



“LAY COUNSELLING IN HUMANITARIAN ORGANISATIONS”

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REPORT

OF THE

LITERATURE REVIEW ON LAY COUNSELLING

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1 Introduction to the Report

The aim of this report is to gain an overview on lay counselling and to give further advice based on the literature review on the development of training materials for lay counsellors in the psychosocial area. To give an overview of the literature on „lay counselling“ relevant databases were searched on the existing literature on lay counselling (table 1), using key words as mentioned in table 2.

<i>DATABASES</i>
PsychInfo
Psyndex
SocIndex
Academic search premier
Social science citation index

Table 1 Databases

<i>KEY WORDS</i>
Lay counselling
Voluntary counselling
Paraprofessional counselling
Psychosocial support
Social support
Lay social support
Lay psychosocial support
Natural helpers
Peer helper

Table 2 Key words

For initial selection of literature we included all studies that matched a) one of the key words mentioned in table 2 and b) that dealt with lay counselling as described in the definition of the project description (see section “definitions”).

After selection of the literature we had **361** studies, handbooks and guidelines that we included in our overview. In the report we focussed on the studies and we put a special emphasize on volunteers and psychosocial support.

The research report consists of an overview of the results of the literature research. First we will give a short **definition** of volunteers/volunteerism and lay counsellors/paraprofessionals. These two terms are highly connected to each other. As we will demonstrate that the term “lay counsellors” may be used as a variation of the term “volunteer”, but is not necessarily exchangeable. In this section we also summarize studies that show the changes in volunteers themselves after training.

Thereafter we summarize (psychosocial) **interventions** used by volunteers and lay counsellors. This summary is extracted from the literature review. The effectiveness of the interventions is also an important part of the report. We reviewed studies that proved the **effectiveness** of psychosocial interventions used by volunteers and lay counsellors. Some studies also could show that psychosocial interventions done by volunteers are as effective as interventions done by professionals (e.g. Durlak, 1979).

Numerous studies refer to recommended **training** in general or report about contents of trainings for volunteers. In the section on training we summarize aspects of trainings for volunteers. We conclude this section with the mostly named aspects that were included in trainings and we recommend being included in trainings for volunteers.

Moreover we include a section on the **framework of working with volunteers**. Necessary frameworks for volunteers working in the psychosocial field such as training, insurance or reimbursement and security as well as support issues are often mentioned, a small number of studies also report selection criteria. Selection and training are often seen as the important aspect for the effectiveness of interventions (e.g. Brown, 1974). Moreover the organization itself can contribute to the effectiveness of interventions and support its' volunteers. We summarize possibilities of support of the volunteers to underline the importance.

In the last section of this report we will give a **resumé** on the most important findings of the literature and first recommendations on the development of the training materials.

2 Research Review Results

2.1 LAY COUNSELLING / PSYCHOSOCIAL SUPPORT

A subjective impression after doing the literature research was that the term “lay counselling” was strongly connected to “Christian lay counselling” (e.g. Tan, 1991). Wide ranges of terms for lay counselling were used in the literature. Further terms for lay counselling are “paraprofessional counselling” (e.g. Delworth, 1974a; Delworth 1974b) and “peer/natural helpers” (e.g. Timpson, 1983; Tanaka & Reid, 1997).

2.1.1 Definitions

LAY COUNSELLING

In many definitions it was tried to distinguish paraprofessionals/volunteers from professionals. A study on Christian lay counselling demonstrated that volunteers and paraprofessional counselling could be divided into three different models for paraprofessional counselling (Tan, 1997):

1. The informal, spontaneous model: support in natural settings such as bars, restaurants, churches etc. because of informal friendship. The paraprofessional may not have any training in helping skills.
2. The informal, organized model: paraprofessionals still worked in informal setting, but had basic training and supervision.
3. The formal, organized model: paraprofessionals worked in official settings such as agencies, were they had training and supervision.

For our purpose we had to describe the term “lay counselling” in a much broader sense. Thus we defined lay counselling as follows:

“A key activity in many humanitarian organisations is support to individuals in crisis provided by trained volunteers. This activity can be called social support, psychological support or lay counselling, and the activity is likely to consist of active listening, information sharing, and support to take informed decisions, all with the objective of empowering the individual to cope with stressful and critical situations, Furthermore, if a person needs professional help, the volunteer can ensure referral to the relevant specialists/ doctors/therapists.”

Therefore our definition of lay counselling is very near to psychosocial support in general which we will define in the following.

PSYCHOSOCIAL SUPPORT

According to the IFRC reference centre for psychosocial support trainer's manual on Psychosocial support (2009) psychosocial support refers to the actions that address both the psychological and social needs of individuals, families and communities. Psychosocial support aims at enhancing the resilience of the affected individual, group and community, resilience being the ability of an individual or group to find back to normality after adverse experiences. Psychosocial support includes promoting the resources of individuals, families or groups as well as the community as a whole. It can prevent distress and suffering from developing into something more severe and shall help overcome adversities, coming back to normality and recover after crisis. Psychosocial support activities range from psychological first aid in the basic services after disasters or other critical events to family and community support after crisis and more focused non-specialised services such as special programmes for children and adolescents to overcome the death of a caregiver. It may include the following activities: Psychological first aid, support hotlines, discussion groups, visiting services, practical learning about psychological reaction patterns, school-based activities where children can play and regain trust and confidence or vocational training.

2.1.2 Lay counselling and psychosocial support: Roles & Fields of Activity of Volunteers/Paraprofessionals

The roles of volunteers/paraprofessionals in the psychosocial field are multifaceted. Roles of volunteers/paraprofessionals can range from lay counsellor to teaching assistant, "listener" or peer supporter. Volunteers/paraprofessionals in the field of psychosocial support often have the role of an "advocate" or "facilitator" between beneficiaries and the formal mental health system for instance in helping the affected persons to better use their resources or to find new resources. A psychosocial response in the basic services might involve advocating that these basic services and protections are put in place and are done in a respectful and socially appropriate way. Volunteers may encourage social support networks or provide specialized services for children and adolescents or other vulnerable groups. Volunteers do not substitute the formal health system but shall ensure a better linkage between the affected and the formal health system by forming a "go between". As stated by the IFRC reference centre Handbook on Community based Psychosocial Support (2009) providing psychosocial support to affected people can be done in many different ways:

- by being available and listening to how a distressing event has affected a family
- by contacting relatives
- by organizing practical matters
- by encouraging and supporting community initiatives, such as home-based support, school-based interventions, vocational and skills based trainings, establishing community centres

- by establishing support groups

In their study on a student paraprofessional counselling service, Wasserman et al. (1975) showed that paraprofessionals are acting as a role model in assertive training groups, working individually with students and serve as simulated clients for other practicum students. Also Easton et al. (1985) described the roles of paraprofessionals at a University counselling centre as behavioural coach, model therapy group member, research group member or audio-visual aide.

In schools peer helpers are used as support for other children /adolescents and often functioned as role model and support for teachers (Downe et al., 1986; Tanaka & Reid, 1997; Keat, 1976). The work of volunteers/paraprofessionals in the psychosocial field has a wide range of activities. In a survey on 263 school counselling association members of about 305 schools the field of activity of peer helpers included the areas of substance abuse, self-esteem, eating disorders, coping with loss, depression, violence/exploitation, counselling groups, stress management, tutoring, suicide prevention, social skills and relations, conflict resolution, one to one counselling and classroom groups (Lewis & Lewis, 1996).

In their study on 15 voluntary sector support workers and carers of schizophrenia sufferers Weinberg and Huxley (2000) found that the activity of the family support workers contained counselling, listening, information and advocacy advice - this was perceived by both, carers and the support workers. The diary schedules revealed that family support workers invested about 40% of their time giving emotional and /or practical support (Weinberg & Huxley, 2000). In a study on 330 lay helpers in psychiatry setting it was concluded that mainly older women work as lay helpers with main tasks such as activities in the leisure time or supportive talks. Most lay helpers worked for a long time as lay helpers and reported high satisfaction with the work. Even higher satisfaction was found when lay helpers got professional support (Rössler et al., 1996). Tessaro et al. (2000) find two patterns of natural helpers: a) participation in programs because of own health concerns or others in their personal network and b) participation in programs due to a larger sense of importance of health and prevention.

Although there are some critical voices regarding volunteer/paraprofessional work overall it is stressed that paraprofessionals and professionals can complement each other in their work (Cantoni & Cantoni, 1965; Burtchen, 1986).

Only a few older studies find limits in volunteer/paraprofessional work (Steenland, 1973, McKee et al., 1977). When comparing the preference of recipients regarding volunteer/paraprofessional counselling and professional counselling we find in a survey of Zwibelmann (1977) comparing 3092 cases in a peer counselling facility to 2048 cases in a professional counselling centre, that students went to a professional counselling centre for academic, vocational and social interaction problems, but sought peer counselling more because of drug or sexual issues. 130 paraprofessional counsellors in their role as paraprofessional

counsellors and as recipients of counselling state that most commonly shared problems in the work as paraprofessional counsellors are finances, personal relationships and work. Severe issues named are marital problems and divorce. As recipients of paraprofessional counselling they share financial problems, issues in personal relationships, physical health and parenting (Kilty, 1985). These studies show that there is only little or no difference in the problems shared with volunteer/paraprofessional and professional counsellors.

Also Renner (2008, 2011b) found that Chechnyan refugees profited more from a group intervention done by trained peers than from a psychotherapeutic intervention.

DeMoss (1974) found that a team of volunteers could handle most emotional and psychological problems effectively; for other more severe problems clients were referred to other agencies (alcohol, drugs, mental illness, psychotic problems, medical problems, lack of food, money shelter) (DeMoss, 1974). This is concordant with other findings where peers/paraprofessionals / volunteers are also trained and encouraged in referring a client to other agencies or to a professional if needed.

Some groups of clients such as emergency workers prefer peers over professional helpers (Mitchell & Everly, 1998). Tanaka & Reid (1997) hypothesize that students confide more in peers than in adults. Senior peer counselling is thought to be effective for addressing mental health needs of the elderly, because 1) elderly are often uncomfortable with professionals, 2) costs are less, 3) peers serve as role models, 4) professionals may be reluctant to work with elderly, 5) transportation to senior centre or counselling at home by paraprofessionals, 6) counselling for indefinite time for isolated, depressed seniors and 7) peers have more credibility and similar life circumstances (Garcia et al., 1997).

Some authors even stated that lengthy professional training is not necessary, individuals who have non-possessive warmth, interpersonal sensitivity, empathic understanding, and overt genuineness can rapidly develop therapeutic skills; volunteers with limited training can be as effective as professionals and facilitate client change (Carkhuff & Truax, 1965).

The following two tables shall give an overview over the roles of volunteers/paraprofessionals in the psychosocial field as well as their target groups.

<i>VOLUNTEERS TRAINED</i>	<i>REFERENCES</i>
Lay palliative caregivers	Hudson et al., 2002
Peer navigators for breast cancer patients (breast cancer patients after treatment)	Giese-Davies et al., 2006; Claxton-Oldfield et al., 2007
Elderly	Losee et al., 1988; Garcia et al., 1997

Peers in schools, college, university	Tanaka & Reid, 1997; Lewis & Lewis, 1996; Keat, 1976; Whitlock, 1995; Campbell, 1983; Jacobs et al., 1976; McKee et al., 1977; Wasserman et al., 1975; Winniford et al., 1995; Winston & Buckner, 1984
Peer asylum seekers /refugees	Kieft et al., 2008; Neuner et al., 2008; Uitterhaegen, 2005
Survivors of conflict trained as community promoters	Anckerman et al., 2005; Wuthnow, 1998
Ngo and relief workers	Bisson et al., 2007; Hobfoll et al., 2007; Mollica et al., 2004; van Ommeren et al., 2005; Yule, 2006; Shetty et al., 2005; Kukafka et al., 2009; Thara et al., 2008
Members of Christian ministries	Goraieb, 1999; Most & Guerny, 1983; Lukens, 1983; Scanish & Wheaton, 1996; Tan, 1987; Tan, 1991
Inmates	George, 1978
Traditional healers	Somsè et al., 1998

Table 3 Volunteers trained

Volunteers trained can have different characteristics. In non-Western societies volunteers that are used in disaster settings are often young, single, inexperienced and part of the affected population (Thormar et al., 2010). Volunteers in western societies have a different demographic structure. In their survey on demographics of the psychosocial workforce Blankertz et al. (1994) showed that Western volunteers are usually white, female and have some type of college training.

Volunteers/Paraprofessionals are active with various groups of beneficiaries. In the research review we find many groups of people who are being cared for by volunteers. These target groups are summarized below:

TARGET GROUP	REFERENCES
Cancer patients (e.g. breast cancer)	Giese-Davies et al., 2006; Cook Gotay & Bottomley, 1998; Cameron et al., 1997; Carlsson et al., 2005; Dunn et al., 1999; Sutton & Erlen, 2006; Smith et al., 1998; Cope, 1995; Coreil & Behal, 1999; Maisiak et al., 1981; Matsunaga & Cook Gotay, 2005; Plant et al., 1987; Smith et al., 2002; Yaskowich & Stam, 2003; Zeigler et al., 2004; Curran & Church, 1998; Reed, 2004; Solberg et al., 2003; Gustafson et al., 1993; Hoybye et al., 2005; Klemm et al., 1998; Lieberman et al., 2003; Sharf, 1997; Shaw et al., 2000; Weinberg et al., 1996a; Weinberg et al., 1996b; Ashbury et al., 1998; Geiger et al., 2000; Rankin et al., 2004; Rogers et al., 1985; McGovern et al., 2002; Klemm et al., 1999; Weber et al., 2004; Rudy et al., 2001; Vos et al., 2004; Gustafson et al., 2001; Winzelberg et al., 2003; Alter et al., 1996; Hoey et al., 2008
Patients with chronic illness (e.g. lupus erythematosus, ms)	Peterson et al., 1993; Schwartz & Sendor, 1999
Disaster affected communities	Rao, 2006; Vindhya, 2005; Norris et al., 2005; Ager, 1997; Ager, 2002; Altindag et al., 2005; Goenjian et al., 1997
Students in schools, college and universities	Tanaka & Reid, 1997; Lewis & Lewis, 1996; Keat, 1976; Whitlock, 1995; Aiken et al., 1974; Bowman & Myrick, 1985; Campbell, 1983; Easton et al., 1985; Jacobs et al., 1976
Couples (premarital couples or newly-wed)	Most & Guerny, 1983
Elderly	Garcia et al., 1997; Petty & Cusack, 1989; Losee et al., 1988; Milligan et al., 1987
Asylum seekers/refugees	Kieft et al., 2008; Neuner et al., 2008; Mollica et al., 1996; Mollica et al., 2004; De Jong et al., 1999
Psychiatry in-patients	Utschakowski et al., 2009; Nussbaumer, 2009; Brackhane et al., 1990; Mackinger et al., 1983; Mark & Dohren, 1981
Rape and assault survivors	Silver & Stonestreet, 1978; Riutort & Small, 1985; Flisher & Isaacs, 1987
Clients with depression, alcohol problems	Goraieb, 1999
Clients with hiv/ aids	Somsè et al., 1998; Peltzer et al., 2010; Shetty et al., 2005; Kukafka et al., 2009; Omoto & Snyder, 1993
Dying people	Claxton–Oldfield et al., 2007
Caregivers/relatives	Claxton–Oldfield et al., 2007; Stoppe & Geilfuss, 2004; Weinberg & Huxley, 2000

Table 4 Target groups

2.1.3 The tense relationship between volunteers/paraprofessionals and professionals in the psychosocial field

From what we said until now it can be concluded that volunteers can be as effective as professionals when well selected and trained. There is no doubt that volunteers can provide a greater access to the mental health system and are of high value to the community. Volunteers as peers can get better access to people (e.g. cancer, seniors, children, and adolescents) and facilitate the work with especially vulnerable groups (e.g. disaster affected communities, refugees, etc.). They can close a gap between perceived needs and difficulties in entering the mental health system (e.g. Kieft et al., 2008; Bowman & Myrick, 1985; Garcia et al., 1997).

There is no doubt that volunteers are valuable, important in everyday community life and can be assigned to a wide range of activities.

However, there were some studies that doubted the effectiveness of volunteers' unreasonably. In the following we will shortly illustrate the discussions on the effectiveness of volunteers/paraprofessionals compared to professionals.

Many studies on the effectiveness of lay counselling were conducted in the 70ies and 80ies. During this time programs were implemented to train and use volunteers. Brown (1974) describes that at first the initial policy of the American Personnel and Guidance Association in 1967 and the American Rehabilitation Counselling Association in 1968 limited the activities of paraprofessionals to gathering and processing occupational information, administering and scoring routine standardized tests and other performances of sub functions of the counsellor's role.

Lay counselling has been described in positive and negative aspects. Positive aspects are:

- Lay people as medium between professionals and the community (e.g. Opitz, 1982)
- Access to people who may have restraints to enter mental health services (e.g. Everly, 2002)
- Access to children/adolescents to confide in peers and as a consequence of this in adults (e.g. Bowman & Myrick, 1985)
- Growth, enhancement of knowledge, increase in self-confidence etc. in trained paraprofessionals (e.g. Keat, 1976)
- Access to especially vulnerable groups (e.g. refugees) (e.g. Kieft et al., 2008)
- Sharing experience (e.g. Utschakowski et al., 2009)
- Normalizing effects (e.g. Carkhuff & Turax, 1965)

Frequently reported negative aspects are:

- Limitation of paraprofessional activity and limits of paraprofessionals themselves (e.g. Klingemann, 1986; Brandes, 1983)
- Experts restraint to acknowledge the effectiveness of paraprofessionals (e.g. Aiken et al., 1974; Wirth, 1980)
- Request for further studies on effectiveness and evaluation of the training and the work of paraprofessionals (e.g. Lindsey, 1997; Morrill et al., 1987)

A discussion evolved whether to use lay people, how to use them and how to restrict paraprofessional activities. Sometimes political issues enter the discussion when professionals fear that paraprofessionals could take over the jobs of professionals because they are cheaper. In our view it is important to see the complementary role of volunteers in the mental health system and not to treat volunteers as a substitute for formal mental health care. Wirth (1980) suggests that self-reflection would improve the cooperation between paraprofessionals and professionals. If professionals would reflect more on the value of volunteers/paraprofessionals there might be less bias. Opitz (1982) sees the function of volunteers as medium between the community and professionals. They open the access to mental health systems for people who are unfamiliar with it or are resistant to it (Everly, 2002). But volunteers have to be able to work with the given group of beneficiaries. Timpson (1983) for example discussed the problem of using e.g. non-Indian paraprofessionals in an Indian village. He argues for the need of peers in certain settings. Schmiedbauer (1985) establishes that the difficulties between volunteers and professionals in psychiatry are often based on unmet expectancies. Professionals fear replacement by paraprofessionals and therefore do not cooperate. In a study on lay helpers in the rehabilitation of mentally ill people it has been shown that clients, volunteers and professional workers have different expectations and ambivalences are revealed. Morrill et al. (1987) urge caution to use paraprofessionals and demanded more studies on the effectiveness of paraprofessionals. Delworth (1974b) claims that the disappointment to integrate volunteers/paraprofessionals was due to the failure to train volunteers/paraprofessionals properly to do their job and that the agency personnel tried to “cool them out”.

However, lay help is considered to be a very useful and necessary tool (Brackhane et al., 1990). Also the support by lay helpers for families that care for dementia patients is reported as effective (Stoppe & Geilfuss, 2004). As there were a high number of volunteers and people who take care of someone, Braun (1988) recommends an exchange of experience between paraprofessionals and professionals and an improved cooperation between the two groups. The communication between paraprofessionals and professionals is emphasized in some studies, regardless of the setting volunteers/paraprofessionals work in (Southall, 1992). Garzon et al. (2009) hypothesized that experiences made with volunteers/paraprofessionals may alter the expectations for psychotherapy.

Even if there is discussion on the specific roles and effectiveness of volunteers'/paraprofessionals' in certain fields, we can conclude that volunteers are of overall value in the psychosocial field and are needed to complement the formal mental health system and close gaps as well as reach vulnerable groups. Global data on the efficiency of lay counselling have shown that volunteers/paraprofessionals can be as effective as trained psychotherapists. Especially the greater access to mental health services and the costs of psychological services are positively named (Nielson, 1995; Everly, 2002). Volunteers can guarantee an improved and wider access to the mental health care system and volunteers often have a unique position, e.g. as Claxton-Oldfield et al. (2007) describe that dying patients often find it hard to share their fears about death with relatives who are also suffering, but do not have these restraints towards volunteers.

2.1.4 Risks and chances of volunteers/paraprofessionals work in the psychosocial field

Volunteers in the psychosocial field often work with vulnerable groups and are exposed to various forms of trauma and crisis. Working in these areas may lead to distress and mental health complaints. For example working in disaster settings may lead to a variety of mental health complaints ranging from Post-Traumatic Stress Disorder to depression or somatic complaints. With regard to complaints the range of volunteers can be between professionals and direct victims. They often are part of the affected community and can therefore be seen as active survivors (Thormar et al., 2010). Volunteers in her review (Thormar et al., 2010) identified the following risk factors for mental health complaints in volunteers: Identification with victims as a friend, severity and/or length of exposure to gruesome events during the disaster work and lack of post-disaster social support. Also mentioned were the personality type, anxiety sensitivity, various coping styles, little experience with disaster work and role confusion or ambiguity about what was expected of them. Therefore volunteers need a high amount of training, supervision and support in order to stay healthy.

If volunteers are working in a well structured environment also positive effects of volunteering can be found. For example Paton (2006) analysed Posttraumatic Growth in professional emergency workers. Ortlepp and Friedman (2002) found positive effects like enhanced affect tolerance in lay trauma counsellors. Also others (e.g. Raphael et al., 1980) found positive effects in helpers.

Studies on the evaluation of training indicate that trainees gain enhanced confidence, knowledge, competence, increased probability of being a leader, cooperativeness, community involvement, personal growth, communication skills and counselling skills (Manickam, 1998; Froh, 2004; Peterson et al., 1993). In their evaluation of a peer helping program with a pre-, post-test and follow-up as well as an experimental and a control group Aladag and Tezer (2009) showed that the experimental group had significantly more reflection and empathic skills, but did not differ in communication skills in general.

Furthermore the experimental group showed an increased self-esteem and self- acceptance over time.

Trainees also exhibited significant changes in helping behaviour, more confidence in helping and higher numbers of interactions and an improvement of dissemination strategies over time (Ehrlich et al., 1981; D'Augelli & Ehrlich, 1982; Tessaro et al., 2000; Garcia et al., 1997). A study on volunteers in palliative care also showed that volunteers after training reported more confidence in coping with death and felt better prepared when death occurred (Claxton-Oldfield et al., 2007).

Self-reports on the experience of paraprofessionals showed that paraprofessionals/peer supporters perceived an increase in self-awareness and personal growth (Jenks, 1974; Schwartz & Sendor, 1999). Community level workers involved in psychosocial interventions after the Tsunami reported great benefits from the training and made suggestions about refining the training (Thara et al., 2008).

Peer helpers in schools are also experienced an increase in self-concept, personal growth, self-assurance, respect for others and interest in others and an enhanced sense of responsibility or other positive experiences (Keat, 1976; Whitlock, 1995). A study on senior peer counsellors found that senior peers had a more active part in the community support after the training. After a training program resident assistants (undergraduate students working with other students) showed significantly less stress compared to a group of residence assistants that has not received any training (Winston & Buckner, 1984). In a pre- and post-measurement of facilitativeness and action-orientatedness Flisher and Isaacs (1987) found that facilitativeness remained the same after a rape intervention training for lay therapists, whereas action – orientatedness increased after training. When comparing members of organizations to lay therapists who are no members of any organization they found that facilitativeness was higher in lay therapists who are not in any organization. In a study on video-taped training of inmates George (1978) it was stated that peer inmates know significantly more about counselling after the training.

But Peterson et al. (1993) found evidence that helplessness, loneliness, self- esteem and personal competence remained the same in peer helpers with lupus erythematosus.

It was also suggested that an evaluation can result in more reflection upon the work and should therefore accompany the work of paraprofessionals (Gardiner et al., 2003).

In their study on a training program for senior peers Garcia et al. (1997) find that peer counsellors uniformly rated the training positive; they perceive a general closeness of group members, respect and trust for group members. In their experience of self as counsellors they perceive their lack of counselling experience as major weakness but they also see their strengths in their age, life experience and empathy. The level of depression is tested in senior peers pre- and post-training. The senior peer counsellors rated the training of at three points in time during training and individual interviews were conducted to assess aspects of training experience.

2.2 VOLUNTEERISM

Volunteer work is becoming more and more important. It constitutes a significant force in the non-profit sector. Salamon and Sokolowski (2001, 2003) studied 24 countries and 12 different areas of volunteering (education, health, culture, social services, environment, development, advocacy, philanthropy, religious congregations, business, professional and “unions” and other). Volunteer work provides the equivalent of 11 Mio FTE jobs (FTE: 1700 hours of work per year). The study was extended to 35 countries in 2006 (Anheier & Salamon, 2006) and shows that over 40% of FTE non-profit jobs are staffed by volunteers, an equivalent of 16,8 Mio. full time workers.

Especially in disaster settings volunteers are of utmost importance. At the world conference on disaster reduction 2005 in Kobe it was stated that in order to take full advantage of community resilience after a disaster, affected communities need to be well prepared. A first step in this direction is the formal recognition of the value of local volunteer efforts. Such recognition needs to be translated into provision of adequate financial and human resources and the integration of effective volunteer management practices into disaster management programs (Report on the world conference on disaster risk reduction, 2005). Empowering volunteers in these settings seems to be an important step in community participation. In a conclusion it was therefore stated that “good governance for disaster reduction exists where there is adequate space for the participation of different stakeholders, including vulnerable communities, state, civil society, volunteers, volunteer involving organizations and other development partners. In such a multi-stakeholder spectrum, the involvement of local level communities and volunteers remains an important factor in enabling people to cope with risks and prevent them from becoming part of the disasters themselves. The effectiveness of governance structures for disaster reduction will reflect the extent to which governments recognize the contribution and capacities of local volunteers and are prepared to ensure an environment within which volunteer contributions can be maximized” (UN volunteers, 2005, p 4).

The use of volunteer labour in times of disasters is very common throughout the world. Today, the Red Cross/Red Crescent Movement has about 90 million volunteers worldwide that respond to the needs of about 200 million people yearly (www.ifrc.org). The volunteers vary in their composition, not only in the usual demographic characteristics but also in the duration and intensity of their exposure, in previous training and experience, and in volunteer status. Many of them are young, with the majority being younger than 25 years old. Volunteers in western countries like in Europe or the US are in general older and better trained than volunteers in other countries of the world (Thormar et al., 2010).

According to the IFRC “Two in every thousand people around the world volunteer for the International Red Cross and Red Crescent Movement. Active Red Cross Red Crescent volunteers donated nearly 6 billion US dollars worth of volunteer services in 2009 worldwide, or nearly 90 US cents for every person on earth. While many volunteers work

across multiple fields, the most volunteers – and the greatest proportion of – were related to health promotion, treatment and services; followed by disaster preparedness, response and recovery, and then general support services. Slightly more women than men volunteer for Red Cross Red Crescent National Societies (54 % vs. 46 %) overall, though this ratio varies by region. Voluntary service is at the heart of community-building. It encourages people to be responsible citizens and provides them with an environment where they can be engaged and make a difference. It enhances social solidarity, social capital and quality of life in a society. It can serve as a means of social inclusion and integration” (IFRC value of volunteers report 2010, p. 7-8).

2.2.1 Definitions

VOLUNTEERS

Defining a volunteer is complex. In general it means no salaried service. Cnaan et al. (1996) try to delineate the boundaries of the term by using 11 widely used definitions. Furthermore they asked 514 respondents to assess the term by using a 21 item questionnaire. Some definitions (e.g. National Association of Counties, 1990) include that a volunteer is a person who engages in a task of public relevance, without receiving moneys which results in self-satisfaction, community reputation or any other form of non-monetary reward.

Thus in a broad sense voluntary work is any uncoerced helping activity that is done not primarily for monetary gain. The voluntary act as well as the lack of financial gain are important aspects of most definitions. Scheier (1980) defined voluntary work as “unsalaried service to others in a structured setting” (p. 8). In this definition only organised work in a structured setting can be voluntary work. In some definitions voluntary work can only be done for strangers, in others it can also be given to well-known beneficiaries such as relatives or friends. In the broadest definition the volunteer can also be a beneficiary as in self-help groups. The four relevant dimensions according to Cnaan et al. (1996) are (1) free will (2) no monetary gain (3) structured context and (4) beneficiary is a stranger. In their study they gave a questionnaire to 514 respondents and found the following results. The item that had the most acceptance was: a volunteer is an adult who offers his or her time to be a Big Brother or Sister. The authors stated that this was because it was purest in all four dimensions of the definition. The authors suggest to define pure versus broad volunteering along the four postulated dimensions.

Thus the four main elements of typical volunteers are that they are working out of their free will, they are working for a benefit other than money, they are working in a structured context and they are normally working with strangers as beneficiaries.

Volunteers work for humanitarian organizations without payment for their time and service. Volunteers may or may not have professional training in the area they are volunteering in, but they are not employed. Volunteers in the field of psychosocial support often are complementary to the formal health system. They do not replace formalized mental health approaches but they shall complement them. Furthermore they shall facilitate the access to

the mental health system and open the access to especially vulnerable groups (e.g. refugees, elderly, women, children etc.) (Kieft et al., 2008; Rao, 2006), on the other hand they can be used as personal power to fill (personnel) gaps in the mental health system (Nielson 1995; Everly, 2002; Kieft et al., 2008).

VOLUNTEERISM

According to the Interparliamentary Union volunteerism is defined by the following three characteristics (Interparliamentary Union, IFRC & UN Volunteers, 2004):

<i>ELEMENTS OF THE DEFINITION OF VOLUNTEERS</i>
No financial reward
Voluntary
Benefit for others

Table 5 Volunteerism

NO FINANCIAL REWARD

Voluntary activity is not undertaken primarily for financial reward, although reimbursement of expenses and some token payment may be allowed and even recommendable to facilitate access of individuals from all economic backgrounds.

VOLUNTARY

It is undertaken voluntarily, according to an individual’s own free will.

BENEFIT FOR OTHERS

Voluntary activity brings benefits to people other than the volunteer, although it is recognized that volunteering brings significant benefit to volunteers as well.

The above mentioned element that volunteers work for beneficiaries that are not known to them does not apply to all volunteers and is therefore left out.

PARAPROFESSIONALS / LAY COUNSELLORS

In the following we will give a definition of paraprofessionals/lay counsellors. Paraprofessionals/lay counsellors can be seen as a variation of volunteers. Nevertheless paraprofessionals may be distinguished from volunteers in their employment and payment. Contrarily to volunteers paraprofessionals can be employed by organizations and receive payment for their time and service.

“The term *paraprofessional* seems to have as many definitions as there are individuals who use it” (DeMoss, 1974, p.315). In this quotation DeMoss sums up the difficulties in defining non – professional personnel. Also Delworth (1974a) describes the problem of defining

paraprofessionals. She states, "...we are defining paraprofessionals as persons who are selected, trained, and given responsibility for performing functions generally performed by professionals"(p. 250).

Tan (1997) describes paraprofessional/lay counselors as persons who do not possess formal credentialing, training, and experience as mental health professionals.

Mackinger et al. (1983) describe lay people with no training in the psychiatric- psychological activity. DeMoss (1974) defined a paraprofessional as a person doing the same tasks as a professional, but who did not have an advanced degree in that specific kind of area.

"To me, a paraprofessional –in counselling, social work, or psychology- is any individual who engages in activities usually reserved for a professional, that is, an individual with an advanced degree in the field." (DeMoss, 1974, p. 315). Furthermore he saw the differences between professionals and paraprofessionals in their fees and that paraprofessionals are usually employed by agencies.

In some definitions paraprofessionals have a relevant background, experience and interest in the specific field of volunteering. Paraprofessionals are defined by their lack of skills and training as a mental health professional. Nevertheless, most paraprofessionals have some kind of training tailored to the specific needs in their field of activity (Delworth, 1974a; Silver & Stonestreet, 1978; Tan, 1997).

Volunteers and paraprofessionals are sometimes defined by their activity. In some areas (counselling refugees/asylum seekers; chronic ill people; church-based ministries; schools etc.) it is necessary that volunteers are peers. Paraprofessionals can be defined as lay people who do not possess formal credentialing and training as mental health professionals. Volunteers can also be professionals who work voluntarily in humanitarian organizations but do not get payment for their time and service.

2.2.2 Legal Aspects of Volunteering in General

As per definition lay counselling is usually carried out by volunteers, the general criteria for volunteerism apply to lay counselling as well as some general legal aspects of volunteerism. Different legislative frameworks exist throughout the European countries. An overview and details on specific countries can be found at the homepages of the Association of Voluntary Service Organisations (AVSO) and the European Volunteer Centre-Centre Européen du Volontariat (CEV):

<http://www.avso.org/en/activities/CEV&AVSO.htm> and http://www.cev.be/legal_status.htm.

Definition of volunteerism used by the European Volunteer Centre:

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

(CEV & AVSO, 2003, p. 2)

In a joint project of the International Federation of Red Cross and Red Crescent Societies, the Inter-Parliamentary Union and United Nations Volunteers, a guidance note on Volunteerism and Legislation was published in 2004. One of the core problems concerning volunteerism and law is the lack of a legal definition and a unique legal status of volunteers in many countries. Several areas of law have an impact on volunteerism, which often complicates situations.

Areas of law that have an impact on volunteerism:

- Fundamental rights and freedoms
- International law
- Labour law
- Tax law
- Social welfare law
- Immigration law
- Regulatory frameworks for non-profit or charitable organisations

International law and immigration law for example often cannot protect volunteers working in foreign countries, because they rarely offer an appropriate legal status for volunteers. This often results in using student-, tourist- or business-visa – none of which adequately fits the situation of volunteers.

The most obvious and common legal problems in regard to volunteerism result from overlaps of some areas of volunteer work with other activities and conditions (such as paid work or diplomatic activities as well as more complicated issues such as questions of taxation, insurance or liability).

DESIRABLE ELEMENTS IN LEGAL FRAMEWORKS

“General principles of volunteerism:

- *volunteers participate on the basis of freely-expressed consent;*
- *volunteering is not compulsorily undertaken in order to receive pensions or government allowances;*

- *volunteering is not carried out in expectation of any financial gain;*
- *volunteering complements, but must not result in, the downsizing or replacement of paid employment;*
- *volunteerism should be encouraged with a certain degree of autonomy from the public authorities, to safeguard its independence;*
- *volunteering is a legitimate way in which citizens can participate actively in the development of community and social life and address human needs;*
- *volunteers act for the common good and on the basis of a social commitment;*
- *volunteering promotes human rights and equality;*
- *volunteerism respects the rights, dignity and culture of the communities involved;*
- *volunteer recruitment is based on equal opportunity and non-discrimination;*
- *volunteering is inspired by democratic, pluralistic, participative and caring social tenets.”*

(Inter-Parliamentary Union, IFRC & UN Volunteers, 2004, p. 20)

Based on these general principles two measures could be of great value and adjuvant for the further development of volunteerism:

1. a clearly defined legal status for volunteers (in national- and international laws)
2. including elements corresponding to this code of conduct;

“A **code of conduct** for volunteers and volunteer-involving organisations could include the following provisions:

“Protection of volunteers:

- *The right to receive the necessary information, training, supervision, personal and technical support for the discharge of their duties;*
- *Insurance against the risk of accidents and illness related to the volunteer activity;*
- *The right to work in safe, secure and healthy conditions;*
- *The right to be reimbursed for reasonable expenses related to the volunteer activity, as well as to be provided with basic subsistence support for food and accommodation whenever the volunteer assignment so requires, and previously agreed with the host organisation; and*
- *Appropriate accreditation, describing the nature and length of time of the volunteer activity, as well as certification acknowledging the volunteer's*
- *Contribution at the end of the service*

Duties of volunteers:

To respect the objectives and observe the regulations of the organisation in which they are involved;

- *To respect the rights, beliefs and opinions of beneficiaries; and*
- *To participate in any necessary training courses provided by the host organisation.*

Responsibilities of volunteer-involving organisations:

- *To ensure that an appropriate insurance policy is in place for volunteers, covering eventual risks of accident or illness directly related to the volunteer activity;*
- *To reimburse any expenses incurred by volunteers in fulfilling their volunteer tasks, up to the reasonable limits previously agreed with the volunteer;*
- *To provide volunteers with appropriate infrastructure for the discharge of their duties;*
- *To provide appropriate information to their volunteers on the nature and condition of their voluntary assignment;*
- *To provide volunteers with appropriate training;*
- *To ensure safe, secure and healthy conditions at work, in accordance with the nature of the volunteer activity;*
- *To provide their volunteers with accreditation and issue a certificate acknowledging their contribution at the end of their service; and*
- *To assume third-party liability for any damages or injuries their volunteers may cause by any action or omission in the course their voluntary work, provided that the volunteers act with due diligence and in good faith.”*

(Inter-Parliamentary Union, IFRC & UN Volunteers, 2004, p. 21)

Currently – 2011 is the “European Year of Volunteering” – some promising initiatives are carried out in many European countries, to realize some of the above in national and international law (see: <http://www.avso.org>).

2.2.3 Volunteer motivation: collective versus reflective attitude

There is a changing position and meaning of paid work in western societies. Therefore a new role and potential are attributed to voluntary work in times of structural crisis of fulltime employment. Hustinx & Lammertyn (2004) interviewed 652 volunteers of the Flemish Red Cross and found the following: no matter how important their volunteer work is the paid job will always come first for the volunteers. They also consider it normal that society values paid work more than unpaid. Only a minority would be willing to cut down working hours

because of financial reasons. They all had a strong work orientation. Both spheres are associated with different meanings and functions. Volunteer work has to be “serious” leisure for the volunteers; it does not just supplement the paid job but is seen as important for their self-development.

Lee and Brudney (2009) state that policies that promote a sense of embeddedness in the community and that link the workplace and volunteer opportunities would help rational persons to volunteer. Collective volunteerism has its roots in a local community or a relatively closed group of reference. It is initiated and coordinated by groups, irrespective of the objectives of the individual group members (Eckstein, 2001, p. 829). Through strong social-cultural and locally anchored group embeddedness, stable modes of living and self-understanding are ensured. Volunteering is a natural and unquestioned aspect of the collectively prescribed code of conduct. The individual biographical course only acquires meaning and direction through a self-evident subordination to collective goal setting. Volunteering is essentially an expression of the volunteer’s group belonging and a way of delineating community boundaries (cf. Eckstein, 2001; Jakob, 1993; Kühnlein & Mutz, 1999; Wuthnow, 1996, 1998).

Motivations to volunteer have been well investigated. Chacon and Vecina (2000) declared that, motivations have long been considered a crucial factor in distinguishing a long-term volunteer from one who decides to stop. On the other hand, motivations influencing the decision to become a volunteer are different from those influencing volunteerism retention (Gidron, 1984; Oda, 1991; Winniford et al., 1995). It was demonstrated that individuals who think volunteerism to be an opportunity to learn capacities and competencies useful to themselves, are involved in the service for a shorter time (Capanna et al., 2002). In the view of Marta and Pozzi (2008) self-oriented motivations seem to favour the choice to become a volunteer, but not the choice to maintain the commitment. This seems to be typical of young volunteers. Only if volunteerism becomes part of their identity they stay committed.

According to Haski-Leventhal and Bargal (2008) the elements of volunteer motivation may change significantly during the period of volunteering. People may start to volunteer for certain reasons, such as a desire to help others, and continue to do so for different reasons, such as a strong affiliation with a volunteer peer group. Costs and benefits, perceptions and attitudes, as well as relations with others, may all alter over time. Thus, the features of volunteering should not only be categorized according to the different kinds of people who volunteer but also according to the different stages they are in regarding their careers as volunteers. Omoto and Snyder (1993, 2002) developed a theory about the ‘life cycle of volunteers’. They distinguished three modules: antecedents (including motivation to volunteer); the volunteer experience; and the consequences of volunteering. They described the characteristics of the agency, the volunteer and the social system in each stage, but did not explain the process volunteers undergo in the roles they undertake. Other researchers have focused on volunteer training (Mumford, 2000) and how it can increase organizational identification of volunteers with their organization (Simon et al., 2000).

Hustinx and Lammertyn (2004) found the following factors defining volunteer attitude:

(a) *The perception of the organizational environment*: the perceived level of bureaucracy and the volunteer's valuation of the mission of the organization.

(b) *The motivation to volunteer*: the importance attached to recognition, satisfaction and self-development derived through volunteering.

(c) *The volunteer's commitment to organization and volunteer work*: the degree of loyalty, devotion, and choosiness of the volunteers, as well as their preference for a low level of commitment.

(d) *The tolerance toward organizational demands*: tolerance toward training demands and toward interference in the intensity of commitment.

Hustinx and Lammertyn (2004) differentiate between the collective and the reflexive attitude: the collective volunteers are very loyal and devoted and willing to accept a demanding commitment. They identify strongly with the mission of the organization and are less critical regarding bureaucratic tendencies. They are primarily other-oriented: They put great emphasis on recognition received from the broader community and gain satisfaction through social contacts and feelings of belonging to the volunteer group. As they are strongly embedded in collective traditions, self-development is of secondary importance. Because they value greatly the voluntary nature of volunteering, they will take a negative stance toward professional demands imposed by the organization. But their strong identification with the goals of the organization they tend to accept prescriptions concerning the intensity and length of their involvement.

Reflexive volunteers take the opposite position on each dimension. But nevertheless a high level of reflexivity does not prevent volunteers from strongly identifying with the mission of the organization, being loyal and devoted, or striving for social recognition.

In a cluster analysis 4 clusters could be identified two of which (1 and 4) were the collective resp. reflexive type; the other two were mixtures of the two attitudes. According to the authors one could interpret the clusters in terms of the level of identification with and subordination to the organization. On the one hand, the clusters could be distinguished according to the strength of the general identification with or the commitment to the organization and volunteer engagement (indicators were the factors Mission, Bureaucracy, Recognition, Satisfaction, Self-Development, Loyalty, and Devotion). On the other hand, the volunteer types differ according to the extent to which they subordinate themselves to organizational demands or put their own needs and preferences first (indicators are the factors Choosiness, Low Commitment, Training, and Intensity).

The 4 clusters were named as follows: *Unconditional* (Cluster 1), *Critical* (Cluster 2), *Reliable* (Cluster 3), and *Distant* (Cluster 4) volunteer type. The *Unconditional* cluster is reflected in a very strong identification with and subordination to the organization and volunteer experience. The volunteers of the *Distant* cluster are characterized by their remarkably weak identification and subordination. The group of *Critical* volunteers also displays high levels of

devotion and identification, but the most characteristic property of this cluster is the critical evaluation of the organizational environment. The *Reliable* attitudinal cluster only moderately identifies with the Red Cross involvement and is not particularly inclined to set aside the individual preferences. However, this does not constrain the volunteers' level of devotion, therefore they were named reliable.

The *Unconditional* and *Critical* types are equally intensively involved and clearly overrepresented among the volunteers who participate on at least a weekly basis and who invest more than 24 hours per month. A larger proportion of the volunteers of the *Unconditional* group are involved on a long-term basis, but compared to the other two clusters, both groups have served Red Cross Flanders significantly longer.

The *Critical* cluster personifies the type of volunteer, who is extremely versatile and entrusted with the vital tasks within the organization. Compared to the other clusters, these volunteers have a significantly greater chance to hold a position on an executive board, and they participate considerably more often in meetings and decision-making processes. Furthermore, they are substantially more likely to take responsibility for the organization of activities, administrative tasks, training activities, and lecturing. These volunteers are also most likely to take care of funding activities and to do the odd jobs.

The *Unconditional* cluster volunteers form a front line when it comes to the actual assisting or supporting work with which the Red Cross is concerned. Together with the *Critical* volunteer group, they also contribute the largest share of the fund-raising activities. Compared to the *Reliable* and *Distant* volunteer groups, the *Unconditional* cluster is better represented in volunteer committees and substantially more involved in the organization of activities and in administrative tasks. On the other hand, they are least likely to perform training and lecturing activities, and do not attend meetings or participate in decision making.

The *Distant* volunteer group is clustered around the volunteers with a typically loose type of involvement: infrequent, not really time-consuming, and on a short-term basis. Moreover, the nature of their activities is much focused: Apart from providing assistance, these volunteers are relatively well represented in meetings and training activities. They are remarkably less responsible for the organization of activities and for administrative tasks.

In comparison with the *Distant* cluster, the *Reliable* volunteer group is more frequently involved and invests more time in the volunteer activities. The volunteers of the *Reliable* cluster also have a significantly larger number of years of experience as a Red Cross volunteer. The *Reliable* volunteers do not occupy a central position in the organization: They are underrepresented on executive boards, in meetings and decision-making processes, and in the organization of activities. Nevertheless, they are involved on a steady and fairly intensive basis and provide a considerable volunteer force for the performance of

supporting and funding activities. Taking into consideration that these volunteers perceive themselves as very devoted and loyal volunteers, and that they are involved on a dependable basis, this is an essential group for supporting the organizational work despite its rather subsidiary position.

On the basis of the basic assumption of collective versus reflexive types the authors assume that the more collective the volunteers' cultural embedding, the more unconditionally they will relate to the volunteer experience, whereas the more reflexive the cultural frame of reference, the more distant the volunteers' dispositions will be.

2.3 PSYCHOSOCIAL INTERVENTION FORMS, METHODS AND OBJECTIVES

We will first present an overview on intervention forms in the following table. Thereafter we will give more detailed information on the intervention methods presented here.

2.3.1 Overview and description of the intervention methods

PSYCHOSOCIAL SUPPORT

As stated above, the term psychosocial support refers to the actions that address both the psychological and social needs of individuals, families and communities. Psychosocial support aims at enhancing the resilience of the affected individual, group and community, resilience being the ability of an individual or group to find back to normality after adverse experiences. In Psychosocial support this is done by promoting the resources of individuals, families or groups as well as the community as a whole. It can prevent distress and suffering from developing into something more severe and shall help overcome adversities, coming back to normality and recover after crisis. Silove and Zwi (2005, p. 270) gave the following examples of psychosocial support interventions after disasters and stated that "there is a growing consensus that psychosocial programmes should operate a multiple levels and should: (1) provide early, accurate, and well-targeted information about trauma and grief responses and their natural histories; (2) promote and resource the work of indigenous recovery systems (religious, spiritual and cultural), as well as local nongovernmental organizations and public-sector services; (3) attend to context-relevant training, mentoring support, and supervision of front-line personnel across the sectors of health, education, police, and social services; (4) assist in developing community mental-health services to extend skills and ensure geographical coverage; and (5) advice on the coordination and planning of services, and in so doing, maintain a medium-term to long-term horizon aimed at sustaining developments."

PSYCHOLOGICAL FIRST AID (PSFA)

Psychological first aid is a term that refers to a separate and unique form of community-based psychological support that is complementary to disaster mental health (Jacobs & Meyers, 2005) Psychological first aid contains the following 8 principles of action: Contact and engagement, safety and comfort, stabilization, information gathering: needs and current

concerns, practical assistance, connection with social supports, information on coping, linkage with collaborative services first used in the Field operations guide (Brymer et al., 2006).

There is a big amount of literature and guidelines on the principles and effectiveness of PSFA and psychosocial support (see for example Schreiber et al., 2004; Silove & Zwi, 2005; Van Ommeren et al., 2005; Vandelpol et al., 2006; Vernberg et al., 2008; Brewin et al., 2008; Sibrandij et al., 2009; Vazquez et al., 2010; Bisson & Lewis, 2009; Snider et al., in press).

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INTERVENTION	ACTIVITIES	How	REFERENCES
Giving of information	Information on what to expect as well as on coping, Information on the crisis: a reliable flow of credible information about the emergency, efforts to establish physical safety, relief efforts of each organization and location of relatives	Face to face, via telephone, via the media given in an empathic manner	Cook Gotay & Bottomley, 1998; Giese-Davis et al., 2006; Hudson et al., 2002; Rainey, 1985; van Ommeren et al., 2005; Rao, 2006
Emotional and practical support	Listening not forcing talk, conveying compassion, ensuring basic needs, facilitating support from family members and significant others, protection from further harm, non-intrusive emotional support, coverage of basic needs, protection from further harm, organization of social support and networks	Face to face or via telephone	Bisson et al., 2003, 2007; Mollica et al., 2004; National Institute of mental health, workshop, 2002; NICE, 2005; NSW Disaster Mental Health Response Handbook, 2000; van Ommeren et al., 2005
Creating a safe place	Creating a safe place, re-establishing the protective shield, limiting horror talk and overexposure in social settings, information about friends and relatives, protection from bad rumours, provision of accurate information on events but also on coping. Normalization of life is one important aspect of promoting safety. It is done by the encouragement of normal activity, re-establishing cultural and religious events, schooling for children, recreational activities, reduction of diseases, normal social and economic activities, family reunification and protection from violence.	Face to face	Hobfoll et al., 2007; van Ommeren et al., 2005; Mollica, et al., 2004; Rao, 2006
Psychoeducation	Normalization of stress reactions, psychoeducation, inducing positive emotions, encouraging people to increasing activities that foster positive emotions, distancing oneself and reducing information input about event (let family member tell about event but no media	Face to face or via other media, one on one and group activities	Hobfoll et al., 2007; Wessely et al., 2008; Bisson et al., 2010; Zurek et al., 2007; Butollo & Krüsmann, 2006; Zurek et al., 2008

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	<p>exposure), help breaking down problems into small manageable tasks, sleep hygiene, guidelines for media exposure, relaxation training and anxiety management techniques.</p>		
<p>Empowerment</p>	<p>Use of local healers, collective rituals, rebuilding resources together with the affected, restoration of school community, promotion of self-sufficiency and self-government, teaching emotional regulation skills when faced by reminders and enhancement of problem solving skills in regard to post trauma adversities, special interventions for children such as age appropriate mourning rituals and pro social activities in schools, rebuilding and conservation of resources (close cooperation with development initiatives)</p> <p>Encourage people to engage in tangible, purposeful activities of common interest, inclusion into social networks of people without family</p>	<p>Group meetings and shared activities, economically productive activities, conscious social communication and social participation in groups</p>	<p>Ager, 1997, 2000, 2002; Anckerman et al., 2005; Dybhal, 2001; Hobfoll et al., 2007; McDonald, 2002; Mollica et al., 2002, 2004; Saltzman et al., 2006; van Ommeren et al., 2005</p>
<p>Social support</p>	<p>Fostering connections as quickly as possible after mass trauma and assisting people to maintain them, group interventions with adolescents teaching forms of social support (emotional closeness, feeling needed, reassurance of self-worth, reliable alliance, advice, assistance, material support) identifying resources of such support and how to appropriately recruit support being aware of social support loss cycles after trauma as well as negative social support (minimizing problems or needs, unrealistic expectations regarding recovery, invalidating messages etc., identifying those who lack strong social support, who are isolated or whose social support is negative and then</p>	<p>Reestablishment of trust, group cohesion and effective social support in group settings</p>	<p>Anckerman et al., 2005; Andrews et al., 2003; de Jong, 2002 b; Hagan, 2005; Hobfoll et al., 2006, 2007; Hobfoll & London, 1986; Mollica et al., 2004; Layne et al., 2001; Litz & Gray, 2002; Sattler et al. , 2002; Shalev et al., 2004; Ursano et al., 1995; van Ommeren et al., 2005</p>

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	keep them connected, teach them how to access social support and/or provide more formalised support, re-establish social networks, treating temporary camps as villages rather than camps with village councils, village welcoming committees, places of worship, places of services, meeting places, entertainment places, places for teens to meet under supervision.		
Strengthening resources	Providing services to people that help them get their lives back in place in terms of housing, employment etc. (employment status best predictor of hope developing advocacy programs for victims, normalizing and decatastrophizing, interventions focused on already identified strengths and benefits rather than promoting benefit finding before the person is ready to do so	Focus on community and group interventions that help to develop accurate risk assessment, positive goals and strengths they have as individuals and community Home visits, involving members of community	Crowson et al., 2001; Hobfoll et al., 2006, 2007
Promotion of emotion expression and experience sharing	Promotion of emotion expression and sharing of experience in group interventions discussion of trauma related topics, Community based self-help groups: problem sharing, solutions for better coping, mutual emotional support, promotion of community level activities	Via telephone or face to face	Anckerman et al., 2005; Cook Gotay & Bottomley, 1998; de Jong, 2002a, 2002 b; Giese-Davis et al., 2006; Hudson et al., 2002; van Ommeren et al., 2005

Table 6 Intervention methods

GIVING OF INFORMATION

Information on the crisis should include a reliable flow of credible information about the emergency, efforts to establish physical safety, relief efforts of each organization and location of relatives. Information should be given in a comprehensible and empathic manner (van Ommeren et al., 2005). Rao (2006) also stresses that information after an event should be accurate, reliable and clear.

Giving information includes information on what to expect as well as on coping. This can be done either face to face and/or via telephone (Hudson et al., 2002; Giese-Davies et al., 2006; Cook Gotay & Bottomley, 1998). Information is often best given by people who have the trust of the affected population. Somsè et al. (1998) for example trained traditional healers to reach out to the community to give information on Aids/HIV and sexually transmitted diseases. In a study on cancer patients it was found that affected persons find it important to speak with someone who has the same cancer, but has lived through the crisis of treatment and is leading a 'normal' life (Giese-Davies et al., 2006).

Giving information should be based on a thorough needs assessment and include also information on where to seek further help such as giving links to community services, outreach services and psychological help (Rainey, 1985; Kukafka et al., 2009, Somsè et al., 1998).

EMOTIONAL AND PRACTICAL SUPPORT

Emotional and practical support (Psychological first aid) contains listening, but not forcing talk, conveying compassion, ensuring basic needs, facilitating support from family members and significant others and protection from further harm (Disaster Mental Health Response Handbook, 2000, NSW; Mollica et al., 2004, National Institute of Mental Health, Consensus workshop, Washington, 2002) including non-intrusive emotional support, coverage of basic needs, organization of social support and networks (van Ommeren et al., 2005), practical support (NICE 2005, Bisson et al., 2003, 2007) and emotional support (NICE 2005, Bisson et al., 2003, 2007).

CREATING A SAFE PLACE

The provision of a sense of safety is one important step to manage a traumatic situation. Hobfoll et al. (2007) state the importance of creating a safe places, re-establishing the protective shield, limiting horror talk and overexposure in social settings. People need information about friends and relatives, protection from bad rumours, provision of accurate information on events but also on coping in order to gain a sense of safety (Hobfoll et al., 2007; Rao, 2006). Furthermore it is important to provide a safe physical space (van Ommeren et al., 2005). Especially after disasters the protection of unaccompanied minors and the protection of girls and women is of utmost importance. Normalization of life

contains the encouragement of normal activity (van Ommeren et al., 2005), encouraging community participation, e.g. re-establishing cultural and religious events, schooling for children and recreational activities (van Ommeren et al., 2005). Normalization of everyday life can be achieved through reduction of diseases, establishment of normal social and economic activities, family reunification and protection from violence (Mollica et al., 2004).

PSYCHOEDUCATION

Psychoeducation is increasingly used following trauma. The term covers the provision of information about the nature of stress, posttraumatic and other symptoms, and what to do about them. The provision of psychoeducation can occur before possible exposure to stressful situations or after exposure. The intention is to ameliorate or mitigate the effects of exposure to extreme situations. Educational information can be conveyed in a number of ways and is also part of what has been termed psychological first aid. (Wessely et al., 2008). It aims at calming the affected person by normalization of stress reactions and by inducing positive emotions and encouraging people to increase activities that foster positive emotions. Further methods to promote calming is distance oneself and reduce information input about the event, that includes to let family member tell about event but do not expose to the media. Further interventions target on helping to break down problems into small manageable tasks, sleep hygiene, guidelines for media exposure, relaxation training and anxiety management techniques.

EMPOWERMENT

Empowerment is an important aspect of psychological first aid and psychosocial support. It is done by involvement of the affected population, the use of local healers, collective rituals, rebuilding resources together with the affected and restoration of school community. The promotion of self-sufficiency and self-government, the teaching of emotion regulation skills when faced by reminders and the enhancement of problem solving skills in regard to post disaster adversities should be also targeted in interventions. It is of importance to have special interventions for children such as age appropriate mourning rituals and pro-social activities in schools (Saltzman et al., 2006). Rebuilding and conservation of resources can be done in close cooperation with development initiatives. Moreover it is vital to encourage people to engage in tangible, purposeful activities of common interest, that people without families are also included into social networks (van Ommeren et al., 2005) and community based resiliency and adaption is mobilized (Mollica et al., 2004; Rao, 2006).

For refugees economically productive activities (Mollica et al., 2002), group meetings and shared activities have been promoted (Ager, 2000, Dybdahl, 2001). The enhancement of wellbeing as well as repairing damaged social structures is a central psychosocial intervention strategy (Mollica et al., 2004). The focus on particularly affected areas should be on human capacity such as skills, knowledge and capacities; social ecology like social connectedness and networks; culture and values (Mollica et al., 2004; Uitterhaegen, 2005).

People need support to enhance wellbeing by strengthening each of these areas (McDonald, 2002; Ager, 1997; Ager, 2002). Furthermore all activities should be based on cultural competence which involves the following: knowledge of the population, diversity in organization governance and decision making, mandatory cultural competence training, promoting delivery of culturally competent health care, measurement of outcomes (Mollica et al., 2004).

Empowerment of the affected includes the respect of autonomy and freedom of the affected population. All activities should moreover be based upon consent, community input and community participation (Mollica et al., 2004). The protection of and respect for survivors' defences should be granted as well as being careful with talking about trauma especially in early stages (Mollica et al., 2004).

Community Empowerment (Anckerman et al., 2005) aims at developing and strengthening community members' social and organizational participation in decision-making processes in local and national politics.

Intervention strategies include conscious social communication and social participation, accomplished through group sessions. The methods are inspired by systemic dialogue and embrace conflict resolution and respect for diverse perspectives (e.g. Rao, 2006). Anckerman et al. (2005) also mentioned the importance of coordinating different intervention programs. *"Empowering the affected community involves the support and encouragement of:*

- *Group cohesion in the community*
- *Verbalization of problems and resources, leading to narratives promoting active social participation in the development of the community*
- *A sense of belonging in a practical, active, participatory and contributing way to the community, i.e. the building of social support systems*
- *The maintenance of adequate interpersonal relations through trust, solidarity and dialogue*
- *Increase in discussions on educational and health related issues*
- *Subjectivity as the process of performing informed choices between alternatives and being respected in this*
- *Discussions on ethical and political issues, including conflict resolution and reconciliation."*

(Anckerman et al., 2005, p. 147)

SOCIAL SUPPORT

Almost all researchers in the field recommend to foster connections as quickly as possible after mass trauma and crisis and by assisting people to maintain these connections (some of them being: Litz & Gray, 2002; Shalev et al., 2004; Ursano et al., 1995; Hagan, 2005; Hobfoll et al. 2007). In the further course of events special projects can be done in order to enhance connectedness and group cohesion, for example gGroup interventions can be done for

example with adolescents teaching forms of social support (emotional closeness, feeling needed, reassurance of self-worth, reliable alliance, advice, assistance, material support), identifying resources of such support and teaching how to appropriately recruit support (Layne et al., 2001). It is necessary to be aware of social support, loss cycles after trauma as well as negative social support (minimizing problems or needs, unrealistic expectations regarding recovery, invalidating messages etc.) (Andrews et al., 2003; Hobfoll & London, 1986). It is crucial to identify those who lack strong social support, who are isolated or whose social support is negative and then keep them connected, teach them how to access social support and/or provide more formalized support and re-establish social networks: one form is to treat temporary camps as villages rather than camps with village councils, village welcoming committees, places of worship, places of services, meeting places, entertainment places, places for teens to meet under supervision (de Jong, 2002 b; Sattler et al., 2002). Moreover it is essential to be aware that in- group out- group processes become reactivated after mass trauma (Hobfoll et al., 2006).

Community Healing (Anckerman et al., 2005) has the main focus on the problems emerging in the interaction between people and their practical living and revolves around unmet needs in communities with high numbers of individuals and families affected by torture and other forms of organized violence. The overall objectives of interventions for community healing are to support the community members and to develop appropriate knowledge and skills useful for the healing process in the affected community.

Intervention strategies include the community reflection groups and self-help groups.

In order to (re)-establish reliable interpersonal relationships through discussions and analyses of problems, participants express their problems and opinions. These need to be reflected upon in the group in a positive manner, thus supporting personal and collective recovery. The group process is utilized to actively build up a trustful social support system.

Methods used are the following:

- *“Collecting a description of the problems and resources as recognized by the members of the community*
- *Telling and listening to the stories about what happened and jointly reframing these stories in a shared, meaningful and coherent narrative*
- *Initiating and supporting a dialogue about problems and resources*
- *Fostering a sense of meaning and spiritual understanding*
- *Nurturing social coherence, including togetherness and mutual support.*
- *Generating a community based sense of belonging and being a community.*
- *Promoting a jointly negotiated conscience, i.e. a comprehension of right and wrong, good and evil.*
- *Promoting solidarity in interpersonal relationships and encourage group cohesion.”*

(Anckermann, 2005, p. 145-146)

STRENGTHENING RESOURCES

Instilling hope (Hobfoll et al., 2007) by providing services to people that help them get their lives back in place in terms of housing, employment etc. The employment status has shown to be the best predictor of hope (Crowson et al., 2001). Developing advocacy programs for victims, normalizing and decatastrophizing can instil hope. Interventions focused on already identified strengths and benefits rather than promoting benefit finding before the person is ready to do so (Hobfoll et al., 2006). The focus is on community and group interventions that help to develop accurate risk assessment, positive goals and strengths they have as individuals and community, including home visits, and the involvement of members of the community (see also Schreiber, 2004).

Community Development (Anckerman et al., 2005) consists of changing the practice of living to more participatory social actions, leading to locally based economic development and community welfare. People should be able to participate and be actively involved. Intervention strategies focus on participants taking an active role in the identification and analysis of community problems and the development of capacities for problem solving and action. Kieft et al. (2008) trained refugees to close a gap of restraint of entering the health care system, but also to empower the refugees and prevent the occurrence of bigger problems. Community life projects contain joint activities that revolve around shared initiative and collaboration in a present–future perspective (e.g. around problems with water distribution or transportation) as well as continuous reflection (reflection group).

PROMOTION OF EMOTION EXPRESSION AND EXPERIENCE SHARING

An intervention method that has proven effectiveness especially in the mid and longterm phases after disaster or in the field of chronic trauma such as living through a life threatening illness was the promotion of the expression of emotion and sharing of experience (Cook Gotay & Bottomley, 1998, Giese-Davies et al., 2006, Hudson et al., 2002). Giese-Davis et al. (2006) found in their study that women with breast cancer want to speak with other women who have lived through the same type of cancer. Promotion of emotion expression and sharing of experience was used in group interventions via telephone; discussion were on topics like death and dying, impact of illness etc. (Cook Gotay & Bottomley, 1998) Telephone counselling for cancer patients can reduce feelings of loneliness- especially in those patients who are isolated-, but a safe distance and some anonymity can be guaranteed (Cook Gotay & Bottomley, 1998).

Peer helpers within the psychiatry are experienced people who hand their experience over to others. Utschakowski (2009) stated that peers play an important role in the Psychiatry because they cannot only deliver information and education, but also share experience. He emphasized that especially in the Psychiatry the experience with stigmatization and discrimination; shared experience can advance solidarity and the feeling of being understood.

De Jong (2002a, 2002b) recommends the organization of community based self-help groups, problem sharing, solutions for better coping, mutual emotional support and promotion of community level activities as further interventions (van Ommeren et al., 2005, Anckerman et al. 2005).

2.4 EFFECTIVENESS OF INTERVENTIONS

In the following we summarize studies on the effectiveness of lay counselling/paraprofessional counselling and psychosocial support. These studies analysed whether there were any measurable changes in the clients and how satisfied the clients were with the interventions. Evaluation is seen as a very important aspect of psychosocial programmes. The IFRC reference centre for psychosocial support recommends needs assessment, monitoring and impact assessment (Psychosocial interventions: a handbook, IFRC reference centre for psychosocial support, 2009). DeMoss (1974) claimed that the success of a counselling centre employing paraprofessionals is also dependent on publicity, training, community relations, strong liaison with other resource agencies, models, planning, pilot studies, research, evaluation, program development, implementation, evaluation as well as budgeting.

2.4.1 Evaluation Methods

Methods used in evaluating psychosocial support programmes include a broad variety of quantitative and qualitative methods such as questionnaires, interview guidelines, focus group discussion or observation guidelines. Garzon & Tilley (2009) conclude that not enough empirical studies exist to proof the efficiency of Christian lay counselling, also Brown (1974) criticizes that most research on the effectiveness of interventions done by volunteers lack in methodological coherence. Scanish & Wheaton (1996) demand the development of ethical standards for Christian lay counselling as they are still lacking. Gruver (1971, in Brown, 1974) find that only 25% of all reports on the effectiveness of paraprofessional counselling use experimental and control samples, pre-and post- assessment or objective criteria. However, Kurland (1973) stresses that interventions done by volunteers can be effective when trained properly.

As stated above methods used for evaluation range from questionnaires and interviews to professionals' structured observations of changes in the communities, which may form the basis for a pilot testing of a semi-structured interview guide for focus group discussion sessions with program participants. Other evaluation methods are pre- and post-assessment of the clients or trainees (e.g. Aladag & Tezer, 2009), feedback from clients, interviews with clients (e.g. Easton et al., 1985) or counsellors (e.g. Thara et al., 2008) or standard tests on e.g. depression or other outcome criteria (e.g. Silver & Stonestreet, 1978). Further methods are the measurement of objective outcome criteria (institutional factors), also as the rate of usage of the counselling centre by the client. Silver & Stonestreet (1978) argue that a higher

usage of the counselling centre can be connected to a higher satisfaction of the client with the service of the centre.

Evaluation studies also test changes in paraprofessionals themselves, the effectiveness of the training or how effective paraprofessionals are in their work. Sometimes changes in paraprofessionals and either the effectiveness of the training or the effectiveness of paraprofessional counselling are combined.

2.4.2 Effectiveness of Interventions

As stated above many studies have shown that psychosocial support and its main elements are effective (see for example Hobfoll et al., 2007). Furthermore, some studies could also show that lay counselling can be as effective as professional counselling (Carkhuff, 1968; Collins, 1987; Gunzelmann et al., 1987; O'Donnell, & George, 1977). Effectiveness of paraprofessional counselling has been shown for example with lay people working in psychiatry or as lay therapists (Mackinger et al., 1987; Schöck, 1996; Müller-Kohlenberg, 1996, Debate & Plescia, 2004-2005; Tan, 1987; Carkhuff & Truax, 1965). Bowman & Myrick (1985) report positive effects of helpers and children who were being helped by a peer helper program.

PSYCHOSOCIAL SUPPORT/PSYCHOLOGICAL FIRST AID

Among others Mollica et al. (2004) stated that psychosocial interventions are effective. An evaluation of psychosocial interventions post-Tsunami for example showed that the community was very happy with the interventions, but the duration of interventions should be at least six months and one-on-one settings were preferred except in children. Psychosocial support trainings and interventions should be coordinated to prevent overlaps (Thara et al., 2008).

Hobfoll and his colleagues (2007) reviewed the literature on psychosocial support and psychological first aid and came to a strong consensus that psychological support should be provided for those involved in disasters; that responses should promote the following five aspects:

- a sense of safety
- self and community efficacy
- connectedness
- calm
- hope

The provision of a sense of safety is effective in reducing stress and is working against dysfunctional cognitions (Ozer et al., 2003; Silver et al., 2002; Bleich et al., 2003; Grieger et al., 2003; Bryant 2006). Also the promotion of calming is effective (Davidson et al., 2002; Foa et al., 2000; Davidson, 2010).

The promotion of a sense of self and community efficacy is proven to be efficient (Saltzman et al., 2006, Goenjian et al., 1997, 2005; De Jong & Clark, 1996; de Jong, 2002b). The more the victims are empowered the more they move to the survivor status (de Jong, 2002b; de Jong, 1995; Paardekooper, 2001; Benight et al. 2000, Benight, 2004).

There is also evidence for the effectiveness of empowerment for example by enabling economically productive activities in Cambodian refugees (Mollica et al., 2002), group meetings and shared activities in Bosnian refugees (Ager, 2000; Dybdahl, 2001). Evaluation of effectiveness of a six months peer counselling for breast cancer patients showed significant improvement in trauma symptoms, emotional well-being, cancer self-efficacy, and desire for information; it was shown that the effective phase was within the first year after the diagnosis (Giese-Davies et al. 2006).

The promotion of connectedness is effective (Norris et al., 2002; Vaux, 1988; Bleich et al., 2003; Rubin et al., 2005; Stein et al., 2004; Galea et al., 2002, 2003; Hobfoll et al., 2006; Punamäki et al., 2005; Norris et al., 2005; Altindag et al., 2005; Solomon et al., 2005). Teaching support seeking skills is shown to be most effective (Cox et al., 2005). Moreover the effectiveness of interventions creating social support is also proven (Simeon et al., 2005; van Ommeren et al., 2005). Also instilling hope is effective (Carver & Scheier, 1998; Antonovsky, 1979; Hobfoll et al., 2003).

According to Hobfoll et al (2007) the promotion of calming is effective. It should be done by normalization of stress reactions, psychoeducation, inducing positive emotions, encourage people to increase activities that foster positive emotions, distance oneself and reduce information input about event (let family member tell about event but no media exposure), help breaking down problems into small manageable tasks, sleep hygiene, guidelines for media exposure, relaxation training and anxiety management techniques (see also Davidson et al, 2002, Foa et al, 2000, Davidson et al, 2000).

Instilling hope is effective (Carver and Scheier 1998, Antonovsky 1979, Hobfoll et al 2003). According to Hobfoll (2003) it is important to have not an action oriented view on hope, not efficacy oriented but based on past experience and belief. There is a danger of basing hope only on an internal sense of agency. Psychosocial Interventions in this field should be: services to people that help them get their lives back in place in terms of housing, employment etc. (employment status is the best predictor of hope Crowson et al 2001).

COMMUNITY SUPPORT PROGRAMMES

In an evaluation of a community support program after conflict (Anckerman et al., 2005) community healing, community empowerment and community development were the given objectives. Healing indicators were respect, trust, solidarity, commitment and

communication. Empowerment indicators included self-definition as group members and as members of the community (e.g. by verbally expressing their achievements, needs, limitations and problems in plural, such as 'we think', 'we did', and 'we propose'; respect for the diversity of the participants). Development indicators contained observations of the reflection group and the political and economic development of the community. The development outcome in terms of sustainability was measured by the institutional level, and by the financial and technical level of the reflection group. A focus group discussion was led with program participants about their co-operations with other organizations and participations in other community groups, such as committees, pastorals, churches, that are also working for community development. All three objectives could be reached by the programme.

FACE - TO - FACE COUNSELLING

Evaluation of effectiveness of a six months peer counselling for breast cancer patients showed significant improvement in trauma symptoms, emotional well-being, cancer self-efficacy, and desire for information; it was shown that the effective phase was within the first year of the diagnosis. (Giese-Davis et al., 2006).

Recipients of lay counselling stated positive changes (e.g. regarding marital problems), less stress and a decrease of symptoms, high satisfaction with the counselling, increase of knowledge (e.g. STD, Aids), and a decrease of aggression (Most, & Guerny, 1983; Winston, & Buckner, 1984; Walters, 1987; Losee et al., 1988; Toh et al., 1994; Toh & Tan, 1997; Somsè et al., 1998; Goraieb, 1999; Peltzer et al., 2010; Allicock et al., 2010). Most & Guerny (1983) evaluate paraprofessional counsellors with qualitative observations and pre- and post-measurements assessing the efficiency of a training. Premarital couples that received paraprofessional counselling show enhanced self-assessed skill levels, an ability to deal with hypothetical marital problems and confidence to resolve future marital. Goraieb (1999) finds that in 29 subjects receiving church-based lay counselling; alcohol consumption, aggression and general pathological symptoms decrease after three months in the training program. They filled in several questionnaires on spiritual well-being, symptom checklists, index of alcohol involvement and aggression scales. Studies on paraprofessionals/volunteers in elementary and secondary school show that paraprofessionals/volunteers bring some positive (mostly significant) changes. They are appointed to work with problem students; retired people volunteered to meet students once or twice a week and counselling (Hoffmann & Warner, 1976). Also Renner (2011b) could find positive effects of self help groups for refugees guided by peers.

But there are also studies not reporting overall satisfaction. In a survey on the satisfaction of clients receiving paraprofessional counselling Walters (1987) find that some clients reported satisfaction independent from progress; other reported no satisfaction even with progress. Overall depressed clients reported less satisfaction than others. The same is true also for professional therapy.

Easton et al. (1985) find that clients rate their satisfaction good, very good or excellent after being recipients of paraprofessional counselling at a University counselling centre.

In one-on-one peer programs for cancer patients program users have better self-reported health status and better relationships with doctors than non-users (Ashbury et al., 1998). They also indicate more social support than control group (Weber et al., 2004; Vos et al., 2004). Cancer patients further report more satisfaction with pre-surgery care and provision of information and support (Geiger et al., 2000). Meetings with people who had lived through the same are perceived as beneficial (Rankin et al., 2004). Users of peer support or other forms of support do not differ in emotional or physical well-being (Rogers et al., 1985) or quality of life (McGovern et al., 2002).

TELEPHONE COUNSELLING

Losee et al. (1988) find in a study on elderly peer counsellors of a telephone hotline mainly used by elderly callers that volunteers with high technical effectiveness after training achieve more effectiveness in helping callers, but no greater satisfaction in callers. Volunteers with high clinical effectiveness after training achieve reverse outcome.

Several evaluations of telephone counselling have shown that telephone counselling with patients other than cancer is well established. There is noticeably an enhanced compliance (Lando et al., 1992), resource savings (Weinberger et al., 1993) and an increase in individual and family wellbeing (Johnson & Frank, 1995; Hornblow & Sloane, 1980; Preston et al., 1992; Cherry and Rubinstein, 1994). However, there is no effect on quality of life.

The major psychosocial problems of (cancer) patients are: depression, loneliness, anxiety and social concerns (Derogatis et al., 1983, Breitbart, 1995). The interventions by telephone are aimed at giving information on cancer (Vann et al., 1996, Morra et al., 1993, Kessler et al., 1993).

In an evaluation of a program that used trained volunteers Rainey (1985) found, that six months after the program the biggest concerns are anxiety, family problems and difficulties in the doctor patient communication. Interventions techniques used included information, needs assessment, linkage to community services, psychological help and outreach services. Polinski et al. (1991) report that in one - on -one telephone counselling by therapists (Mermelstein & Holland, 1992), trained nurses (Alter et al., 1996) or social workers (Polinsky et al., 1991) intervention methods included case management, information, emotional expression and cognitive restructuring. The outcomes contain mood improvement. In group telephone counselling interventions aimed at promoting expression of emotions and share experiences; interventions by trained and experienced facilitators included screening before entering group (Colon, 1996), discussion of topics like death and dying, impact of illness and other related topics. Smith et al. (1998) finds that in one-on-one telephone counselling

clients report positive experiences and an increased sense of confidence to succeed in rehabilitation. For patients in isolation benefits included sense of reduced isolation and safe distance (easier to share in anonymity). In general curricula and interventions that were not well described, no improvements in quality of life were found.

An evaluation of group intervention for cancer patients via telephone has shown that there are benefits for patients in isolation such as a sense of reduced isolation (Cook Gotay & Bottomley, 1998; Curran & Church, 1998) and safe distance (Cook Gotay & Bottomley, 1998). Participants of peer-support programs also report informational and emotional support (Rudy et al., 2001). Clients additionally report that they feel good to talk to others in similar situations (Reed, 2004). Smith & Toseland (2006) also report increased informational and emotional support for caregivers of frail older adults after participating in a telephone support group.

In group telephone counselling setting clients were also dissatisfied with the short duration of the sessions, the lack of face - to -face interaction (Reed, 2004; Curran & Church, 1998), lack of follow-up support and the unfamiliarity with the equipment (Curran & Church, 1998) as well as hearing the distress of others (Reed, 2004). Solberg et al. (2003) finds in a study on women with breast cancer using group telephone counselling that first the women get connected to the network, how to speak with each other, connect with others and finally become empowered.

It can be concluded from the results of the review that telephone counselling is perhaps only effective for certain groups of patients, moreover it is perhaps better if the intervention is done by peer counsellors.

Telephone support can contribute to an improvement in psychosocial status. However, even if there is a positive evaluation by patients, no effect could be established in quality of life. These results indicate that the intervention is perhaps useful only for certain groups of patients such as isolated persons, it can be used only by persons who have certain communication skills and perhaps it is better applied by peer counsellors, and there may be an optimal duration.

INTERVENTIONS THROUGH THE INTERNET

Internet based group interventions for cancer patients are perceived as valuable because of the provision of information, support and understanding. Feelings such as fear, anxiety, depression and hopelessness are reduced (Gustafson et al., 1993; Liebermann et al., 2003; Shaw et al., 2000; Winzelberg et al., 2003). Participants had higher scores on social and informational support and participated more in health care (Gustafson et al., 2001). Most participants of internet-based programs preferred these programs because of the anonymity (Sharf, 1997; Shaw et al., 2000), the temporal availability (Shaw et al., 2000) and comprehensiveness (Gustafson et al., 1993), Hoybye et al. (2005) state that the

empowerment of women through internet-based programs goes along with the provision of knowledge, the shared experience, the social intimacy and the new social world. Topics in internet-based programs are information (Sharf, 1997; Klemm et al., 1999), expression of personal opinions, shared experiences, thankfulness, humour, difficulties with posting messages (Klemm et al., 1998). Sharf (1997) additionally finds social support and empowerment as dimensions of internet-based programs. The programs are perceived as most helpful when clients perceive hope, group cohesion and universality (Weinberg et al., 1996a, 1996b).

2.5 FRAMEWORK OF LAY PSYCHOSOCIAL SUPPORT

2.5.1 General principles of psychosocial support in mental health care

Some general principles of psychosocial support in mental health care are the following:

According to many of the guidelines for psychosocial support (see guidelines in the reference section) it is important to do needs assessment, have a multi-layered coordinated response, do screening and have an outcome assessment. As stated above volunteers in the psychosocial field may complement the formalized mental health system but never substitutes it.

Needs assessment is the basis of all interventions (Rainey, 1985, Cook Gotay & Bottomley, 1998, NICE 2005, Bisson et al., 2003, 2007, Mollica et al., 2004; Eng & Young, 1992; Göskén et al., 1995; Waßmuth & Veelken, 1995; Haines et al., 2007). First one has to assess what people need before making further decisions such as what interventions to use. Interventions must meet different needs (Rao, 2006). According to the stage of the disaster interventions may have to supply different needs. Furthermore psychosocial support has to be multi-layered. Multi-layered response and stepped approaches from nonformalised psychosocial support, to more structured and specific interventions and finally specialized professional interventions, are also important (Hobfoll et al., 2007, Bisson et al., 2007, Ruzek, 2007, Mollica et al., 2004). Additionally also the media, Internet and telephone should be used to supplement the traditional forms (Ruzek, 2006). Coordination of mental health services and activities are outlined to counteract overlap of programs (Mollica et al., 2004; Thara et al., 2008). Population based mental health assessment (Mollica et al., 2004), a triage for serious mental health problems and the identification of high-risk individuals via screening (Mollica et al., 2004; Nice 2005) should be made. De facto the mental health system should be built up and used by integrating local healers, local primary healthcare practitioners and disaster relief personnel (Mollica et al., 2004; Rao, 2006; Somsè et al., 1998).

A link to community services (Cook Gotay & Bottomley, 1998) facilitates the access to formalized services (NICE 2005; Bisson et al., 2003, 2007; Kieft et al., 2008) and making mental health services available within primary health care (World health report, 2001).

Outcome assessment and research should be using simple and standardized methods (Mollica et al., 2004).

2.5.2 Volunteer Training - Core elements

According to the International Federation of Red Cross Red Crescent Societies (Progress report 1999-2007) the most obvious challenge concerning training is the establishment of regular volunteer management training programs and well-functioning volunteer management systems in all regions. Linked to this is the need to have proper structures in place at national and branch level in terms of human resources (volunteer managers), as well as policies and strategies to improve volunteer management. Financial constraints also limit training activities. It is difficult to find funding and, in some cases, volunteers have to pay for their own training.

Training varies according to the field of activity. The variation ranges from the duration of the training, contents of training, on- going training and supervision. Duration of training programs differed from several hours up to several months of training. Some institutions describe a curriculum that define the contents of training and is tailored to the needs of the activity as paraprofessional/volunteer, the background of the paraprofessionals/volunteers or the needs of the clients.

Paraprofessionals/volunteers can be used as a reservoir of person power and they are assumed to be able to connect better with clients due to their similarity to clients, at least better than professionals.

A summary of the aspects that were mentioned most often in trainings contains the following training elements:

<i>CORE ELEMENTS OF TRAINING</i>	<i>ASPECTS IN TRAININGS</i>	<i>REFERENCES</i>
Stress and stress management	Crisis intervention; basics in adult education; stress management; relaxing techniques; intervention strategies; helping abilities; Coping strategies and solution strategies;	World Health Report, 2001; National Institute of Mental Health, 2002, Mollica et al., 2004; Easton et al., 1985; Kobetz, 2005; Fladung-Köhler, 1998, Claxton-Oldfield et al., 2007; Calzada et al., 2005
Assessment (stressors and needs)	Assessment of environmental stressors (e.g. in emotional disorders); needs assessment	Prater, 1987; Rao, 2006; EUTOPA, 2009; IASC, 2007; NICE guidelines, 2005; NATO, 2008; TENTS, 2008; Haines et al., 2007
Psychological first aid	Training in psychological first aid techniques such as basic mental health care, self-help etc.	WHO, 2001; National Institute of Mental Health, 2002, Mollica et al., 2004; Brymer et al., 2005

Counselling techniques	Counselling techniques, including strategies for problem-solving; Cognitive-behavioural elements; cognitive and solution focused approaches	Hoffmann & Warner, 1976; Tindall, 2009; Danish & Brock, 1974; Fladung - Köhler, 1998; Shetty et al., 2005; Haines et al., 2007; Calzada et al., 2005; Easton et al., 1985; Gallagher, 1993; Garzon & Tilley, 2009;
Active Listening	Active listening & Communication skills, (including empathy, genuineness and warmth)	Müller-Kohlenberg, 1996; Hoffmann & Warner, 1976; Garzon & Tilley, 2009; Tindall, 2009; Carkhuff, 1973; Claxton-Oldfield et al., 2007
Self- awareness and self-reflection	Self- awareness, including reflecting one's own limits, being aware of own prejudices and attitudes	Tanaka & Reid, 1997; Gardiner et al., 2003; Petty & Cusack, 1989; Eck & Gohde, 1983; Silver & Stonestreet 1978; Calzada et al., 2005
Cultural & gender sensitivity	Cultural awareness and cultural sensitivity; gender awareness and gender sensitivity	Mollica et al., 2004; Rao, 2006; Vindhya, 2005, Kieft et al., 2008
Empowering techniques	Techniques of community outreach & empowerment; advocacy	Utachakowski et al., 2009; Uitterhaegen, 2005; Kieft et al., 2008; Nussbaumer, 2009
Target group specific knowledge	Specific knowledge depending on the context of volunteer work (psycho-education; Information about illnesses; medical information, psychotraumatology; legal and ethical aspects); Group dynamics; group interventions and team building	Kukafka et al., 2009; Somsè et al., 1998; Lickorish, 1972; Nussbaumer, 2009; Claxton-Oldfield et al., 2007; Shetty et al., 2005; Calzada et al., 2005

Table 7 Core elements of training

STRESS AND STRESS MANAGEMENT

Stress management including basics in adult education, stress management techniques, relaxation techniques, helping abilities and coping strategies are commonly used in interventions and are therefore also topics in trainings.

Easton et al. (1985) based their 28- weeks training program on, assertion, relaxation, stress management and social skills. Additionally they complemented the program with personal growth exercises because the personal growth and increased self-awareness of student peers in training would also enhance growth and learning in their future clients (Delworth & Moore, 1974). Coping with stress is also a topic for volunteers in palliative care (Claxton-

Oldfield et al., 2007), but also crisis management skills are important in training (Utaschowski et al., 2009; Calzada et al., 2005, Garcia et al., 1997).

Fladung-Köhler (1998) suggests that lay people working in hotline services (specialized in children and adolescents) should be trained in helping and working on different problematic situations. Training in psychosocial intervention contained the following aspects: 1) basics in adult education, stress management and relaxing techniques 2) Debriefing, self-regulation and counselling techniques, 3) ethical dimensions of crisis intervention, psychologically ill persons 4) mediation and referral in crisis, and 5) intervention strategies (Buchmann, 1999). Training in handling crisis situations, accurate information on specific topics (e.g. drugs) and referral of clients if needed are also stressed in studies on training programs (Jenks, 1974).

ASSESSMENT (STRESSORS AND NEEDS)

A high priority is given to the assessment of stressors and needs before setting interventions. Prater (1987) emphasizes explicitly the importance of the assessment of environmental stressors. Haines et al. (2007) state that interventions should be tailored to the deficiencies in practice. Therefore stress and needs assessment must be done before starting with interventions. Volunteers working in this field should be able to conduct these assessments (see for example IFRC reference centre for psychosocial support Handbook on psychosocial interventions, 2009). Specific knowledge of the target group can help to understand their needs better and shall therefore be part of the training (see also section on target group specific knowledge).

Amongst others Rao (2006) stresses that disaster affected communities have rather different needs according to the stages of the disaster. In his view psychosocial intervention on a community level must take place first. Psychological care will be needed in a later stage. He describes four phases after a disaster and intervention possibilities. The stages contain **a) the rescue phase:** involving the care to ensure that there is no plundering of relief material and no exploitation of vulnerability; He describes the importance of help-in lines, walk-in clinics; outreach service with clear, accurate and reliable information and underlines that rumours are a source of panic; **b) the relief phase** containing of support from community and voluntary agencies, reducing emotional distress in survivors, facilitating problem solving and returning to normal functioning. Techniques include empathy and active listening; ventilation; mobilization of social support; activity scheduling and externalization of interests; relaxing and tension-reduction methods; spiritual healing and growth; **c) the rehabilitation phase** is characterized by the returning to the homes; establishing some semblance of normal routine; participating in community – and group-based activities is important in this stage; **d) the rebuilding phase** is marked by community –level initiatives for economic and social development and growth. The aim is to strengthen the resources of the community and enhance resilience.

This general knowledge on the phases after the disaster shall be included in the target group specific knowledge part of the training for psychosocial volunteers working with disaster survivors.

PSYCHOLOGICAL FIRST AID

Early training in basic mental health care and psychological first aid are recommended (WHO, Progress report 2001; National Institute of Mental Health, 2002, Mollica et al., 2004). There is an urgent need for training of mental health and NGO personnel (Yule, 2006) and training of staff including self-help and care giving skills (Dunning, 1990, Keough & Samuels, 2004). Brief mental health training is recommended also to policy makers, doctors, teachers and relief workers. Studies also recommend evaluating the effectiveness of training (Henderson et al., 2005). Trainings should be made publicly available and lessons learnt should be written down (Mollica et al., 2004).

COUNSELLING TECHNIQUES

Cantoni and Cantoni (1965) emphasize the importance of counselling techniques in adult education. The studies summarized focus on counselling techniques in their training program (e.g. Fladung-Köhler, 1998, Nussbaumer, 2009). Skill based trainings centre around specific skills that are seen as essential for counselling. Evaluation of the skill-based training program show that trainees reach the defined training goals, but there was no outcome study, whether or not the recipients experienced the trained paraprofessionals as helpful or supportive (Danish & Brock, 1974). Shetty et al. (2005) report that community volunteers for HIV counselling are trained in counselling techniques using role play and scripts. Counselling techniques contain also exploration of feelings (e.g. Funnell, 2010). Utaschowski et al.(2009) name in their training program for peers the development of abilities such as counselling, crisis intervention, learning and teaching, life planning and advocacy for the affected. But also for senior peers training programs include counselling interventions; life review; problem solving; listening skills; and role-playing of basic counselling techniques (Garcia et al., 1997).

Tindall (2009) recommends training of attending, empathizing, summarizing, questioning, genuineness, assertiveness, confrontation and problem solving for future peer helpers. Funnell (2010) shows that techniques such as problem solving are used in training programs for peers and Haines et al. (2007) explicitly emphasize that training institutions should teach more problem-solving approaches. Gallagher (1993) reports that counsellors need to develop their own problem-solving process to help others in developing a more effective problem solving. Trainees also appraised their problem-solving effectiveness as more positive after the training.

Paraprofessionals in behavioural therapy teams are effective in reducing students' absenteeism, disruptive behaviour and an increase in study behaviour of students. Paraprofessionals working alone receive even without any training significantly better results than professionals (Hoffmann & Warner, 1976).

Cognitive & solution focused approaches are also found in Christian based programs. These are assumed to have presumably some efficacy in mildly to moderately depressed clients (Garzon & Tilley, 2009). Funnell (2010) states that behavioural goal setting for developing a concrete short -term goal is used in peer programs for clients with chronic illnesses (e.g. diabetes). Behavioural goal setting also increases self-efficacy and empowerment in clients. According to Gallagher (1993) training programs should also include a wide variety of experiences of behavioural, cognitive and conscious levels.

Paraprofessionals can be effective with institutionalized or outpatient people. Training in empathy and behaviour therapy can give them important tools to be effective (Hoffmann & Warner, 1976).

ACTIVE LISTENING

Active listening skills are very important to be included in training (e.g. Funnell, 2010; Garcia et al., 1997). Volunteers should be able to apply active listening. Schwartz & Sendor (1999) report that peer supporters for telephone counselling were trained in active listening and non-directive support. Also Rao (2006) emphasizes the importance of active listening as intervention in the work with survivors of disasters. Tanaka & Reid (1997) also report that peers should be trained in listening. Neuner et al. (2008) trained volunteers in non-directive active listening and a wider program in narrative exposure training;

Lay people were trained in communication skills (Easton et al., 1985; Nussbaumer, 2009), especially in empathy. It was shown that one hour of training is enough to receive some effectiveness, but it is also mentioned that a minimum of 20 training hours is required for minimum effectiveness (Hoffmann & Warner, 1976).

Hoffmann & Warner (1976) make in their review recommendation for the usage of volunteers/paraprofessionals. Overall it has been established that training can increase the effectiveness of paraprofessionals counselling. Training does not need to include advanced psychological concepts. They state that 20-40 hours of empathy training will be enough. All paraprofessionals need that kind of training regardless of their working setting; also behavioural therapy components seem to be useful for the work in paraprofessional counselling (Hoffmann & Warner, 1976).

They recommend that parents of troubled children should also receive training. Moreover elementary and secondary schools can employ interested parents or retired people as resource for paraprofessionals/volunteers for reading programs, special discussion groups, classroom meeting or guidance activity (Hoffmann & Warner, 1976). On contrary to some critics about the restriction of paraprofessionals to e.g. clerical assistance (see Brown, 1974), they state that paraprofessionals can be used more in guidance and counselling, in areas of reading, study and academic achievement and vocational exploration (Hoffmann & Warner, 1976).

Müller- Kohlenberg (1996) describes different aspects included in trainings. Similar to Hoffmann & Warner (1976) she names empathy as importance competence of paraprofessionals. The constructs of genuineness, warmth and empathy by Carl Rogers are often measures for the effectiveness of therapy. Müller- Kohlenberg describes that there is no difference in the display of empathy and warmth in professionals and paraprofessionals, but experienced therapists displayed genuineness most convincingly (in Müller- Kohlenberg, 1996). Garzon & Tilley (2009) show that the Rogerian principles are also included in some Christian lay counselling approaches.

According to Müller- Kohlenberg training programs for paraprofessionals add competences in behaviour (responsive and initiative behaviour). It is based on four goals: Attention, reaction, initiative and communication (Carkhuff, 1973).

Volunteers/Paraprofessionals can be trained effectively in empathy, respect, concreteness, genuineness, confrontation, and immediacy.

In collegiate programs it is shown that resident assistants who are counselling- orientated are significantly more effective than administrator-orientated resident assistants. Resident assistance's warmth and empathy is connected with students' academic achievement, and connected to a positive evaluation of the resident assistance (Hoffmann & Warner, 1976).

Mothers of troubled children that receive training in reflective and empathic behaviour use less directive behaviour (Hoffmann & Warner, 1976).

Garzon & Tilley (2009) find in their review different approaches of Christian lay counselling: an active listening approach that combines Rogerian principles (empathy, positive regard and supportive listening) with prayers, scripture and biblical themes; cognitive & solution focused approaches; inner healing prayers that contain a „journey back“ seeking to uncover familial, personal and/or ancestral experiences. It emphasizes on current life stressors and sought to enlighten stressors through prayer (involving the client's past); mixed lay Christian models show some similarity to the approaches of active listening, cognitive & solution focused approaches and inner healing prayers.

Garzon & Tilley (2009) state that there are not enough studies on the effectiveness of Christian lay counselling to establish that Christian lay counselling is highly effective.

Tan (1991) state that Christian interventions, spiritual gifts and the power of the Holy Ghost contribute to counselling effectiveness and Lukens (1983) examines the strength of a scriptural basis in training programs.

SELF-AWARENESS AND SELF- REFLECTION

Most training programs include didactics that shall help volunteers to apply their knowledge in practical steps, trainings or exercises before they start working with the given population. Many training programs also include elements of self-awareness and self-reflection. For example Eck & Gohde (1983) included in a training program for lay people teaching knowledge and abilities in order to prepare them for the problems of others. Trainees also

acquire three components such as understanding of the own person, knowledge about helping abilities, experience through applying abilities (Danish & Brock, 1974).

In training programs for peers in schools, colleges and Universities it is named that peers should have basic competencies, training and they need to attend to their own issues (Tanaka & Reid, 1997). Peers should learn basic competences such as helping skills (listening, paraphrasing, asking questions, and empathy), relying on a team of experts, being willing to get and accept help when needed, accept the limits of their role as peers and confidence in referring a student to others (Downe et al., 1986; Tanaka & Reid, 1997; Keat, 1976; Myrick et al., 1995).

Self-awareness is emphasized to be of great importance as the volunteers/peers/paraprofessional needs self –awareness and reflection in their work and for self-care (e.g. Nussbaumer, 2009).

Eck & Gohde (1983) present a training program for lay people working in different fields at a community level: working with children or youth, working with adults and crisis intervention. Contents of the training program were self- awareness, dealing with fear and conflicts, respecting one’s own limits, reflection on one’s own attitudes and one’s prejudices. Also Silver & Stonestreet (1978) underline the importance of self-awareness of personal attitudes. Their proposed training programs for rape counsellors included furthermore a total of 70 hours training consisting of lectures, discussions, multimedia presentations, role playing, experiential activity and observation.

Self-awareness and awareness to the working process can also be enhanced by evaluation. Petty & Cusack (1989) aim at the active participation of elderly in developing and maintaining the program. The seniors become more active after the training program.

However, everything should be accompanied by research: training, implementation of training, evaluation and effectiveness of paraprofessionals (Hoffmann & Warner 1976). Evaluation is hypothesized to enable the staff to reflect upon their work (Gardiner et al., 2003).

CULTURE & GENDER SENSITIVITY

According to many authors training in cultural competence is required (Mollica et al., 2004) and especially of importance in the work with refugees or in disaster affected areas (Rao, 2006; Kieft et al., 2008).

Rao (2006) stresses that trainings should be gender sensitive and culture sensitive. Also Christian based programs emphasize the importance of gender and culture sensitivity (Prater, 1987). Vindhya (2005) highlights the importance of the inclusion of gender, religious affiliation sensitivity, caste and informed consent in community intervention programs after the Tsunami in India. Community level workers will be best suitable to work with the

disaster-affected community, as they are familiar with the affected, speak the language and know the culture (Rao, 2006).

In a study on 1348 Southeast Asian refugees interned in a refugee camp and the effects on mental health it was hypothesized that people who got into the country by private sponsors would report less stress, but this is not true. When private sponsors are involved whose religion is different from the refugee's one it is an additional source of stress for the refugees (Beiser et al., 1989).

EMPOWERING TECHNIQUES

Empowerment techniques are core elements of psychosocial support. Training volunteers how to empower people is therefore a crucial element of training.

Peer helpers within the psychiatry are experienced people who hand their experience over to others. An emphasis is put on how to share their experience to help others and their further function as peers to support and teach others. Utschakowski et al. (2009) state that peers play an important role in the Psychiatry because they cannot only deliver information and education, but also share experience. He emphasizes that especially in the Psychiatry the experience of stigmatization and discrimination is high; shared experience can help to advance solidarity and the feeling of being understood. Therefore peers in the psychiatry convey a new quality of support. Utschakowski et al. (2009) further explains the central aspects of the training of peers in the Psychiatry are an attitude that is conducive to good health, empowerment, experience and sharing and recovery. Central for peers in the Psychiatry is sharing their experience and teaching of their experience.

Training of peer helpers of refugees/asylum seekers stresses topics such as psycho-education, psychosocial support and empowerment. Peers learn more about trauma, grief, acculturation, guilt, stress, alcohol and drugs, but also how to cope with these, rediscovery of their strength and confidence to move forward (Uitterhaegen, 2005). Kieft et al., (2008) also emphasize the empowerment of participants. Trained peer asylum seekers / refugees aim at people who have difficulties entering the mental health system. The authors conclude that the study has shown that there is a gap between perceived needs and the mental health care system. This gap can be over won by the peer asylum seekers and prevent more serious problems arising. Empowerment of clients is also of importance in chronically ill clients (e.g. diabetes) (Funnell, 2010), and in Christian based trainings (Prater, 1987).

TARGET GROUP SPECIFIC KNOWLEDGE

As volunteers work in different fields also specific knowledge regarding the given target group is needed. Most training includes specific knowledge such as psycho-traumatology or knowledge on coping with chronic diseases like HIV Aids or others.

There are also some studies on the implementation of a training program for senior peer counsellors (France, 1989; Garcia et al., 1997; Petty & Cusack, 1989; Gösken et al., 1995). Garcia et al. (1997) include in their training of elderly physiology and psychology of aging; depression and suicide; grief and loss issues. Nussbaumer (2009) describes a pilot project for peer coaches in the Psychiatry. They implemented a curriculum with: medical-psychological knowledge, counselling, legal aspects, self-awareness and reflection, communication and group processes. Also volunteers in palliative care had topics on death, dying and grief in their training to prepare them for their work (Claxton-Oldfield et al., 2007) or knowledge about basic mental health issues (Calzada et al., 2005).

In Aids/HIV - care psycho-education, including information about Aids /HIV and prevention were core aspects of the training (Kukafka et al., 2009; Somsè et al., 1998). Nussbaumer (2009) describes a pilot project for peer coaches in the Psychiatry. They implemented a curriculum with five modules: medical-psychological knowledge, legal aspects and group processes (Fladung –Köhler, 1998). Despite the numerous positive aspects ranging from the feeling of being understood to increased efficiency in the work of peers (especially in people with restraints against professionals) there are also negative aspects such as expectations of peers to be treated equally by professionals but also asking for care. Peer helpers in the Psychiatry could be supportive in self-help groups and therapy.

Lickorish (1972) names additional reading and seminars in general and abnormal psychology and the observation of the counselling process as components to be included in a training program.

In general theoretical models are included in trainings to enhance the understanding of the client's experience. For example a transtheoretical model was implemented in a training curriculum for paraprofessional counselling to enhance the effectiveness and the understanding of women in different mammographic stages (Kobetz, 2005). The transtheoretical model focuses on the individuals' readiness to engage in healthier behaviour. It also provides strategies to change and maintain this healthier behaviour.

2.5.3 Supervision, on-going Training, Guidance & Support for Volunteers

It was already mentioned above that not all volunteers receive further training after the initial training. Also the importance of supervision and guidance is discussed in several studies. Guidance, supervision and support of volunteers are highly recommended.

SUPERVISION & ON-GOING TRAINING

Most studies recommend further training and supervision of paraprofessionals. Lewis & Lewis (1996) showed that 58% of 305 Washington schools currently use peer helper programs. Most programs use standardized training materials (Natural helpers or conflict

managers). Non-counselling professionals (teachers, building administrators) often supervise the programs. They find in their study that suicide rates among students are highest, when supervisors are such non-counselling professionals. Lewis & Lewis (1996) emphasized the importance of training and selection of peer helpers and that supervision should be carried out by professionals (e.g. psychologist, social school worker, trained mental health worker). Referral of clients is done after matching clients with the senior peers. The progress of counselling is reviewed weekly. Moreover community professionals provide monthly in-service training for the senior peer counsellors (Garcia et al., 1997).

Wasserman et al. (1975) stress in their training program aspects of the social theoretical learning concept, structured training program, defined service role functions, on-going training and supervision for the paraprofessionals. Training programs should be tailored to the need of the school, the students and the coordinator (Campbell, 1983).

Not all organizations provide on-going or advanced training. Lukens (1987) described in his study that only three out of 17 subjects receive additional training after the original training. Furthermore on-going training and supervision are essential aspects of employing lay people (Lukens, 1987; Wenzel & Thomsen, 1997).

Much guidance and support from mental health professionals is needed (Hudson et al., 2002). It was named that careful training and supervision of navigators were crucial (Giese-Davies et al., 2006; Lewis & Lewis, 1996; Everly, 2002; Worthington, 1987; Eck & Gohde, 1983). Moreover staff training, supervision and a referral system is needed (de Jong et al., 1999, World health report, 2001, van Ommeren et al., 2005). The volunteers shall be trained in or encouraged to make referrals of clients if they cannot deal with the situation. Some studies emphasize that it is necessary that the volunteers can rely on a team to get support and advice if needed and that they are encouraged to make referrals (Tanaka & Reid, 1997).

Mental health specialists should provide training and supervision to health care staff (de Jong et al., 1999, van Ommeren et al., 2005). Eck & Gohde (1983) emphasize the importance of supervision on a regular basis and Lewis & Lewis (1996) drew attention to their result that supervision conducted by a non-counselling professional (e.g. teacher, administrative staff) in peer programs was associated with higher suicide rates among students. Everly (2002) stresses that paraprofessionals/ volunteers should be carefully applied to and supervised to be able to fulfil their responsibility. Worthington (1987) emphasizes the importance of the selection of supervisors for paraprofessionals.

SUPPORT FOR VOLUNTEERS (PEERS)

Self-care and risk of burnout in health care providers is very high. It should be kept in mind that a dose response relation between the experience of trauma events and anxiety symptoms is maintained. The vulnerability will be greatest in workers on first assignment and those with history of pervious trauma; also locals may be especially vulnerable. Effective

mental health protection should be guaranteed also for the helpers (Mollica et al., 2004; Wheaton et al., 2008). Also Whiting (1998) asked whether part time volunteers can drink deep enough to avoid intoxication.

The National Red Cross and Red Crescent Societies of the International Federation and the Federation Secretariat stated in their 2007 report that they are committed to promoting volunteering as a significant and positive contribution to improving the lives of vulnerable people, and to strengthening communities and civil society (Volunteering Policy 4.1.1, 2002, p. 28) and are aware and value informal volunteering in communities, outside the formal organization of National Society programs and activities (Volunteering Policy 4.1.4, 2002, p. 28)

Volunteer support includes measures to guarantee safety and health of volunteers such as equipment, insurance and training but also peer support and support by mental health professionals. According to the IFRC policy National Societies shall provide appropriate:

<i>ELEMENTS OF VOLUNTEER SUPPORT</i>	<i>How</i>
Training	Training that will enable a volunteer to meet his or her responsibilities towards the Movement, the specific task or role they were recruited to carry out, and for any emergency response activity they may be asked to carry out (Volunteering Policy 5.1.6, 2002, p. 28)
Equipment	Equipment for the task or role they are asked to carry out (Volunteering Policy 5.1.7, 2002, p. 28)
Insurance	Insurance protection for volunteers (Volunteering Policy 5.1.11, 2002, p. 28)
Psychosocial support for volunteers	In addition, volunteers must have access to psychosocial support
Reimbursement	Reimbursement (Haines et al., 2007)
Involvement	Involvement of volunteers in decision making

Table 8 Volunteer support

Networking and peer-to-peer support in the area of volunteer development is, to some extent, taking place in all regions, whether formally or informally. Since the adoption of the Volunteering Policy and added focus on networking at international level, several functional volunteer and organizational development networks and peer support mechanisms have been established.

Until 2011 the International Federation plans to address the existing and future challenges highlighted in the 2007 report through volunteering development activities.

Volunteering development is considered a means of providing people with the possibility to make a difference to their community and to improve the lives of the most vulnerable. In 2008–2011, the planned volunteering development in the IFRC aims to:

- Ensure and support National Societies to adopt volunteer management systems, procedures and practices in order to better support and manage volunteers
- Develop and spread knowledge about volunteering in emergencies
- Promote, celebrate and recognize the achievements of volunteers
- Advocate and work to establish volunteer- friendly environments

Delworth (1974b) states that the effectiveness of volunteers is also dependent on the agency they are working for, not only on volunteers themselves. There is also a recommendation how to integrate volunteers:

WHAT	How	REFERENCES
Selection	Selection of „natural leaders“ and helpers who already have some abilities to work with others.	Delworth, 1974b; Hoffmann & Warner, 1976; Stahl & Hill, 2008; Hart & King, 1979; Utschakowski et al., 2009; O' Donnel & George, 1977
Training, on-going training, supervision	Training of these persons to be recognized as leaders. Teaching specific skills and modalities of the service they work for, to teach them „system entry skills“, help them identify power and support sources in the system and how to use them. Overall a language must be used that is accessible for volunteers.	Delworth, 1974b; Campbell, 1983; Cantoni & Cantoni, 1965; IFRC & Red Crescent Societies, 2002; Interparliamentary Union et al., 2004; Wasserman et al., 1975; Lewis & Lewis, 1996; Campbell, 1983; Lukens, 1987; Wenzel & Thomsen, 1997; Garcia et al., 1997
Involvement of volunteers	Involving volunteers in all kind of components of the system to give them access to day-to-day operations of the agency, decision-making in resource and task allocation, on-going training in the purpose, goals and the delivery plan of the agency.	Delworth, 1974b; Lee & Brudney, 2009; Interparliamentary Union et al., 2004
Clear job description	Job description must involve needs and problems of the service, a rationale decision on for grouping functions, looking at the recipient, and assigning tasks to all level of workers. The	Delworth, 1974b; Interparliamentary Union et al., 2004; Haines et al., 2007

	professionals have to be ready to work with volunteers and hand over tasks that were formerly performed by them.	
Support	Provide a community among volunteers to give them a support system as paraprofessional. Professionals can help to foster opportunities to help to develop a community among volunteers (peer community). Providing structured tasks so volunteers work together, responsibility of the volunteers to make meaningful decisions, an area in which volunteers can work together and get to know each other, can facilitate a peer community.	Delworth, 1974b; Inter-parliamentary Union et al., 2004; Haines et al., 2007; Wheaton et al., 2008

Table 9 Integration of volunteers in agencies

2.5.4 Recruitment and Selection

Not all, but some studies indicate selection criteria or study the influence of selection on the effectiveness of paraprofessional counselling. Careful selection is important for the effectiveness of volunteers (Hoffmann & Warner, 1976; O'Donnell & George, 1977). Fluck & Raabe (1984) recommend that higher criteria for selection may result in a higher appreciation of volunteer work and increase self-esteem in volunteers. Hart & King (1979) find in their study on one selection group and one random group both groups receiving training that training is a significant predictor for effect, but selection was not.

The studies report that selection was made through:

SELECTION	REFERENCES
Nomination from other students (in case of peer helpers in schools)	Tanaka & Reid, 1997
Recruitment interviews	Cerling, 1983
Volunteering peers	Utschakowski et al., 2009; Garcia et al., 1997
Selection on the basis of psychological health; psychological tests; screening	Brown, 1974; Cerling, 1983; Garcia et al., 1997
Locus of control	Martin & Shepel, 1974
Recommendation letters	Cerling, 1983; Schwartz & Sendor, 1999
External criteria: Transportation, Willingness to work for no or little money; willingness to commit to a certain amount of counselling sessions; age	Cerling, 1983; Shetty et al., 2005, Schwartz & Sendor, 1999

Self-reports on natural helping ability	Stahl & Hill, 2008
Short Training and initial Supervision	Anthony & Wain, 1971; Schwartz & Sendor, 1999

Table 10 Selection criteria

NOMINATION FROM OTHERS

Training programs for peers in schools that also mentioned selection criteria are described by Downe et al. (1986); Tanaka & Reid (1997) and Keat (1976). The selection process for peers in schools is essential. Nomination for peers is given from other students with regard to empathy of nominated peers.

RECRUITMENT INTERVIEWS

Even if not mentioned often, recruitment interviews play an important role in the selection of volunteers. Agencies use interviews to find most suitable volunteers. Cerling (1983) finds that sometimes recruitment interviews were conducted.

VOLUNTEERING PEERS

Most studies used peers that volunteered for the training program. Hence, the first step they used was to find peers or lay people to volunteer in the training /program (Utschakowski et al.; 2009; Nussbaumer, 2009; Garcia et al., 1997). Garcia et al. (1997) used flyers and ads in newspapers to attract people. However, Garcia et al. (1997) additionally used screenings by a committee and Utschakowski et al. (2009) explains that there may arise some difficulty if all volunteering peers are used without further selection.

PSYCHOLOGICAL HEALTH & SCREENING

Garcia et al. (1997) recruited future senior peers through flyers and ads; selection is made through a screening by a committee, using also the Beck Depression Inventory, Social Readjustment Rating Scale, Facts on Aging Quiz and the Attitude Towards Suicide Scale. Brown (1974) states that selection of volunteers for training is on basis of psychologically health criteria, whereas professionals are usually selected on basis of intellectual criteria to enter further (academic) training.

LOCUS OF CONTROL

Internal locus of control is seen as related to an increase in trust, insight and self-confidence and would thus enhance the effectiveness of the training (Martin & Shepel, 1974).

RECOMMENDATION LETTERS

Cerling (1983) finds in a review of literature on the selection of (Christian) lay counsellors, that there are various aspects included in selection such as written statements of applicants on their adherence to the church’s doctrinal position, personal testimony of Christian

experience, letters of recommendation, personal interviews and Psychological tests (16PF etc.). Additionally questionnaires were used to assess graduate-level training, certification and/or state licensure, stable marital relationship, transportation and willingness to work for little or no money. Peer supporters were also selected after they got recommended by former employers (Schwartz & Sendor, 1999).

EXTERNAL CRITERIA

Cerling (1983) reports in a study on selection criteria that further selection criteria are having transportation (e.g. having a car) and willingness to do unpaid work. Also Shetty et al. (2005) report that they used volunteers who are 25 years or older, willing to work for a certain period of time (Schwartz & Sendor, 1999) and do a certain amount of counselling sessions.

SELF-REPORTS

Stahl & Hill (2008) indicate that self-report measures of natural helping abilities and the intent to pursue a helper's career found most support to identify natural helpers. They tested self-report measures of natural helping abilities and ratings by others to assess the helping ability after two 10-minutes helping sessions.

SHORT TRAINING AND INITIAL SUPERVISION

Careful selection of the paraprofessionals is important. Anthony and Wain (1971) describe a short training as selection (Hoffmann & Warner, 1976). Close supervision in the early stages of working is also recommended. In any case a professional supervisor in later stages should be introduced (Hoffmann & Warner, 1976). Schwartz & Sendor (1999) report that they selected peer supporters after they participated in groups to pre-test coping skills interventions.

3 Summary and conclusions

In the following we give a brief summary of the key points of this report in order to develop a first framework for further use in the project. The summarized key points shall be used for further development of a guideline for the training materials that will be developed throughout the project.

WHO IS A VOLUNTEER?

Along the four dimensions of the definition (free will, no financial rewards, structured approach and strangers as beneficiaries) the studies that we included into our research analysis used a broader definition of volunteers. Most authors of our included studies assumed that volunteers gain no financial reward from their activities; however it may be possible to reimburse their expenses or give them a token payment. Furthermore volunteers work voluntarily, out of their free will. Their activities are marked by benefits for people other than volunteers, even if there are also benefits for volunteers because of their activity. They work in a structured environment or programme and the beneficiaries may or may not be known to them.

The Desirable elements in legal frameworks for volunteers as stated by the IFRC as stated above are the following

- *Volunteers participate on the basis of freely-expressed consent;*
- *volunteering is not compulsorily undertaken in order to receive pensions or government allowances;*
- *volunteering is not carried out in expectation of any financial gain;*
- *volunteering complements, but must not result in, the downsizing or replacement of paid employment;*
- *Volunteerism should be encouraged with a certain degree of autonomy from the public authorities, to safeguard its independence;*
- *volunteering is a legitimate way in which citizens can participate actively in the development of community and social life and address human needs;*
- *Volunteers act for the common good and on the basis of a social commitment;*
- *volunteering promotes human rights and equality;*
- *Volunteerism respects the rights, dignity and culture of the communities involved;*
- *Volunteer recruitment is based on equal opportunity and non-discrimination;*
- *volunteering is inspired by democratic, pluralistic, participative and caring social tenets."*

(Inter-Parliamentary Union, IFRC & UN Volunteers, 2004, p. 20)

WHAT IS LAY CCOUNSELLING/PSYCHOSOCIAL SUPPORT?

According to the IFRC Reference Centre for Psychosocial support the term psychosocial support refers to the actions that address both the psychological and social needs of individuals, families and communities. Psychosocial support aims at enhancing the resilience of the affected individual, group and community and may consist of various activities from psychological first aid to support hotlines or visiting services. We use a rather broad definition of lay counselling as any form of psychosocial support. Lay counselling in our definition is:

“A key activity in many humanitarian organizations is support to individuals in crisis provided by trained volunteers. This activity can be called social support, psychological support or lay counselling, and the activity is likely to consist of active listening, information sharing, and support to take informed decisions, all with the objective of empowering the individual to cope with stressful and critical situations, Furthermore, if a person needs professional help, the volunteer can ensure referral to the relevant specialists/ doctors/therapists.”

EFFECTIVE PSYCHOSOCIAL INTERVENTION STRATEGIES

With regard to the most effective intervention strategies we found the following core elements which we recommend for further use in the materials to be developed (Table 11):

INTERVENTION	REFERENCES
Giving of information	Cook Gotay & Bottomley, 1998; Giese-Davis et al., 2006; Hudson et al., 2002; Rainey, 1985; van Ommeren et al., 2005; Rao, 2006
Emotional and practical support	Bisson et al., 2003, 2007; Mollica et al., 2004; National Institute of mental health, workshop, 2002; NICE, 2005; NSW Disaster Mental Health Response Handbook, 2000; van Ommeren et al., 2005
Creating a save place	Hobfoll et al., 2007; van Ommeren et al., 2005; Mollica et al., 2004, Rao, 2006
Psychoeducation	Hobfoll et al., 2007, Wessely et al., 2008; Zurek et al., 2008; 2007; Bission et al., 2010
Empowerment	Ager, 1997, 2000, 2002; Anckerman et al., 2005; Dybhal, 2001; Hobfoll et al., 2007; McDonald, 2002; Mollica et al., 2002, 2004; Saltzman et al., 2006; van Ommeren et al., 2005
Social Support	Anckerman et al., 2005; Andrews et al., 2003; de Jong, 2002b; Hagan, 2005; Hobfoll et al., 2006, 2007; Hobfoll & London, 1986; Mollica et al., 2004; Layne et al., 2001; Litz & Gray, 2002; Sattler et al. , 2002; Shalev et al., 2004; Ursano et al., 1995; van Ommeren et al., 2005
Strengthening resources	Crowson et al., 2001; Hobfoll et al., 2006, 2007
Promotion of emotion expression and experience sharing	Anckerman et al., 2005; Cook Gotay & Bottomley, 1998; de Jong , 2002a, 2002b; Giese-Davis et al., 2006; Hudson et al., 2002; van Ommeren et al., 2005

Table 11 Intervention methods

TRAINING REQUIREMENTS

With regard to the literature we analysed, the suggested core elements of volunteer training in the fields of lay counselling and psychosocial support are the following (Table 12):

CORE ELEMENTS OF TRAINING	ASPECTS IN TRAININGS	REFERENCES
Stress and stress management	Crisis intervention; basics in adult education; stress management; relaxing techniques; intervention strategies; helping abilities; Coping strategies and solution strategies;	World health report, 2001; National Institute of Mental Health, 2002, Mollica et al., 2004; Easton et al., 1985; Kobetz, 2005; Fladung-Köhler, 1998, Claxton-Oldfield et al., 2007; Calzada et al., 2005
Assessment (stressors and needs)	Assessment of environmental stressors (e.g. in emotional disorders); needs assessment	Prater, 1987; Rao, 2006; EUTOPIA, 2009; IASC, 2007; NICE guidelines, 2005; NATO, 2008; TENTS, 2008; Haines et al., 2007
Psychological first aid	Training in psychological first aid techniques such as basic mental health care, self-help etc.	World health report, 2001; National Institute of Mental Health, 2002, Mollica et al., 2004; Brymer et al., 2005
Counselling techniques	Counselling techniques, including strategies for problem-solving; Cognitive-behavioural elements; cognitive and solution focused approaches	Hoffmann & Warner, 1976; Tindall, 2009; Danish & Brock, 1974; Fladung - Köhler, 1998; Shetty et al., 2005; Haines et al., 2007; Calzada et al., 2005; Easton et al., 1985; Gallagher, 1993; Garzon & Tilley, 2009;
Active Listening	Active listening & Communication skills, (including empathy, genuineness and warmth)	Müller-Kohlenberg, 1996; Hoffmann & Warner, 1976; Garzon & Tilley, 2009; Tindall, 2009; Carkhuff, 1973; Claxton-Oldfield et al., 2007
Self- awareness and self-reflection	Self- awareness, including reflecting one's own limits, being aware of own prejudices and attitudes	Tanaka & Reid, 1997; Gardiner et al., 2003; Petty & Cusack, 1989; Eck & Gohde, 1983; Silver & Stonestreet 1978; Calzada et al., 2005
Cultural & gender sensitivity	Cultural awareness and cultural sensitivity; gender awareness and gender sensitivity	Mollica et al., 2004; Rao, 2006; Vindhya, 2005, Kieft et al., 2008
Empowering techniques	Techniques of community outreach	Utachakowski et al., 2009;

	& empowerment; advocacy	Uitterhaegen, 2005; Kieft et al., 2008; Nussbaumer, 2009
Target group specific knowledge	Specific knowledge depending on the context of volunteer work (psycho-education; Information about illnesses; medical information, psychotraumatology; legal and ethical aspects); Group dynamics; group interventions and team building	Kukafka et al., 2009; Somsè et al., 1998; Lickorish, 1972; Nussbaumer, 2009; Claxton-Oldfield et al., 2007; Shetty et al., 2005; Calzada et al., 2005

Table 12 Core elements of Training

THE FRAMEWORK OF VOLUNTEERING

As volunteering requires a structured setting a certain framework is recommended by the literature that shall help to guarantee effectiveness of volunteer work as well as volunteer health and wellbeing. Volunteer support includes measures to guarantee safety and health of volunteers such as equipment, insurance and training but also peer support and support by mental health professionals. According to the IFRC policy National Societies (1999) shall provide appropriate structures for volunteers. Also other researchers recommended frameworks for volunteers. As for us selection is of utmost importance we recommend the following elements (Table 13):

WHAT	How	REFERENCES
Selection	Selection of „natural leaders“ and helpers who already have some abilities to work with others.	Delworth, 1974b; Hoffmann & Warner, 1976; Stahl & Hill, 2008; Hart & King, 1979; Utschakowski et al., 2009; O' Donnel & George, 1977
Training, on-going training, supervision	Training of these persons to be recognized as leaders. Teaching specific skills and modalities of the service they work for, to teach them „system entry skills“, help them identify power and support sources in the system and how to use them. Overall a language must be used that is accessible for volunteers.	Delworth, 1974b; Campbell, 1983; Cantoni & Cantoni, 1965; IFRC, 2002; Interparliamentary Union et al., 2004; Wasserman et al., 1975; Lewis & Lewis, 1996; Campbell, 1983; Lukens, 1987; Wenzel & Thomsen, 1997; Garcia et al., 1997
Involvement of volunteers	Involving volunteers in all kind of components of the system to give them access to day-to-day operations of the agency, decision-making in resource and task	Delworth, 1974b; Lee & Brudney, 2009; Interparliamentary Union et al., 2004

	allocation, on-going training in the purpose, goals and the delivery plan of the agency.	
Clear job description	Job description must involve needs and problems of the service, a rationale decision on for grouping functions, looking at the recipient, and assigning tasks to all level of workers. The professionals have to be ready to work with volunteers and hand over tasks that were formerly performed by them.	Delworth, 1974b; Inter-parliamentary Union et al., 2004; Haines et al., 2007
Support	Provide a community among volunteers to give them a support system as paraprofessional. Professionals can help to foster opportunities to help to develop a community among volunteers (peer community). Providing structured tasks so volunteers work together, responsibility of the volunteers to make meaningful decisions, an area in which volunteers can work together and get to know each other, can facilitate a peer community.	Delworth, 1974b; Inter-parliamentary Union et al., 2004; Haines et al., 2007; Wheaton et al., 2008

Table 13 Volunteer support

With regard to the protection of volunteers the IFRC stated the following:

“Protection of volunteers:

- *The right to receive the necessary information, training, supervision, personal and technical support for the discharge of their duties;*
- *Insurance against the risk of accidents and illness related to the volunteer activity;*
- *The right to work in safe, secure and healthy conditions;*
- *The right to be reimbursed for reasonable expenses related to the volunteer activity, as well as to be provided with basic subsistence support for food and accommodation whenever the volunteer assignment so requires, and previously agreed with the host organisation; and*
- *Appropriate accreditation, describing the nature and length of time of the volunteer activity, as well as certification acknowledging the volunteer's*
- *Contribution at the end of the service.”*

(Inter-Parliamentary Union, IFRC & UN Volunteers, 2004, p. 21)

All in all, even though there is an on-going discussion on the effectiveness of volunteers’ intervention compared to interventions done by professionals, many studies have proven the effectiveness and high value of volunteers. Therefore we summarize that it is especially important to focus on the involvement, integration and support of volunteers within the

agency. Integration of volunteers also means to build a volunteer community, involvement in decision making, to guarantee continuous exchange with professionals and reflection of professionals on the value of volunteers.

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