Lessons learned in psychosocial care after disasters

Participating countries:

Austria, Belgium, Czech Republic, Denmark, Finland, France, Germany, Greece, Italy, Luxembourg, Netherlands, Norway, Slovenia, Spain, Sweden, Turkey

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Introduction

This report is the result of a survey conducted in the various European countries which are members of the European Federation of Psychologists' Associations (EFPA) by the Standing Committee on Crisis and Disaster Psychology. Each member describes an example of psychosocial care after a disaster in their own country. The examples are randomly chosen and there are, of course, many more which could be described. It is of great importance that we learn from our experiences and collect the best practices, while also looking into the things which went wrong. We realise that a disaster means chaos and that we will never be able to plan for every possible scenario. But we have a responsibility to aim for the best response.

To really learn from the experiences, it is necessary to collect the relevant data in a systematic way. Up to now, this has not been common practice in European countries. This report could set off discussion of how to compile and describe the lessons learned so that we can draw on them in our future planning.

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

Contents

Austria – Flood in Lower Austria, August 2002 7

Belgium – Rail crash, March 2001 10

Czech Republic – Tsunami in South-East Asia, December 2004 13

Denmark – Tsunami in South-East Asia, December 2004 16

Finland – Road accident in Konginkangas, March 2004 19

France – AZF disaster in Toulouse, September 2001 21

Germany – School shooting in Erfurt, April 2002 24

Greece – Earthquake in Attica, September 1999 26

Italy 30

- Earthquake in central Italy, October 2002 30
- The 2009 L'Aquila earthquake 33

Luxembourg – Plane crash, November 2002 38

The Netherlands – Firework disaster in Enschede, May 2000 41

Norway – Maritime disaster on Norwegian coast, November 1999 45

Slovenia – Landslide in Log pod Mangartom, November 2000 48

Spain – Terrorist attack in Madrid, March 2004 50

Sweden – Tsunami in South-East Asia, December 2004 57

Turkey – Earthquake in Marmara, August 1999 61

Concluding remarks 65

Austria – Flood in Lower Austria, August 2002

Eva Münker-Kramer

On 7 August 2002, the “flood of the century” hit Lower Austria (the northern part of Austria close to the Czech and Slovakian border) when the Danube and its northern tributaries were unable to cope with water levels during a period of extreme rainfall. There was a second floodwater peak on 12 August, which was of the same intensity and had an extremely demoralising impact on the public.

Some figures: Whole villages were cut off by the floods, there was no electricity, drinking water or dry places to sleep and people had to be housed in camps for many days. 17,500 houses and companies suffered severe damage in Lower Austria alone, many of them being destroyed along with all their contents in only a few hours. Apart from houses, cars and other property were also destroyed and disappeared.

The total damage amounted to €370,000,000 in Lower Austria, and more than 30,000 people were affected in the area.

Early intervention

The Lower Austrian psychosocial acute support team is financed by the health department of the federal government for “individual disasters”. It consists of 50 psychologists, medical doctors and psychotherapists trained in interventions following the methods of disaster and crisis psychology, as well as six social workers who care for the social needs of the people. In the case of the flood, the team staff actually consisted of 23 psychologists, five social workers, two medical doctors and seven psychotherapists.

The situation we found after being alerted by the federal government was one of people in severe shock who were helpless and partly unable to take necessary decisions. They did not know where to start, were desperate and were disorientated. The symptoms were Acute Stress Disorder (ASD), combined in many cases with post-traumatic stress symptoms (including individuals with retraumatisation – many old people were reminded of “war”), many conflicts within families, severe lack of motivation, refusal to make plans for the future, despair, people completely overwhelmed by the demands of the situation, depression, panic attacks and excessive fear of death.

What we did was on-site psychological screening ("triage"), which was performed by psychologists, sometimes in co-operation with volunteers. We offered clinical diagnoses and therapies for those people who obviously needed them. We developed plans for longer-term care and built up a network with clergy, the fire brigade, the Red Cross and the mayors of the communities affected. We established a hotline and organised financial and debt counselling by social workers.

In terms of interventions, we offered one-to-one crisis intervention, psychoeducation, Critical Incident Stress Management (CISM) interventions in communities, consultancy for communities, work with families to prepare them for decisions in the future, conflict management in communities and families and information and counselling for senior officials and mayors.

Altogether, 500 persons were cared for, 300 were supported on an individual basis and in groups (defusing, debriefing) and a further 200 were reached through screening and psychoeducation.

Longer-term intervention

The team worked 2,500-3,000 hours between 7 August and 28 August. Individual support was provided until Christmas for those who needed it, and the hotline was operational until May 2003. A year after the event, we received many fresh requests because of people being reminded of the floods. Four larger projects were also conducted. In a few communities, new facilities were established and we supported the organisers by counselling them regarding the dynamics that could arise, while some day-care facilities and schools were supported through group meetings with the children (debriefing and information sessions on symptoms and reactions and ways to put things behind them). There were also similar information groups for teachers who observed symptoms in classes, some local firefighter groups were debriefed and the engineers who had to assess the amount of damage were greatly struck by the amount of work, the short time span to do it in and the great responsibility they had with their assessments for each individual family.

Evaluation and implications for the future

It was very good to have clear co-operation with the social workers following the motto "Stick to what you know" (and thus do your best).

The social workers drew up the duty roster, co-ordinated the staff, contacted the local authorities, liaised with the government on practical issues, organised the resources for the provision of further facilities and services (hotline, mobile counselling unit) and arranged financial support.

The conclusions were: there is a need for clear responsibilities in a joint professional support approach, the contacts of both professions can be used for networking, very good management and definition of the interface is necessary and ongoing and institutionalised transfers of information must be ensured. Through this division of labour, "normality" is presented to the persons affected from the outset and they know who they are dealing with. They therefore perceive the transfer and co-operation as being effective.

The result is ideal use of the respective professional skills, and both professions feel secure in what they are doing.

To achieve this, it is helpful to know each other and crucial to be familiar with the contents of the other discipline. Both professions should know about operation management and networking and both need their own deputy in the process; they cannot deputise entirely for each other. The work and support of the related discipline should be used to maximise the impact of the respective parties' own work ("fill the gaps", "build bridges"); relaxation for both disciplines and for individual helpers (handover of responsibility) must be ensured.

The concentration on core activities improves quality and the approach is useful for both sides in individual disasters as well (and is already employed).

Belgium – Rail crash, March 2001

Olivier Serniclaes

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

Early intervention

An information and support centre was opened in Florival (500 m from the train crash), where all the psychosocial carers were assembled to support and identify the victims' families. More than 80 people affected (bystanders, people living near the crash scene, families) contacted this information and support centre.

The psychosocial workers were as follows (20 the first day):

- Psychologist and social worker volunteers from the Red Cross (Dutch and French-speaking)
- Staff from the stress team of the federal police
- Psychologists working for victim assistance for the local police (from the whole area)
- Local government social workers
- Local authority
- Psychologists from the national railway company (SNCB) (more specifically to make the first visits to the families of the deceased)

The governor chose to assemble all the services there in the information and support centre, including for the press, the rescue workers and the political authorities. On the first day, the centre was more a crisis centre than an effective information and support centre for the victims.

The centre was open for two days.

Victims and their families were provided with information, emotional and social support, practical information about identification, initial practical assistance, a call centre and support when they were confronted with their dead relatives.

The day after the crash, all the team and the psychosocial workers involved came together for an initial post-crisis evaluation and to co-ordinate future activities. All the victims' needs were assessed and an information meeting for the victims was held three weeks later. Debriefings were done only for rescue workers, while psychological support was offered to all the direct victims and their families.

In the three months after the crash, there were eight co-ordination meetings to follow up the psychosocial activities. The psychosocial manager from Ministry of Health was in charge of co-ordination

Longer-term intervention

A one-year anniversary ceremony was held at the crash site, with the inauguration of a stone column bearing the names of the victims. 300 people attended the ceremony and around a dozen psychosocial workers were present to support and comfort the families.

Some victims or their relatives were still in therapy a year after the crash (mainly wounded individuals and relatives of the dead).

Three years after the crash, the trial was still in progress.

Evaluation and implications for the future

- There was no effective psychosocial plan in the province before the rail crash (thus no prevention), the psychosocial manager was initially working for another province and had no knowledge of the local authority; this was more a problem for the first day (initial contacts and difficulties identifying who was responsible for what) and for long-term co-ordination (less support from the authority).

- The information and support centre was overcrowded, with no specific place for the victims and their relatives; there were some difficulties between victims and reporters or with rescue workers (we now have specific rules on the establishment and organisation of information and support centres).

- During the first day and the anniversary ceremony, politicians and the local authority took a too prominent role without any respect for the needs of the victims (privacy, respect, truthful information, recognition, protection).

- There was good collaboration between all the psychosocial workers, but a lot of difficulties with their specific authorities with regard to their involvement (duration, financing, reports…).

- Important partners for the psychosocial follow-up included insurance companies, the justice system, the local authority and the railway company.

- The University of Leuven and the Ministry of Health planned to conduct research into psychological after-effects, but nothing came of this. Without any specific authorisation, however, the University of Maastricht joined with a local doctor in conducting a study on the psychological symptoms (PTSD) in people living near the crash site. It was only in 2004, after the gas explosion in Ghislenghien, that the first effective co-operation for a study of post-disaster psychological symptoms in Belgium took place.

Czech Republic – Tsunami in South-East Asia, December 2004

Jana Malikova

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

As the system of psychosocial support has not been fully activated since the tsunami disaster, I will describe the tsunami disaster as a suitable example. A few thousand 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 had been identified. Now eight people have been identified. About 500 Czechs were seriously mentally traumatised by the event.

Early intervention

A co-ordinating team of experts in mental health included five persons, plus two psychologists as leaders; 14 regional co-ordinators (fire rescue psychologists) and 140 specialists in psychosocial support at regional level (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. The psychological help line ran for three weeks after the event. Around 18 people provided psychosocial support; nine of them were in the field.

Longer-term intervention

We are aware of several cases in psychotherapist care. We are also aware of missions that NGOs have conducted in the affected area in South-East Asia but we have not been involved.

Evaluation and implications for the future

Main difficulties:

In general:

- Unclear levels of competence;
- Insufficient care for the mental well-being of the professionals (no debriefings…);
- Lack of model plans for this type of disaster.

Specifically:

- Obtaining a database of “affected” people (we did not have a full database of tourists at our disposal);
- Some of the Czech tourists were not protected from journalists upon landing (risk of secondary psychotrauma);
- Psychological support was not provided in Czech hospitals;
- There are few psychotherapists focused on long-term therapy with PTSD clients in the Czech Republic.

What worked well?

- Central co-ordination;
- All services were provided free of charge;
- 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;
- Principle of solidarity and reciprocity.

Denmark – Tsunami in South-East Asia, December 2004

Anders Korsgaard

Approximately 3,000 Danish nationals were in the disaster area. Most of them were on Christmas holiday in Thailand. They were exposed to trauma in varying degrees. 46 Danes died as a result of the disaster. 45 of these have been identified. Many of the survivors were exposed to life-threatening situations and near-death experiences. There were many children among both the survivors and the deceased.

Early intervention

Psychosocial intervention in the early phase took place:

In Thailand:

Several Danish crisis teams were sent to Thailand from different organisations. Both private and official organisations took part in early intervention.

In Copenhagen:

Crisis teams were at Copenhagen Airport 24 hours a day for two weeks to receive returning Danes and to some extent other Scandinavians.

Local crisis teams in Denmark:

In the counties throughout Denmark, local crisis teams prepared for Danes returning to their neighbourhoods.

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 prioritise help to the persons most in need of psychosocial assistance. Screening for high-risk reactions is necessary. Debriefing of crisis team members was also essential.

Longer-term intervention

Survivors and relatives of the deceased were living all over Denmark. From the early phase, it was important to start organising long-term psychosocial intervention at a local level.

The following interventions were provided:

People were able to contact local psychologists on an 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 of the dead, survivors. These group interventions were offered in collaboration with the Danish Red Cross.

A memorial service was held in Thailand in April 2005. 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 the 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 received help from social workers.

A research study covering all Danes who were in the disaster area and who filled in the questionnaires identified those who showed signs of more severe post-traumatic distress. They were offered psychosocial intervention.

Evaluation and implications for the future

- The importance of fast response times in the activation of disaster crisis teams, including in disasters involving nationals involved in disasters outside the home country.

- Close co-operation with official agencies from the outset (in this case, the Danish Ministry of Foreign Affairs).

- Somatic doctors are always important, including in psychosocial crisis teams.

- A memorial service at the disaster site at the right time, when people are emotionally ready for it, has invaluable importance in the healing process.

- Frequent training sessions beforehand with all agencies and organisations involved in planning for future disasters.

- There were very few persons with psychiatric reactions in the acute phase.

- Select experienced senior staff for psychosocial disaster work.

- The fact that this disaster was an act of nature had an impact on the reactions of the victims compared to the reactions after a terrorist attack.

- We also learned to establish better procedures when a disaster strikes Danish nationals outside Denmark.

Finland – Road accident in Konginkangas, March 2004

Salli Saari

A most serious road accident occurred in Finland in March 2004 when a bus and a heavy goods vehicle collided in Konginkangas. There were 37 passengers in the bus. In total, 23 people died and 15 were seriously injured. The passengers were travelling to ski in Lapland. They were all young people, 90% of whom were from southern Finland.

Early intervention

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

Longer-term intervention

- The Finnish Red Cross psychologist team organised peer support weekends (two days, with overnight stay) both for family members of the deceased and for the injured and their family members. The first two weekends were three months after the accident, the second two were six months after the accident and the third two were near the anniversary of the accident. The meeting of family members of the deceased was attended by 55 persons (family members of 19 of the 23 deceased) and the meeting of the injured and their family members by 30 persons (13 of the 15 injured). Two weekend meetings are still to come. Both groups will meet again two years after the accident.

- All these meetings were planned and led by crisis psychologists. The small peer groups were also led by psychologists. For one weekend, about 10 psychologists are needed to lead the groups. Small peer groups are, for example, a group of mothers, group of fathers, group of brothers and sisters, group of spouses of brothers and sisters, group of widows and group of children. At the weekend for the injured, they form a special group.

- Many family members have also had individual therapy.

- The Finnish Mental Health Society has also organised peer support for family members of the deceased. These groups have met once a week for 1½ hours, 10 times in total. There have been two such groups: parents' group and a group of brothers and sisters.

Evaluation and implications for the future

The psychological first aid and early intervention were organised in a manner that ensured effective care for the families of the deceased. The co-ordination of the various bodies (public crisis centres and Red Cross) in southern Finland was also very good. Some problems were encountered in the co-operation with the central hospital in Jyväskylä and great problems with church workers, who did not care about co-ordination and visited family members without being invited. The quality of the church crisis work was also quite problematic.

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

Many therapies for victims and survivors of the accident are still in progress. Even though the victims received more psychological assistance than victims of road accidents usually do, many of them are bitter that they lost their children and, as a result, their futures. There is still a lot of anger in the minds of the family members of the young people who died.

France – AZF disaster in Toulouse, September 2001

Dominique Szepielak

On 21 September 2001, a major explosion destroyed the AZF factory in Toulouse and, with it, the lives of many individuals. Some people died, some lost their homes and some were left in shock (perhaps for life).

For the first time in France, there was a massive demand for psychological assistance. The 11 September attacks in the United States of America were still fresh in people's minds, and some thought the explosion was a military or terrorist attack.

Early intervention

- Medical and psychological teams (CUMP, Medical and Psychological Emergency Teams) from all over France came to help.

- On 22 September, the Red Cross contacted the national union of psychologists (SNP) for more psychologists.

- More psychologists came to volunteer.

On the whole, something like 500 psychologists came for the Toulouse disaster. The psychologists took care of victims in hospitals, the town hall, gymnasiums and schools. The official emergency teams stayed for one week, but they determined the psychological assistance needed for four months. All the psychological staff stayed in place and were paid for a month and a half.

Evaluation and implications for the future

- Time and money

The official emergency teams (CUMP) stayed for only one week. The other psychologists worked unpaid at first.

- Logistics

Psychological assistance was not properly organised and there were some problems in terms of accommodation and reception. For example, some people came to hospitals to find out if a family

member was dead or alive. They queued up in the reception areas and a secretary or a nurse gave them the information without preparation. The trauma for many was very great.

Another logistical problem is that no one recognises that people need psychological help in disaster situations. It is certainly true that no one thinks that victims need to be helped by psychologists. Psychological assistance was therefore organised on an emergency basis, without specific methods or protocols.

The duration of the assistance was limited and, although some people needed more time, the psychologists were paid for only a month and a half.

In that sort of situation in France, psychologists depend on doctors or on the Ministry of Education and are therefore only able to arrange what others authorise, not what is needed from a psychological point of view.

Most of the psychologists agreed that, in the AZF disaster, they relied on their ability to adapt without applying any specific theory.

The first adaptation is being able to work in an unknown context.

In my view, psychologists, like doctors and others, need crisis and disaster training.

Clinical observation

People’s symptoms:

- flashback,
- loss of speech,
- memory disorders,
- attention disorders,
- hypervigilance,
- flight behaviour,
- sleep disorders,

- survivor syndrome,
- breakdowns,
- constant buzzing in head,
- somatic disorders.

For children:

One major problem was that children asked their parents all kinds of questions, but the parents were unable to respond adequately because they were in shock themselves.

Psychologists therefore worked a lot with teenagers and children.

Some schoolchildren had the same symptoms as the adults and had great difficulties concentrating on their school work for a long time.

Other observations: A lot of people who were affected by mourning and trauma lived in poor social conditions. AZF was near a disadvantaged area, so the disaster created an opportunity to discuss the social issues and develop a new sense of community and a new social identity in the area.

Conclusion:

Where do psychologists stand in Toulouse today?

In practice, they all showed a great ability to adapt and were highly rated in all testimonies.

Germany – School shooting in Erfurt, April 2002

Georg Gewepieper

In a school shooting in Erfurt a 17-year-old pupil killed 12 teachers, a secretary, two pupils, a policeman and himself. Some months earlier, he had been expelled from school.

Early intervention

Initially, there was a crisis intervention team set up by the police.

Police headquarters asked all psychologists in the town and the region to come to the school and take care of the pupils and teachers affected. 74 psychologists came the first day, while more psychologists from other parts of Germany arrived some days later. The individual psychological interventions differed greatly and there was no standardised early intervention programme.

Some psychologists did debriefings, some tried to do counselling, while others tried progressive muscle relaxation and some Eye Movement Desensitisation Response (EMDR).

There was no leading psychologist who told them what to do. Most psychologists were overstretched.

Longer-term intervention

Three weeks after the shooting, a cognitive-behavioural programme for the traumatised pupils and teachers was approved and implemented by the government. Every class in the school was assigned two psychologists who trained the whole class in “coping with the trauma”, especially through psychoeducation, once a week for two hours.

There was a diagnostic phase where we measured Post-Traumatic Stress Disorder, depression and psychopathology. For those pupils and teachers who were highly traumatised, we offered psychotherapy on an individual basis. Teachers had the opportunity to join a group therapy programme. Every class was treated with in vivo exposure and visited the old school where the shooting took place.

Once a month, guidance was offered for all 53 psychologists. This was necessary in order to resolve problems and to make sure that

they realised the therapeutic aims of the treatment programme. A year after the event, all the victims were included in the planning of the anniversary.

A second diagnostic phase was conducted after one year to study the development of PTSD, depression and psychopathology.

Evaluation and implications for the future

Best practices:

- Work with the whole system, not only the severely traumatised individuals.
- All psychologists were required to work under one programme and were supervised in that way.
- Development of a “Seven-step programme for treating acutely traumatised individuals” (SBK) which was a cognitive-behavioural programme combined with EMDR.

Lessons learned

- We need a better system of psychologists who are trained in early interventions. There is a need for crisis intervention teams which are able to come to the places concerned very quickly.
- It was not clear which organisation or which ministry was responsible for the implementation of psychosocial interventions.
- The school head was greatly upset by the shooting but she stayed in her job and took a very subjective approach to the psychological interventions.

Greece – Earthquake in Attica, September 1999

Vasso Boukouvala

On 7 September 1999, an earthquake measuring 5.9 on the Richter scale hit Attica, causing widespread damage to the area. The epicentre was in the area of Mount Parnis, about 18 km north of Athens. According to official figures, 143 people were killed, 700 were injured and 40,000 families or about 100,000 people were left homeless. There was extensive damage to buildings (houses, industrial buildings, schools, hospitals, etc) across Attica and, according to the Ministry of the Environment, Spatial Planning and Public Works, 3,340 buildings had to be demolished. The aftershocks from the earthquake continued for many months and were quite intense.

Early intervention

There was prompt mobilisation of state services immediately after the earthquake. There was close co-operation between all services involved in handling the crisis, such as the Co-ordination Centre of the Ministry of Health, the Ministry of the Interior, Civil Protection, the Army, the Special Rescue Team of the Fire Brigade (EMAK), the ambulance services, the Greek Police, the Earthquake Planning and Protection Organisation (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 and several non-governmental organisations such as Médecins du Monde, etc.

The contribution of the Association of Greek Psychologists (AGP) to post-disaster crisis intervention was of prime importance and was structured as described below. (It should be noted that it was the first time in the history of the AGP that an operation of this nature and magnitude was organised).

The Association of Greek Psychologists made its members available to the Ministry of Health and the local authorities from the very beginning. An initial assessment of the situation was carried out in close co-ordination with the Ministry of Health, the Municipality of Menidi and other local authorities. Efforts were made to collect as much data as possible regarding the number of people injured, the extent of the natural disaster, the demographic characteristics (given the significant number of immigrants and Roma in the area), the

nature and type of problems that they were facing and 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 Centre: The AGP Crisis Reception Centre was operating out of the KAPOTA military base in Menidi in Attica. Its purpose was to offer immediate psychological support to the local population three days after the devastating earthquake. The CRC worked in close contact and co-operation with the Co-ordination Centre of the Ministry of Health and Welfare, the Municipality of Menidi and the local authorities and was housed in the health services area at the military base, together with the other non-governmental organisations. Every day for almost three months, 55 clinical psychologist 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, teenagers, children or teachers. The work also involved noting and recording all psychiatric cases in the camps that were set up for the homeless and all referrals to the psychological and psychiatric services of the wider area.

- Mobile Unit of the Crisis Reception Centre: The aim was to visit all the camps that were set up for the homeless and also local schools in order to offer the population information and practical advice about dealing with the crisis.

- Intervention for people rescued from collapsed buildings: in order to care for people rescued from collapsed buildings, clinical psychologists conducted individual debriefing meetings with them in the general hospitals. This intervention was conducted in close co-operation with the Co-ordination Centre of the Ministry of Health.

- Psychologists' hotline: psychological first aid and support. This service was widely advertised through the mass media.

Longer-term intervention

Psychologists' (AGP) intervention lasted approximately three months, (September-November 1999).

Evaluation and implications for the future

- 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 co-ordinator of psychosocial assistance is of paramount importance.
- Volunteers should not operate independently of the state co-ordinator.
- 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 a heightened 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.
- A network for co-operation between European states is needed 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 they are one of the most effective ways of reaching the public and society. Psychologists should have the necessary training in responding to media enquiries or providing support to people through the media (eg, advising parents to limit exposure of their children to media coverage of the disaster).

Missed opportunities

- Valuable time was lost in the beginning. The first four days were mainly devoted to setting up and putting in 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 to study and evaluate the impact and the effectiveness of the post-disaster crisis intervention by AGP.

Italy

Earthquake in central Italy, October 2002

Isabel Fernandez

In October 2002, an earthquake in central Italy caused the destruction of an elementary school in a small village. The only building that collapsed during the earthquake was the school, killing 27 children out of 59. The village population was evacuated, lived in tents for three weeks and then returned to rebuilt or new houses provided by the civil defence force and the government.

Early intervention

Psychological support was provided right from the first week. There was a "Psychological Support" tent in the camp where the population were housed. Active listening and support were provided there for victims and rescuers, along with psychoeducation on stress reactions. Interventions were provided by associations of psychologists that volunteered. The local health unit and the regional psychological association co-ordinated all groups and all interventions, which ended within the first month.

After two to three weeks, all emergency workers, civil defence personnel and psychologists left the site. No further psychological intervention was provided for the population after a year, so they were left without medium and long-term support. Only child survivors received further treatment, with different cycles of trauma therapy at one month, three months and a year after the event.

Longer-term intervention

After one month, three months and the first anniversary, EMDR treatment was provided for children who survived. It was the only intervention more than one month after the event and was carried out by the National EMDR Association. Since the disaster met all the DSM IV-TR criteria for PTSD (the children were trapped for hours under the rubble of the school, where they were confronted directly with the death of their classmates and feared for their own lives) and since EMDR has proven to have a high level of efficacy for this kind of disorder, it became the preferred treatment for the school population. EMDR was agreed upon and supported by the national health service, the authorities, the school personnel and the parents

of the children treated. The school staff were co-operative and supportive during the implementation of the treatment. They were also offered psychological support in the form of active listening, group debriefings, group meetings about children's reactions to stress, information sessions on how to manage the classes on a daily basis given certain complex aspects after the earthquake and information on EMDR treatment. Educational meetings with parents were a fundamental part of the intervention programme, covering stress reactions and advising them on how to deal with their traumatised children in order to offer them more effective support and moderate and normalise their reactions. The support and information given to the parents were useful tools for helping and reassuring their children. A questionnaire on symptoms was issued and comprehensive information was provided about the intervention with children and EMDR so that informed consent could be obtained. Questionnaires focusing on the children's post-traumatic stress reactions were issued to identify the children's conditions and enhance collaboration during the whole process.

Evaluation and implications for the future

Best practices

- Analysis of the assessments before and after each cycle of EMDR treatment confirmed the effectiveness of EMDR in the context of a dramatic post-emergency situation. Not only did the EMDR treatment enable the experience to be resolved adaptively, it also enabled 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 measuring the intervention's effectiveness before and after in order to show the importance of the psychological intervention and demonstrate that improvements in symptoms were not only due to the passage of time.

- Local co-ordination of the different disaster psychology experts working at the earthquake site was an effective measure by the local mental health team. They classified the groups who could receive support: adult population, children and teenagers, emergency workers and so on.

Missed opportunities

All the measures co-ordinated by the local health unit were, unfortunately, managed somewhat passively, with a degree of reluctance to reach out to the population. Although they could come for support, it was not offered proactively. Apparently, the co-ordinators did not want to create a need for psychological support among the population, but merely to respond when support was requested.

This was a missed opportunity since experts were in the field with many resources.

Another missed opportunity was ignoring one of the groups most seriously affected by the earthquake: the parents of the children who died. As they were not involved properly, their reactions and choices since the earthquake have been very harmful for the rest of the population and surviving children. This group did not receive any support or psychological care.

Firefighters involved in rescuing children did not receive any support, although they were the most exposed to stress. Even now, they still report that they are suffering from stress reactions.

Lessons learned

It is important to remember that both children and parents and the community involved in the disaster were all affected by post-traumatic reactions, mourning processes, loss of their homes, a sense of guilt and conflicts that arose in the community. It is well known that adult anxieties are perceived and absorbed by children and can become an obstacle to the resolution of psychological disorders. Many children said they were affected most of all by their parents' behaviour and display of emotions. Interventions should therefore not be focused solely on child trauma victims but also on their parents.

It is important to reach out proactively to the groups most exposed by trying to forge an alliance with the authorities in order to be allowed to provide psychological support in a structured way.

Psychological support in the aftermath of the 2009 L'Aquila earthquake

Giuseppe Luigi Palma, Girolamo Baldassarre, Isabel Fernandez

The disaster that hit Abruzzo was a tragedy for the whole of Italy. The 2009 L'Aquila earthquake occurred in the region of Abruzzo, in central Italy. The main shock occurred at 3:32 local time (1:32 UTC) on 6 April 2009, and measured 5.8 on the Richter scale; its epicentre was near L'Aquila, the capital of Abruzzo, which together with surrounding villages suffered most damage. The earthquake left 150 people dead, 1,500 injured and 70,000 homeless. There were also extensive losses in community and cultural terms, involving cathedrals and buildings from the Middle Ages. The whole region was hit, not only the capital, L'Aquila. People were housed in tents from 6 April (date of the disaster) until September/October. There were thousands of aftershocks for months.

The earthquake which destroyed L'Aquila and Abruzzo again confronted us dramatically with a "natural" disaster involving many deaths and great suffering, leading to increased awareness of the possible psychological effects of disasters on the populations affected. There was also an increased focus on "day-to-day" crises such as individual, family and group traumas (rapes, robberies, accidents, suicides, etc) and on the need for prevention and care activities, leading to the development of several specific approaches, models and techniques.

From the very beginning, psychologists acted generously and with dedication, doing valuable and difficult work capably and with a great sense of solidarity. Psychologists took part through institutions (local psychological associations, universities), associations (APE, AUPI, Emergency, EMDR, Psychologists for People, SIPEM) and as voluntary members in the various regional civil defence relief convoys.

Very varied work was done throughout the region, from the "crater" to the coast, to the shelter areas where large number of homeless people were accommodated. Psychologists worked in close co-operation with the civil defence force from the very first hours after the devastating earthquake, supporting both people who had lost friends and relatives and people who were anxiously waiting for information about the fate of their loved ones. Psychologists worked in 170 camps in L'Aquila and Abruzzo for six months. They monitored all the

phases of stress reactions in adults, children and the community as a whole.

A meeting with civil defence directors highlighted mutual willingness to engage in fruitful co-operation and identified areas of common interest: the definition of high-quality training curricula, including with regard to the organisational and operational dynamics; the collection of documentation, studies and experiences from the field; and the conduct of research. A need to attend civil defence field operations was also identified, with the aim of integrating psychologists more effectively in the complex system of relief operations, while providing experiential training in addition to theoretical training.

Psychologists worked with all kinds of groups: displaced people, children, old people and relief workers, wherever the need arose, using many psychological first aid “tools” (informational, psychoeducational, psychosocial, clinical and research).

The National Psychological Association’s contribution followed the civil defence force’s guidelines: first of all, preventing individual volunteers who could interfere with rescue and relief operations from going to the disaster area on their own, and at the same time, planning the allocation of available resources so as to ensure the proper distribution of psychological support activities in the long term.

On 6 April, the national association published an announcement on its website inviting psychologists to indicate their availability and, on 7 April, the same announcement was repeated in the mass media. Psychologists, groups and associations all responded generously.

All resources available were placed at the disposal of the L’Aquila/Abruzzo regional psychological association, who had a clear picture of the local requirements and could make the best use of them, based on the needs identified in co-operation and co-ordination with the civil defence force and the local health authorities.

Participating psychologists were informed that professional interventions had to comply with the aforementioned criteria and therefore had to be conducted upon the explicit request of, and in co-ordination with, the institutions in charge.

There is still a lot to do. Buildings (houses, schools, hospitals, etc) must be reconstructed, and the individual, social and relational issues of people involved in various ways must be resolved. Psychology and

psychologists play a great role in this field, which is why I hope our profession will be appropriately involved in the different phases of reconstruction.

The latest survey showed that most local bodies had organised activities, co-operated with associations and/or groups of psychologists, drawn up memoranda of understanding with agencies and institutions and initiated training events.

So far, the work of psychologists in Abruzzo has been recognised by everyone, starting with the media who understood and reported on their vital importance. The role of psychologists in our society is being recognised and appreciated increasingly widely.

The number of participants from the whole country helped establish a medium/long-term support programme, extending well beyond the immediate needs.

A very major contribution was made by the associations. National health service personnel alone would not be sufficient in some emergency situations and “for the intervention to be effective, extensive co-ordination is needed and we, as the National Council, must deploy all energies and resources in order to achieve this and create synergies among the different players involved”. The next goal of the National Psychological Association is therefore holding a meeting with the associations and scientific societies indicated by the regional associations.

Discussion also focused on the legislative framework, in particular the President of the Council of Ministers’ Decree-Law dated 13/6/2006 on “Overall criteria on psychosocial interventions to be implemented in case of disasters”.

This calls for an organisational model based on regional teams consisting of national health service personnel, possibly assisted by “additional resources identified in voluntary associations, local agencies and professional associations”.

Regions are required to set up the teams on the basis of the specific risk factors in their territory and identify a focal point with specific co-ordination responsibilities.

The decree-law also describes training as one of the main resources of prevention strategies.

Emergency personnel must have extensive knowledge of "risk scenarios, organisational procedures and the most appropriate behaviours to adopt" in order to improve the ability to respond quickly and significantly offset the negative impacts of the emergency. The general aim of any training event is to "…disseminate and consolidate effective coping strategies in response to dangers, involving quick activation of perceptual selection and complex cognitive processes when faced with intense emotions and unusual communication processes".

Appropriate training must therefore also prepare the emergency personnel for "risk exposure" in order to prevent both vicarious traumatisation and traumas arising from exposure to dramatic scenes.

Examination of different realities has shown a great variety of experiences, experiments and organisational models, as well as contributions and observations, which certainly deserve to be analysed in greater depth.

Our psychological association has therefore been involved in developing skills, drawing up guidelines and codes of behaviour, starting an awareness-raising process both with institutions and with colleagues and building synergies with associations and scientific societies.

We have exchanged information with other European countries, especially after the London and Madrid terrorist attacks, for instance, which resulted in a substantial increase in the level of attention paid to the psychological problems connected with the management of the various phases of "crises" and the prevention of mental and relational suffering.

EFPA has set up a standing committee responsible for disaster psychology, crises and traumas, which has co-operated in recent years with the Council of Europe.

We followed EFPA's disasters standing committee guidelines for psychological support for the disaster victims.

We hope that the European and Mediterranean Major Hazards Agreement, as an organisation comprising 26 European and Mediterranean countries, finds our experience useful for providing

appropriate support in the event of disasters which usually overwhelm the response capacity of individual countries.

Luxembourg – Plane crash, November 2002

Marc Stein

In November 2002, a plane (Fokker 50) belonging to the Luxembourg airline LUXAIR arriving from Berlin (Germany) crashed in thick fog near the airport, killing 20 of the 22 people on board.

It was carrying 19 passengers and three crew members. The plane caught fire on the ground. Seventeen people died in the crash, while three of the five survivors died in hospital.

Early intervention

On the first day: The SAI victim support plan was launched immediately. This brings together the psychological unit of the police and the psychological support group of the civil defence force in order to provide psychosocial first aid during crises and disasters.

The psychotraumatology group (GROUPE-PSY) of the Ministry for the Family was also involved. The group is a network of psychologists who have been trained in psychotraumatology.

Further assistance was provided by the Lufthansa CARE team (around 10 members), which is made up of Lufthansa employees specially trained in assisting the relatives of victims.

Psychosocial interventions:

- Setting up a special desk to take care of relatives and families waiting at the airport, offering them psychosocial support while they waited for further information.
- Taking care of the families of the crew members separately.
- Taking care at the scene of three witnesses to the air crash.
- Taking care at the scene and giving psychosocial support to intervention teams (firefighters, police officers).
- Setting up a hotline to give information to families and relatives abroad, as many of the victims came from Germany (109 relatives called the hotline).

The following days:

- Making arrangements with Luxair and Lufthansa for relatives to fly to Luxembourg, arranging their stay and giving them support.
- Organising a more private religious ceremony with various clergy (Catholic, Protestant) 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 clarifying further details regarding burial.
- Holding debriefings for the intervention teams (firefighters, police officers, identification team) and also for the psychosocial unit.

Longer-term intervention

For long-term psychosocial support, some families and relatives were taken in charge by GROUPE-PSY, but most were referred to psychologists in Germany, as the families lived near Berlin. Some of the costs of therapy were also met by Luxembourg's Ministry for the Family.

A private psychologist was employed by Luxair to take care of and give support to the two survivors (a passenger and the pilot).

A civil ceremony was held a year after the crash. A monument has been erected at the crash site.

On the second anniversary, a smaller ceremony was held because a few of the families still expressed a need for one.

Evaluation and implications for the future

Three separate hotlines were set up, which created a lot of confusion.

Lessons learned:

- Only one central hotline next time; purchase a software program to pool information and share it more effectively.

- Some relatives and victims could not wait to see the bodies of the deceased. Because of a misunderstanding, they were brought to the place where the identification teams were working, but were not, of course, allowed access to the bodies. This created a lot of tension. The next day, the prosecutor allowed the families to see the bodies after every victim had been identified (mostly by their dental records). Nearly all the families wanted and were able to see their relatives for one last time even though most bodies were severely burned.

- The families and relatives were grateful to see the bodies even though they were in a poor condition.

- The identification team reported that they experienced huge psychological pressure because they not only had to deal with the identification but were also confronted with the grief reactions of the family members, which caused a lot of tension.

- The identification team should be physically separated from the place where family members can see the victims.

Luxembourg's Ministry for the Family and GROUPE-PSY were somewhat reluctant to hold a second anniversary ceremony, but they indicated that, in the final analysis, the ceremony had proven to be a meaningful and useful event.

Interestingly, the crash also had quite a big national impact, probably because it shattered the nation's unconscious (and, of course, naive) belief that a plane crash could not happen in Luxembourg.

The Netherlands – Firework disaster in Enschede, May 2000

Magda Rooze

On 13 May 2000, a fire broke out in the SE Fireworks firework storage depot/firework factory. 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. Overall, 22 people were killed (including four firefighters 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 4,163 people, and the outer ring to 2,400. A total of 205 homes were completely destroyed, and 293 declared uninhabitable. Many business premises were damaged.

Early intervention

In total, including volunteers, some 4,500 emergency services workers were deployed on the first day by the various emergency services. During the first week, the numbers were even higher. Some people only provided assistance during the first day, whilst others assisted for the full two-week period.

As regards expert assistance, on 13 May, 680 doctors were providing assistance and there were 270 ambulance personnel active, as well as 80 first-aiders and 45 general practitioners. Ambulances arrived from the entire surrounding area, including Germany.

The relief effort got under way 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 had been learned that it was essential to discover the cause of the disaster.

Against this background, an independent investigation committee known as the Oosting Committee was set up after the disaster. 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.

Shortly after the disaster, in the afternoon of 13 May, the Institute for Public Health and the Environment (RIVM) also carried out measurements of concentrations of substances in the air, which were subsequently repeated over the following days, in order to determine possible exposure to hazardous concentrations of substances for the emergency services workers and other people affected.

As regards the organisation of psychosocial care, three approaches were followed:

- An Information and Advice Centre
- Integrated psychosocial aftercare
- Health surveys

The Information and Advice Centre was set up in Enschede, on the initiative of the Ministry of Public Health, Welfare and Sport and the local authorities. The centre was actually up and running during the first week after the disaster. Premises, 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. Psychosocial and legal assistance were available immediately, as was material support in the form of clothing, money, a telephone, accommodation, furniture and other household goods. Other people who had experienced the disaster were able to give their accounts and find a calm environment in the ‘living room’ set aside for the purpose.

As an organisation, the Information and Advice Centre passed through a number of phases. Alongside the initial phase, there was a build-up phase during which internal organisational arrangements were made and a network was set up with other important

organisations. Work agreements were concluded with these institutions as a basis for support and assistance for the victims of the disaster.

During the consolidation phase, the number of requests for practical and material support fell, but it became clear how complex the remaining problems were. Now, almost three years after the disaster, the Information and Advice Centre is in the wind-up phase. It will soon cease to exist as an independent body, 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 individuals and organisations in Enschede specialising in psychosocial care worked closely together. In particular, they included general practitioners, social workers, home carers and the mental health care institutions, and they formalised their co-operation in a foundation. This initiative was also intended to pool 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 developing.

The initial idea was that psychosocial care would also be provided via the Information and Advice Centre. However, this proved unfeasible, since the IAC was accommodated on the municipality's premises, which was unacceptable for a number of psychosocial care organisations. Privacy legislation also meant it was difficult to exchange information. As a result, two organisations were effectively established, each preparing their own reports and their own information registers. With hindsight, this was an unfortunate development, as much information was lost as a result.

Evaluation and implications for the future

- Information and advice centre

The IAC functioned satisfactorily for five years after the disaster, disseminating information and acting as a referral centre for all kinds of services which the people affected need in the aftermath of a disaster. Since people affected by a disaster have to deal with so many different problems (health issues, insurance, financial, housing, etc), a central body helps greatly to minimise 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 co-ordinate 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, which was unacceptable to a number of care agencies. Invoking data protection legislation, the care agencies were also unwilling to transfer victims' personal details to an IAC database.

- Health monitoring

Extensive data are available now on the health situation of the people affected. The lesson learned here is that these data only became available after several years. For professionals and the people affected themselves, their value is minor. There is a need for health monitoring which is readily available for professionals to guide the care that is needed and enable people affected to understand their health situation better.

Norway – Maritime disaster on Norwegian coast, November 1999

Atle Dyregrov and Rolf Gjestad

On 26 November 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 which was undertaken during very difficult weather conditions with strong winds and high waves. Sixteen people died and 69 survived. The boat was designed in such a way that it was generally believed that it could not sink. However, 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 immediate support was Haugesund, the city closest to the disaster, where the injured and dead passengers were taken. Crisis reception centres were also set up in Bergen, the boat's intended destination, and Stavanger, its point of departure. Police, clergy and health personnel did their best to support family members of the passengers in this initial 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 transferred to Bergen or other places as they wished. Family members gathering at the crisis reception centres received emotional first aid. Despite the inevitable stress involved in a transport disaster and the fact that there will always be much confusion and stress at the outset, immediate help seemed to be well organised and was perceived as helpful by those affected by the disaster. Following previous Scandinavian disasters, criticism had been voiced about the lack of follow-up received (Dyregrov, 1992). The company that owned the Sleipner contacted the Centre for Crisis Psychology (CCP) in Bergen for professional advice on how best to care for the survivors and bereaved over time. CCP had experience in organising follow-up services in disasters and war situations, both nationally and internationally, and was asked to draw up a plan for long-term support for the groups affected. This was done in co-operation with Haugesund Hospital, which had organisational responsibility for the disaster work.

Longer-term interventions

- Psychological debriefings for all survivors were offered and conducted one week after the disaster.

- Follow-up debriefing meetings took place approximately six weeks after the disaster.

- Meetings between survivors and rescuers were held during February 2000.

- Screening of survivors and subsequent referral of those above a clinical cut-off level took place during late January and early February.

- In May 2000, survivors were offered a boat trip back to the scene of the disaster. Five mental health professionals supported the survivors on the trip. For many, it was their first time on board a ship again. Possible adverse reactions during the trip were anticipated, and after returning to land, they were offered an opportunity to talk about their experiences.

- Further follow-up was organised locally on the basis of the needs expressed by the survivors in 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.

- When the wreck was brought to the surface in late August 2000, some survivors made trips to look at (and enter) the wreckage. Support personnel were present at the scene, and a short memorial was held before they entered the wreck.

Evaluation and implications for the future

Although the exposure was rather extreme during this particular maritime disaster, leading to consequences that impacted on various aspects of survivors' lives, the great majority coped well over time. Hopefully, lower distress levels compared to other maritime disasters reflect a structured and caring system that was implemented to care for survivors.

Participants who take part in debriefings greatly appreciate the meetings. As “consumers,” they are able to differentiate among the functions served by the meetings. Those who seek out debriefing meetings have had longer disaster-exposure times and seem to be more distressed than non-participants. Screening may provide the basis for sensitive outreach towards 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. Regardless of their symptom levels, some people will not be inclined to illness or help-seeking behaviour. An aggressive outreach focus towards this group may be viewed as disrespectful and may make them more resistant to subsequent 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 in Log pod Mangartom, November 2000

Marko Polic

In November 2000, a landslide hit the village of Log pod Mangartom in two stages on two consecutive days. The distinct stages were probably the main reason for casualties. 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 were local roads. A number of people were moved into temporary accommodation in the local hotel in the nearby town of Bovec.

People were killed by the landslide because they failed to heed the order given by the civil protection force to stay in the safe area. The situation is not yet completely stabilised; a warning system has been built with sensors at the sites of possible landslides above the village and sirens in the village.

Early intervention

Responsibility for organising all assistance (technical and other) lay with the civil protection force, which co-ordinates all the relevant activities. On the first day, psychological first aid was provided by the local physician, while psychologists from the Ministry of Defence, trained in such interventions, were on the spot helping local people later on.

There were stresses connected to human losses, as well as material ones. It should be noted that this region is prone to earthquakes, of which there have been several in recent years.

Psychological support mainly consisted of individual work which was done in the local health centre. Some of the clients came of their own accord, while others came on the suggestion of a physician. It was mainly women who sought help. Besides individuals, there were a few couples and parents with children who needed this kind of help. As regards age, they were middle-aged or older (accumulation of stress because of various disasters over a few years, as well as other stress factors, for example, death in family, alcohol, etc). Clients reported typical symptoms connected with traumatic events. They needed a particular kind of advice, support, etc, which was given to them. In this connection, attention should be drawn to a kind of

mistrust of strangers that is characteristic of people from smaller places like those involved in this disaster.

Longer-term intervention

After a few months, the army psychologists returned to their regular duties and inhabitants were able to get help at the local health centre from their physician, or – if more complex psychological assistance was necessary – from psychologists in relevant health institutions in larger towns.

Evaluation and implications for the future

On the one hand in Slovenia there is a tendency to train people, especially those involved in rescue activities, about stress and PTSD, and on the other, there are psychologists in health institutions and the army trained in providing professional assistance in cases of this kind. As Slovenia is a small country, we could not afford to have a psychologist in every small community, but there are a number of professionals who can help if necessary and help is never far away.

While psychological aspects of disasters were not much emphasised before the nineties, the need for psychological assistance came to the fore later on – especially because of the large numbers of traumatised refugees from former Yugoslav republics. There are a number of professional institutions where psychologists have the relevant training, for example, the centre for children, teenagers and parents, army psychologists and psychosocial centres, etc. With the exception of army psychologists, psychologists in these institutions are trained for different kinds of professional activities, assistance during trauma being only one.

Spain – Terrorist attack in Madrid, March 2004

Catherine Perello Scherdel

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

Early intervention

The intervention was part of the PLATRECAM Emergency Territorial Plan of Madrid Region. The Official Psychologists' Association of Madrid, COPM, offered to co-operate with SUMMA 112 (Co-ordination Centre for Emergencies) and the municipal emergency service, SAMUR. Immediately after the attack, COPM set up two psychological crisis centres, one on the association's premises and another at the SUMMA 112 Centre. From 9 am on Thursday 11 March, COPM set up an emergency unit comprising the following:

- 4 co-ordinators
- 2 psychologist team managers
- 8 hotlines that remained open until Monday 22 March.

COPM first selected psychologists who were specialists in crises and disasters and then called psychologists who had some experience in trauma even though they did not have specialist training in this area; the groups were co-ordinated by a crisis and disaster specialist.

- Psychologists contacted: 1,415
- Psychologists who intervened: 948

Intervention areas:

- IFEMA (Madrid Congress Centre)
- Morgues
- Hospitals
- Cemeteries

- Police stations
- Hotels with affected relatives
- Hotlines (112, SUMMA, etc)
- Home care

Groups concerned

- Relatives of the deceased
- Relatives of injured people
- Injured people
- People living near to the sites of the attacks
- Victims' friends

Persons who intervened at the sites of the attacks:

- Police officers
- Firefighters
- Doctors
- Psychologists
- Psychiatrists
- Nursing staff
- Social workers
- Volunteers
- Journalists

Psychological assistance:

- Direct attention: More than 5,000

- Telephone assistance: 13,540
- Requests for home assistance: 183

Psychologists provided:

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

The Official Psychologists' Association of Madrid (COPM) co-ordinated their intervention with the various national, regional and local institutions and their representatives:

- National level: Ministry of Health, Civil Protection, Ministry of the Interior.
- Madrid Community: Presidency, Vice-Presidency, Ministry of Health (Counsellor, Deputy Counsellor for Health, Regional Office for Mental Health Co-ordination), Ministry of Justice and Interior, Directorate General of Immigration, SUMMA 112.
- Madrid municipal council: Deputy Mayor's Office, Department of Social Services, Public Health Administration, SAMUR.

Psychologists drew up the following guidelines:

- Guidelines on keeping calm after the 11 March attacks
- How can I help by giving support after the loss of a loved one?
- Guide for parents
- Psychological intervention in disasters

- Assistance with well-being and performance protocols
- Work with children affected by traumatic experiences
- What to do with children in disasters
- Debriefing: models and applications for relating traumatic experiences
- Support documents for professionals involved in psychological care for disaster victims
- Initial psychological support. Which protocols should we use?
- http://www.copmadrid.org

Media:

The Official Psychologists' Association of Madrid (COPM) deployed a special range of services and information about the psychological assistance that was being provided:

- Press conferences: COPM issued seven press releases to 200 different media outlets, on 11, 12, 13, 14, 15, 16, 17 and 22 March, and held a press conference attended by 42 media outlets on 17 March.
- Communiqués: COPM issued two communiqués condemning the attacks and expressing condolences and solidarity with the victims on 11 and 12 March.

Listed below are the media outlets which were in contact with the press office of the Official Psychologists' Association of Madrid (COPM) and reported on the assistance that was being provided 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 Vanguardia, 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 and 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, etc.

- News 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 Press (United States), Reuters (United Kingdom), Accused Agency (France), Maxi Agency (Italy), etc.

- Radio: Radio ITR (Chile), Radio RTL (France), etc.

Longer-term intervention

Psychologists phoned the victims to find out:

- How they felt to see whether they needed more psychological support and arrange it if necessary.

- Whether the victim had sufficient skills for coping.

- Whether 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 for people re-experiencing the memory, adaptation skills, appropriate spaces and logistics, justice and reparation, sharing experiences, information, victim protection;

- After the trial.

Lessons learned

- All psychologists should follow the directions and information from the authorities.

- All agencies and institutions should co-ordinate their efforts, putting their differences to one side.

- Information should be transmitted continuously.

- The victims need comprehensive, multidisciplinary care at the scene.

- It is necessary to avoid constant exposure which could worsen the psychological effects.

- All psychologists should consider beforehand whether they are adequately trained to intervene.

Improvements to be made:

- Increase the number of psychologists trained: There were two psychologists for every 10 victims.

- Increase the level of cohesion and communication between professionals.

- Separate areas should be provided for the victims.

- Assessment of workshops to monitor emotions.

- Acknowledge the reasons for victims' attendance.

- Consider why psychologists were sometimes not able to provide the support needed.
- Intervene as soon as possible.
- Ensure confidentiality.
- Have a body which co-ordinates the intervention, indicating clear steps to follow.
- Psychologists should not leave without informing the relevant official so as to ensure the continuity of the psychological support.
- Make sure that psychologists have special training in C&D.
- Make sure that psychologists have special skills and clinical experience.
- Psychologists should listen to their own bodies and be aware of their emotional strain, and stop when necessary.
- Share experiences with other psychologists.
- Appoint a communication officer for dealing with the media.
- Write reports on all interventions to keep track of their outcomes.
- Keep protocols for every victim, in alphabetical order (giving addresses, telephone numbers and the names of psychologists concerned) for a database.
- Ensure quality control.
- Co-ordinate the network.
- Research.

Sweden – Tsunami in South-East Asia, December 2004

Eva Håkanson

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

Stockholm was probably the most seriously affected capital in the industrialised world. About 5,000 people living in the county of Stockholm returned from South-East Asia and were registered by the police at Arlanda airport. 205 Stockholm citizens were reported missing.

Many survivors had been exposed to life-threatening situations, having been on the beach when the wave hit. They witnessed relatives and other people being swept away by the waves. Many experienced immediate threats to their lives, suffered the loss of significant individuals or sustained physical injuries. On returning to Sweden, some of them needed further hospital care. Of the 13,000 people who arrived at Arlanda airport, 461 persons, of whom 147 had been hospitalised, were transferred to one of the emergency hospitals in Stockholm. In addition, approximately 1,000 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 psychological and social support teams to Thailand and also to some other areas affected by the tsunami. NGOs and official and private organisations took part in the early intervention. The immediate rescue work by the Swedish authorities was criticised in the public media as being poorly prepared, poorly organised and inadequate.

In order to respond to the medical, psychological, social and emotional needs of the survivors, crisis centres were set up at the main Swedish airports the first day after the tsunami. These centres operated day and night for three weeks and were manned by

personnel from the Civil Aviation Administration, the police, medical authorities and social services, as well as volunteers from the Red Cross and the Church of Sweden.

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

In the county of Stockholm, hospitalised 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 from child and teenager 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 arranged follow-up.

Information about post-traumatic 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 personnel were offered defusing and, depending on needs, psychological debriefing.

Longer-term intervention

Support and trauma therapy was offered by psychotherapists working in primary care, occupational health services and 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 after the disaster.

NGOs like the Red Cross and Save the Children organised support groups for children, teenagers and adults, survivors and relatives of the deceased.

In January 2005, the Swedish government set up a new national public authority: the Swedish Co-ordination Council for people affected by the Tsunami Disaster. The council was wound up in 2006. The main task of the council was to disseminate various kinds of information to survivors and relatives of deceased people, for instance about the identification procedures for missing persons. The council also put people in contact with appropriate authorities concerning legal, economic or insurance matters, as well as for psychotherapeutic treatment.

At a later stage, the council was responsible for arranging memorial ceremonies both in Thailand and in different parts of Sweden. The council distributed money to survivors and bereaved people so that they could attend the memorials in Thailand.

Whether all the support efforts were effective and of assistance 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 assume the necessary responsibilities soon after a disaster.

It is important to have a formalised plan of action for both immediate and long-term support. If medical and psychological personnel are to be sent to the site of a disaster, proper organisation is necessary and the personnel must be trained for the task. High-quality support in the immediate aftermath of a disaster will lead to increased trust among the survivors and thus enable further supportive measures to be taken.

Co-ordination and co-operation between organisations is crucial. Otherwise, there is a high risk of survivors being left without adequate support.

Setting up a national co-ordination council was a good decision. 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 who were not actively offered support reported difficulties in obtaining the proper assistance. In some of the non-proactive communities, there was a lack of knowledge in the field of psychotraumatology among people working in local government, a lack that must be overcome.

Timing is of great importance when offering various kinds of support and therapy. As disasters often have long-term consequences, 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 being carried out on a national and regional basis in Sweden. These studies are investigating different aspects of long-term consequences after the tsunami for affected individuals, families and societies, as well as helpers, organisations and governmental authorities. Special attention is being paid to evaluation of various methods used for psychological support.

Turkey – Earthquake in Marmara, August 1999

A Nuray Karanci

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

Early intervention

- First day and week:

There were major difficulties in reaching the region and establishing communication networks. The first days were therefore taken up with search and rescue work and catering for basic needs such as food and shelter. This was done by the Turkish civil protection force, search and rescue teams, local citizens and some volunteers and NGOs. No specific psychological support was provided. There was a massive call for assistance with rescue efforts and shelter/food. International search and rescue teams and national NGOs were involved. Co-ordination and co-operation between national and international teams was an important issue.

- Psychosocial interventions:

Setting up temporary accommodation and providing tents. This was the responsibility of the Turkish Red Crescent. Due to the difficulty in satisfying the massive demand, other national and international organisations also provided assistance. The Turkish Red Crescent is responsible for providing tents and food for survivors of disasters in Turkey. They erect mobile kitchens and provide food for all survivors. Of course, given the massive casualties, their response capacity was initially inadequate and they were heavily criticised.

Central and local crisis centres were set up in accordance with the Turkish Disaster Law, and decisions were made on meeting the physical needs of the survivors and the arrangement of funeral services, etc. The crisis committees involved all local public authorities and the representatives of local authorities/municipalities and the armed forces.

Following days: the Turkish Psychological Association (TPA) responded very quickly despite a lack of preparation for disaster support services. In collaboration with the central crisis committee set up in the Turkish capital, Ankara, TPA sent personnel to the region without delay and conducted a rapid assessment of needs.

Later stages:

- Brochures for adult survivors, parents and emergency workers were prepared, taking similar brochures published in other countries as a basis.

- TPA obtained support to provide services initially in the five provinces hit by the 17 August earthquake, which was later expanded to the areas affected by the November earthquake. Services were provided in nearly 30 camps and other areas of the provinces and involved debriefing and information, normalisation, distribution of booklets and screening, as well as referral for professional help when needed. All the services were provided by the psychologists on a voluntary basis. Debriefing was provided for survivors (adult women and men; teenagers; emergency workers) and the TPA field staff.

- The TPA field staff also assisted in connection with tents for children provided by the Turkish Social Welfare organisation. Children were given the opportunity to express themselves in plays and drawing activities organised by the TPA staff.

- Turkish Ministry of Health psychological/psychiatric support teams, Turkish Psychiatric Association teams and numerous NGOs all also provided psychosocial support in the disaster area.

- Rapid training programmes in debriefing, trauma psychology and common responses observed in survivors were given to field staff before they went to the area. Capacity building and international support in the form of trainers from various countries was therefore available.

Longer-term intervention

For long-term psychosocial support, a number of psychosocial rehabilitation centres were set up with the co-operation of the Turkish Red Crescent and the International Red Cross and other international organisations and NGOs. Trauma centres were set up in psychiatric

hospitals and at the TPA Istanbul branch. Local NGO activities became much more important following the 1999 earthquakes in Turkey. NGOs targeting the psychosocial needs of specific groups like the disabled, women and children played an active role in offering services. The establishment of local NGOs was of vital benefit following the devastation.

In collaboration with UNICEF, TPA launched a training programme for trauma psychosocial interventions with teachers. In collaboration with ECHO, TPA also provided trainers' basic disaster-awareness and preparedness training in the five provinces hit most seriously by the quakes.

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

One year after the earthquake, survivors either had the keys to their new houses (constructed by the state) or were living in prefabricated housing. In some provinces, they were supported by local NGOs. Psychosocial support continued through rehabilitation/community centres set up in the area.

Evaluation and implications for the future

Lessons learned:

- The devastating earthquake highlighted the importance of mitigation and preparedness, ie risk management, and that Turkey was not ready to offer psychosocial services.

- Psychologists were caught unprepared for the event, and massive training programmes were needed to build capacity for responding to the needs of survivors.

- Community participation and capacity building is necessary before a disaster.

- Volunteers in the form of NGOs provide valuable input and their activities need to be fostered.

- Co-ordination of all the activities of the various stakeholders and information is a vital need that must be addressed.

- Six years after the devastating quake, although 98% of our population live in seismically active areas, we tend to forget and attention shifts to other priorities. Sustainability of capacity building for psychosocial intervention teams, community organisation and empowerment are therefore needed.

Best practices:

- The Turkish Psychological Association responded very efficiently and rapidly considering the lack of preparedness for such a massive, devastating disaster.

- There was co-operation with the official crisis centre at the central and local levels.

- Capacity building for psychologists was achieved through the assistance offered both nationally and internationally concerning trauma psychology and intervention methods.

- Many NGOs offered psychosocial support in the region affected. A general increase in public awareness of hazards and vulnerabilities occurred. This offers a window of opportunity for changes in legal frameworks for mitigation and preparedness and for community involvement organisations.

- Co-operation with international agencies and co-ordination of activities for sustainable risk management (eg, training of trainers in disaster management; establishment of local community networks and centres).

Concluding remarks

Definition

The European Federation of Psychologists' Associations employs an all-inclusive conceptualisation of disasters and crises. This means that, by definition, natural disasters such as earthquakes, floods, tsunamis and landslides are included alongside man-made disasters like transport accidents, terrorism, violence and war. Disasters may be local, smaller-scale emergencies or large-scale crises, their onset may be sudden or slow and they may vary in duration.

Disasters often have an impact on an international level in the case of tourism or migration or when national disasters exceed the capacity of the country concerned and there is a need to call for international involvement.

Mission statement

To give direction to the policymaking on psychosocial care after disasters, there is a need for a clear vision of what psychosocial care should be. What is meant by psychosocial care, who is it aimed at and what is its purpose?

In general, there are a few key concepts which express the EFPA's vision of psychosocial care after disasters.

- Psychosocial care should be an integral part of disaster planning and preparedness.

- Psychosocial care should occupy a key position within disaster relief, including in terms of all disciplines and all responsibilities.

- Psychosocial aspects should be considered from the outset.

- Psychosocial care should be provided to high standards of quality on the basis of scientific evidence and best practices.

People's needs

When disasters strike they are sudden, unexpected and "earth-shattering" for those affected by them. The people directly exposed often talk about how their lives have been radically altered. They describe a state of confusion, pervasive anxiety and helplessness.

Disaster victims also speak about not being the same and of how they have lost their inner sense of safety and ability to count on the stability of their environment. Some also speak about feeling powerless and having lost the structure of their daily lives.

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

Target groups

The people affected by a disaster are not confined to those directly affected, but also include various other groups, for instance witnesses to the event, survivors, children, the bereaved, immigrants, refugees, psychiatric patients, elderly people and disabled persons.

In short, it is important to identify the different groups, as 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 traumatising 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 previous psychiatric problems, adults from ethnic minorities, people with a low socio-economic status and people lacking social networks are known to be at risk of developing long-term health complaints.

Psychosocial care should be focused on these different groups. A demographic analysis can be helpful in preparing for disasters.

Outreach

It is well known 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 the people affected should be one of understanding and respect, which is both sensitive and non-intrusive. Outreach activities should be co-ordinated. People have the right to say no to the services offered. Crisis managers, rescue workers and professionals should be sensitive to the reactions and emotions of the people affected after a disaster. They should be aware of the normal reactions of people and the dynamics which occur.

It is in the aftermath of disasters when people start picking up their daily lives again, relief workers return home and the media switch their attention to other matters that the people affected often fully experience the consequences of what they have been living through. It is often during this medium to long-term phase that the group who develop long-term health complaints have difficulty finding the care they need. They often do not believe that the care programmes of mental health institutions are for them. It is important to organise the psychosocial care right from the beginning so as to be able to identify the needs of the people at risk and reach out to them.

Psychosocial interventions and treatment

Treatment and interventions are often diffuse and interventions are extremely diverse. The aim is to use scientifically evidence-based interventions. When there is a lack of sufficient evidence, consensus-based and common-sense-based knowledge and interventions should be applied. According to the state of the art, the following can be said:

- In the acute phase, victims need practical, social and emotional support.

- In early psychosocial interventions, the specific characteristics (eg, 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, stimulating mutual aid among victims and promoting self-reliance and resilience.

- Depression and anxiety disorders, including acute stress disorders and post-traumatic stress disorders, are the most common long-term psychological consequences of a disaster for which effective treatment should be offered.

Victims of developmental age

Assisting child and teenage victims of trauma or mass disasters is important as a means of preventing long-term emotional harm. Their reactions may become obvious soon after the tragic event, but most will recover within the first few months, although others will develop PTSD or other psychological problems that may require treatment. It is important to know what reactions to expect depending on their developmental age and what adults (parents and teachers) can do to help. Some children and young people have more risk factors than others which may make them more vulnerable; such 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 significantly to influence children's capacity for recovery. Interventions should not therefore be focused solely on child trauma victims, but also on their parents, especially when both children and parents and the community involved in the disaster are all affected by post-traumatic reactions, mourning processes, loss of their homes, a sense of guilt and conflicts that may arise in the community. It is well known that adult anxieties are perceived and absorbed by children and can become an obstacle to the resolution of psychological disorders. Given the developmental age of some victims, in the absence of focused and effective treatment, the child's personality could develop around the traumatic event and adapt to it, increasing the risk of their 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 a disaster, providing psychological support and appropriate treatment. Among the methodologies that may be employed with this group are psychoeducation for adults on how to recognise stress reactions in children and teenagers, what to do in the days after the event, communicating bad news, finding resources to help children cope and how to reassure them, as well as active listening and trauma treatment like Trauma-Focused Cognitive Behaviour Therapy and EMDR. These interventions can be helpful in enhancing their resources, reducing stress reactions and normalising their behaviour. After a mass disaster experience, it is important that victims of

developmental age are able to understand what happened and have the possibility of talking in a safe environment in the presence of a psychologist so that they can express in words any irrational ideas, fears, images and physical or emotional feelings.

Timing of psychosocial interventions and treatment

Preparedness is an important issue in disaster relief. Failing to prepare is preparing to fail. Although that is common knowledge among policymakers and disaster relief experts, it is a difficult task to keep disaster preparedness on the agenda in 'quiet' periods. Lessons from recent disasters have shown time and time again how important preparedness is.

Different phases have been identified to describe the consequences of a disaster in general and, more specifically, the consequences for the health of the people affected and the health complaints they are at risk of developing: the acute phase (for four weeks after the disaster), the medium-term phase (from four weeks until five years after) and the long-term phase (five years and more).

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

- There is a need for a mental health presence right from the start and, at the very least, psychosocial information should be widely disseminated; there should be a balance between safety issues, material and physical needs and psychosocial needs;

- When people are in shock, they should be offered psychological first aid (acute phase);

- When people start to realise what has happened, early interventions can be offered (medium-term phase);

- When people do not recover on their own, treatment is indicated (long-term phase).

Co-ordination/structural response

A central body such as a national crisis team should be responsible for psychosocial care after a disaster. Psychosocial care should be managed from a single focal point for the short and the longer term.

The national crisis team should draw on local experience and local input and should also make use of professionals who have experience with previous disasters.

In larger countries, a single central body may not be sufficient; a federal structure is then needed between central and local 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 body. A co-ordinating body should also be available on a European level.

Co-operation

The co-operation between the various services at operational level is satisfactory most of the time. In terms of management, it is often not clear who is responsible from the point of view of the government. In this connection, it is important to differentiate between responsibilities and tasks. There should be a system of co-operation and collaboration between psychosocial partners and emergency agencies. The structure, mechanisms and principles of such a system need to be planned ahead.

Aftercare for professionals and volunteers

There should be a properly developed system of aftercare for professionals and volunteers, who should be fit and trained for the job. Training is an important factor in preventing post-trauma psychopathology. On the other hand, professionals and volunteers are at risk of long-term health complaints because of their involvement in this kind of work.

Competencies and capacity building

There is a need for sustainable capacity building for psychosocial interventions. This requires the identification of resources and the empowerment of staff who will be involved in crises and disasters. Development and training guidelines are needed, along with continued training to increase capacity. Various 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 for post-disaster psychosocial care.

An information and advice centre is one of the community-based interventions which takes the form of a one-stop shop for meeting all the needs of the people affected; it should be in an easily accessible location and should be large enough for all the people, with separate rooms for different groups (for example, people looking for missing persons, the bereaved, survivors and rescue workers).

Rituals and commemorations are necessary community-based interventions. The timing of rituals and commemorations is important, as is the role played by the people affected.

Information and the media

Risk and crisis communication should be in tune with psychosocial care; the role of the media in supplying information is also essential. Key issues here are how to communicate and what should be prepared together with the media. It is vital to supply the best evidence-based information available, and co-operation with the Dart Centre, the network of journalists on ethical journalism and trauma, offers important opportunities here. Information hotlines should be available for the public.

Preparedness

In terms of preparedness, education, training and exercises are necessary, but are often lacking or inadequate.

In this phase, attention needs to be paid to reducing the impact of potential disasters by incorporating notions of mitigation. Education and training need to be provided for all sections of the community, as well as professionals.

Research

The EFPA Standing Committee strongly recommends that professionals and scientists in the field of post-disaster psychosocial care publish reports on the issue. This should be done on an international level and be practice-based and opinion-based so that the members of the international community can learn from one another. Psychosocial care after disasters is still a relatively young field of knowledge and would benefit from an active publication policy among professionals and scientists.

Research should be aimed at supporting professional practice. This, of course, has implications for the questions covered and the design of research. Assessing the needs of the people affected by a disaster is one very important topic for research, as it can serve as an effective basis for planning psychosocial responses. The other end of the continuum involves evaluating psychosocial interventions according to their effectiveness. To date, there has been too little knowledge for evidence-based psychosocial interventions.

Network

A European network should be established for the purpose of developing a systematic means of exchanging and evaluating lessons learned from recent disasters. The key outcome of such a network should be an annual report with recommendations on improving psychosocial care.

Legal issues

No specific examples are described in this document, but we know how legal issues can impinge on efforts to enhance the well-being of the people affected. It is recommended that the relevant expertise be taken into account.