of people come together and rely on / lean on each other."*
> Daniel Homsey

Gordon (2013) suggests that a major focus within recovery needs to be on maintaining and protecting the quality of life for those involved in recovery so that they preserve the activities, values and relationships that give their lives meaning. Similarly, Block and McKnight (2010) challenge approaches that focus solely on defining needs and figuring out how professional service organisations (both government and non-government) can fix those needs. Rather, Block and McKnight support a focus on families, neighbourhoods and communities, considering their strengths and how they can and do care for each other and meet the human needs of their members.

> *"Best predictors of recovery are strong community connections."*
> Daniel Aldrich

Putnam (1993, cited in Block 2008) undertook extensive research on community wellbeing to find out why some towns have better health, wellbeing and educational outcomes. He found that the difference lies in social capital: the quality of the relationships and the cohesion

among citizens. Specifically, the more successful towns had more social capital than the less successful ones. As Aldrich (2012) argues, the extent of social capital – more than the actions of politicians or bureaucrats – determines the differences in neighbourhood and community recovery over the medium to long term: "Areas with greater social capital can overcome obstacles to collective action that often prevent groups from achieving their goals" (p 13).

Community leadership

"People should have an active role in making decisions, not just being informed about decisions."
Daniel Aldrich

An adaptive community can act to reduce the vulnerabilities and increase the resilience of the people within it (Bronfenbrenner, cited in Britt et al 2012, p 8). How adaptive a community is can only really be measured by its actual response to change. However, some informative characteristics are local leadership, communication channels within the community, and the community's ability to organise itself (Maguire and Cartwright 2008; Britt et al 2012). Paton (2000) suggests informal community leadership is helpful in building social capital and community resilience. He reports that using community resources to make a community more adaptive is more effective than imposing institutional decisions on a community.

"Stop focusing on self-proclaimed community leaders and start providing communities with leadership training."
Jim Diers

Bornstein (cited in Block 2008, p 27) has pinpointed common features of the most successful social innovations: they begin with little money, deeply committed leadership, and a commitment to making a difference in the lives of as many people as they are able to reach.

Community groups and neighbourhood networks

"Social networks are more important than aid, than wealth, than the level of physical damage, than governance."
Daniel Aldrich

Community-based social networks and social dynamics are helpful in building social capital and community resilience. During the 1995 heat wave in Chicago, for example, neighbourhoods whose members participated in community life and so had more social contact were significantly more likely to experience better outcomes, including lower death rates, than other neighbourhoods (Klinenberg 2002).

Neighbourhoods and communities often respond to the opportunities and threats created by a disaster in innovative, spontaneous ways. Initiatives where survivors begin working together and trusting each other can connect people in a positive way and re-establish a sense of place following the losses that a community has experienced (Prewitt Diaz and Joseph 2008).

According to Gordon (2004d), it is helpful to continue to support new, self-determined structures and groups in the community and to make it easier for the groups that are established to communicate with each other. Creating opportunities where people share experiences and anecdotes supports them in gaining perspective. Spontaneous altruistic behaviour helps to strengthen pre-existing social networks and to break down barriers between groups and individuals (Gordon 2006). This effect was confirmed in greater Christchurch as neighbours assisted others and worked together. Even 15 months after the February earthquake, neighbourly support continued through spontaneous gatherings in backyards and on street corners (Thornley et al 2013).

> "Fantastic to see the participation in community events."
> Extract from Focus Group, 2013

Community planning, community action, activities and resources

> *"Important that people have a sense of control."*
> Extract from Focus Group, 2013

In Gordon's (2004d) experience, promoting community-based events, including cultural events, is beneficial. Mobilising a community builds capacity, allowing communities to put their own initiatives into action. When a community plans its own activities, people gain more opportunities to express themselves (Prewitt Diaz and Joseph 2008). They are effective as a group when they share a willingness to work for the common good of their neighbourhood (Norris et al 2007). Thornley et al (2013) found that communities characterised by cooperative networks, a sense of belonging and strong links to services before an

earthquake responded with the same community networks of care and support for recovery and revitalisation after a disaster. In this way, the Canterbury earthquake experience led to "stronger collaborations between community organisations, and new networks and partnerships" (Thornley et al 2013, p 25). Because supportive relationships with other affected people as well as with those who are part of the service response are helpful to recovery, an important goal should be to encourage people to support each other (Boyd et al 2010, cited in Mooney et al 2011).

> *"It's important to engage with community members and not just community groups and community leaders but people who live in communities, people who may not usually participate."*
>
> Daniel Aldrich

Mapping of assets is a useful way to identify the strengths of individuals, groups and organisations, as all neighbourhoods – no matter what their problems – can build from a position of strength despite their problems and communities can benefit from the opportunities that come with change (Paton 2006, cited in Maguire and Cartwright 2008). The asset-based approach sees abundance in the community and, in this sense, is consistent with the mental health notion of resilience as a set of inner strengths (Torjman 2007, p 13). As Paton suggests (2006, cited in Maguire and Cartwright 2008), "Social resilience is more than merely returning to a previous state, it includes the capacity of people and communities to learn and/or to recognise and benefit from the new possibilities that change brings" (p 9).

Inclusiveness is another important aspect of community initiatives and community planning and action (Ministry of Social Development 2011). This approach avoids marginalising particular population groups in the community recovery. It also avoids exacerbating inequalities that already existed before the disaster, which is critical because disasters do tend to exacerbate existing inequalities. So in Canterbury, populations that were marginalised before the earthquakes through such factors as lower socioeconomic status may continue to be marginalised afterwards. For example, residents in the eastern suburbs observed that fewer portaloos were supplied in their suburbs than in other city areas, underlining their economic marginalisation (Lambert 2012).

> *"Some communities need extra capacity."*
>
> Extract from Focus Group, 2013

If communities are to be empowered to contribute to the recovery, as Collins et al (2011) point out, they need resources and support so that they can "develop processes and systems to respond to and contribute to the formal and informal recovery processes" (p 19). Accommodating spiritual and cultural expectations and practices is also recognised as valuable in the recovery process, allowing people to give meaning to their experience (Mooney et al 2011).

Physical spaces for communities to be, meet and do

"Create opportunities and gathering places to come together."
Jim Diers

One impact of a disaster is that communities lose shared physical spaces and assets such as infrastructure (Davidson and McFarlane 2006). Re-establishing a sense of place is important. For example, during the response of the American Red Cross to the 2004 tsunami in Banda Aceh, "the re-establishment of a sense of place and the development of an individual and group sense of community came as a result of psychosocial support activities over a span of two to five years" (Prewitt Diaz and Joseph 2008, p 822).

"More opportunities for community-based activities and giving support."
Extract from Focus Group, 2013

Volunteering

"Any activities that provide volunteering also increase community connectedness."
Daniel Aldrich

Having volunteers in communities and a diverse range of engaged citizens is a sign of a strong, healthy and resilient community (Sladowski et al 2013). Providing opportunities to volunteer builds individual and collective capacity and helps to identify and develop community strengths. Where people feel unable to move forward, being part of positive collective action can be a cathartic experience. These types of systems become a virtuous cycle, creating larger pools of volunteers and more participants.

Key factors in building a resilient community, in which volunteering is common practice, have been identified by Becker et al (2011) as:

- self-efficacy and collective efficacy

- expectations of positive outcomes
- critical awareness
- problem-focused action
- competent and skilled leadership
- active community participation
- ability to describe and discuss community issues
- a planned response to emergencies
- a sense of community and a positive sense of attachment to place
- feeling empowered
- having trust in relevant individuals and organisations
- positive attitudinal and behavioural norms
- responsibility for emotions and feelings of self and others
- previous experience of disasters
- sufficient resources and psychological preparedness and resilience.

> *"Government should not disenfranchise community from their responsibility to each other but rather should amplify the opportunities."*
> Daniel Homsey

To achieve successful community outcomes, including widespread participation and volunteering by community members, Diers (2012) suggests both government and communities need to change the way they have traditionally behaved at neighbourhood and community levels:

> … for government, the change involves: recognising that neighbourhoods and communities have skills and strengths to contribute; moving beyond the notion of delivering services to customers to a community empowerment approach; and providing neighbourhood and community members with resources, tools and training rather than focusing on self-proclaimed community leaders and community representatives.

> For communities, the paradigm shift involves starting to think and act as citizens rather than customers or ratepayers and communities taking their own share of responsibility; and not waiting for government to do what they can do for themselves. Communities can make themselves strong partners for government by making it a priority to build broad and inclusive community participation in neighbourhood and community groups

and to work collaboratively with other community groups and neighbouring communities. (Diers 2012)

In keeping with such changes, key informants suggested that organisations with leadership roles in recovery could delegate tasks to communities and community groups wherever possible. They also described bottom-up community planning as valuable for achieving sustainable solutions.

"Support volunteer-based community groups to make sure they don't fall over."
Extract from Focus Group, 2013

There is a risk that volunteers in the community and community groups can work in 'silos', disconnected from the activities of each other and of other organisations. In a recovery environment, Gordon (2013) suggests, a useful way of avoiding such silos – and the antagonism and conflict that can come from this way of working – is to actively ensure the coordination of groups as part of a network that includes government, NGOs and community. Having an overarching inclusive coordination mechanism in which all are invited to participate, in Gordon's view, provides a better foundation for relationships between the different parties involved in the response efforts.

"Coordination of volunteer groups as part of a network that includes government, NGOs and private enterprise."
Dr Rob Gordon

There are many examples of community efforts that contribute significantly to recovery. According to Freedy et al (1992, cited in Gordon 2004d), the organisation and processes of the social environment hold the greatest potential for personal recovery, for mitigating the impact of stress and trauma and for influencing health and wellbeing in the aftermath of a disaster.

"Live a life that is valued. Live a life with hope."
Extract from Focus Group, 2013

Defining features of an effective community-led response

Focus groups identified the following as features that help a community-led response to be effective:

- positive, inclusive activities and processes build on assets and strengths

- volunteer-based social networks and community groups are in operation and new ones are formed
- community-initiated activities foster community participation, connectedness and mutual support
- positive relationships and connections are established and maintained with and between individuals and groups
- capacity building is available for community leaders
- tools and resources build community skills and capability
- collaborative partnership opportunities and mechanisms provide interaction and knowledge sharing between those delivering services and those implementing community responses
- physical places and spaces available for communities to be, meet and do things together.

Effective responses to date

Particular responses in Canterbury that focus groups and key informants identified as examples of effective community-led responses include:

- Gap Filler, an initiative focused on using temporarily vacant sites for a variety of community art projects
- Kirwee Neighbour Support and phone tree
- Farmy Army, comprising volunteers from the Canterbury farming community
- Student Volunteer Army, which organised the efforts of volunteers who had emerged to assist with shovelling liquefaction and to use their skills to entertain children
- Greening the Rubble project for planting and landscape design of selected sites around the city
- Ministry of Awesome, funded by a community trust to support individuals and groups wanting to foster local and city-wide initiatives
- Lyttelton Time Bank
- wellbeing visits by local churches and community groups.
- Canterbury Communities' Earthquake Recovery Network (CanCERN).

Recommended goals for community-led recovery

Positive, inclusive, self-organising and often spontaneous, diverse and satisfying responses at neighbourhood and community levels are an important priority for effective psychosocial recovery.

The specific goals recommended for this priority area are that:

- communities have the capacity to lead their own recovery

- existing and emergent community groups and networks have information and support

- volunteers and volunteerism are actively encouraged

- positive and inclusive community action and activities connect people and build resilience

- influential community-based planning opportunities are well attended

- spaces are available for communities to be, meet and do

- community building tools and resources are accessed

- collaborative leadership development and joint learning opportunities are available and well used.

Priority Two: Innovative service provision

Kaupapa 2: Ratonga hapori

Leaders of successful collective impact initiatives have embraced a new way of seeing, learning, and doing that marries emergent solutions with intentional outcomes.
 - John Kania and Mark Kramer

Effective psychosocial recovery of individuals and communities in greater Christchurch involves an innovative service response that is strengths-based, collaborative, coordinated, reliable, accessible and adaptable.

This second priority is concerned with providing innovative support services for those who need them, with targeted services for those most in need.

Cross-sectoral collaboration, coordination and integration

> *"Cross-sectoral collaboration has been extremely useful."*
> Extract from Focus Group, 2013

Effective large-scale social responses require broad cross-sector coordination and a common agenda for addressing a specific social issue (Kania and Kramer 2011). It is advantageous to improve all parts of the service continuum rather than one single point of it, and to focus the whole continuum on a single set of goals measured in the same way.

> *"Funding should be contingent on collaboration."*
> Chris Jansen

Mooney et al (2011) suggest that the services people need are part of an overall service system and must be provided in a coordinated and integrated manner. Without the active collaboration of all involved, psychosocial support will be imposed on the community, rather than established in a more consultative way, and will therefore be less sustainable and less beneficial. Collaboration extends to working closely with the affected community. Given communities that already have cooperative networks, a sense of belonging and strong links to services can put them to use in recovering from a disaster (Thornley et al 2013), it follows

that recovery can be achieved faster and in a more sustained way by promoting local empowerment and engagement.

A cross-sectoral way of working helps to engage multiple perspectives and to provide multiple information sources for planning, funding, delivery and monitoring.

> *"Sharing workspaces and working together building real collaborations."*
> Extract from Focus Group, 2013

As key informants observed, in genuine cross-sectoral collaboration a single organisation does not dominate to the exclusion of others, and openness and transparency are important. Key informants also suggested collaboration is a powerful tool in advocating for change or for support to an agreed course of action. They emphasised that service delivery organisations should not do for communities what communities can do for themselves. Therefore before mobilising a service response, organisations should consider whether the response that is needed is best led by the community or service organisations.

An adaptable approach

> *"Services being flexible to meet people's individual needs."*
> Extract from Focus Group, 2013

Adaptability is another significant component of an effective service response. Services need to respond to an individual's particular and distinctive set of needs and to the specific needs of different vulnerable groups. Agencies can respond more effectively when they:

- work from the strengths of the individual, their family and whānau
- involve the individual in the process of reaching out for help and support them to identify and access appropriate services
- encourage a sense of self-efficacy – the individual's belief in their own ability to succeed and to do things for themselves competently.

> *"Don't make communities dependent."*
> Jim Diers

A strengths-based approach

> *"Services focusing on strengths and not the deficits of people."*
> Extract from Focus Group, 2013

Benefits for individuals come from using a strengths-based approach that focuses on empowerment and resilience, and using individuals' own capacities and resources (Mooney et al 2011).

> *"Recognises that community members have valuable expertise."*
> Jim Diers

Block and McKnight (2010) encourage a focus on strengths in providing support to families, neighbourhoods and communities. They suggest actions can be taken to support families, neighbourhoods and communities to connect and care for each other.

Accessible services

> *"Services using different points of connection to get in touch with people to let them know about their service."*
> Extract from Focus Group, 2013

Access to social support, services and resources is linked to positive outcomes (Fawcett et al 1998). Services need to be accessible at the community level; people need to know about these services and how to access them. A variety of information channels can be used, including channels that people are most familiar with and/or trust, such as places people go to or media they use as part of their day.

A common agenda

> *"Community can't partner with the government when it is divided by functions, so develop a more holistic community-based approach."*
> Jim Diers

When a large-scale social response is required, as in greater Christchurch, agencies are effective if they share a common agenda (shared vision and joint approach) to address the specific social issue and coordinate a broad cross-sectoral effort to achieve that agenda (Kania and Kramer 2011).

In discussing the key conditions that services need in order to have a positive collective impact, Kania and Kramer (2013) propose that they should have:

- a common agenda – a shared vision and joint approach rather than different organisations pursuing their individual agendas
- shared measurements – consistent data collection across all organisations
- mutually reinforcing activities – different activities within a mutually reinforcing plan of action
- continuous communication – consistent and open communication to build trust and common motivation
- backbone support – a structure to coordinate participating organisations.

> *"In some instances the school, the Ministry of Education and some NGOs were all working together delivering better integration of services to resolve problems."*
> Extract from Focus Group, 2013

Dealing with secondary stressors

> *"Working with individuals to support them and also to connect them in to their own communities."*
> Extract from Focus Group, 2013

Secondary stressors (the circumstances indirectly related to a disaster) have a significant impact on individual recovery (see Section 2). Part of an effective service response, therefore, is to reduce that impact by prioritising delivery of appropriate and timely responses to the stressors.

Responsive services

If it is to be appropriate, the mental health service response needs to match the cultural context and needs of victims, which will depend on both the impact of the disaster and the unique vulnerabilities of special populations within affected communities (Davidson and McFarlane 2006). As Davidson and McFarlane (2006) argue, the best way to achieve an appropriate response is to involve the community in evaluating its own needs and determining which activities are most appropriate. Providing appropriate supports to affected populations during recovery is an important factor in achieving positive outcomes (Palm et al 2004, cited in Mooney et al 2011).

> *"Organisations need to understand the stress their behaviour and decisions are causing."*
> Extract from Focus Group, 2013

Monitoring and assessing

"Services responding to real-time information and trends and adapting to meet the different needs."

Extract from Focus Group, 2013

Also important to achieving positive outcomes is ongoing monitoring and assessment over several years to respond to any distress that emerges as time goes on and the ongoing recovery needs of communities (Galea et al 2008, cited in Mooney et al 2011).

The workforce

"Recognises that government staff have got valuable expertise."

Jim Diers

While much of the focus of psychosocial recovery is on people who receive psychosocial services, staff providing those services also need to be considered. Frontline staff need support (Palm et al 2004, cited in Mooney et al 2011), which can strengthen the recovery effort over the longer term.

Lee et al (2013) suggested that one of the key reasons why organisational resilience is important is "because community and organisational resilience are interdependent" (p 30).

Defining features of innovative service provision

Focus groups identified the following as features of innovative service provision:

- there is collaborative leadership
- adaptable, flexible strengths-based services respond in a timely way to real-time trends and service demands
- there is collaborative service planning, funding and delivery
- emerging needs are monitored, outcomes are evaluated and knowledge is shared
- funded services actively promote self-efficacy, natural social relationships and building connections at a neighbourhood/community level as part of their service delivery model
- innovative and successful initiatives are identified and supported
- accessible and responsive services target those most in need
- simple, straightforward referral pathways and service information are available, using natural, trusted communication channels

- barriers to recovery (eg, secondary stressors) are reduced
- staff involved with psychosocial service provision at all levels are well supported and resilient.

Effective responses to date

For focus groups and key informants, the most effective services in recovery are collaborative, strengths based, well coordinated, innovative and adaptive, and take a holistic approach. Particular services they identified as containing at least some of the central features of an innovative service response include:

- Earthquake Support Coordination Service
- 0800 Canterbury Support Line
- free counselling provided through Relationships Aotearoa
- Canterbury District Health Board's post-traumatic stress response
- Pegasus model of counselling and mental health support through general practitioners (including Brief Intervention Counselling)
- Families of the Bereaved response managed by the Ministry of Social Development in partnership with the Canterbury District Health Board and a number of NGOs
- Red Cross grants and outreach
- Victim Support's initial support to families and whānau of the bereaved.

Recommended goals for innovative service provision

Effective psychosocial recovery of individuals and communities in greater Christchurch involves innovative service provision that is strengths-based, coordinated, consistent, reliable, accessible and adaptable.

The specific goals recommended for this priority area are that:

- service planning, delivery and funding work from collaborative and innovative models that are coordinated, accessible and adaptable and build on strengths
- data and trends are actively monitored to inform understanding, planning and responses and this information is shared with communities
- targeted responses to emergent trends and to those population groups most in need are provided
- successful initiatives for individuals and communities are identified and supported
- service delivery is based on a strengths-based practice model that promotes self-efficacy

- organisations and communities gather information and share it with each other
- workforce resilience is maintained
- performance and outcomes are regularly monitored and evaluated.

Priority Three: Communication and engagement

Kaupapa 3: Taumata korero

While visions, plans, and committed top leadership are important, even essential, no clear vision, nor detailed plan, nor committed group leaders have the power to bring this image of the future into existence without the continued engagement and involvement of citizens.
- Peter Block

Effective psychosocial recovery of individuals and communities in greater Christchurch involves communication, interaction and engagement between the service response, the self-organising responses and individuals and communities.

Engaging the community in the process of recovery is important to an effective psychosocial recovery following a disaster (Attree et al 2011, cited in Collins et al 2011; Thornley et al 2013). Actively engaging citizens as "shapers of their communities and of their own future" (Torjman 2007, p 3) promotes individual and community resilience. As key informants observed, community participation in decision making gives people a sense of agency and a sense that they can positively contribute to some aspect of their life, at a time when many feel powerless.

Moreover, the nature of that engagement is critical to its success. Rather than simply inviting the community to take part in discussion, Biedrzycki and Koltun (2012) argue, it is necessary to:

> acknowledge and emphasize community knowledge and other assets, as well as enacting a truly collaborative process between all stakeholders. This requires early and sincere outreach, reflective listening, demonstrating patience in relationship-building, acknowledging deficits, practicing transparency in process, sharing the true rationale behind the policy, and equitable evaluation of progress toward mutually agreeable goals. (p 2)

Responsible agencies need to listen to and acknowledge community concerns and actively consult communities to allow people to express their concerns (Gordon 2004d). Similarly, Paton (2000) comments that planners at an institutional level should promote empowerment and find ways to facilitate a meaningful interaction with community members.
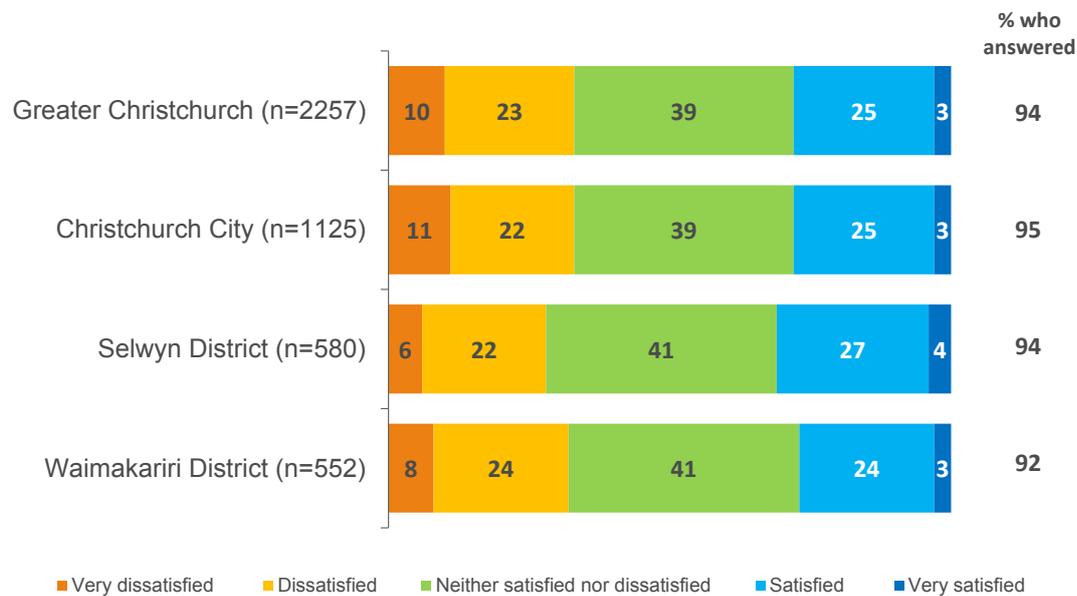
The process of engagement leads to tensions and sometimes conflicts. If agencies and communities work together on a recovery effort in which leadership and coordination are shared, potential areas of tension include, for example, those "between hurrying to achieve short-term goals and taking more time to achieve a longer-term goal; between local and national interests; and between commercial and public interests" (Gluckman 2011). Although tensions are inevitable, engagement can continue to be effective if they are handled transparently and with sensitivity, and by involving the community openly in resolving them.

In the April 2013 CERA Wellbeing Survey, 28% of residents said they were satisfied or very satisfied with opportunities the public has had to influence earthquake recovery decisions, 33% were dissatisfied or very dissatisfied and 39% were neutral (Figure 9). Satisfaction levels were lower than in the September 2012 survey.

The April 2013 CERA Wellbeing Survey also found mixed results on people's confidence in the decisions and communications of agencies involved in the earthquake recovery. In all, 38% were not confident that decisions were in the best interests of greater Christchurch compared with 30% who were confident about those decisions. Satisfaction with the information about earthquake recovery decisions was likewise split (33% satisfied, 29% dissatisfied). In regard to communications from CERA specifically, over twice as many respondents were satisfied (37%) compared with those who were dissatisfied (16%).

Figure 9: Level of satisfaction with public's opportunities to influence earthquake recovery decisions, among greater Christchurch residents and by city/district (%)

% who answered

	Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied	% who answered
Greater Christchurch (n=2257)	10	23	39	25	3	94
Christchurch City (n=1125)	11	22	39	25	3	95
Selwyn District (n=580)	6	22	41	27	4	94
Waimakariri District (n=552)	8	24	41	24	3	92

■ Very dissatisfied ■ Dissatisfied ■ Neither satisfied nor dissatisfied ■ Satisfied ■ Very satisfied

Base: All respondents, excluding those who said don't know - Excluding NA

Providing psychosocial and other information

"Positive stories getting told, working with the media."
Extract from Focus Group, 2013

It is very important to exchange psychosocial information, share knowledge and learn about psychosocial recovery. Specifically people and communities need psychosocial information about:

- the normal range of feelings, emotions and other psychological effects people can expect to experience at different stages after a disaster (Gluckman 2011)
- explanations of post-disaster social processes so that people are less likely to personalise negativity (Gordon 2004b)
- how to access psychological assistance when necessary, with straightforward referral pathways (Gluckman 2011)
- community narratives and stories of hope, which help to develop a shared sense of purpose and meaning (Collins et al 2011) and foster the interactions between government agencies and communities
- issues and trends related to psychosocial recovery, which have been identified through monitoring (Gluckman 2011).

"Good to tell people about emotional supports available."
Extract from Focus Group, 2013

"Need clearer pathways about who to talk to."
Extract from Focus Group, 2013

More generally, providing relevant, accurate information about all aspects of the disaster recovery promotes common understanding and collective identity and allows people to make better decisions (Gordon 2004a). It also reduces daily stressors (Prewitt Diaz and Joseph 2008). In addition to psychosocial information, the literature has identified the following as other forms of information that help with psychosocial recovery:

- clear information on reconstruction and rehabilitation plans (Gluckman 2011)
- how governance arrangements can help with local engagement and empowerment (Gluckman 2011).

Gordon (2004a) noted that communication is more effective when precise factual information is communicated repeatedly.

"Honesty is required to give realistic timeframes for people."
Extract from Focus Group, 2013

Conversations and shared stories

Also useful are conversations at neighbourhood and community levels, in which people can share their stories and hear about how others have managed. These conversations give members of the community the opportunity to talk through the issues and think through the challenges and problems they are facing together.

Social marketing

"More information needs to be put out."
Extract from Focus Group, 2013

Social marketing has been proven to influence behaviours and attitudes and is an important tool for communication in the psychosocial recovery environment. In particular, the Five Ways to Wellbeing is an evidence-based set of public health messages aimed at improving mental health and wellbeing of the whole population. The messages were developed by the

New Economics Foundation in the United Kingdom and have relevance in a recovery environment. The Five Ways are:

Connect: with people around you

Be active: go for a walk or run

Take notice: be curious

Keep learning: try something new

Give: do something nice for a friend or stranger. (New Economics, n.d.)

Key informants highlighted social marketing and public messaging as two valuable ways of normalising people's experience and providing useful and practical tips on how people can help themselves.

"Too much jargon; simple language is important."
Extract from Focus Group, 2013

Making engagement happen

"We need to communicate with people and tell them about how they can put their ideas forward."
Caroline Bell

Gluckman (2011) highlights that agencies need to promote local empowerment and engagement by working with the affected population in a collaborative way.

A commitment to including and engaging diverse stakeholders in community planning processes is important (Federal Emergency Management Agency 2011). In Canterbury "emergent community groups were formed and initiating contact with Councils and agencies with requests for information and participation in the recovery processes" (Collins et al 2011, p 22).

When communities are not engaged in recovery there are clear negative consequences. Gordon (2004d, p16) describes the result as an "emergence of cleavages" when "social, political, ethnic, cultural and economic 'fault lines' reassert themselves". Failing to engage communities can delay the recovery phase and increase anger and frustration (Gluckman 2011). The All Right? Wellbeing Campaign research report identified that "people felt disempowered, resulting in stress, frustration and anger. People felt they were 'forgotten' or 'secondary' in the recovery" (Ministry of Health 2013, p 7).

As Vallance (2011, p 21) noted, there is a subtle distinction between "pre-existing communities that can be engaged with, and emergent communities that may need to be engaged". From her research, she has advised that it cannot be assumed that authorities are willing or have the capacity to effectively engage with a public who is also willing and able to participate. These points raise questions about both how to create opportunities for genuine engagement and how community groups themselves can use the opportunities presented in disaster recovery to come together to build and use social capital.

Key informants discussed the need to provide opportunities for genuine community engagement in decision making about recovery. The engagement itself needs to be deliberate and sincere. Key informants were clear that agencies should avoid token approaches; for example, holding a one-off event that not everyone knows about or can attend, and from which no feedback goes back to the community. Because community meetings are not always useful mechanisms for getting community input, they suggested it is important to consider and encourage imaginative ways of gathering people's ideas to solve problems and discover possibilities.

Agencies who undertake engagement or consultation need to be prepared to listen and keep listening over time. In addition, they should always provide feedback to communities on what has come from their participation and engagement.

> *"Clear, frequent and repeated communication by using credible people and credible organisations delivering the communication."*
> Caroline Bell

In the complex recovery environment, Collins et al (2011) support the use of a wide range of participation methods as a way to encourage more people to become involved in decision making. In their view, "Engagement strategies that use an interactive, participatory approach to a disaster context are more likely to facilitate a community-led approach to recovery" (p 18).

Defining features of effective communication and engagement

Focus groups identified the following as central features of effective communication and engagement:

- communication is two-way
- simple, straightforward information related to psychosocial recovery is provided regularly, explaining what is happening and why, what is expected to happen next and when
- simple, straightforward information related to broader aspects of recovery is provided regularly, covering what is happening and why, what is expected to happen next and when
- strategies, tools and resources foster psychosocial knowledge and understanding for individuals and communities
- a simple, straightforward and accessible referral pathway to psychosocial services is available through a variety of trusted and accessible communication channels
- mainstream and local media as well as natural community channels provide information about psychosocial services and ways to access them, as well as information about community groups and social networks and how individuals can access these
- appropriate two way communication methods are used for the different audiences
- communities have opportunities to engage with planners, decision makers and service providers (NGO and government)
- community knowledge, values and aspirations contribute to recovery planning and decision making
- stories of individuals, neighbourhoods and communities overcoming adversity are widely distributed
- emergency preparedness planning is collaborative and integrated.

Effective responses to date

Focus groups and key informants identified the following as positive examples of effective engagement and communication responses:

- the All Right? campaign and its associated social marketing and public messaging
- community meetings with Dr Rob Gordon, an Australian specialist in disaster psychology
- newsletters from community, neighbourhood and resident groups
- positive, relevant and helpful media coverage and stories
- Christchurch City Council's 'Share an Idea' initiative.

Recommended goals for effective communication and engagement

Effective psychosocial recovery of individuals and communities in greater Christchurch involves communication, interaction and engagement between service responses and

community-led responses, with individuals and communities and with the broader recovery efforts.

The specific goals recommended for this priority area are that:

- recovery planners/decision makers and communities participate in effective two-way engagement
- clear and accessible information about referral pathways to psychosocial services and community supports is available
- coordination mechanisms between community groups, local and central government and non-government organisations are in place
- individual and community stories of hope and overcoming adversity are regularly communicated
- collaborative planning for future emergencies and building community resilience takes place
- information is provided to assist communities to understand psychosocial recovery and find ways to care for each other and meet members' needs.

Section 5: Conclusion

Community in Mind: Greater Christchurch Psychosocial Background Document has identified what both individuals and communities in greater Christchurch need to achieve effective psychosocial recovery. With this information it offers a guide to organisations (both government and non-government) and community groups in their collaborative planning, coordinating, funding and delivery of psychosocial recovery.

This report has been shaped by the three priorities required for effective psychosocial recovery of individuals and communities.

1. **Community-led response** *(Mō te hapori, mā te hapori*): Effective psychosocial recovery involves positive, inclusive, self-organising and often spontaneous, diverse and satisfying responses at neighbourhood and community levels.

2. **Innovative service response** *(Ratonga hapori):* Effective psychosocial recovery involves positive, inclusive, self-organising, diverse, satisfying and often spontaneous responses at neighbourhood and community levels.

3. **Engagement and communication** *(Taumata kōrero):* Effective psychosocial recovery involves communication, interaction and engagement between the service response, community-led responses, individuals and communities.

Each of these three priorities emerged from a series of focus groups and the understanding of them was developed further by a literature review and analysis of key informant interviews. To achieve an effective psychosocial recovery for greater Christchurch, *Community in Mind* recommends a focus on the three priorities above, including the goals specified within each one. For an effective recovery, how these three priorities interact also needs to be considered.

Neighbourhoods and communities, not just government and community organisations, have an enormous part to play in achieving psychosocial recovery in greater Christchurch. Good organisations have a role in helping families, neighbourhoods and communities to connect with and care for each other but, no matter how hard they try or how good they are, they cannot do some things that only families, neighbourhoods and communities can do for themselves. Families, neighbourhoods and communities can and already do care for each other, and what they can do for themselves is a key influence in keeping individuals well and

communities resilient. It is important that organisations actively involved in achieving psychosocial recovery enable neighbourhoods and communities to play their part in leading their own recovery.

As *Community in Mind* makes clear, psychosocial recovery is a complex process. Each of the three priorities necessary for effective psychosocial recovery contains many different components that interact with, and respond to, other elements in the other priority areas. Complexity, as Snowden and Boone (2007) describe it, is characterised by:

- a large number of interacting elements
- many multifaceted interactions in which an action in one area can have a major consequence somewhere else
- a dynamic system in which solutions often emerge from the circumstances
- continuous change
- understanding that what has taken place previously (or in another country or in another disaster) does not necessarily predict the future.

The recovery environment of greater Christchurch has been constantly changing and many of the most effective solutions have emerged from circumstances rather than being pre-planned and prescribed solutions. While we cannot be sure of the exact outcome of the interaction between the various service responses, community-led responses and the processes of communication and engagement, it is clear that all are important to effective psychosocial recovery. There is an absolute need for grassroots, community-based initiatives in which neighbours help each other out and communities take responsibility for their own needs and recovery. Without doubt, an innovative service response is required for those who need psychological assistance and for the few who will be most severely affected. Effective communication and community engagement are challenging to achieve but vital in a recovery environment.

While the psychosocial recovery process may be difficult for many individuals and communities across greater Christchurch, the potential exists for an improved sense of wellbeing and resilience to result. Understanding what is needed for effective psychosocial recovery is an important step.

Recommendations

Priority One: Community-led response *(Mo te hapori, mo te hapori)*

Effective psychosocial recovery involves positive, inclusive, self-organising and often spontaneous, diverse and satisfying responses at neighbourhood and community levels.

The specific goals recommended for this priority area are that:

- communities have the capacity to lead their own recovery
- existing and emergent community groups and networks have information and support
- volunteers and volunteerism are actively encouraged
- positive and inclusive community action and activities connect people and build resilience
- influential community based planning opportunities are well attended
- spaces are available for communities to be, meet and do
- community building tools and resources are accessed
- collaborative leadership development and joint learning opportunities are available and well used.

Priority Two: Innovative service provision *(Ratonga hapori)*

Effective psychosocial recovery involves an innovative service response that is strengths-based, coordinated, consistent, reliable, accessible and adaptable.

The specific goals recommended for this priority area are that:

- service planning, delivery and funding work from collaborative and innovative models that are coordinated, accessible and adaptable and build on strengths
- data and trends are actively monitored to inform understanding, planning and responses and this information is shared with communities
- there are targeted responses to emergent trends and to those population groups most in need
- successful initiatives for individuals and communities are identified and supported
- a strengths-based practice model promotes self-efficacy
- organisations and communities gather information and share it with each other
- workforce resilience is maintained
- performance and outcomes are regularly evaluated.

Priority Three: Communication and engagement *(Taumata korero)*

Effective psychosocial recovery involves communication, interaction and engagement between service responses and community-led responses, with individuals and communities and with the broader recovery efforts.

The specific goals recommended for this priority area are that

- recovery planners/decision makers and communities participate in effective two way engagement
- clear and accessible information about referral pathways to psychosocial services and community supports is available
- coordination mechanisms between community groups, local and central government and non-government organisations are in place
- individual and community stories of hope and overcoming adversity are regularly communicated
- collaborative planning for future emergencies and building community resilience takes place
- information is provided to assist communities to understand psychosocial recovery and find ways to care for each other and meet members' needs.

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Appendix 1: Methodology and design

Process of developing the Background Document

Community in Mind: Greater Christchurch Psychosocial Background Document has been developed by the General Manager, Community Resilience Team, CERA. Its development has involved input from, and consultation with, the Greater Christchurch Psychosocial Committee (technical advisory group to CERA's Community Resilience Programme).

The Background Document was originally proposed as a Strategy. However, it has subsequently become the background document report that will inform the Strategy and the Programme of Action. This change was negotiated and agreed in June and July 2013.

Qualitative approach

For this research project, a qualitative research approach was chosen as a way of understanding context and meaning through words and text. Qualitative research is relevant when trying to understand more about the social world and how people are affected by what goes on around them. As Paton (2000) described it, the goal of qualitative data analysis "is to uncover emergent themes, patterns, concepts, insights and understandings". Qualitative research explores the complexity, extent and range of experiences. It can be used to investigate the topic of study below the surface to gather insights in to opinions, behaviours, emotions, motivations and values associated with it.

An aim of qualitative research is to generate hypotheses from the discussion on the particular topic. All research approaches seek answers to questions, follow a process, collect evidence and produce findings. However, qualitative research has the additional feature of attempting to better understand the social context and the perspectives of the people involved, which is well suited to the topic of psychosocial recovery. Qualitative research produces text data through methods such as open-ended questions.

For the purpose of this qualitative research, an appreciative inquiry (AI) line of open-ended questioning was considered appropriate. An AI approach allows the research to focus on strengths, solutions and ideas that have positive potential in terms of psychosocial recovery. AI encourages imagining what could be, based on the best of what there has been and is.

The questions try to draw out what was the best experience in the psychosocial recovery to date; what worked well for individuals, communities and organisations. AI questioning is broadly categorised in to four main areas: Discovery, Dream, Design and Destiny. AI questions can be used in a variety of forms, from one-to-one interviews to focus groups to large group processes and from formal to informal processes. An AI approach with open-ended questioning was used in this research for both focus groups and key informant interviews.

Open-ended questions are appropriate when the primary purpose of the research is exploratory. Answers are not suggested and the respondent is allowed to answer in his or her own words without being constrained by a set of preselected answers.

Focus groups

Focus groups are a useful way to obtain multiple views and perspectives, as well as to draw on participants' experiences, attitudes and reactions. They follow a structured process with set questions and a facilitator to ensure participation by all present and to keep the discussion moving so that all the questions are covered.

This focus group research involved an organised topic of discussion with a selected group of individuals. The general intention was to have an average of 10 people participating in each focus group. While studies range in size from four to fifteen focus groups, seven focus groups were considered a reasonable number for the purpose of this study, as after seven had been conducted it seemed a saturation level had been reached, with no new data or themes emerging. The focus groups included participants who had something in common as well as some differences: that is, a target population was defined for each focus group but within each one some participants were associated with activities that existed prior to the earthquakes and others with activities that had emerged or developed since the earthquakes.

Focus groups were used to provide primary data for the research, as the information was obtained specifically for the purpose of this research and obtained directly from the sources. Primary data collection was useful as it allowed for specific research issues and questions to be addressed and it could be tailored to fit directly to the project needs; it also allowed a level of control in relation to timing, participation and questions.

A series of semi-structured focus groups was undertaken with seven different target audiences over January and February 2013, using emergent, thematic analysis to identify key priorities in effective psychosocial recovery. Focus groups were held over six weeks. Each focus group targeted a different participant group. There was an average of 11 attendees at each focus group.

Focus group	Target audience
Focus Group 1	Government funders and government-funded non-governmental organisations delivering psychosocial services (funding and delivering business-as-usual as well as earthquake-specific services)
Focus Group 2	Government employees delivering psychosocial services (delivering business-as-usual as well as earthquake-specific services)
Focus Group 3	Funders of community development and emergency preparedness activities and programmes including local government; and employees of organisations delivering community development and emergency preparedness activities and programmes (funding and delivering business-as-usual as well as earthquake-specific community development and emergency preparedness programmes)
Focus Group 4	Community members and community leaders of populations normally considered vulnerable (including Māori, culturally and linguistically diverse communities, disability sector, Pacific, youth sector)
Focus Group 5	Public Sector Organisational Resilience Team (public sector organisations with client-facing services) (delivering business as usual as well as earthquake specific services)
Focus Group 6	Community Wellbeing Planners Group ; Technical Advisory Group to Social Recovery (members included central and local government agencies, iwi, NGO sector, Red Cross and church-based groups)

Inductive thematic analysis

Over March and April 2013 an inductive thematic analysis of data from the focus groups was undertaken. Inductive thematic analysis, a common method of qualitative research, examines priorities within and relationships between data. This method is useful in dealing with complex data about communities, social systems and recovery which have many interacting components. The analysis identifies implicit and explicit ideas within the data gathered.

This type of approach is exploratory and generates its own hypotheses from the data. Its purpose is to identify patterns of meaning between the different words and phrases used in order to answer the questions being asked. Inductive analysis makes no assumptions or predictions about what the themes will be, but lets the content of the data develop from the categories and eventual themes.

Preliminary analysis began during data collection, with a categorising frame developed as the preliminary themes emerged and further categories added as new data emerged. Categories were then examined in a more in-depth analysis, and data categories were organised into broader categories and synthesised further into descriptive and interpretive themes. From the initial 40–50 categories, three key priorities emerged from the data.

Key informant interviews

Key informant interviews provided the second source of primary data for this research. Individual semi-structured interviews were undertaken using open-ended questions that again emphasised an AI approach. The criterion for selection of key informants was individuals who have knowledge from research or experience in psychosocial recovery. The results of the semi-structured interviews were analysed using a confirmatory qualitative approach, which seeks evidence to confirm the hypotheses already formed from the focus groups. This confirmatory approach contrasts with the exploratory approach used for focus groups.

Prof Daniel P Aldrich is an associate professor of political science at Purdue University. He was an American Association for the Advancement of Science fellow at USAID during the 2011/12 academic year. He was on leave for the 2012/13 academic year as a Fulbright research fellow at the University of Tokyo's Economics Department. He has

been a visiting scholar at the University of Tokyo's Law Faculty in Japan and a visiting professor at the Tata Institute for Disaster Management in Mumbai, India. Lincoln and Victoria Universities brought Daniel to New Zealand to present on social capital and the role of community in disaster and recovery. Daniel has published *Building Resilience: Social capital in post-disaster recovery*.

Dr Julia Becker is a social scientist with the Natural Hazards Research Platform. Her focus is primarily on planning for natural hazards and environmental issues. Julia has been involved with projects looking at earthquake planning at a local level and been involved in a range of community resilience projects. Julia's areas of expertise include: hazard assessment, volcanology, community resilience, effective warning response, impact assessment, interviewing, land use planning, risk communication, social vulnerability analysis, and survey design.

Dr Caroline Bell, BM BCh (Oxon) MD (Brist) MRCPsych is head of Mental Health Clinical Research Unit, a senior lecturer and a consultant psychiatrist. Caroline is clinical head of the Anxiety Disorders Unit in Christchurch. This is the only publicly funded specialist service for treating patients with severe anxiety disorders in New Zealand. Caroline is also a senior lecturer at the Department of Psychological Medicine at the Christchurch School of Medicine and Health Sciences, University of Otago. Since the February 2011 earthquakes, she has held a leadership role for the Canterbury District Health Board in planning the service response for the anticipated small number of people from greater Christchurch who will experience severe post-trauma stress and anxiety.

Sharon Des Landes is the clinical leader at Berry Street Mental Health Centre, Melbourne, Australia. Sharon did most of her schooling in Christchurch and completed her clinical psychology training at Canterbury University. Sharon has worked at the Alcohol Counselling Centre, Templeton and Sunnyside Hospitals, and then at the Campbell Centre in Christchurch. After February 2011 Sharon took a recovery role connected to Refugees as Survivors New Zealand, who were working with families of the bereaved in Christchurch. Since moving to Victoria in 1997, Sharon has worked in child and adolescent mental health. Sharon's interest in post-emergency interventions began in the 1990s and continued in a part-time, casual and/or voluntary way alongside her full-time work until 2009. Since the Victoria bushfires it has been Sharon's full-time role, developing latterly into a role as clinical consultant – recovery. Sharon has been involved in recovery counselling, facilitating support groups for victims, community talks to disaster

affected communities and delivering training about psychosocial recovery.

Jim Diers has developed models and strategies for community development. His book, *Neighbor Power: Building community the Seattle way*, chronicles his involvement with Seattle's communities. This book is about participatory democracy and offers practical applications and lessons for ordinary citizens who want to make a difference. It also provides government officials with stories and programmes to help them recognise citizens as partners. Jim began as a community organiser in 1976, then moved on to help establish and staff a system of consumer-elected medical centre councils. This led him to Seattle city government, where he served under three mayors as the first director of the Department of Neighborhoods, and has become recognised as the national leader in such efforts. In the 1990s, Jim Diers helped Seattle neighbourhoods face challenges ranging from gang violence to urban growth. Inspiring Communities brought Jim to New Zealand following the Canterbury earthquakes.

Dr Rob Gordon is a clinical psychologist with more than 25 years' experience supporting the recovery of individuals and families following events such as the 1983 Ash Wednesday bushfires, the Bali bombings, the 2004 Boxing Day tsunami, Cyclone Larry and, most recently, the 2009 Victorian bushfires. Since the February 2011 earthquakes Rob has visited Canterbury on several occasions, speaking to community members, agencies and organisations working in recovery. Combining research findings and his extensive experience working with survivors of bushfires, cyclones, road accidents, terrorist attacks and other traumatic experiences, Rob has developed a specialist understanding of how to work effectively with people affected by mass trauma.

Daniel Homsey is the director of strategic initiatives for the City Administrator's Office, City and County of San Francisco. He has spent the last 25 years as a communications professional in both private and public sectors. Daniel was appointed Director of the Mayor's Office of Neighbourhood Services in 2004. In 2008 he joined the Recovery Project Team in the City Administrator's Office where he is now the programme manager for the San Francisco Neighborhood Empowerment Network. Daniel visited Christchurch after the Canterbury earthquakes and spoke to groups that included urban planners, community groups and representatives from CERA and stays connected to various people and organisations in Canterbury.

Chris Jansen is a senior lecturer in Organisational Leadership at the University of

Canterbury where he teaches and supervises leaders studying in the Masters of Educational Leadership and Postgraduate Diploma of Strategic Leadership. Chris works alongside organisations in the education, health, business and community sectors in a range of projects, including design and delivery of leadership development programmes, change management initiatives, organisational capability and strategic planning. Chris is also involved in executive coaching and regularly facilitates workshops and presentations for a range of organisations around New Zealand, Australia, the Pacific and Asia. Chris has written a range of international journal publications including "Leadership for emergence: Exploring organisations through a living system lens" and "Leaders building professional learning communities: Appreciative inquiry in action".

Associate Professor Sarb Johal is a clinical and health psychologist at Massey University. He has clinical interests and expertise in capability and capacity building for psychological support before and after disaster events. Sarb is involved in extensive research in the area of disaster mental health. Sarb has spent time in Christchurch since the February earthquakes working with organisations and agencies involved with psychosocial service planning and provision.

Paddy Pawson has an international reputation in outdoor adventure-based learning with young people. Currently he holds several roles in the NGO social service sector where among other things he develops, implements and manages projects relating to young people and their needs. Paddy has also worked as a practice leader with the collaborative Earthquake Support Coordination Service. He has a significant amount of experience in both paid and unpaid roles in community development, including working in post-disaster communities of Papua New Guinea and Nepal.

Dr Suzanne Vallance began teaching full time at Lincoln University in 2008 after completing her PhD on urban sustainability in New Zealand. She has a reputation as a human geographer with a particular interest in social sustainability and the socio-natural dimensions of (urban) everyday life. Through her own work and supervision, she has participated in debates about the ontological status of the city, the meanings and practices associated with urban sustainability and resilience, and ways in which formal and informal planning approaches diverge (often with 'perverse effects'). Through her work on gardens, sprawl, vacant spaces, seafood gathering, the commodification of community and civic expertise, she seeks a better understanding of people's collective (human and non-human) attempts to shape the world in which they live, according to

their needs, aspirations, and their awareness and framing of risk. The recent earthquakes in Canterbury have added a distinct focus to her work in this area and she currently has Marsden Fast Start funding to compare and contrast the contingent planning strategies associated with various 'emergent' and 'insurgent' public and community-led planning networks.

Literature review

Secondary data were obtained from a literature review. These data provided information that it was not practicable to obtain by other means because of barriers such as access, timing and cost. It considered peer-reviewed research, as well as grey literature which included government and non-government organisation reports, statistical publications, workshop/conference proceedings, published books that have not been peer reviewed, and technical reports. It looked at both international research and local research, such as analysis from the Community Wellbeing Index 2013 and CERA Wellbeing Surveys 2012 and 2013. As with the analysis of the key informant interviews, the literature review used a confirmatory qualitative approach, searching the literature and research that confirmed the hypotheses, themes and priorities that had already emerged from the focus groups.

Consultation

Consultation on the draft document began in May 2013. It was circulated for feedback to the Psychosocial Committee member agency and network representatives, key informants, and the national offices of Ministry of Social Development, Ministry of Health and Ministry of Education (as the key central government funders and deliverers of psychosocial services). More than 20 organisations or network representatives provided feedback including: Canterbury District Health Board, Ministry of Social Development, Ministry of Health, Ministry of Education, He Oranga Pounamu, Te Puni Kōkiri, Christchurch City Council, Waimakariri District Council, Selwyn District Council, Red Cross, Mental Health Education Resource Council, Mental Health Foundation, Ministry of Pacific Island Affairs, Human Rights Commission, Relationships Aotearoa, NGO sector (Council of Social Services in Christchurch, Social Service Providers Aotearoa, One Voice Te Reo Kotahi), Inland Revenue, Dr Sarb Johal, Dr Rob Gordon and Chris Jansen (key informants). Most of the feedback related to the structure and layout of the document and the Programme of Action. The structural issues have been addressed through separating the Background Document from the Strategy and from the Programme of Action. The layout issues have also been addressed.

In June 2013, a Stakeholder Forum was held, at which the primary audience was technical advisory groups to the various social recovery programmes. The forum focused on key emergent trends from the Canterbury Wellbeing Index and the CERA Wellbeing Survey and included one workshop on the psychosocial recovery. The two questions discussed within the psychosocial workshop were:

- Does the data validate your operational realities? (Does this reflect what you are seeing?)
- What are the priority actions needed? (What has worked well to date? Who is doing this already? Who should do this? What is missing? What are the future opportunities?)

Feedback from the Stakeholder Forum was considered in this research, although feedback received from the psychosocial workshop generally related to the Programme of Action.

Four further focus groups were held following the release of the Wellbeing Survey, with people with health and disability issues, people living in TC2, TC3 and Red Zone, people from different ethnic groups and families with children.

The final *Community in Mind: Greater Christchurch Psychosocial Recovery Background Document,* was prepared over July and August, 2013.