Standing Committee on Crisis and Disaster Psychology
European Federation of Psychologists Associations, EFPA
February 2009

LESSONS LEARNED IN PSYCHOSOCIAL CARE AFTER DISASTERS

Participating countries

Austria, Belgium, Cyprus, Czech Republic, Denmark, France, Finland, Germany, Greece, Italy, Luxembourg, Netherlands, Norway, San Marino, Slovakia, Slovenia, Spain, Sweden, Switzerland, Turkey, United Kingdom.

■ Introduction

This document is the result of an inquiry in the different European countries who are a member of the European Federation of Psychologist Associations (EFPA), the Standing Committee on Crisis and Disaster Psychologists. Every member describes an example of psychosocial care after a disaster in their own country. The examples are randomly chosen and of course there are many more examples which could be described. It is of great importance that we learn from our experiences, that we collect the best practices but also look into the things which went wrong. We realize that a disaster means chaos and that we will never be able to plan for every possible scenario. But we have the responsibility to go for the best.

To really learn from the experiences it is necessary to collect the relevant data in a systematic way. Up until now this is not common practice in the European countries. This document could give a start to the discussion of how to collect and describe the lessons learned, so that we can use the lessons for our future planning

The Standing Committee on Crisis and Disaster Psychologists has reviewed the different examples and has come to some general conclusions. These conclusions are open for discussion. The next step should preferably be to share these experiences with the representatives of the European Council and try to formulate recommendations for further policy development

Content

■ **Austria** - FLOOD IN LOWER AUSTRIA August 2002

Eva Münker-Kramer

On August 7th, 2002 the "flood of the century" came over Lower Austria (the northern part of Austria close to Czech and Slovakian border). The Danube and its northern 'zuflüsse' did not bear the amount of water during an extraordinary rain period and flooded. There was a second pike on August 12th, which came with the same intensity and demoralized people extremely.

Some figures: Whole villages were enclosed by the water, no electricity, no water to drink, no dry places to sleep were available and evacuation had to be conducted for many days in camps. 17.500 houses and companies with suffered from severe damages alone in Lower Austria, many of them ruined within a few hours with all the contents in them. Apart from houses also cars and other properties were destroyed and disappeared.

The total damages were amounting to € 370.000.000 in Lower Austria and more than 30.000 people were struck in the area.

Early Intervention

The so called Lower Austrian psycho-social acute support team is financed by the health department of the Federal Government normally for "individual catastrophes". It consists of 50 psychologists, medical doctors and psychotherapists trained in interventions following the methods of disaster and crisis psychology and besides 6 social workers who care for the social needs of the people. In the flood the staff actually consisted of 23 psychologists, 5 social workers, 2 medical doctors, and 7 psychotherapists in the team.

The situation we found after being alarmed by the federal government were people shocked to their roots, helpless, partly incapable to come to necessary decisions, they did not know where to start, they were desperate, and had no orientation. The symptoms were Acute Stress Disorder (ASD) and in not few cases also post traumatic stress symptoms. (those with retraumatization – many old people were reminded to "war"), many conflicts within the families, severe lack of motivation, refusal to make plans for the future, despair, complete and excessive demands, depression, panic attacks, excessive fear of death.

What we did was psychological screening ("triage") "on site", this was done by psychologists in cooperation sometimes with volunteers. We offered clinical diagnoses and therapies for those people who obviously needed it. We made concepts for the longer term care and built

up a network with clergy, the fire brigade, the Red Cross and the mayors of the struck cities. We built up a hotline and organized financial and debt counselling by social workers.
Concerning interventions we offered one to one crisis intervention, psycho-education, Critical Incident Stress Management (CISM) interventions in communities, consultancy to communities, work with the families to be prepared for decisions in the future, conflict management in communities and families, information, counseling of commanders and mayors.
All together 500 persons were looked after, 300 Persons were supported on an individual basis and in groups (defusing, debriefing), another 200 were reached by screening and psycho education.

Longer term intervention

There were 2.500-3.000 hours on duty between August the 7th and August the 28th. Individual support was given until Christmas for those who needed it and until Mai 2003 the hotline was operational. After one year we had many requests again because of people being triggered again. Besides that 4 greater projects took place. In a few communities new facilities were built up and we supported the organizers by counseling them concerning the dynamics that would eventually arise, a few day care facilities and schools where supported by group meetings with the children (debriefing and information hours on symptoms and reactions and methods to get distance again – also there were similar information groups for teachers who watched symptoms in the classes, a few local fire-fighter groups had debriefings and the technicians who had to assess the amount of damage were struck very much because of the amount of work, the short time span to do that and the high responsibility they had with their assessment for each individual family.

Evaluation and implications for the future

It was very good to have the clear cooperation with the social workers following the motto: „Cobbler stick to your last“ (and thus do your best*).*
The Social workers established the roster, coordination of staff, they contacted the local authorities, kept the link to the government concerning practical questions, organized the resources to installation of further structures and services (hotline, mobile unit for counseling), and the organization of financial support.
Thus the conclusions were: clear responsibilities should be apparent in a „two fold“ professional help, contacts of both professions can be used for networking, a very good

management and definition of the interface is necessary and permanent and institutionalized transfer of information has to be guaranteed. By this division of labour “normality” is presented to the affected persons from the beginning on and they know with whom they have to do. So they can feel the transfer and cooperation as a good package.

So it is an ideal use of the professional skills, both professions feel secure in what they are doing.

To reach this it is helpful to know each other and crucial to know the contents of the other discipline („headlines“) both professions should know about operation controlling and networking, both professions need an own deputy in the operation controlling situation, they can not completely deputize each other. The work and support of the related discipline should be seen and taken to maximize the effect of the own work („fill the gaps“, „build bridges“), relaxation for both disciplines and for the individual helper (responsibility passes over) has to be made sure.

The concentration on core business improves the quality and for each the pattern is useful for individual catastrophes “as well (and already used).

■ **Belgium** - RAIL CRASH March 2001

Olivier Serniclaes

March the 27th 2001, a crowded commuter train has collided head on with an empty train in Central Belgium (village of Pécrot, 16 miles east of Brussels) during the morning rush hour. 8 people, including the 2 drivers, died and 12 were injured in what was Belgium's worst railway crash in 25 years. The empty train is reported to have been wrongly switched into the path of the passenger train. The rescue workers have worked in the wreckage to search for bodies or trapped survivors during 10 hours. The governor decided to start the provincial disaster plan, more than 60 rescue workers were at scene. The National railway company (NMBS/SNCB) admitted that the accident was caused solely by human error (inexperience for the driver of the empty cab, language barrier between the stations staff and between the drivers (Dutch and French speaking))

Early Intervention

One information and support centre was opened in Florival (500 form the train crash) were all the psychosocial actors were regrouped to ensure the support and identification of the victim's family. More than 80 people affected (bystanders, people living near the crash scene, families) reach this Info and support centre.

The psychosocial workers were (20 the first day):

- Volunteers from the Red Cross (Dutch and French) psychologist and social workers
- Personal from the stress team of Federal police
- Psychologist working for victim's assistance for the local police (from the whole area)
- Social workers from the local administration
- Local authority
- Psychologists from de National railway (SNCB) was there more specifically to do the first visit to the family of the deceased.

The governor decided to regroup all the services there in this information and support centre, also for the press, the rescue workers, and the political authority. The first day this centre was more a crisis centre than an effective info and support centre for the victim's.
The centre was opened during 2 days.

Victims and their family received information, emotional support, social support, practical information about identification, first practical help, Call centre, and support during confrontation with the dead relative.

The day after the crash, all the structure and psychosocial workers involved were regroup for a first post crisis analysis, the coordination of the future activities were planned. All the victims' needs were assessed and an information meeting for the victims' was planned 3 weeks after. Debriefings were done only for rescue workers, psychological support was offered for all the direct victims' and their families.
During the three months after the crash there were 8 coordination meetings for the follow-up of the psychosocial activities. The manager psychosocial from Ministry of health had the leading for this coordination.

Longer term intervention

A one year anniversary ceremony was held on the crash place, with inauguration of a stele with the name of the dead people. 300 people attended the ceremony, around 12 psychosocial workers were present to support and encourage the families.
Some victims of their relatives were still in therapy after one year, essentially wounded and mourned victims.
Three year after the crash the trial was not ended

Evaluation and implications for the future

- At this time, there was no effective psychosocial plan in this province before this rail crash (thus no prevention), the manager psychosocial was working initially for another province and had no knowledge of the local authority, it was more a problem for the first day (initial contact and difficulties to identify who is who) and for the long term coordination (less support from the authority).
- Info and support centre was overcrowded, with no specific place for the victims' and their relatives; it gives some trouble between victims and reporters of with rescue workers (we have now specific rules for the installation and the organisation Info and Support centre).
- During the first day and during the anniversary ceremony, politicians and local authority have taken too much place without any respect for the needs of the victims (intimacy, respect, truthful information, recognition, protection).

- Good collaboration between all the psychosocial workers, but a lot of difficulties with their specific authorities in regard to their engagement (duration, financing, reports…).
- Important partners for the psychosocial follow-up are: Insurance, Justice, local authority, Railway Company.
- The university of Leuven and the Ministry of Health had planned a research about psychological after effects but with no results. But without any authorisation the University of Maastricht with the help of a local doctor has made a study on the psychological symptoms (PTSD) for people living near the crash place. It is only in 2004, after the gas explosion in Ghislenghien, that the first effective collaboration for a prospective study of psychological symptoms after disaster in Belgium was conducted.

■ **Czech Republic** - TSUNAMI SOUTH EAST ASIA December 2004

Jana Malikova

We have recently had experience of various disasters (for example: extensive floods in 2002, in which 75,000 people were affected; traffic accidents with many causalities; tornado). Since then the system of psychosocial support has been developed for emergency situations. Currently we have a system of posttraumatic intervention care within the Ministry of the Interior - primarily intended for police officers and firemen. The system is made up of around 120 trained professionals, specializing in Critical Incident Stress Management (CISM) and crisis intervention.

The system of psychosocial support hadn't run properly since Tsunami disaster, that's why I will describe Tsunami disaster as a suitable example. A few thousands Czech tourists were in Asia at the time of the tsunami. A few hundred Czechs were in the affected areas in South-East Asia. More than three hundred Czech citizens were still missing on the third day after the disaster. Three weeks after the tsunami 11 people were still missing and one body was identified. Now 8 people have been identified. About 500 Czechs were seriously mentally traumatized by this event.

Early Intervention

A coordinating team of experts in mental health contained 5 persons + 2 psychologists were leaders; 14 regional coordinators (fire rescue psychologists) and 140 specialists in psychosocial support by regions (including trained non-professionals).
The main goals were:

- Bring back home the maximum number of Czech citizens
- Provide relevant information to the maximum number of "affected" Czech citizens
- Provide relevant information to rescue workers and professionals

The first week of readiness was the most intensive. Psychological help line ran 3 weeks after the event. Around 18 people provided psychosocial support, 9 of them were in the field.

Longer term intervention

We know about several cases in psychotherapist care. We know about missions that NGOs have organised to affected area in South East Asia but it has run without our participation.

Evaluation and implications for the future

Main difficulties:
In general:

- Unclear levels of competences
- Insufficient care for the mental well-being of the professionals (no debriefings…)
- Lack of model planes for this type of disaster

In specific:

- Obtaining the database of "affected" people (we didn't have a full database of tourists at our disposal)
- Some of the Czech tourists weren't protected from journalists upon landing (at stake secondary psycho-trauma)
- Psychological support wasn't provided in Czech hospitals
- There are few psychotherapists focused on long-term therapy with PTSD clients in the Czech republic

What worked well?

- Central coordination
- All services were provided for free
- Psychological monitoring at the airports
- Psychological assistance in the collection of DNA material
- Flexibility and creativity of the psychosocial team
- Highly motivated workers and enthusiastic professionals
- Principe of solidarity and reciprocity

■ **Denmark** - TSUNAMI SOUTH EAST ASIA December 2004

Anders Korsgaard

Approximately 3000 Danish nationals were in the disaster area. Most of them were on Christmas holiday in Thailand. They were exposed to the trauma in varying degrees. 46 Danes died as result of the disaster. 45 of these have been identified. Many of the survivors were exposed to life-threatening situations and near death experiences. Many children were amongst both survivors and deceased.

Early Intervention

Psychosocial intervention in early phase took place:
In Thailand:
Several Danish crisis-teams were sent to Thailand from different organizations. Both private and official organizations took part in early intervention.
In Copenhagen:
Crisis teams were in Copenhagen Airport 24 hours a day in two weeks to receive homecoming Danes and to some extent other Scandinavians.
Local crisis teams in Denmark:
In the counties in Denmark local crisis teams prepared for homecoming Danes in their neighbourhood.
The Crisis teams consisted of psychologists, psychiatrists, nurses, priests, medical doctors and specialists in logistics.
The early intervention aimed at providing structure in an overwhelming and chaotic situation. Providing information, practical help and emotional, empathic assistance is essential.
It is also important to prioritize help to the persons in most need of psychosocial assistance. Screening for high risk reactions is necessary. Debriefing of crisis team members were also mandatory.

Longer term intervention

Survivors and relatives to the deceased were living all over Denmark. From early phase important to start organizing long term psychosocial intervention at a local level.
Following interventions has been provided:

There was the possibility of contact to local psychologists on individual basis, either at a local hospital or with a local practising psychologist.
Group interventions aimed at specific groups: surviving children, parents who lost children, relatives to the dead, survivors. These group interventions has been offered in collaboration with the Danish Red Cross.
Memorial service in Thailand in April, 2005 was held. The Danish Prime minister invited 200 relatives of the deceased to attend a memorial service in Thailand at the disaster site in Khao Lak. Almost all accepted the invitation. A crisis team also attended this memorial service in order to assist the relatives if needed. One year after the disaster several memorial services were held all over Denmark. Many of the relatives of the deceased got help from social workers.
In a research study which included all Danes who were in the disaster area and who filled in the questionnaires showed signs of more severe post traumatic distress. They have been offered psychosocial intervention.

Evaluation and implications for the future

- The importance of fast response time of activation of disaster crisis team, also in disasters including nationals involved in disasters outside home country.
- Close cooperation with official agencies from point zero. In this case Danish Ministry of Foreign Affairs.
- Somatic doctors are always important also in psycho social crisis team
- Memorial service on site of disaster at the right time, when people are emotionally ready for it, has invaluable importance in the healing process.
- Frequent training sessions before the disaster with all agencies and organizations involved in a future disaster.
- There were very few persons with psychiatric reactions in acute phase.
- Select experienced senior staff for psycho social disaster work.
- The fact that this disaster was an act of nature had an effect on the reactions of the victims compared to the reactions after a terrorist attack.
- We also learned to establish better procedures when disasters strikes outside Denmark to Danish nationals.

■ **Germany**- SCHOOL SHOOTING ERFURT April 2002

Georg Gewepieper

In a school shooting in Erfurt a 17 years old pupil killed 12 teachers, one secretary, two pupils, one policeman and himself. Some months this pupil was expelled from school.

Early Intervention

At first there came a crisis-intervention-team by the police.
The head office of the police informed all psychologists of the town and the region to come to the school and to take care of the victimized pupils and teachers. 74 psychologists came the first day, some days later there arrived more psychologists out of other parts from Germany. The psychological interventions were very different there was no standardized early intervention program.
Some psychologists did debriefings, some tried to do counselling, and others tried progressive muscle relaxation, some Eye Movement Desensitisation Response (EMDR).
There was no leading psychologist who told them what to do. Most psychologists were overtaxed.

Longer term intervention

Three weeks after the school shooting a cognitive-behavioural program for treating the traumatized pupils and teachers was accepted and implemented by the government. Every class of the school got two psychologists and trained the whole class in “coping with the trauma”, especially psycho education once a week for two hours.
There was a diagnostic phase where we took the measures of Post Traumatic Stress Disorder, depression and psychopathology. For those pupils and teachers who were highly traumatized we offered psychotherapy on an individual base. Teachers had the opportunity to join a group therapy-program. Every class was treated with exposition in vivo and visited the old school, where the shooting took place.
Once a month there was supervision was offered for all 53 psychologists. The supervision was necessary in order to solve problems and to make sure that they realized the therapeutic

aims of the treatment program. After one year all victims were included into the planning of the anniversary.
A second diagnostic phase was done after one year to study the development of PTSD, depression and psychopathology.

Evaluation and implications for the future

Best practices:

- To work with the whole system not only with the severe traumatized people.
- All psychologists were obliged to one program and were supervised in that way.
- Development of a "Seven-step-program for treating acute traumatized people" (SBK) which is a cognitive-behavioural program combined with EMDR.

Lessons learned:

- We need a better system of psychologists who are trained in early interventions. There is a need of crisis intervention teams which are able to come to the place very quickly.
- It was not clear which organisation, which ministry was responsible for the implementation of psychosocial interventions.
- The director of the school was very infected by the school shooting but she stayed in her job and decided about the psychological interventions in a very subjective way.

■ **Finland** - ROAD ACCIDENT KONGINKANGAS March 2004

Salli Saari

A most serious road accident in Finland happened March 2004 when a bus and a heavy-duty vehicle combination collided in Konginkangas. In the bus there were 37 passengers. All together 23 person deceased and 15 persons were seriously injured. The passengers were travelling to ski in Lapland. They were all young persons. 90% were from Southern Finland.

Early Intervention

- Psychological first aid for family members of the deceased and injured and their family members (those who travelled to Jyväskylä) done by the crisis team of Central Hospital in Jyväskylä.
- Hotline of psychologists of Finnish Red Cross. During the 3 first days and nights this line was used by many family members and relatives and friends of at least 30 passengers of the bus. Many contacts lead to visits to homes of family members
- Psychological first aid of public crisis centres (Helsinki, Espoo, Vantaa)
- Psychological debriefing for families and friends of the deceased followed by follow up meetings 4 weeks later by Red Cross Psychologists and local crisis teams
- Psychological support of the injured continued in hospitals

Longer term intervention

- Psychologist team of Finnish Red Cross organised peer support week ends (two days, stayed over night) for both family members of the deceased and for the injured and their family members. First two weekends were 3 months after the accident, second two 6 months after the accident and third two near the year day of the accident. In the meeting of family members of the deceased 55 persons took part (family members of 19 of 23 deceased) and in the meeting of injured and their family members 30 persons took part (13 of 15 injured). Two weekend meetings are still to come. Two years after the accident both groups will meet again.

- All these meetings were planned and lead by crisis psychologists. Also the small peer groups were lead by psychologists. In one weekend about 10 psychologists are needed to lead the groups. Small peer groups are for example group of mothers, group of fathers, group of sisters and brothers, group of spouses of sisters and brothers, group of widows, group of children. In the week end of the injured they form a special group.
- Many family members have also had individual therapy
- Finnish Mental Health Society has also organised peer support for family members of the deceased. These groups have met once a week 1½ hour in time, 10 times in total. There have been two such groups: parents group and a group of sisters and brothers.

Evaluation and implications for the future

The psychological first aid and early intervention were organised with a good covering of the families of the deceased. Also the coordination of the actors (public crisis centres and Red Cross) in Southern Finland was very good. Some problems were found in collaboration with the central hospital in Jyväskylä and great problems with workers of church, who did not care about the coordination and visited the family members without any invitation. Also the quality of the crisis work of church was quite problematic.

The experiences of professionally lead peer support were very good. Many family members said they got the best help from this crisis intervention. It was organised by experts and the level of intervention was high.

Many therapies of victims and survivors of the accident are still going on. Even, when the victims got more psychological help than usually victims of car accidents, many of them are bitter that they lost their child and through this their future. There is still a lot of anger in the minds of the family members of the deceased young ones.

■ **France** - AZF DISASTER TOULOUSE September 2001

Dominique Szepielak

The 21st September 2001, at Toulouse, a big explosion destroyed the AZF factory and certainly life of lot of people. Some people died, some people lost their house, some people were in shock (perhaps for life).

For the first time in France, people had a massive demand for psychological help. Some people had the 11th September in the United States of America in memory, and some of them think about a military attack or about terrorism action.

Early intervention

- Medical and Psychological teams (CUMP – Medical and Psychological Urgency Team) from all over France came to help
- On the 22nd of September the Red Cross contacted the SNP (National trade-union of psychologists) for more psychologists
- More psychologists came to volunteer

On the whole, something like five hundred psychologists for the Toulouse disaster came. All the psychologists received victims in hospitals, in the town hall, in gymnasiums and schools. The CUMP stayed for one week, but they set a value on need psychological help for four months. In fact all the psychological help stayed and was paid for one month and half.

Evaluation and implications for the future

- Time and money

The official help, the CUMP, stayed for only one week. The other psychologists worked unpaid at first.

- Logistics

Psychological help was not organized and some problems of place, of reception was revealed. For example, some people came to hospital to know if a member of the family is

dead or alive. In the reception, they queued up and a secretary or a nurse gave them the information without preparation. For more of them it was a big trauma too.
Other problems in logistics are that no one recognizes that people need psychological help in disaster situation. No one certainly thinks that victims have a need to be helped by psychologists. So, in fact they organized psychological help in the urgency, without method and without protocol.
Time of help can't be continued, and if some people need more time, the psychologists were paid only one month and half.
In France, psychologists, in that sort of situation, depend on the doctors or on the Ministry of Education, so they can only organise what others authorize, and not what is needed from a psychological point of view.

In fact, more of the psychologists agree to say that, in AZF disaster, they used their adaptation capability. Not any theory was adapted.
The first adaptation is to be able to work in unknown context.
In fact, I think that the psychologists, like doctors and others, need crisis and disaster training.

Clinical observation

Peoples symptoms :

- flash-back,
- speechless,
- memory troubles,
- attention troubles,
- hyper-vigilance,
- flight behaviour,
- sleep troubles,
- survivor syndrome,
- break-down,
- noise in the head every time…,
- every somatisations.

For children :

One important problem was that children ask their parents all kind of questions, but parents can't respond adequately because they are shocked themselves.
So, psychologists worked a lot with the adolescents and children.
Some children in school have the same symptoms as the adults. And they have a long time many difficulties to concentrate on their school work.
Other observations: A lot of people who were touched by mourning and trauma, lived in a bad social situation. In fact, AZF was near a weak social district, so this disaster created an opportunity to speak about the social problems and give birth to a new solidarity, and new social identity, in this district.

Conclusion:

What's about psychologists of Toulouse today?
For practice, all showed a good adaptation power, and in all the testimonies they said that there were first quality.

■ **Greece**- EARTHQUAKE ATTICA September 1999

Vasso Boukouvala

On 7 September 1999 an earthquake of 5.9 on the Richter scale hit the county of Attica, causing widespread damage to the area. The epicenter was placed in the area of Mount Parnis, about 18 km north of Athens. According to official figures, 143 people were killed, 700 were injured, 40.000 families were left homeless or about 100.000 people. There was extensive damage to buildings (houses, industrial buildings, schools, hospitals, etc.) across the county and according to the Ministry of Environment, Land Planning and Public Works, 3.340 buildings were ordered to be demolished. The aftershocks from the earthquake continued over many months after and were quite intense.

Early Intervention

There was prompt mobilization of state services immediately after the earthquake. There was close cooperation of all services involved in handling the crisis, such as the Coordination Centre of the Ministry of Health, the Ministry of Internal Affairs, Civil Protection, the Army, Special Rescue Team of the Fire Brigade (EMAK), Ambulance services, Greek Police, the Earthquake Planning and Protection Organization (OASP), the Greek Section of the Red Cross, the Medical School of the University of Athens, the University Psychiatry Clinic of the Eginiteion Hospital, the Association of Greek Psychologists, several non-governmental organizations such as Medicines du Monde et al.

The contribution of the Association of Greek Psychologists (AGP) in post disaster crisis intervention was of prime importance and this was structured in the following manner. Let it be noted that it was the first time in the history of the AGP that an operation of this nature and magnitude was organized.

The Association of Greek Psychologists made its members available to the Ministry of Health and the Local Authorities from the very beginning. There was an initial assessment of the situation in close coordination with the Ministry of Health, the Municipality of Menidi and other local authorities.There was an effort to collect as much data as possible regarding the number of people injured, the extent of the natural disaster, the demographic characteristics as in the area there is a significant number of immigrants and gypsies, the nature and type of problems that they were facing, the living conditions after the earthquake, etc. At the same

time, we appealed to our colleagues to get in touch with the Association in order to offer their services on a voluntary basis. Assessment of the needs led to the following decisions and actions:

- Crisis Reception Center: The Crisis Reception Center of AGP was operating out of the KAPOTA military base in Menidi in the county of Attica.Its purpose was to offer immediate psychological support to the local population three days after the devastating earthquake. The CRC was in close contact and cooperation with the Coordination Centre of the Ministry of Health and Welfare, the Municipality of Menidi and the Local Authorities and was housed in the area of the Health services at the military base together with the other non-governmental organizations. Daily, for almost three months, fifty five clinical psychologists, members of the Association, offered their services on a voluntary basis.
- Briefly post disaster intervention included psychological first aid and support, psychological debriefings (individual debriefing meetings, debriefing meetings with the relatives of the victims, family debriefing meetings) and group discussions led by psychologists with adults or adolescents or children or teachers. Also, noting and recording all psychiatric cases in the camps that were created for the homeless and referrals to the psychological and psychiatric services of the wider area.
- Mobile Unit of the Crisis Reception Center: The goal was to visit all the camps that were created for the homeless and the local schools with the purpose of offering information and practical advises to the inhabitants in handling the crisis.
- Intervention for the rescued from collapsed buildings: in order to care for the rescued from collapsed buildings clinical psychologists conducted individual debriefing meetings with them in the General Hospitals. The above mentioned intervention was in close cooperation with the Coordination Centre of the Ministry of Health.
- Hot line of psychologists: psychological first aid and support. This service was being widely advertised through the mass media.

<u>Longer term intervention</u>

Psychologists (AGP) was lasted approximately three months. (September – November 1999)

<u>Evaluation and implications for the future</u>

- Best practices

- Debriefing meetings
- Group discussions led by psychologists.
- Family psychological support

Lessons learned:

- In the case of a major disaster, the presence of a central coordinator of psychosocial assistance is of paramount importance.
- Volunteers should not operate independently of the State Coordinator.
- In the aftermath of a major disaster, in order to meet the needs of the general public adequately, both the state and the national associations of psychologists need to be in an elevated state of readiness.
- Educational work before disasters is very important. Psychology undergraduates should be taught Disaster, Crisis and Trauma Psychology as part of their main curriculum.
- Psychologists in hospitals should undergo Compulsory Training in Disaster, Crisis and Trauma Psychology. Other professional psychologists should be able to follow courses or undergo training in the same field in order to offer their services in the aftermath of a major disaster .
- It is imperative that the state develops specialised centres in Disaster, Crisis and Trauma Psychology.
- The existence of a network of cooperation between European states is necessary to ensure readiness in the aftermath of a major disaster
- The role of the mass media is very important in the aftermath of a major disaster because it is one of the most effective ways to reach the public and society. Psychologists should possess the necessary training in responding to media requests or providing support to the people through the media (ex. advising parents to limit exposure of their children to media presentations of the disaster).

Missed Opportunities:

- Valuable time was lost in the beginning. The first four days were mainly devoted in setting up and putting into place the necessary support mechanism.
- No provision was made for debriefing meetings with the members of rescue teams (fire officers etc.).
- There was no possibility for follow up in order to study and evaluate the impact and the effectiveness of the post disaster crisis intervention of AGP.

■ **Italy** - EARTHQUAKE CENTRAL ITALY October 2002

Isabel Fernandez

On Oct. 2002 an earthquake in Central Italy caused the destruction of an elementary school in a small village. Actually, the only building that fell during the earthquake was the elementary school killing 27 children out of 59. The village population was evacuated, stayed in tents for 3 weeks and then returned to restored houses or to new houses provided by the Civil Defense and by the government.

Early Intervention

Psychological support was organized right from the first week. There was a tent of "Psychological Support" in the camp where the population was evacuated to. There active listening and support were provided as well as psychoeducation on stress reactions to victims and rescuers. Interventions were provided by associations of psychologists that volunteered. The local Health Unit and the regional Psychological Association coordinated all groups and all interventions, which ended within the first month.
After 2 to 3 weeks all emergency workers, Civil Defense professionals and psychologists left the site. No further psychological intervention was done after 1 year to the population, so they remained without middle and long term support. Just surviving children got further treatment with different cycles of trauma therapy at 1 month, 3 months and a year from the event.

Longer term intervention

After 1 month, 3 months and after the first anniversary EMDR treatment was provided to children that survived. It was the only intervention planned after one month from the event. It was carried out by the National EMDR Association. Since the event met all the DSM IV-TR criteria for PTSD (the children were trapped for hours under the rubble of the school, in direct contact with the death of their class mates and feeling their own lives being threat) and since EMDR has proven to have a high level of efficacy for this kind of disorder, it became the elective treatment with the school population. EMDR was agreed upon and supported by the National Health Service, the authorities, and the school personnel and by the parents of the

children treated. The school faculty was collaborative and supportive during the implementation of the treatment. These people were also supplied with psychological support given through active listening, group debriefings, and group meetings about children's reactions to stress, information sessions on how to manage the classes daily under certain complex aspects after the earthquake and information on EMDR treatment. Educational meetings with their parents were a fundamental part of the intervention program addressing stress reactions and advising how to manage their traumatized children in order to offer them a more effective support to reduce and normalize their reactions. The support and information given to the parents were useful tools to help their children and to reassure them. A questionnaire on symptoms was administered and full information about the intervention with children and about EMDR were given in order to obtain an informed consent. Questionnaires focusing on post-traumatic stress reactions of the children, were given to allow them to identify the children's conditions and to enhance collaboration during the whole process.

Evaluation and implications for the future

Best practices

- The analysis of the assessment before and after each cycle of EMDR treatment has validated the hypothesis of the EMDR effectiveness in the context of a dramatic post-emergency situation. Not only did the EMDR treatment allowe the resolution of the experience to happen in an adaptive manner, but also allowed the subjects to talk about their individual experiences, the most disturbing ones and situations that became problematic after and because of the earthquake.
- Another best practice was to measure the intervention's effectiveness before and after in order to show how important is the psychological intervention and prove that amelioration of symptomatology is not only due to time.
- Local coordination of the different disaster psychology experts that worked at the earthquake site was an effective action by the local mental health team. They classified the groups that could receive support: adult population, children and adolescents, emergency workers and so on.

Missed opportunities

All actions coordinated by the local health unit were unfortunately managed in a passive way, with some reluctance to outreach the population. They could come for support but this was

not offered proactively. Apparently coordinators did not want to create a need for psychological support among the population but just respond to it when it was requested.
This was a missed opportunity since experts were in the field with many resources.
Another missed opportunity was to ignore one of the groups most striken by the earthquake: the parents of the children that died during the earthquake. Since they were not involved appropriately their reactions and choices since then have been of great damage for the rest of the population and surviving children. This group had not any support or benefit from psychological care.
Firemen involved in the rescue of children had no support and they were the most exposed to stress. Even now they are reporting that they are suffering from stress reactions.

Lessons learned

It is important to remember that both children and parents and the community involved in this disaster were sharing all posttraumatic reactions, mourning processes, loss of homes, sense of guilt and conflicts that aroused in the community. It is well known that adult anxieties are perceived and absorbed by the children and can become an obstacle in the resolution of psychological disorders. Many children said they were affected most of all by their parents' behaviour and display of emotions. So, interventions should not be focused on children victims of trauma but also on their parents.
It is important to reach proactively the groups most exposed trying to create an alliance with authorities in order to be allowed to provide psychological support in a structured way.

■ **Luxembourg** - AIRPLANE CRASH November 2002

Marc Stein

A plane (Fokker 50) of the Luxemburg's air company LUXAIR arriving from Berlin (Germany) crashes in thick fog near the airport, killing 20 of the 22 people on board.
It was carrying 19 passengers and 3 crewmembers. The plane took fire on ground. 17 people died in the crash, while 3 of the 5 survivors died in hospital.

Early Intervention

On the first day: Immediately the SAI plan was launched. This plan brings together the psychological unit of the police and the Psychological support group of Civil protection in order to provide psychosocial first aid during D&C.
Furthermore, the GROUPE-PSY of the ministry of family was implicated. This group is a network of psychologists who got training in psychotraumatology.
More assistance was provided by the CARE-team of Lufthansa (around 10 employees). This team regroups employees of Lufthansa specially trained to assist the relatives of victims.

Psychosocial interventions:

- Putting up a special location to take care of relatives and families waiting at the airport, giving psychosocial support while waiting for further information.
- Taking separately care of the families of the crew-members
- Taking care on scene of 3 witnesses of the air crash scene
- Taking care on scene and giving psychosocial support to intervention teams (firemen, policemen)
- Putting up a hotline to give information to families and relatives abroad, as a lot of the victims were living in Germany. (109 relatives called this hotline)

The following days:

- Organising with Luxair and Lufthansa that relatives can fly in to Luxembourg, organize their stay and giving them support.
- Organising a more intimate death ceremony with different religious priests (catholic, protestants) and giving support to the 140 family members and relatives.
- Organising a national religious ceremony and giving support to family members and relatives
- Organising the return of the coffins by plane to Germany and clarify further details of the burying
- Organising debriefings for the intervention teams (firemen, policemen, identification team) but also for the psychosocial unit!

Longer term intervention

For long term psychosocial support, some families and relatives were taken in charge by the GROUPE-PSY, but most were referred to psychologists in Germany as the families were living near Berlin. Some costs of therapy were also taken in charge by the Luxemburg's ministry of family.
A private psychologist was engaged by Luxair to take care and give support to the 2 survivors (a passenger and the pilot)
After one year, there was a civil ceremony. At the place of the accident, a monument has been erected.
On the second anniversary, a smaller ceremony has been organised because a few of the families still expressed the need for a ceremony.

Evaluation and implications for the future

3 different hot lines had been created which made a lot of confusions.

Lessons learned:

- Next time only one central hotline, acquire a software program to centralize and share in better way information
- Some relatives and victims could not wait to see the dead bodies. Due to misinformation, they were brought to the place where the identification teams worked, but they could of course not access the dead bodies. This created a lot of tensions. Finally, the following day, the prosecutor could allow the families to see the dead bodies after every victim had been

identified (mostly by their teeth scheme). Nearly all the families wanted and could see for the last time their relative, even if most bodies were severely burned.

- Family and relatives were thankful to see the bodies even if the bodies were in a bad condition.
- Identification team gave the feedback that they experienced huge psychological pressure because they had not only to handle the identification, but they were also confronted to the grief reactions of the family members which provoked a lot of tension.
- Separate physically the Identification team from the place where family members can see the victims.

Luxemburg's ministry of family and GROUPE-PSY were somewhat reluctant to organize a second anniversary ceremony, but they indicated that in the end, this ceremony had shown to be a meaningful and useful event.

Interestingly, this airplane crash also had quite a big national impact, probably because it deeply shocked the nations unconscious (and of course naïve) belief that an airplane crash could not happen in Luxembourg.

■ **Netherlands** - FIREWORK DISASTER ENSCHEDE May 2000

Magda Rooze

On 13 May 2000, a fire started in the firework storage depot/firework factory SE Fireworks. In broad daylight, a massive firework display, as it were, started to develop. Many passers-by moved closer, to get a better look. The first fire alarm was received at the control post at 15.03 hours; an initial explosion followed at 15.34 and 45 seconds, followed by a second explosion with disastrous consequences. Finally, 22 people were killed (including four fire fighters and three individuals of whom no remains were ever found) and 947 were injured, of whom 527 received hospital treatment in hospitals in Enschede and the surrounding area. The disaster area covered a total of 40 hectares (approximately 100 acres).
The inner ring of the disaster area was home to 4163 people, and the outer ring to 2400. 205 homes were utterly destroyed, and 293 declared uninhabitable. Many business premises were damaged.

Early intervention

In total, including volunteers, some 4500 emergency services workers were deployed on the first day, by the various emergency services. During the first week numbers were even higher. A number of people only provided assistance during the first day, whilst others assisted for the full two-week period.
As concerns expert assistance, on 13 May, 680 doctors were providing assistance, there were 270 ambulance personnel active, 80 first-aiders, and 45 general practitioners. Ambulances arrived from the entire surrounding area, including Germany.
The relief effort came about rapidly, and was needed for a considerable time. The area was unsafe, and fires kept re-igniting. A criminal investigation was started.

Longer term intervention

Based on experiences from previous disasters, the lesson was learned that it was essential to discover the cause of the disaster. Against this background, following the disaster, an independent investigation committee was established, the so-called Oosting Committee. The conclusion of the Oosting Committee report was that SE Fireworks had failed to comply with the regulations concerning the storage of firework material. The stored fireworks were of a heavier calibre than reported and the storage method had been unsafe. No licences had been issued for storage purposes.

Also shortly after the disaster, in the afternoon of 13 May, the Institute for Public Health and the Environment (RIVM) carried out measurements into concentrations of substances in the air, and these measurements were subsequently repeated over the following days, to be able to determine possible exposure to hazardous concentrations of substances for the emergency services workers and other affected.

As concerns the organisation of psycho-social care, three lines were projected:

- An Information and Advice Centre
- Integrated psycho-social aftercare
- Health surveys

The Information and Advice Centre was established in Enschede, on the initiative of the Ministry of Public Health, Welfare and Sport, and the local authorities. During the first week after the disaster, the centre was actually up and running. Building, infrastructure, telecommunication, registration, software and staffing were all made available, on an improvised basis.

During the first weeks, hundreds of people were received by front-office workers. Visitors were thus able to express their concerns, and were referred on as necessary. Psycho-social and legal assistance were available immediately, as was material support in the form of clothing, money, a telephone, accommodation, furniture and other household goods. Others who had experienced the disaster were able to tell their tale, and find a calm environment in the 'living room' set aside for that purpose.

As an organisation, the Information and Advice Centre passed through a number of stages. Alongside the initial pioneering phase, there was a build-up phase during which the internal organisation and a network were established, with other important organisations. Work agreements were reached with these institutions and on that basis, the victims of the disaster received support and assistance.

During the consolidation phase, the number of requests for practical and material support fell, but it became clear how complex the remaining problems were. At present, almost three years after the disaster, the Information and Advice Centre is in the wind-up phase. The IAC will soon cease to exist as an independent organisation, but for the longer term, a separate counter will remain available in the town hall, to deal with questions relating to the disaster.

Right from the start, the organisations in Enschede specialising in psycho-social care worked closely together. These were general practitioners, social workers, home carers and the mental health care institutions. They formalised this cooperation in a foundation. This

initiative was also intended to combine resources on behalf of the victims, to ensure that all available expertise was deployed as effectively as possible, and to support one another in counselling and caring for the victims. Additional care providers were called in, so that everyone could be provided with the best possible care, without waiting lists emerging.
The initial idea was that psycho-social care would also be provided via the Information and Advice Centre. However, this proved unfeasible, since the IAC was accommodated in the municipality's premises, which was unacceptable for a number of psycho-social care organisations. Privacy legislation also meant it was difficult to exchange information. As a consequence, two organisations were effectively established, each preparing their own reports, and their own information registers. In hindsight, this was an unfortunate development, because as a consequence much information was lost.

Evaluation and implication for the future

- Information and advice centre

The IAC has proven to function adequately for 5 years after the disaster. Disseminating information and acting as a referral centre for all kinds of services the affected people need in the aftermath of the disaster. Since affected people by a disaster have to deal with so many different problems: health issues, insurance, financial, housing etc. This central location helps a lot to minimize the disaster after the disaster.

- Integrated psychosocial approach

The integrated approach is understood to mean that the problems are examined and decisions are taken as to what is required, who can best provide the assistance, and how the available human and other resources can best be deployed. This proved rather more difficult to put into practice than expected. The original intention was that the IAC would coordinate the whole effort, but this too proved a bridge too far. This was because in Enschede it was decided to make the IAC a municipal institution accountable to one of the executive councillors. This was unacceptable to a number of care agencies. Invoking data protection legislation, the care agencies were also unwilling to transfer victim' personal details to an IAC database.

- Health monitoring

Extensive data are available now on the health situation of the affected people. Lesson learned is that it was only after years these data came available. For professionals and the affected people themselves the value is minor. One should look for health monitoring which is readily available for professionals to guide the care which is needed and for affected people to understand their health situation better.

■ **Norway** - MARITIME DISASTER NORWEGIAN COAST November 1999

Atle Dyregrov and Rolf Gjestad

On November 26, 1999, the catamaran Sleipner struck a reef at high speed north of the coastal city of Haugesund, Norway. It sank within an hour. A number of ships and a helicopter participated in the rescue operation that was undertaken during very difficult weather conditions with strong winds and high waves. Sixteen people died and 69 survived. The boat was constructed in such a way that it was generally believed that it could not sink. The reef penetrated so many of the bottom compartments that when the wind and waves took it off the reef after about 30 minutes, the ship sank quickly.

Early interventions

The main place for the immediate support was Haugesund, the city closest to the disaster, where the injured and dead passengers were transported. Also in Bergen, the destination for the boat, and Stavanger, the point of origin for the trip, crisis reception centers were set up. Police, clergy, and health personnel did their best to support family members of the passengers in this first extremely stressful period of uncertainty about who had survived and who had died. Surviving passengers who were not taken to hospitals were cared for in the smaller communities close to where they were taken onshore before being transported to Bergen or to other places as they wished. Family members gathering at the crisis reception centers received emotional first-aid. Despite the inevitable stress involved in a transport disaster and the fact that there always will be much confusion and stress at the outset, immediate help seemed to be well organized and perceived as helpful by those affected by the disaster. Following previous Scandinavian disasters, criticism has been voiced against the lack of follow-up received (Dyregrov, 1992). The company that owned Sleipner contacted the Center for Crisis Psychology (CCP) in Bergen to get professional advice on how best to care for the survivors and bereaved over time. CCP had experience in organizing follow-up services in disasters and war situations nationally and internationally and was asked to set up a plan for long-term support for the affected groups. This was done in cooperation with Haugesund Hospital which had the organizational responsibility for the disaster work.

Longer term interventions

- Psychological debriefings to all survivors were offered and conducted one week following the disaster.
- Follow-up debriefing meetings took place approximately six weeks after the disasters
- Meetings between survivors and rescuers were carried out during February 200
- A screening of survivors and subsequent referral of those above a clinical cut-off level was organized during late January and early February.
- In May 2000, survivors were offered a boat trip back to the site of the disaster. Five mental health professionals supported the survivors on this trip. For many, this was their first time on board a ship again. Possible adverse reactions during the trip were anticipated, and after returning to shore, an opportunity to talk about their experiences was offered.
- Further follow-up was organized locally based upon the needs expressed by the survivors during meetings or through the screening questionnaire. In June 2000, meetings were held at several geographical locations close to where survivors lived. These meetings were mostly informal, although mental health professionals were present to assist, answer questions, and make referrals for those who requested additional services.
- As the wreck was brought to the surface in late August 2000, some survivors undertook trips to look at (and enter) the wreckage. Support personnel were present at the site, and a short memorial was undertaken before entering the wreck.

Evaluation and implications for the future

Although the exposure was rather extreme during this maritime disaster, leading to consequences that impacted survivors in various spheres of their life, the great majority were doing well over time. Hopefully, lower distress scores compared to other maritime disasters reflect on a structured and caring system that was implemented to care for survivors.
Participants who take part in debriefings greatly appreciate these meetings. As “consumers,” they are able to differentiate among the functions served by the meetings. Those that seek out the debriefing meetings have had longer disaster-exposure time and seem to be more distressed than non-participants. Screening may provide the basis for a sensitive outreach to those in need who want more professional follow-up. However, non-participants should be respected for their decision not to take part in debriefing or other mental health follow-up. Some people will, regardless of their symptom levels, not be oriented to illness or help-seeking behavior. An aggressive outreach focus toward this group may be viewed as

disrespectful and may make them more resistant to later help. Regardless of the debate on early intervention, it is important from a psychosocial perspective to provide survivors with the sense of a caring system that reaches out to assist them. Ursano, Fullerton, Vance, and Wang (2000) state that: “Debriefing, like sleep medication or pain medication, may have little or no impact on standard health measures but still be an important intervention to limit pain, discomfort, and disability.

■ **Slovenia** - LANDSLIDE LOG POD MANGARTOM November 2000

Marko Polic

In November 2000 landslide hit the village “Log pod Mangartom” in two stages on two consecutive days. The distinct stages were probably the main reason for causalities. While the first landslide stopped before reaching the village, the next one struck it. Seven people were killed and a number of houses destroyed (6) or demolished (13) as well as the local roads. A number of people were moved to nearby town Bovec into a provisional shelter in the local hotel.

People were killed by landslide due to violation of the order given by Civil Protection to stay in the refugee. A situation is not yet completely stabilized; warning system was constructed with sensors on the places of possible landslide above the village and sirens in village.

Early Intervention

Organization of all help (technical and other) was in the hand of Civil Protection. which coordinate all the relevant activities. On the very first day the psychological first aid was given by local physician, while later psychologists from the Ministry of defence, trained in such interventions were on the spot, helping local people.

There were stresses connected to human looses as well as material one. It must be mentioned that this region is prone to earthquakes and there were a number of them in recent years.

Psychological support included mainly individual work with people. Individual work was going on in the local health center. Some of the clients came by themselves, some on the suggestion of physician. Mainly women search for help. Besides individuals there were also a few couples and parents with children that needed this kind of help. Regarding age they were in their middle age or older (accumulation of stresses because of different disasters in a few years, but also other stressful events e.g. death in family, alcohol, etc.). Clients reported typical signs connected to traumatic events. They needed a kind of advice, support, etc.), what was given to them. We must mention her a kind of distrust toward strangers that is characteristics for people from smaller places like those involved in this disaster.

Longer term intervention

After a few months army psychologists returned to their regular duties while inhabitants can get help at local health centre either from their physician, or – if a more complex psychological help was necessary – from psychologists in relevant health institutions in bigger towns.

Evaluation and implications for the future

On one side in Slovenia there is a tendency to educate people, especially those engaged in rescue activities about stress and PTSD, and on the other side, there are psychologists in health institutions and Army educated for professional help in such a cases. As Slovenia is small country we could not afford psychologist in every village, but there is a number of professionals that could help if necessary and help is never far away.
While before nineties psychological aspects of disasters were not so much emphasized, later on – especially due to great number of refugees from former Yugoslavian republic, with their traumas, put the need for psychological help in the forefront. There is a number of professional institutions where psychologists have relevant training, e.g. Centre for children, adolescent and parents, psychologist in army, Psychosocial centres, etc. With the exception of Army psychologists, psychologists in this institutions are trained for different kinds of professional activities, help during trauma being only one of them.

■ **Spain** - TERRORIST ATTACK 11 MARCH in Madrid

Catherine Perello Scherdel

On the 11th of March 2004, Madrid trains were bombed, killing 191 people and wounding 1,755. The official investigation by the Spanish Judiciary determined the attacks were directed by an al-Qaeda-inspired terrorist cell.

Early intervention

This intervention was part of the PLATRECAM, Emergency Territorial Plan of Madrid Region. COPM offered collaboration to SUMMA 112 (Coordination Centre for Emergencies) and to SAMUR. COPM organised, immediately after the attack, two psychological crisis centres, one in the psychological association and another one in SUMMA 112 Centre. From Thursday 11 March, at 9h a.m., the Official Psychologist's Association of Madrid, COPM organized an emergency structure composed by the following persons:

- 4 coordinators
- 2 responsible for the psychologist's teams
- 8 telephonic lines that stayed working till Monday 22 March.

COPM made first a selection of psychologists making sure that they were specialists in crisis and disaster; then they called psychologists who had some experience in trauma even if they hadn't special training in this topic; these groups were coordinated by a crisis and disaster specialist.

- Contacted psychologists: 1.415
- Psychologists who intervened: 948

Intervention areas:

- IFEMA
- Morgues
- Hospitals
- Cemeteries
- Police Stations
- Hotels with affected relatives
- Telephonic attention (112, SUMMA etc.)
- Home care

Affected population

- Victims relatives
- Relatives of injured people
- Injured people
- Neighbours of the places of the attacks
- Victims friends

Interveners in the place of the attack:

- Policemen
- Firemen
- Doctors
- Psychologists
- Psychiatrists
- Nurse staff
- Social workers
- Volunteers
- Journalists

Psychological assistance:

- Direct attention: More than 5.000
- Telephone assistance: 13.540
- Demands for domiciliary assistances: 183

Psychologists carried out:

- Information
- Support
- Cognitive approach
- Relaxation techniques
- Termination
- Follow up

The Official Psychologists Association of Madrid, COPM coordinated their intervention with the institutions: national, regional, local, with their representatives:

- National level: Ministry of Health, Civil Protection, Ministry of the Interior.
- Madrid community: Presidency, Vice-Presidency, Ministry of Health (Counsellor, Vice counsellor of Sanitary Ordering, Regional Office of Mental Health Coordination), Ministry

of Justice and Interior, General Direction of Immigration and Voluntary Workers, SUMMA, 112.

- Madrid town hall: Vice Mayor's Office, Department of Social Services, Management of Public Health, SAMUR.

Psychologists elaborated the following guidelines:

- Guidelines of self-control after the 11 march attacks
- How can I help giving support after the loss of a loved being?
- Guide for parents
- Psychological intervention in disasters
- Helping for the for well-being and performance protocols
- Performance with children subjected to traumatic experiences
- What to do with children in disasters
- Debriefing: models and applications of the traumatic story in order to integrate them
- Support documents for professionals who participate in the psychological attention to disaster victims
- First psychological support. Which protocols should we use?
- http://www.copmadrid.org

Media:

The Official Psychologists Association of Madrid, COPM, developed a special deployment of services and information about the psychological assistance that was being produced:

- Press conferences: COPM carried out seven press releases, which were sent to 200 different media, on the 11, 12, 13, 14, 15, 16, 17 and 22nd of March, and a press conference on the 17th March in which 42 media assisted
- Communiqués: COPM carried out two communiqués criticizing the attacks and sending their condolences and solidarity to the victims on the 11 and 12 of March.

We detail next the media that had relation with the press cabinet of the Official Psychologists Association of Madrid, COPM, and have informed about the assistance that was being carried by psychologists:

- radio**:** Cadena Ser, Radio Nacional de España (RNE 1, RNE 5), Onda Cero Radio, Cadena COPE, Radio Intercontinental, Radio Intereconomía, Telemadrid Radio, Canal NOU Radio, Onda Rambla, EFE Radio, radio Euskadi, Onda IMEFE,

- newspapers: El País, ABC, El Mundo, La Razón, La Vanguadia, El Periódico de Catalunya, Cinco Días, El Diario Vasco, Diario Médico, Diario Avui, Diario Metro, 20 Minutos, Heraldo de Aragón, La voz de Galicia, etc.
- television**:** Televisión Española (TVE1, TVE2, Canal 24 horas y TVE Madrid), Antena 3, Telecinco, Canal Plus, CNN+, Telemadrid, Canal Nou (Comunidad Valenciana), Televisión Gallega, televisión de Canarias Localia, ETB (País Vasco), Canal SUR (Andalucía), Televisión Castilla la Mancha, Onda Seis, TV Catalunya,…
- information agencies**:** EFE, Europa Press, Servimedia, Fass Press, OTR Press, Colpisa, Avant Press, EFE televisión, Atlas Televisión and Europa Press Televisión, etc.
- General information magazines**:** El Siglo, Tiempo, Época AND, Cambio 16.

International media:

- television: BBC (United Kingdom), TV CIC (Portugal), RTL (France), ARD (Germany), CNN (United States) etc.
- news agencies: France Presse (France), Associated Presse (The United States), Reuters (United Kingdom), Agency Accused (France), Agency Maxi (Italy) etc.
- radio: Radio ITR (Chile), Radio RTL (France) etc.

Long term intervention

Psychologists phoned the victims in order to know:

- How they feel to know if they needed more psychological support and organise it.
- If the victim has sufficient skills to manage
- If it was necessary to start new approaches
- How they felt about the first psychological intervention

Few victims followed the trial. Psychologists gave psychological support:

- Before the trial
- During the trial: support when re-experimenting, adaptation skills, appropriate space and logistics, justice and repair, sharing experiences, information, victim protection
- After the trial

Lessons learned

- Every psychologist should follow the directions and authority's information
- All agencies and different institutions should coordinate, putting their differences apart

- The information should be transmitted continuously
- The victims need integral and multiprofessional attention at the place of the attack
- We should avoid constant exposure that could worsen the psychological effects
- Every psychologist should consider before if they are enough trained to intervene

Improvements to be made:

- Increase the number of psychologists trained: There were two psychologists for 10 victims
- Increase the level of cohesion and communication between professionals
- The victims should be in independent spaces
- Assessment of workshops to monitory the emotions
- Acknowledge the reason of victims attendance
- Thinking why sometimes psychologists were not to able to provide the support needed
- To intervene as soon as possible
- To assure confidentiality
- Have an organisation who coordinate the intervention with clear steps to follow
- Psychologist should not leave without informing the responsible to assure the continuity of the psychological support
- Assure that psychologist have special training in C&D
- Assure that psychologist have special skills and clinical experience
- Psychologist should listen their body and be aware of their emotional strain, and stop when needed
- Share experiences with other psychologists
- Decided a communication responsible for the media
- Write reports of every intervention to know the consequences of each intervention
- To have protocols for every victim, in alphabetic order, with address, telephone, who was the psychologist that intervene, for a data base
- Secure quality control
- Coordinate the network
- Research

■ **Sweden** - TSUNAMI SOUTH EAST ASIA December 2004

Eva Håkanson

Approximately 17 000 Swedish citizens, the majority on vacation, returned from South East Asia in the weeks following the tsunami in December 2004. It has been estimated that about half of them had been in the affected area at the time of the tsunami. 543 Swedes were reported as missing and of these 527 were identified and confirmed dead by February 2006. Of the confirmed dead persons 111 were under the age of fifteen. Some persons lost more than one family member and
some children lost both their parents.

Stockholm was probably the most seriously affected capitol in the industrialized world. About 5000 people living in the county of Stockholm returned from South East Asia and were registered by polis at Arlanda airport. 205 Stockholm citizens were reported as missing.

Many survivors were exposed to life-threatening situations, being on the beach when the wave hit. They witnessed relatives and other people disappear in the waves. Many experienced life threat, suffered the loss of a significant person, or sustained physical injury. When returning to Sweden some of them needed further hospital care. Of the 13 000 people arriving at Arlanda airport, 461 persons, of whom 147 were hospitalized, were transferred to one of the emergency hospitals of Stockholm. In addition approximately 1000 survivors attended one of the seven primary care centres that were set up in the county of Stockholm, during the first week after the tsunami.

Early Intervention

The Swedish authorities sent medical personnel and teams for psychological and social support mainly to Thailand but also to some other areas affected by the tsunami. NGOs as well as official and private organisations took part in the early intervention. The immediate rescue work by the Swedish authorities has been criticized in public media as unprepared, unorganized and insufficient.

In order to respond to the medical, psychological, social and emotional needs of the survivors crisis centres were set up at he main Swedish airports the first day after the tsunami. These centres were operating day and night for three weeks and were manned by personell from the Civil Aviation Administration, the police, medical authorities and social services as well as by volunteers from the Red Cross and the Church of Sweden.

Local crisis teams in Swedish communities affected by the tsunami were alerted and in function shortly after the disaster took place. In some communities each survivor was approached by a member of a crisis team and they as well as relatives of diseased persons were offered psychological and social support. Other communities decided not to be proactive other than to inform the public of possible supportive resources through the media. The support was organized in various ways in the communities, most often managed by the social services. The supportive work was done by psychologists, social workers, nurses, priests and others.

In the county of Stockholm hospitalized survivors were offered support by well trained members of the psychosocial management teams at the hospital. Affected and bereaved children were offered support by psychotrauma teams belonging to children and adolescent psychiatric clinics.

At the primary care centres social workers and psychologists assisted the medical staff, offered social and psychological support to those in need and organized follow-up.

Information about posttraumatic stress reactions, self-help strategies and access to professional psychological support was given by psychologists and other professionals through pamphlets, television, radio, newspapers and the internet.

Rescue and medical personal were offered defusing and according to needs psychological debriefing.

Long term intervention

Support and trauma therapy was offered by psychotherapists working in primary care, occupational health services, psychiatric outpatient clinics for children and adults as well as by private psychologists and psychiatrists. Treatment offered by the official health services was free of charge during the first three months following the disaster.

NGO.s like the Red cross and Save the Children organized support groups for children, adolescents and adults, survivors and relatives to the deceased.

In January 2005 the Swedish government set up a new national public authority: The Swedish Coordination Council for people affected by the Tsunami Disaster. The council was laid down in 2006. The main task of the council was to distribute various kinds of information to survivors and relatives of deceased people for instance about the identification procedures of missing people. The council also connected people to adequate authorities concerning juridical, economical or insurance matters as well as for psychotherapeutic treatment.

At a later stage the council was responsible for the arrangements of memorial ceremonies both in Thailand and in different parts of Sweden. The council distributed money to survivors and bereaved people in order to enable them to attend the memorials in Thailand.

Whether all the supportive efforts were adequate and of help to the survivors and the bereaved still has to be shown. The results of ongoing research projects will be published in the years to come.

Evaluation and implications for the future

Government authorities have to be on the alert and take necessary responsibilities soon after a disaster.

It is important to have a formalized plan of action for both immediate and long-term support. If medical and psychological personal is to be sent to the site of a disaster it has to be well organized and the personal must be trained for the task. High quality of support in the immediate aftermath of a disaster will lead to increased trust in the survivors and thus enable further supportive measures.

Coordination and cooperation between organizations is crucial. The risk of leaving survivors without adequate support is otherwise high.

It was a good decision to set up a national coordination council. However, the council lacked psychological competence, which had do be attended to at a later stage.

Support offered as part of a proactive outreach programme was generally well received. Survivors that were not actively offered support have reported difficulties in finding the proper help. In some of the non-proactive communities there was a lack of knowledge in the field of psychotraumatology among people working in local government administrations, a lack that has to be provided for.

Timing is of great importance when offering various kinds of support and therapy. Disasters often have long-term consequences why outreach help must continue over time.

In order to increase the effectiveness of various support methods in the aftermath of disasters a number of research projects are carried out on a national and regional basis in Sweden. These studies are investigating different aspects of long-term consequences after the tsunami on affected individuals, families, societies as well as on helpers, organizations and governmental authorities. Special interest is devoted to evaluation of various methods used for psychological support.

■ **Turkey** - EARTHQUAKE MARMARA August 1999

A. Nuray Karanci

On 17 August, 1999 an earthquake with a magnitude of 7.4 on Richter scale hit the most densely populated industrial heartland of Turkey, at 3.02 a.m. The main shock of the earthquake was followed by aftershocks which also resulted in structural damage. The earthquake caused 17,127 deaths and 43,953 injuries. Moreover, the earthquake displaced 25,000 people .

Early Intervention

- On the first day and week:

There were important difficulties in reaching the region and building communication networks. Therefore, first days were involved with search and rescue and mainly by provision of basic needs, such as food and shelter. This was done by the Turkish Civil Protection, Search and Rescue teams, by local citizens, and some volunteers and NGO's. No specific psychological support was provided. There was a massive call for assistance for rescue and shelter/food. International search and rescue teams and national NGOs helped. The coordination and collaboration of national and international teams was an important issue.

- Psychosocial interventions:

Setting up temporary accomodation and providing tents . This is the responsibility of the Turkish Red Crescent. Due to the difficulty in answering the massive demand other national and international organizations helped. The Turkish Red Crescent is responsible for providing tents and food to survivors of disasters in Turkey. They erect mobile kitchens and provide food to all survivors. Of course, due to the massive causualties their response capacity was not adequate initially and they were heavily criticised.
Central and Local Crisis Centers were formed in accordance with the Turkish Disaster Law, and decisions for the care of the physical needs of the survivors, arrangement of funeral services, etc were taken. The crisis committees involve all local public authorities and the representatives of local authorities-Municipalities and the military forces.

The following days: the Turkish Psychological Association (TPA) responded very quickly despite lack of preparation for disaster support services. In collaboration with the central

Crisis Committee formed in Ankara, the capital of Turkey, TPA rapidly went to the region and conducted a rapid assessment of needs.

Afterwards:

- Brochures for adult survivors, parents and emergency workers were prepared, taking similar brochures published in other countries as a basis.
- TPA got support to provide services initially in the five provinces hit by the 17 August, and later expanded this to the November earthquake. Services were given in nearly 30 tent cities and other areas of the provinces by providing debriefing and information, normalization, distribution of booklets and screening and referral for professional help when needed. All the services were provided by the psychologists on a voluntary work basis. Debriefing was given to survivors (adult women & men; adolescents; emergency workers) and for the TPA field staff.
- Tents for children organised by the Turkish Social Welfare organization were also supported by the TPD field staff. Children were given the opportunity to express themselves by plays and by drawing activities organised by the TPA staff.
- In the disaster area there were also Turkish Ministry of Health psychological/psychiatric support teams, Turkish Psychiatric Association teams and numereous NGO's providing pscho-social support.
- Rapid training programs for debriefing, trauma psychology, common responses to be seen in survivors were given to field staff before they went to the area. Therefore, capacity building and international support in the form of trainers from various countries was available .

Longer term intervention

For long term psychosocial support, some centres for psychosocial rehabilitation were formed with the collaboration of Turkish Red Crescent and International Red Cross and other International Organisations and NGO's. Trauma Centres have been formed in Psychiatric Hospitals and TPA İstanbul Branch. Local NGO activities have become very pronounced following the 1999 earthquakes in Turkey. NGO's targeting the psychosocial needs of special groups, like disabled, women, children have played an active role in offering services. The establishment of local NGO's has been a crucial benefit following the devastation.

TPA in collaboration with UNICEF launched a training programme for trauma psychosocial interventions with teachers. Furthermore the TPA in collaboration with ECHO gave training of trainer's basic disaster awareness and preparedness training in the five provinces heavily hit by the quakes.

Several training programs on psychosocial interventions for trauma survivors were offered to professionals (psychologists and psychiatrists) leading to a significant capacity increase in Turkey.

After one year, the earthquake survivors were either given the keys of their new disaster houses (buildings supervised and constructed by the state) or were living in prefabricated housing. In some provinces they were supported through their local NGO's. Psychosocial support continued throughout rehabilitation /community centres established in the area.

Evaluation and implications for the future

Lessons learned:

- The devastating earthquake pointed out the importance of mitigation and preparedness, that is Risk management and that Turkey was not ready to offer psychosocial services.
- Psychologists were caught unprepared for the event, and massive training programs were needed to create a capacity for responding to the needs of survivors.
- Community participation and capacity building is necessary before a devastating event
- Volunteers, in the form of NGO's are a valuable input and their activities need to be fostered.
- Coordination of all the activities of various stakeholders and information is a vital need that needs to be organised.
- Six years after the devastating quake, although 98 % of our population are living in seismically active lands we tend to forget and interest spreads to other priorities. Therefore, sustainability of capacity building for psychosocial intervention teams; for community organization and empowerment are needed.

Best practices:

- The Turkish Psychological Association responded very efficiently and rapidly considering the lack of preparedness for such a massive devastating disaster.
- Collaboration with the official Crisis Centre at the central and local levels was made.
- Capacity building for psychologists occurred by the help offered both nationally and internationally on trauma psychology and intervention methods.
- Numerous NGO's launched into the area and offered psychosocial interventions. General increase in public awareness for hazards, vulnerabilities have been created. This can be a window of opportunity for changes in legal frameworks for mitigation and preparedness and for community involvement organisations.

- Collaboration with international agencies and coordination of activities for sustainable risk management.(e.g.: Training of trainers for disaster management; Formation of local community networks and centres)

Longer term intervention

For long term psychosocial support, some centres for psychosocial rehabilitation were formed with the collaboration of Turkish Red Crescent and International Red Cross and other International Organisations and NGO's. Trauma Centres have been formed in Psychiatric Hospitals and TPA İstanbul Branch. Local NGO activities have become very pronounced following the 1999 earthquakes in Turkey. NGO's targeting the psychosocial needs of special groups, like disabled, women, children have played an active role in offering services. The establishment of local NGO's has been a crucial benefit following the devastation.
TPA in collaboration with UNICEF launched a training programme for trauma psychosocial interventions with teachers. Furthermore the TPA in collaboration with ECHO gave training of trainer's basic disaster awareness and preparedness training in the five provinces heavily hit by the quakes.
Several training programs on psychosocial interventions for trauma survivors were offered to professionals (psychologists and psychiatrists) leading to a significant capacity increase in Turkey.
After one year, the earthquake survivors were either given the keys of their new disaster houses (buildings supervised and constructed by the state) or were living in prefabricated housing. In some provinces they were supported through their local NGO's. Psychosocial support continued throughout rehabilitation /community centres established in the area.

Evaluation and implications for the future

Lessons learned:

- The devastating earthquake pointed out the importance of mitigation and preparedness, that is Risk management and that Turkey was not ready to offer psychosocial services.
- Psychologists were caught unprepared for the event, and massive training programs were needed to create a capacity for responding to the needs of survivors.
- Community participation and capacity building is necessary before a devastating event
- Volunteers, in the form of NGO's are a valuable input and their activities need to be fostered.

- Coordination of all the activities of various stakeholders and information is a vital need that needs to be organised.
- Six years after the devastating quake, although 98 % of our population are living in seismically active lands we tend to forget and interest spreads to other priorities. Therefore, sustainability of capacity building for psychosocial intervention teams; for community organization and empowerment are needed.

Best practices:

- The Turkish Psychological Association responded very efficiently and rapidly considering the lack of preparedness for such a massive devastating disaster.
- Collaboration with the official Crisis Centre at the central and local levels was made.
- Capacity building for psychologists occurred by the help offered both nationally and internationally on trauma psychology and intervention methods.
- Numerous NGO's launched into the area and offered psychosocial interventions. General increase in public awareness for hazards, vulnerabilities have been created. This can be a window of opportunity for changes in legal frameworks for mitigation and preparedness and for community involvement organisations.
- Collaboration with international agencies and coordination of activities for sustainable risk management.(e.g.: Training of trainers for disaster management; Formation of local community networks and centre

■ Concluding remarks

Definition

The European Federation on Psychologist Associations uses an all inclusive conceptualization of disasters and crises. This means that by definition natural disasters such as earthquakes, floods, tsunamis and landslides as well as man made disasters like transportation accidents, terror, violence and war are included. Disasters can be local smaller scale emergencies or large scale crises, they can have a sudden onset or a slow onset, and they can differ in duration.
Disasters often have an effect on an international level in the case of tourism, migration or when national disasters exceed the capacity of the country and there is a need to call for international involvement.

Mission statement

To give direction to the policy making on psychosocial care after disasters there is a need for a clear vision on what psychosocial care should be. What is meant by psychosocial care, for who it is concerned, and what is the aim of psychosocial care.
In general there are a few key notions which express the vision of the EFPA on psychosocial care after disasters.

- Psychosocial care should be an integral part of disaster planning and preparation.
- Psychosocial care deserves a valuable place within disaster relief, including all disciplines and all responsibilities.
- Psychosocial aspects should be considered from the first moment.
- Psychosocial care should be given according to standards of good quality based on scientific evidence and best practices.

People's needs

When disasters strike they are sudden, unexpected, and "earth-shattering" to those affected by them. Often those who are exposed directly talk about how their lives have been radically changed. They describe a state of confusion, pervasive anxiety, and helplessness.
Disaster victims also speak about not being the same, of how their inner sense of safety and the ability to count on the stability of the environment has been lost. Some also speak about feeling powerless, and having lost the structure of their daily lives.

Disaster stress research studies have revealed that these events affect the lives of people for years and even decades. Understanding the effects of these disaster events upon victims' minds, bodies, relationships, and behaviour, is crucial for the planning and organization of the psychosocial care and for the professional field of staff who is involved in disaster relief. The needs of the affected people should be the starting point for tailor made psychosocial care. To support this, assessment guidelines should be developed and planning and service delivery should be based on the results of the assessment.

Target groups

The people affected by a disaster are not only the directly affected people, but exist of different target groups who should be included. One can think of witnesses of the event, survivors, children, the bereaved, immigrants, fugitives, psychiatric patients, elderly people, disabled persons.
In short it is important to identify the different groups, since it is well known that some groups are easily forgotten, for example the children.
A classification schema of victims based upon presumed degree of exposure to the traumatizing environment of a disaster may be helpful, since disaster studies have shown that the degree of exposure is associated with subsequent post-traumatic stress symptomatology. This determination is valuable in the formulation of a plan of intervention.
Vulnerable groups affected by crises need (demand) and must receive specific attention. Mothers with young children, children, people with former psychiatric problems, adults from ethnic minorities, people with a low socio-economic status and people lacking a social network are known to be at risk to develop long term health complaints.
Psychosocial care should be focused on these different groups. A demographic analysis can be helpful in preparing for disasters.

Outreaching

It is a well known fact that in the acute phase after a disaster people are very willing to help, there are enough relief workers both professionals and volunteers and the event has the full attention of the media. The attitude towards affected people should be one of understanding and respect, sensitive and non-intrusive. The outreach should be coordinated. People have the right to say no to the offered services. Crisis managers, rescue workers and professionals should be sensitive to the reactions and emotions of the affected people after a

disaster. They should have knowledge about normal reactions of people and the dynamics that occur.

It is in the follow up of the disaster when people start to pick up their daily life, relief workers turn home and the media focus their attention on other matters that affected people often fully experience the consequences of what they have been living through. It is often in this medium and long term phase that the group who develops long term health complaints has difficulty finding the care they need. They often don't recognize themselves in the care programs of mental health institutions. It is important to organise the psychosocial care right from the beginning to be able to identify the needs of the people at risk and to be able to reach them.

Psychosocial interventions and treatment

Treatment and interventions are often diffuse, there is an enormous diversity of interventions, it is the aim to use scientifically evidence based interventions. When sufficient evidence is lacking, consensus based and common sense based knowledge and interventions should be used. According to the state of the art we can state the following:

- In the acute phase, victims need practical, social and emotional support.
- In early psychosocial interventions, the specific characteristics (e.g. cultural or religious) of the situation and the victims should always be taken into account.
- Psychosocial care in the acute phase aims at restoring the feeling of safety, regaining a sense of physical and mental control, stimulation of mutual aid amongst victims and promoting self-reliance and resilience.
- Depression and anxiety disorders, including acute stress disorders and posttraumatic stress disorders are the most common long term psychological consequences of a disaster for which the effective treatment should be offered.

Victims in developmental age

Assisting children and adolescents victims of trauma or mass disasters is important to prevent long-term emotional harm. Their reactions can become obvious soon after the tragic event, but most will recover within the first months while others will develop PTSD or other psychological problems that can need treatment. It is important to know what reactions to expect according to the developmental age and what adults (parents and teachers) can do to manage them. Some have more risks factors than others that can make them more vulnerable, those factors include severity of the trauma, previous trauma and lack of family support and/or inappropriate and dysfunctional emotional reactions of parents or caregivers.

Parents responses seem to influence in a significant way the children recovering capacity. So, interventions should not be focused on children victims of trauma but also on their parents. Mainly when both children and parents and the community involved in this disaster share all posttraumatic reactions, mourning processes, loss of homes, sense of guilt and conflicts that can arouse in the community. It is well known that adult anxieties are perceived and absorbed by the children and can become an obstacle in the resolution of psychological disorders. Considering the developmental age of some victims, without a focused and effective treatment the child's personality could develop around the traumatic event and adapt to it, eventually increasing the risk of developing psychological disorders later in life. Single or chronic trauma can have a serious impact on psychological functioning even years after the event. For this reason it is essential to intervene in the aftermath of this disaster, giving psychological support and appropriate treatment. Among the methodologies that can be used with this population are psychoeducation to adults on how to recognize stress reactions on children and adolescents, on what to do the following days, on communication of bad news and finding resources to help children cope and how to reassure them, active listening and trauma treatment like Trauma Focused Cognitive Behaviour Therapy and EMDR. These interventions can be helpful to enhance their resources, reduce stress reactions and normalize their behavior. After a mass disaster experience it is important that victims in developmental age can understand what happened, being able to talk in a safe environment with the psychologist's presence, expressing with words irrational ideas, fears, images, physical and emotional feelings.

Timing of psychosocial interventions and treatment

According to timing preparation is an important issue in disaster relief. Failing to prepare is preparing to fail. Although this statement is common knowledge among policy makers, and disaster relief experts it is proven to be a difficult task to keep disaster preparedness on the agenda in times of 'peace'. Lessons from recent disasters show time and time again how important preparation is.

To describe the consequences of the disaster in general and more specific the consequences for the health of the affected people and the health complaints they are at risk to develop, different phases are being identified: the acute phase (for four weeks after the disaster), the midterm phase (from four weeks until 5 years after) and the long term phase (5 years and more)

Of course timing of the interventions after a disaster and phases of the disaster are two separate issues, but:

- There is a need for mental health presence right from the start and at least psychosocial information should be broadly spread, there should be a balance between safety issues, material and physical needs and psychosocial needs
- when people are in shock, they are offered psychological first aid (acute phase)
- when people start to realize what has happened early interventions can be offered (midterm phase)
- when people don't recover on their own, treatment is indicated (long term phase)

Coordination/structural response

A central organ for example a national crisis team, should be responsible for the psychosocial care after a disaster. Psychosocial care should be managed from one central point for the short and the longer term. This national crisis team should use the local experience and the local and should also make use of professionals who have experience with previous disasters
For the larger countries, one central organ may not be enough, a federal structure then is needed between central and local responsible authorities.
The response should be multilevel: local, regional, national and international, depending on the scale of the disaster.
Two structures are needed: reference centres for professional expertise and a management structure. A coordinating structure should be available also on a European level

Cooperation

The cooperation between the different services on an operational level is satisfying most of the times. On the level of the management it is often not clear who is responsible from the point of view of the government. Important is to differentiate between responsibilities and tasks. There should be a system of cooperation and collaboration between psychosocial partners and emergency agencies. The structure, mechanisms and principles of such an organisation needs to be planned ahead.

Aftercare for professionals and volunteers

There should be a developed system for aftercare for professionals and volunteers. They should be fit and trained for the job. Training is an important factor for prevention of post

trauma psychopathology. On the other because of their involvement in this kind of work professionals and volunteers are at risk for long term health complaints.

Competencies and capacity building

Capacity building for psychosocial interventions is needed in a sustainable way. This requires the identification of resources and the empowerment of staff who will be involved in crisis and disasters. Development and training guidelines and continued training to increase capacity are needed. Different systems can be developed to enhance competencies and capacity

- training of family liaison officers in psychosocial aspects
- training and information on psychosocial aspects for rescue services
- information on psychosocial care after disasters for the public
- specific training for professionals
- information on psychosocial aspects for journalists

Local structures

On a local basis the network of social workers, mental health professionals, volunteers, spiritual leaders, key-figures (for example for ethnic minority groups) and a set of community based interventions are important in the psychosocial care after a disaster.
An information and advice centre is one of the community based interventions which is a means to create a one stop shop for all the needs of the affected people, this location should be easy to reach and should be large enough for all the people, with different rooms for different groups (for example people who miss someone, the bereaved, the survivors, the rescue workers)
Rituals and commemoration are community based interventions which are necessary. The timing of these rituals and the commemoration is important and the position that is given to the affected people.

Information and the media

Risk and crisis communication should be attuned to psychosocial care; also the role of the media for information is essential. How to communicate and what should be prepared together with the media. Crucial is to provide the best evidence based information that is available and cooperation with the Dart Centre, the network of journalists on ethical

journalism and trauma, is an important opportunity. Hotlines to get information should be available for the public.

Preparation

Education, training and exercise, preparation is necessary, but often lacks or is insufficient.
In the preparation phase attention needs to be given to reducing the impact of potential disasters, by incorporating notions of mitigation. Education and training needs to be given to all segments of the community as well as to professionals.

Research

The EFPA Standing Committee wants to give a strong recommendation to professionals and scientist in the field of psychosocial care after disasters to produce publications on the issue. This should be on an international level, practice based and opinion based, so that the international community can learn from each other. Psychosocial care after disasters still is a relatively young knowledge field and it profit from an active publication policy among professionals and scientists.
Research should then be aimed at supporting the professional practice. This of course had implications for research questions and designs. To assess the needs of the affected people of a disaster is one very important topic for research. This can serve as the basis for planning psychosocial responses in an effective way. The other end of the continuum is to evaluate the psychosocial interventions according to their effectiveness. Until now there is too little knowledge for evidence based psychosocial interventions.

Network

A European network should be established for lessons learned. This network should develop a systematic way to exchange and evaluate lessons learned from recent disasters. An annual report with recommendations on improving psychosocial care should be the outcome of this network.

Legal matters

No clear example is described in the lessons learned document, but we know how it can interfere with the enhancing of the well-being of the affected persons. It is recommended to include this expertise.