PSYCHO-SOCIAL SUPPORT
IN SITUATIONS OF MASS EMERGENCY

European Policy Paper
concerning different aspects of psycho-social support
for people involved in major accidents and disasters.

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PREFACE

This document offers decision-makers a methodological guide and a coherent model for psychological and social support in situations of mass emergency. Recommendations are the result of a series of exchanges of ideas and discussions between professionals from a wide range of backgrounds, coming from all over Europe. They include professionals with a psychological or social work training, public health physicians, medical emergency services staff, rescuers, academic experts, independent consultants, volunteers, local and central government civil servants. This European Policy Paper also reflects the actual state of scientific consensus on this subject, and builds on the conclusions of earlier European Workshops and Conferences in Arras-Lille (France), Amsterdam (the Netherlands) and Vienna (Austria), and the two most recent working conferences that were organised in Brussels (Belgium).

In the First Brussels Conference of March 9-10th, 2001, international experts and decision makers exchanged experiences and debated different aspects of psycho-social support, linking case studies with existing national guidelines and scientific evidence. An eight member multidisciplinary working party did the necessary preparatory work and further elaborated preliminary documents in three more Workshops (Brussels, Sheffield, and Copenhagen). Contributing authors to the first draft of this Policy Paper include:

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Discussions, critical revisions and comments made during the Second Brussels Working Conference of 14 & 15 September 2001 further contributed to the final version of this Policy Paper, establishing general principles and offering methodological guidance for preparing psycho-social interventions in the aftermath of major accidents and disasters.

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The contribution of many individuals is noted with gratitude, not least the participants of the different European Workshops, and we would also like to give some credit to the Agencies and Institutes that have been so generous to support their efforts. The full list of participants in the European Conferences can be found in Annex 1.

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CONTENT

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INTRODUCTION:
GENERAL OBJECTIVES and LIMITATIONS of this POLICY PAPER

In almost every Member State of the European Union some kind of psycho-social intervention is initiated after mass emergencies. During recent years, different professional and voluntary workers, agencies and organisations have provided a range of services in the immediate aftermath of a mass emergency (ME). There is however a striking variety in activities, methods and approaches to the provision of psycho-social support, depending upon prevailing theories, economic resources, culture, and situational characteristics. Gradually the idea has emerged that psycho-social interventions need to be prepared in advance and must be effectively co-ordinated and structured during the different phases.

To what degree the different forms of psycho-social support meet the real needs of those involved in major accidents and disasters is still open to debate. But it would be socially and morally unacceptable in those situations to do nothing or to provide services in an ad hoc and uncoordinated way. Public authorities have in this context, an undeniable responsibility to make sure that preparing, planning and evaluating psycho-social intervention is part of a sound ME response management. After all, a highly industrialised and civilised society should guarantee each individual, without exception, the unalienable right to support and assistance in all difficult, precarious or emergency situations.

This document offers guidance for policy makers concerning psychological support and social accompaniment for those involved in situations of mass emergency. It reflects the actual state of professional consensus on this subject, resulting from a series of exchanges of experiences and discussions between emergency service workers, academic experts and civil servants, coming from all over Europe. These policy guidelines can of course not be a substitute for scientific research and debate, nor can they be an excuse for excluding the different partners from the whole process of preparing the psycho-social ME management.

The focus of this paper is on preparation, operational management and evaluation of a psycho-social response that is specific for mass emergencies. The recommended principles and methods should assist decision makers and practitioners in order to improve the appropriateness and the quality of response. This guidance is not intended to be prescriptive and it would be inappropriate if the guidelines were mechanically followed as a strict manual. The guidance shouldn't be an obstacle for further evolution. The organisation and provision of expert support services, and the necessary training and planning beforehand should not preclude other helping initiatives or support given by relatives, social networks and services within the framework of general health care. A European Policy Paper should indeed offer the possibility of a flexible implementation according to the evolving nature of the social context, socio-economic possibilities, organisational policy, professional standards, cultural values, customs, and trends in public opinion of each individual country.

There still is a lot of scientific uncertainty about the nature, extent and evolution of the needs of people affected by mass emergencies. Further systematic and critical evaluation is needed to continue to develop a clearer understanding of the psychological and social needs that evolve following mass emergencies. It is also necessary to continue to evaluate the efficiency and effectiveness of psycho-social interventions. It is hoped that this document can contribute to an improved psycho-social support and to a better general mass emergency management in the future.

Psycho-Social Model for Situations of Mass Emergency

Psycho-Social Needs

It may appear evident, but it should be emphasised that psycho-social support should be considered from the point of view of the people involved in a mass emergency. Their needs and the interests of the general public should prevail over sometimes competing or conflicting partial interests (e.g. of press, authorities, organisations...) and over established doctrines.

Experience has taught us that major accidents and disasters do not produce a huge amount of victims with acute psychiatric disturbances. The professional consensus is that there is no need for rushing a large number of psychologists or psychiatrists to the scene. Nor should psycho-social support in mass emergencies be restricted to professionals giving individual critical incident care in large numbers. The psychological reactions of people in the immediate aftermath of a mass emergency can be considered to be "normal", in the context of "abnormal" circumstances. People involved in major accidents or disasters have very practical and social needs which are important as such. Those needs may also have a psychological impact, particularly if they are not appropriately responded to and managed.

The nature and extent of psycho-social needs in ME situations are such that they may exceed the immediate coping capacity of the affected community to the extent that every-day resources are insufficient in order to be able to respond effectively. But major accidents and disasters do not only differ from situations of individual emergency or from small- scale accidents by the sheer number of affected persons. When a lot of people are involved in an emergency, When a lot of people are involved in an emergency, somewhere the quantitative changes add up, resulting in a qualitative jump in complexity.

The response to a ME therefore requires a special approach that is essentially preventive and collective in nature, although curative care can be necessary for some individuals. Both injured and non-injured persons (including relatives and friends) can - especially in the immediate aftermath - have practical, information, social, emotional and psychological needs that require anticipation and a pro-active response of well co-ordinated multidisciplinary support. In these circumstances a combination of various interventions, support and counselling are required. Psycho-social needs are likely to persist over a much longer time frame than the usual intervention period of emergency services. Continuation of collective, pro-active multidisciplinary support may sometimes need to be complemented with specific, punctual psycho-social interventions.

It would however be unrealistic to expect that psycho-social intervention, however well organised, will lead to a rapid and more or less total relief of suffering. It should also be emphasised that the most important psycho-social support for those involved in mass emergencies, results from the helping, healing and emancipating social mechanisms involved in interpersonal relationships and social networks. Experience has shown that witnesses, bystanders and survivors in situations of mass emergency, often react spontaneously by offering help, comfort and compassion to victims, even before emergency services arrive on the scene. The suffering and misery of others can arouse strong feelings of human solidarity, empathy and desire to give mutual assistance.

Even so, is it the family, friends, colleagues, neighbours, and all those people that are part of a social network of a given society that are in the long term, crucial in coping with possible psychological distress and social problems. Socio-economic and cultural factors, and the given social and political context, also determine to a large extent whether authorities or institutions organise a specific intervention (comprising psychological support, social accompaniment, practical assistance and/or medical care) and the way this is perceived by those involved in a ME.

Global assessment of needs and priorities

People involved in a major accident or disaster have different immediate, short- and long-term needs, depending on the type and circumstances of the emergency. Given the urgency and the relative shortage of available resources that characterise a situation of mass emergency, there does exist - from the perspective of those involved - a hierarchy of needs. Even though they all add up and are necessarily linked with each other, a differentiated response is required, priorities must be set and choices need to be made.

1) Rescuing and maintaining the vital functions is of course the number one priority, including:
   - basic and advanced life support and emergency medical care
   - shelter, drinking, eating, sleeping and basic hygiene
   - interpersonal contact, communication and the exchange of information

2) Elementary support should be offered, enabling those involved in a ME to go on with their lives, in respect of their dignity, privacy and liberty:
   - material, logistical, technical
   - social, emotional, psychological
   - information.

3) Finally, maintaining (or regaining) physical, mental and socio-economic comfort and Returning to usual activities in life can require further support:
   - material, logistical, technical, financial, administrative, legal issues
   - social and psychological support (including rituals and memorials)

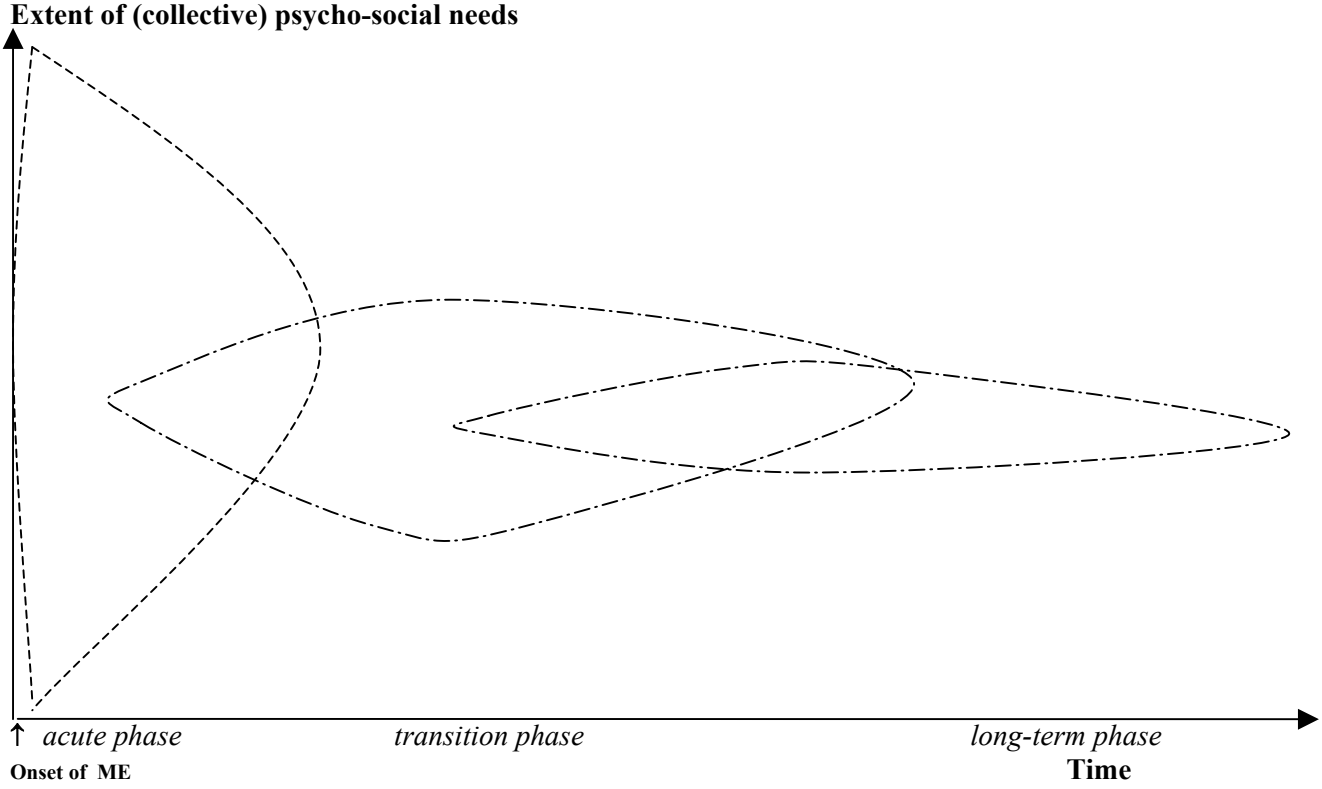
   challenging specific vulnerabilities and enhancing individual and social autonomy. enhancing individual and social autonomy.

In this sense we can differentiate between the physically injured, deceased persons and physically unharmed survivors. However, relatives and close friends of those directly involved also have needs and interests, which should be attended to. Bystanders or witnesses of mass emergencies, reporters and media personnel, and also responders (rescue workers, police, medical emergency services, psycho-social workers) themselves can have specific psycho-social needs. Until recently however, the response to a situation of mass emergency was only considered from a purely medical-therapeutic point of view. Previously, the most common response was to consider the needs of physically injured victims, with little attention paid to the needs of uninjured survivors, relatives and responders.

Development and dynamic of needs: phases

The psycho-social model of this Policy Paper follows the evolution in time of the quantitative and qualitative features of the psycho-social needs of people involved in mass emergencies. A pragmatic classification is used (based on the collective psycho-social needs), where there is an acute phase, a transition phase and a long-term phase. The time line depends on the nature of each ME, and it is therefore difficult to specify the duration of each phase in terms of number of hours, days, weeks, months or years.

Pictorial illustration: the different phases of a psycho-social model



The pictorial illustration above represents the relatively large rise in the needs of a group of affected persons in the immediate aftermath of a mass emergency, followed by decline during the acute phase, be it because of their fulfilment or because they no longer exist. For example, when an uninjured person returns home, providing food and accommodation for them becomes unnecessary.

The fact that there is an overlap between needs during the acute and the transition phase. Indeed, the evolution of needs doesn't follow exactly the same time pattern for each individual. While some have started to visit injured victims (e.g. where practical help with transportation is needed), uninjured victims who have already returned home may already have needs belonging to the transition of return to life as usual (e.g. practical assistance with administrative formalities). On the other hand the specific characteristics of each of the needs of people affected will change over time. Information for example, is always needed but on different topics depending on the time and phase.

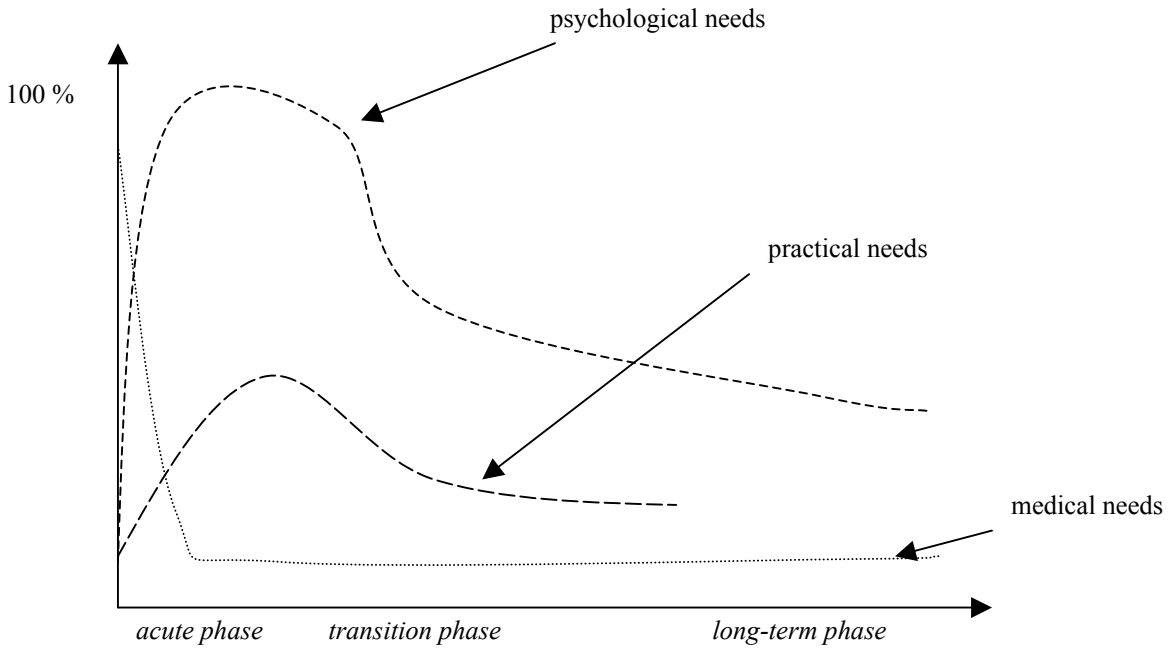
In the immediate phase, it is crucial to know the whereabouts of loved ones involved in a mass emergency, while later advice may be required on how to deal with learning problems of schoolchildren or with career reorientation. Over time (starting during the transition phase and certainly in the long-term phase), a response will be provided more and more by the usual resources of health care and social services.

Case example 1: the discotheque fire in Göteborg, Sweden, 1998

Just before midnight on 29 October 1998, a fire broke out in a discotheque located on the second floor of an old warehouse in the city of Göteborg, Sweden. Some 400 young people aged 12-21 were inside the premises at that time. Despite a rapid response from the Fire and Rescue Service, 60 teenagers died entrapped in the burning building. The medical treatment on scene was limited due to physical abuse of ambulance crews by bystanders and friends of the injured. The "load and go" principle was used bringing nearly 200 injured people to the hospitals within the area in a short time span, most of them were only slightly injured. Thirteen patients had to be transported to Burns Units elsewhere within and outside Sweden. Some had very severe burns that will disfigure them for life. Three persons died in hospital due to burn and lung injuries. A major strain on the Health Care System was caused by an enormous demand for Psycho-Social Support. The majority of the people directly affected were second generation immigrants.

The graph below is an attempt to show how the needs of the group directly affected by the fire changed over time. This graph is only a simple illustration and does not attempt to be precise or accurate in a scientific way.

Graph 1: graphical representation of the percentage of people involved and the evolution of their needs in the aftermath of the 1998 discotheque fire in Göteborg

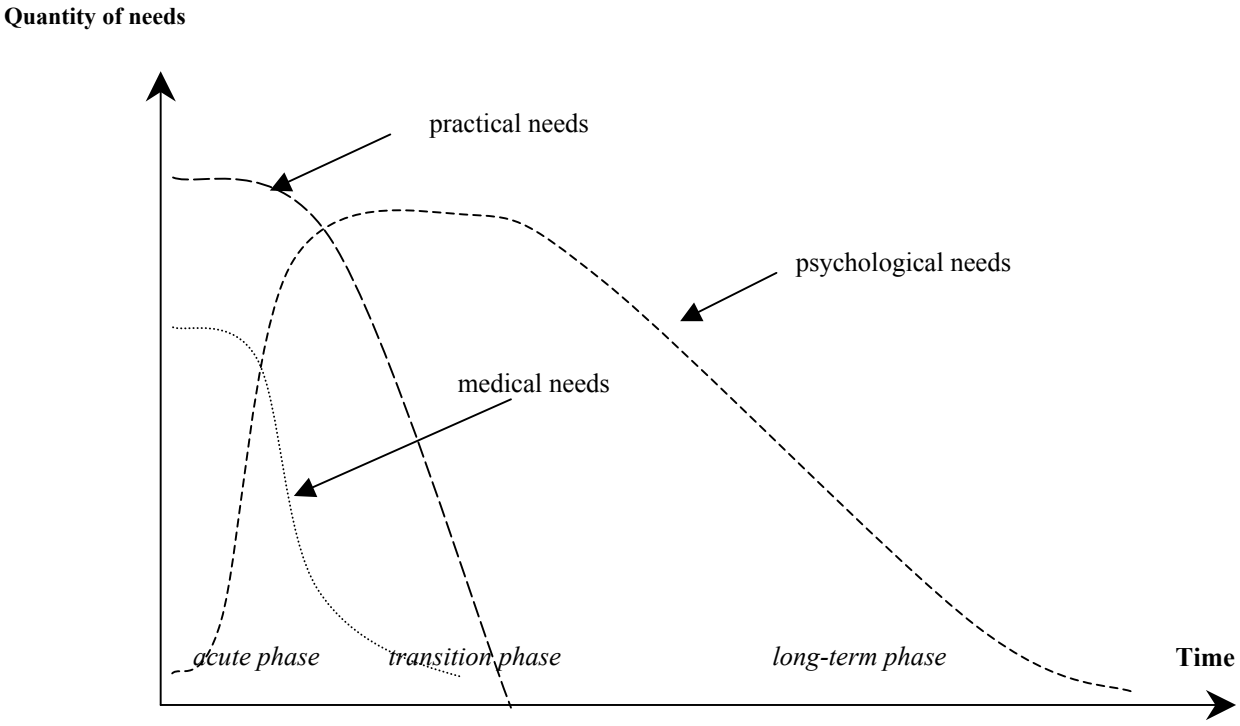


Graph 1. illustrates the evolution of medical, practical and psycho-social needs in the aftermath of the 1998 discotheque fire in the city of Göteborg. Some 200 young people needed some form of medical treatment. The medical need decreased quickly, but lasted for a long time for those with severe burns. Practical needs were limited at the beginning, but increased over time and especially on special occasions like funerals, trials and anniversaries. While in the acute phase, practical and medical needs were prominent, the psychological needs increased rapidly during the first week and remained high during the first year. It is estimated that two years after the accident approximately 30 % of the young people still needed treatment for PTSD and other psychological disorders.

Case example 2: the accident at the Roskilde pop festival, Denmark, 2000

During a concert with the rock band Pearl Jam at the Roskilde Festival in July 2000, 9 young people died in the crowd in front of the stage. Course of death was probably suffocation. The graph is an attempt to show how the needs of the group directly affected by the accident changed over time. This graph is only a simple example and does not attempt to be precise or accurate in a scientific way.

Graph 2: graphical representation of the evolution in time of the needs of the group of survivors from the accident area in front of the Orange stage in the 2000 Roskilde pop festival

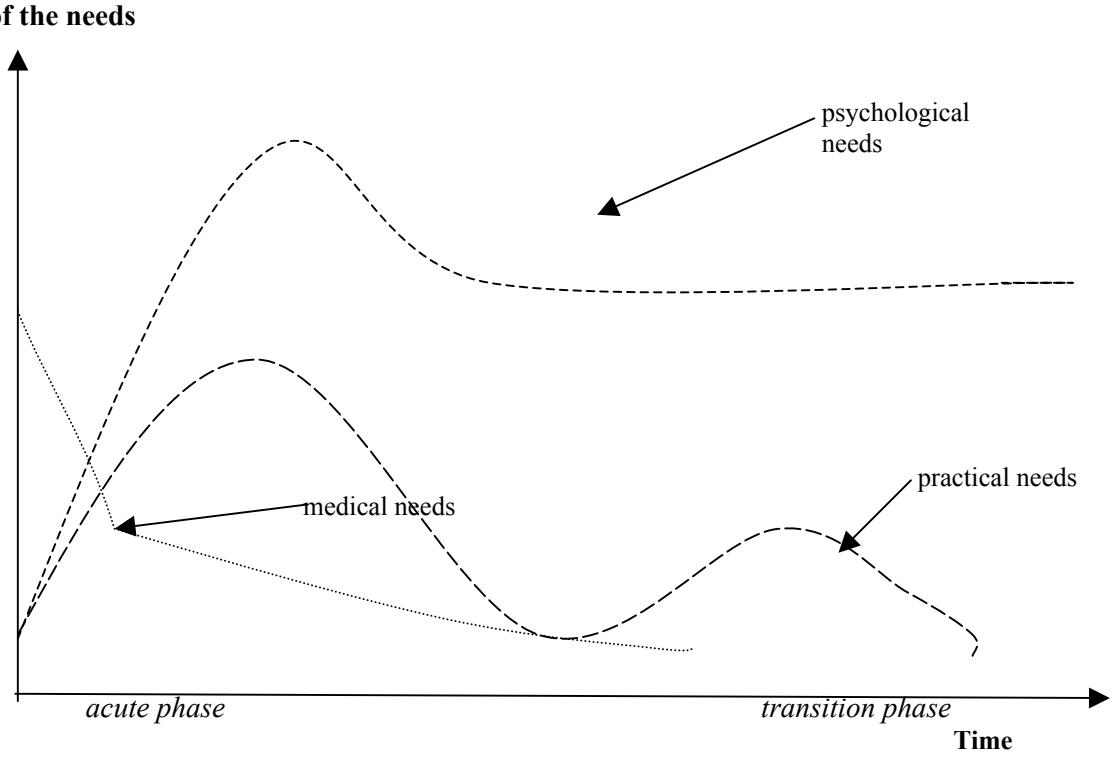


Medical needs: treatment for physical injuries and transportation to hospital.
Psychological needs: psychological support from crisis centre and from each other, assessment and follow-up treatment.
Practical needs: information about the accident and contact to relatives.

Case example 3: the accident at Kaprun, Austria, November 2000

In November 2000 a fire broke out in a small train bringing tourists to a popular place for skiing. Only a few people on board managed to escape and survived, and 155 persons in the train died. People affected comprised families and friends, the Train Company and their workers, and the inhabitants of Kaprun.

Graph 3: graphical representation of the evolution in time of the medical and extraordinary psycho-social needs of one individual family, who lost a son in the train accident in Kaprun, Austria, November 2000



Both the father (who collapsed at the beginning), and the mother (with slight allergic problems), had minor medical needs. There were some practical needs for the family as a whole, such as: transport from their home to Kaprun, care for children of siblings while travelling to Kaprun, collection of items to identify the body, housing in Kaprun, transport of the body, arrangements for the funeral, protection against mass media in Kaprun and in the family's home town. There was a high level of need for the whole family to express emotions and to be supported in their coping process. In 2001 two persons are having psychological treatment, while the practical needs of the family are related to legal problems concerning the insurance. After a relatively high level of need for minor medical care in the acute phase, came increasing psychological needs, which persisted in the long-term phase for at least two family members. Graph 3. is only a simple illustration and does not attempt to be precise or accurate in a scientific way.

Each of the following chapters considers different aspects of psycho-social support. Within each chapter there is an outline of the general principles of managing psycho-social support in mass emergencies, which are also presented in an Executive Summary of this Policy Paper. Examples, anecdotes, case stories and graphics will be used to illustrate the general principles (good and bad practice) and where possible these principles are linked to the evidence base within scientific literature. To assist in sharing a common understanding of concepts and terms, Annex 2. establishes some pragmatic operational definitions that are based on a large consensus in the scientific literature and in the field of emergency services, medicine and psycho-social work. In addition, a Glossary of other terms used in the document is in Annex 3.

Chapter 1
PRINCIPLES of GENERAL and of PSYCHO-SOCIAL MASS EMERGENCY MANAGEMENT

Psycho-Social Response Management for Situations of Mass Emergency

Although techniques and methods of individual support are useful in situations of ME, they should be supplemented with other appropriate measures, specifically a more global approach. This should lead to an integrated multidisciplinary and multi-component psycho-social intervention. Managing psycho-social intervention in a ME requires a different approach, compared to individual or small-scale accidents. The main reason for requiring a different approach is not only the relative inadequacy of resources due to the large number of persons involved, but also the increased complexity and characteristics of group dynamics.

The general principles of management of a ME emerge from consideration of the following issues. This reflects the current professional consensus regarding the effects of a ME.

- People are social beings and their behaviour, appraisal and emotions are not only influenced by their own situation. People are sensitive to harm done to others. This makes them vulnerable to the effect of loss and separation (e.g. of family members). Sharing common experiences and/or the sense of belonging to an affected community can also have a profound psychological impact. It can reinforce feelings of helplessness/ powerlessness, and a sense of identifying with others who are affected. The need for belonging to a group is often reflected in the holding of reunions, ceremonies, collective rituals and memorials.

- Individual perceptions, emotions and behaviour are strongly influenced by the social context (including a given cultural-historical context). A ME can affect people by the changes in their living environment (i.e. displacement and relocation) and challenge their own beliefs about the world.

- The urgency, stress and pressure of a ME can impact on the responders, their professional behaviour and decision-making, as well as emotional state and well being. This adds a further dynamic to the already complex characteristics of a ME.

- Logistics of practical assistance in situations of ME are of a different scale, and can be of a provisional and collective nature. Transport, accommodation, food and drink (for hundreds of people after a transport disaster; for thousands in case of an earthquake) may need to be provided on a much larger scale and may involve a large degree of complexity with regard to co-ordination and implementation.

- The handling of substantially more data and the lack of a general overview of the situation complicate the whole process of information handling (from an operational point of view as well as concerning the impact on those involved). The risk of uncertainty, misinformation or rumours increase, proportionate to the size of the affected group. The identity of affected persons may also take longer to establish.

- In a ME, it is often impossible to have time and opportunity for an individualised relationship ('colloque individuel') between responders and those involved. Attention to individual needs and interests must give way to global priorities and group interests. The prevailing culture of rescuers and emergency services is more event-oriented and collective than focussed on specific individual needs.

- Non-injured people are mobile and more independent of emergency agencies, which makes the response to their needs all the more complicated to manage if there are a large number of them. Some disappear from the scene very rapidly and do not seek assistance from responders. Other people may put their demands or questions to different agencies/helpers at the same time.

- The social, political and media impact of a mass emergency can be more complex and larger than that of minor incidents with the same number of people involved.

The general principles of management that emerge from professional consensus would include the following:

- The psycho-social response in situations of mass emergency should be pro-active, instead of waiting to react to a problem or demand that may arise.

- A more continuous appraisal of the global situation is needed for the long term, and this includes more than the follow-up of each individual affected.

- Continuous evaluation is required, not only of the methodology and approaches used for support of individuals, but especially regarding the ME specific approach, with the objective of integrating lessons learned in the event of new situations of ME.

- It is important to be clear about who is leading the organisation of psycho-social support, and equally important is that the psycho-social support is clearly linked to the medical emergency management function.

Linking the psycho-social response with general mass emergency management

As stated above, this specific approach for preparing the provision of psycho-social support must be integrated in the general management and overall response planning for situations of ME. A pragmatic, and probably the most efficient, way would be to link the psycho-social response with the medical emergency planning. Initiation of psycho-social activities could be coupled with the activation of medical emergency services, rather than establishing ad hoc and separate procedures.

In the immediate aftermath of a mass emergency, psycho-social support should be part of the activities of all emergency services (fire brigade, rescue and medical emergency services, police, logistic and technical teams) as well as being provided for the general population by separate teams of psycho-social workers. However, a psycho-social manager (PSM) or co-ordinating agency should do the operational management and co-ordination of psycho-social support in the acute phase. This is all the more necessary, given the fact that an adequate psycho-social response almost always requires co-operation across administrative borders (municipality/ county/ city/ country) as well as across different organisations and agencies.

When the emergency services have completed their involvement in relation to the immediate aftermath, the co-ordinating manager/agency should also ensure the follow-up for responding to the psycho-social needs in the transition and long-term phases, linking up with the usual (non-emergency) social services and health institutions.

Integrating the psycho-social response into the routine of medical emergency services (ambulance services, pre-hospital medical emergency teams, accident & emergency departments of hospitals) however, requires an adaptation of the thresholds for alert. This means that the criteria for activating a psycho-social emergency plan must be related to the total number and the vulnerability of people affected by an emergency, which is not necessarily the same as the number of injured people. This approach is compatible with the generally accepted multi-factorial approach to the concept of 'health' of persons/communities involved (e.g. bio-psycho-social), which cannot be reduced to the incidence of physical trauma or disease. A traffic accident for example, with a small number of physically injured people and a large number of physically uninjured people, does not require extraordinary measures from the health services, but should provoke an adequate ME psycho-social response. On the other hand, if from the point of view of emergency medical services, there is a situation of mass emergency (i.e. with large numbers of physically injured people), then the psycho-social ME plan should also be activated.

In addition to the above, there should not only be an integration of the psycho-social response for ME situations in local, regional and national plans, but in case of major accidents or disasters involving people from other countries, multinational follow-up and co-ordination should also be prepared. This is a particularly important consideration, given the fact that MEs not only occur close to or across national boundaries, but at any point in time there is likely to be a large number of people travelling outside of their own country, within the European Union.

Chapter 2
PREPARING the Psycho-Social response to mass emergencies

Although it is impossible to anticipate the specific problems of all potential MEs, developing core levels of preparedness for psycho-social intervention is necessary. Psycho-social intervention must be well prepared to ensure maximum **effectiveness** in achieving the objective, making sure that people involved in a ME get what they need, when they need it, and where possible preventing long-term harmful effects. Good preparation can also improve the **cost-efficiency** of psycho-social interventions.

There are four key areas that need to be considered in the context of preparing the psycho-social response to mass emergencies:

1) **Planning** – a key element is the development of a pre-established, general plan that is the basis of the psycho-social response for all type a major accidents and disasters, irrespective of their nature.
2) **Training** – it is crucial that staff who are directly involved in delivering services (psycho-social support, but also emergency services responders) are aware of psychological, social and organisational aspects in the context of responding to a ME. Specific training is important, but will need to take account of existing skills, and will depend on the nature of the roles, responsibilities and tasks expected.
3) **Evaluation** - continuous evaluation of the preparation, of the activities during all stages and of the final results doesn't only serve scientific purposes, but should also be part of preparing the response of the next ME.
4) **Information management** – consideration of systems and approaches for management of information during and following a mass emergency should be incorporated in the preparation and planning stage. There are a large number of issues that need to be considered in relation to information management. For this reason, information management is discussed in detail in chapter 4.

There are also other factors that need to be taken into account, although they do not belong to the preparation of psycho-social interventions as such.
It appears to be increasingly necessary to increase general public awareness on psycho-social aspects of ME, in order to enhance insight and realistic expectations, as well as part of the general approach of empowering people.
Raising awareness of psycho-social aspects of MEs for emergency responders (i.e. firefighters, police and medical staff) is equally important. Joint planning and exercises is one factor. Specific training to these professional groups can sensitise them regarding general attitudes and can assist these staff to develop their skills in responding to psycho-social impact for people injured in MEs, but also towards non-injured survivors and their families. Joint planning also assists in developing a shared understanding of the role and tasks of both emergency services staff and those involved in providing psycho-social support.

Emerging from the experience of previous MEs and from a general professional consensus, there are some agreed general principles that apply to the preparation of the psycho-social response to mass emergencies:

- Flexible arrangements prepared beforehand, and supported by appropriate training for staff, are helpful during the process of **decision-making** especially given the constraints and pressure on resources. In the immediate aftermath of a ME, there is the urgency, uncertainty, confusion, and threat of the situation. Added to this is the pressure of the needs, demands and behaviour of the people affected. The well-meaning, but sometimes euphoric desire to help must also be managed along with the challenge of massive media coverage and the possible confrontation with the particular interests of individuals, politicians and organisations. Simple, standard formats for assessing psycho-social needs and for mobilising resources can assist greatly in providing an adequate organisational response, avoiding duplications in output.

- Mutual understanding on the scene, and **operational co-operation** between psycho-social partners and between different agencies can be improved by pre-established mechanisms of collaboration, building on the routine of every day work, following a common approach and regularly sharing training exercises.

  Mobilising already existing resources and services which deal with small-scale emergencies on a daily basis, is also more cost-effective than the creation of a separate group of staff and resources specifically for ME situations. In the event of a ME, capacity to respond can be easily increased if there has been prior networking between psycho-social staff from different agencies (i.e. social services, hospitals, schools, or specific agencies), and if specific training has taken place.

- In order to ensure follow up and **continuity**, preparation should not be limited to the emergency response phase of evacuation, rescue, triage and initial medical treatment (the acute phase), but also consider the medium and longer-term psycho-social needs of those involved (transition and long-term phase). Prior knowledge, contacts and networking are also necessary for ensuring **appropriate and effective systems for onward referral** and to be able to effectively **advise** services concerning administrative, judicial, therapeutic or other specific needs.

- All of the above implies being able to make a realistic estimate of available/necessary resources that will be required and access to adequate financial support. These estimates of requirements for **resources** (and the **funding** to meet those requirements) may vary between the different European countries and regions. However, in each country and region, decisions will need to be taken about priorities. If these are explicitly made during the preparatory phase, then evaluation of these priorities becomes possible.

The following sections in this chapter outline in more detail, specific issues and general principles that apply to planning, training and evaluation.

PLANNING FOR PSYCHO-SOCIAL SUPPORT IN ME SITUATIONS

The principal emphasis of planning must be on developing a core psycho-social response for a range of MEs. Important aspects of the planning process include:

1. Determining the **scope and extent** of emergencies for which psycho-social support will be offered.

- The **alarm threshold** used for activation of the psycho-social emergency plan is based on criteria for scale and severity of the consequences of an emergency (e.g. number of people involved), depending on the nature of ME. Criteria of psycho-social vulnerability must also be taken into account.
- There may also be **criteria** for **excluding scenarios** or specific situations where psycho-social intervention cannot be organised (because of financial limitations, for ethical or political reasons e.g. armed conflicts).

2. Criteria for identification of **people affected** for the different ME scenarios should be as explicit as possible.

- Based on the nature of their needs, there can be a **categorisation** of people involved and of sections of communities that may be affected (survivors; friends and relatives of deceased, injured, non-injured; witnesses and responders).
- It is also important to identify psychological and social **vulnerabilities** (e.g. specific risk factors – these are outlined further in the chapters relating to the acute, transition and long-term phases), or specific needs of people involved (e.g. children, elderly, disabled, tourists, immigrant workers, temporary residents, and people without legal papers).

3. The selection of the **organisations and local agencies** (health, social, educational), both statutory and voluntary, that are judged to be appropriate to involve in a **network** of psycho-social support for ME, should be based on:

- resources they can offer in relation to the provision of short- and long-term support (supporting, counselling, specialist medical or psychotherapeutic skills; technical, material and logistic resources: leaflets, photocopier, fax machines, telephone lines…)
- the workload they can handle and their availability (weekend and outside office hours)
- situations where they are not able or willing to respond
- aspects of co-operation regarding to ethics, attitudes, approach, experience…

4. Planning the **co-ordination** of the different psycho-social partners.

A) Assignment of a **psycho-social co-ordinator / manager - PSM** (or concluding a "Memoranda of Understanding" with a leading agency/consortium/multi-agency co-ordinating group), who is responsible for managing:

- the preparatory work: establishing training standards, a response network of psycho-social workers and a referral system for psycho-social follow-up or treatment
- the alerting cascade and the initiation of actions (first assessment of the needs, initiating implementation of the psycho-social emergency plan, activation of the response network and of the psycho-social co-ordinating team)
- on-site operational management of people and organisations (external experienced consultants can be used to take the lead in the acute phase), which includes:
  - objective and independent on-the-scene assessment of the psycho-social needs (avoiding inaccuracy, confusion or manipulation to serve personal, media, economic or political interests)

- direction and co-ordination of the immediate psycho-social activities and the effective use of and mobilisation of necessary resources:
  i. teams providing specific psychological and social support
  ii. infrastructure and logistics (transport; radio, telephone, fax, Internet communication; generators; uniforms and distinctive signs; leaflets and educational material; etc.)
  iii. establishing a single focal point for data co-ordination, information handling, documenting the psycho-social actions (keeping a logbook, preserving and archiving documents…) and public relations
  iv. co-ordinating the exchange of information and contact with affected populations (establishing a RISC centre for receiving families e.g.).
- functioning as central agent, spokesperson, advocate and interface regarding the psycho-social needs of people affected and in relation with other agencies and authorities, e.g. providing food, accommodation or telephone lines.

- continuity of psycho-social follow-up in the transition and long-term phase
  - establishing an inventory, formal guidelines and knowledge base regarding social, medical and psychological services (including adequate psychotherapy), legal advice, central and local authorities, insurance matters, …
  - responsibility for developing the response in the transition and long-term phases

B) Planning the **mandates** and **task assignments**, in the event of a mass emergency, for the different agencies/organisations that are part of the **psycho-social response network**:

- conclude clear, formal agreements (Memoranda of Understanding) on the provision of combined and co-ordinated efforts and use of resources in the event of a ME
- establish written guidelines,
  - indicating operational hierarchy (chain of command), describing the extent and limits of responsibilities, authority and accountability of each partner
  - offering standardised operational procedures (protocols), and describing the model of psycho-social intervention (methodology, values, principles and objectives)
- assure a convergence of interests in order to avoid rivalry, tension and conflicts between organisations and/or administrative levels (i.e. personal interests, desire for publicity)
- involve different partners in the preparatory planning, training programs, evaluation processes, feed-back and lessons learned through other experiences

5. Elaboration of a **model** (strategy/methods/approach) for **psycho-social support** that will be effective in both the short and long term

6. **Integration** of the planning of psycho-social support into **general emergency/ contingency plans** and with the operational procedures of **medical emergency services**

- link the alerting cascade and the initiation of actions with the medical emergency dispatching centres
- establish common rules and guidelines for communication and co-ordination with the different management levels of ambulance services, pre-hospital medical teams, hospitals, and with other functional disciplines and authorities (police, fire, rescue, judicial, logistic and technical services, local and central government, industry etc)
- assure legitimisation, credibility and acceptability of their activities (vis-à-vis the other agencies, the authorities, the people and the community involved in a ME)

7. Develop **psycho-social resource and reference centres** with the capacity of research and study, collection, publicising and diffusion of information and experiences on psycho-social support issues.

8. **Continuous evaluation**,
- check the psycho-social emergency plan on a regular basis, verifying if the resources in the network are available, if the will to act is present, etc.
- test the practical implementation of plans by organising exercises. Exercises (discussion based; table top/floor; control post; real time field simulation) should be regarded as an integral part of the emergency planning process, not an isolated option. They should be methodologically designed, carried out and evaluated, so as to be useful for reviewing and amending the plan
- comments and feedback from all those involved in psycho-social support should be integrated into the psycho-social plan
- validated, standardised tools and methods should be developed and implemented in all phases of psycho-social support:
  - measuring, auditing and reviewing performance
  - monitoring the effectiveness of specific measures
  - global evaluation of the intervention in the different stages (comparability of data sets)
- review and update the planning and the model for psycho-social support in ME according to the evolution of scientific knowledge and experience

9. Estimation of the **cost and financial expenses**, explicitly stating who is responsible for the allocation of finance/resources over the appropriate timescale:
- what funds exist/are needed for planning, establishing a network, providing a co-ordination agency, training, evaluation, resource and reference centres
- what is the contribution of the various agencies/organisations of the network and of the different administrative levels (local, regional, national)
- evaluate the cost-efficiency of psycho-social support and the estimated cost per intervention/team/task in the event of a mass emergency

TRAINING FOR PSYCHO-SOCIAL SUPPORT IN ME SITUATIONS

It is of the utmost importance that staff from the different emergency services and the other agencies who respond to a ME are trained, made aware of, and sensitised to the psycho-social aspects. This not only relates to the psychological impact that an event like this might have on themselves (e.g. vicarious traumatisation), but also in terms of developing an appropriate attitude and response with people involved in a ME.

General principles, **objectives** and **guidelines** concerning the training of psycho-social workers for mass emergencies:
- The selection of staff who attend training is important. After training, there is a need for **selection to be an ongoing process**, because some staff on completion of basic training may not fulfil the necessary requirements for being able to be a psycho-social responder. Criteria should be developed to form a **profile** on the basis of the task and individual characteristics required.

- For basic and ongoing training in psycho-social support, as well as for quality control of such training, **standards** should be developed emphasising the scientific base (where it exists), and good practice. Training of a professional quality standard, recognised and evaluated by peers, should be established.

- Training should not only be based on theoretical presentations and prescriptions, but should also include theory/practice links and be based on learning **from experience** and further **developing the resources** of the participants. Training should be a development of skills gained in previous experience of responding to small-scale accidents and critical incidents. Skills and ability to effectively respond can be increased by real-time exercises.

- Training should improve **personal skills**, **attitudes**, **experience** and also **group capability** for providing **psycho-social support**. Training needs to be **adapted** according to the specific roles and tasks that staff will be expected to fulfil, and this should add to and complement training of the **general** model for psycho-social support in situations of mass emergency. For example, some training may focus on developing an awareness of the different roles for staff in the context of the acute phase. More specific training might focus on screening and counselling skills in the transition and long-term phase

- Taking into account the multidisciplinary nature of the teams, a **basic knowledge** and **common language** should be developed on **psycho-traumatology.** All psycho-social workers should be able to detect post-traumatic symptoms (i.e. depression, increased somatic complaints, sleep disturbances, PTSD). They should be capable of assessing these symptoms in order to refer to specialists when required. Training should however, **not** have the objectives of providing **therapy or treatment**.

- **Methods**, **procedures** and **protocols** for the psycho-social response should be explained, discussed and included in training. Examples of this include: communicating in a non-traumatising way with those affected, providing adequate information in a sensitive manner, methods of handling the mass media, and how to support families in the process of body identification. Discussion of **values** and of general **principles** is essential for the development of appropriate attitudes towards people affected by MEs. Training should therefore convey an image of human potential that takes account of the autonomy, survival skills and creativity of "victims" as its starting point. Attention to democratic rights and personal liberties, and developing sensitivity towards cultural diversity, age and gender aspects is also very important. Concepts such as empowerment, salutogenesis, hardiness and coping can also contribute to the avoidance of pathologising and victimisation of the people affected.

- Training with peers, and the use of methods of active learning can help workers to recognise their own personal limits (self-awareness) and the limits of interventions in crisis situations, so as to reduce the risk of compassion fatigue and vicarious traumatisation.

- All aspects of training need to be considered as part of the planning process, but should also be re-evaluated at each stage in the phases following a ME. Financial aspects and plans for continuous evaluation of the effectiveness and outcome of training also need to be considered.

EVALUATING PSYCHO-SOCIAL SUPPORT IN ME SITUATIONS

Evaluation is an important part of the overall response to a ME. Without evaluation there is no way of knowing whether the response is effective, whether it made any difference to those who received that service, but perhaps more importantly whether changes need to be made to improve the response to ME situations in the future.

Evaluation has three core purposes – "proving, improving and learning". The aim here is to consider some of the key challenges and general principles of evaluation, from the perspective of those who are likely to be involved in planning, commissioning and/or co-ordinating the psycho-social support for people affected by a ME.

General principles for the evaluation of psycho-social support ME situations

- Ideally, the preparatory phase and **all stages** of intervention should be evaluated.
- The key elements of **planning** an evaluation should include:
  - clearly identifying the **specific objectives** of the activity (aims of this intervention)
  - consideration of the process of evaluation **at the outset**, when the response is being planned, and not as an "afterthought"
  - the use of existing, or the development of new **assessment measures** in conjunction with specified objectives, and appropriate to the context and objectives (the "impact of events scale" is an example of a widely used standardised measure for PTSD)
  - consideration about **who** will **design and carry out** the evaluation - ideally evaluation should be carried out by people who are not directly involved in the activity that is being evaluated (an external agency can evaluate the response in the acute phase e.g., although the responsibility for commissioning the work could remain with the "lead agency")
  - **involvement/consultation** with the organisations which **deliver** services and with those who will **use the services** (evaluating the psycho-social response in the acute phase e.g. should involve survivors, families, staff etc.)
  - **ethical issues,** especially important issues (informed consent, privacy and data protection)
- Depending on the nature of the questions being asked, the approach could be **prospective**, **retrospectiv**e, **cross-sectional** or **longitudinal**. **Qualitative** and/or **quantitative** criteria can be used, as well as **objective** factors and/or **subjective** elements. The perception or subjective opinion concerning the psycho-social response of those involved does not always correlate with the outcome measured in terms of their actual behaviour (i.e. facts like the number of affected people who lost their job, divorced, accessed psychotherapy, etc.).
- The **objective** of evaluation could be to assess:
  - specific interventions and/or wider organisational/ community approaches
  - service users perspective and/or organisational perspective
  - impact over time (before, during acute phase, later stages).
- Evaluation can consider all or some of the following:
  - **relevance**: the extent to which the objectives address the identified problem
  - **effectiveness**: the extent to which a set of objectives are achieved
  - **efficiency**: measures the relation between input and output, and analyses the results in comparison with the invested means. Efficiency can be translated into costs in terms of material, financial, human resources or time.
  - **output**: the general or specific direct result of the intervention/ approach
  - **outcome**: the direct consequence of the result (short- and long-term effects)
  - **impact**: indirect consequences
  - **acceptability**: considers the utility of the approach/ intervention and the process

A case example illustrating some of the general principles is included in Annex 4., and for more detailed understanding of the evaluation process, further information is included in the CD-ROM that accompanies this paper.

Chapter 3

General principles concerning INFORMATION MANAGEMENT and Psycho-Social Intervention in situations of mass emergency

The same **standards** that dictate the general management of situations of mass emergency should also govern the approach of the crucial aspect of information management, whereby the needs of survivors and the general public interest are the prime criteria. Collection, registration, processing, assessment, verification, storage and communication of data must observe rules of professional and medical confidentiality, and respect for privacy, democratic rights and liberties should govern the whole process of information handling. Here, the principle of informed consent can be a general guidance. There is on the other hand, a legitimate demand for information in order to allow an adequate management of the incident response and to take measures for public safety. In addition, MEs also provoke a great deal of interest from the public and mass media, and the concept of "freedom of the press" also plays an important role in upholding public interest and democracy.

There is no doubt that potential **conflicts** can arise in the management of information, given the complexity of interests of all the people and organisations involved in mass emergencies. There can exist contradictions, competition and incompatibilities regarding the agenda, needs, objectives, priorities, and power among the affected community, survivors, relatives, emergency response agencies, operational management, enterprises and commercial parties involved, administrative, political or legal authorities, and the press. Problems concerning information management reflect these differences, but also interact with the technical and organisational complexities in relation to communication during and after mass emergencies.

Institutional emergency management tends to emphasise problems of handling information, with authorities and agencies having to co-operate closely with parties that are influential or well organised, such as the mass media. Between authorities and the media there can indeed exist various types of conflicts concerning information management, and these are highlighted in Annex 5. The determining criteria in considering information management should be on issues concerning the needs of the people involved in a ME and the interest of the general public. Self-critical operational debriefings and systematic evaluation (including contributions from people affected, external audits, public inquiries and a democratic press) can contribute to maintaining this focus.

From the point of view of psycho-social needs, we can distinguish **different types of information management** (more specific details are given in Appendix 6.):

- as to the **object** of the information, for example, the identity and fate of injured/ non-injured survivors, and of missing persons
- as to the **destination** for example, of the individual involved him/herself.
- as to the **characteristics** for example, the accuracy, impartiality, acceptability, credibility, timing, amount of detail, completeness, relevancy…
- as to the **means**, circumstances and technology of information handling for example, direct personal contact, physically present or by telephone

Needs and rights of the people affected with regard to information management

Experience has shown that information is a vital need for people affected by a ME. Knowing what happened to a loved one, is a pressing, immediate and almost vital need that must be attended to in an appropriate way. Communication of information about the actual situation and perspectives, especially of injured victims, also remains a priority in the later stages. Providing affected people with accurate, factual information on the incident itself is essential in assisting them with coming to terms with what has happened. Some people start this process of asking questions at the site of the accident, others need to know somewhat later (i.e. in hospital, in RISC-centres or at home). It is important that people have access to this information, including updates on victim recovery and identification, and the disposition of personal effects. Ideally this should happen before it is released to the media. Protection of personal privacy needs to be considered and should be part of a code of professional ethics for psycho-social workers that is complementary to existing legal regulations.

Values and principles governing the psycho-social response and the use of information

- Given the survivors' unalienable right of confidentiality and privacy, there should be a strict separation of the handling of information in the context of psycho-social assistance, from that of judicial, and legal responsibilities. Medical and professional confidentiality must guarantee survivors, whatever legal status they hold, protection against all possible uses of information for purpose of administrative sanctions or police repression (even within the scope of authorised law enforcement activity). A person involved in a ME has the unalienable right, for private reasons and without having to put forward arguments, to demand for his/her name not be registered, or to state that his/her involvement in the incident should not be made public.

- Affected people must be protected from intrusion or interference with their private life (i.e. from unwanted assistance, abuse of authority, undesired inquiries). People should have the opportunity, at any time, to express the desire not to be contacted by the press, by family members or even by (well-meaning) psycho-social workers, without having to demonstrate a need or even a reason for such a request.

- Collection and processing of data at the scene of a ME, during triage and medical processes in hospitals and in RISC centres must be governed by strict procedures, standardised protocols, clearly established hierarchies and responsibilities. A number of principles on information practice, establishing conditions for handling/disclosure of personally identifiable information should be included in the psycho-social plan.

- All (para)medical and psycho-social staff responding to MEs should be sensitised to the specific needs of people involved and staff should be evaluated and monitored to ensure that they are acting according to professional ethics and confidentiality.

- Any communication of data, **within the medical and psycho-social structures** must follow formal, pre-established rules, indicating clear responsibilities. Obtaining, registering, and communicating information should be restricted to what is relevant and proven to be useful for an adequate medical and psycho-social response. Agencies should specify their authority and purpose for collecting personally identifiable

information from an individual. They should not maintain records describing how any individual exercises constitutional rights and liberties. Every effort should be made to avoid methods, attitudes, or questions that are unnecessary, or intrusive.

- People affected by a ME should also be provided with a clear explanation about the use and reason for collection of information. The PSM is responsible for informing individuals that a record is maintained on him or her, and there should be provision made for access and a procedure for information to be amended.

- Contacting **relatives and loved ones**, and informing them on the fate and medical situation of a person involved in a ME, can only be done after informed consent. Agencies should obtain verifiable parental consent prior to collecting, using, and disseminating personal information about children under a specified age (minors). Medical good practice should govern the access of parents to their children's personal information and its further use. Gathering evidence and information from the family should be done in a sensitive manner.

- Information from medical records of patients, personal data registered in RISC centres or other private information, should only be communicated to **non-medical** or **non-psycho-social agencies** and **authorities**, if it is expressly authorised (after informed consent) by the individual about whom the record is maintained (or eventually of his/her legal representative).

  Making public the **trauma profile** of a mass emergency is considered to be a matter of general interest. So it can be accepted that the number of deceased, U1-, U2-, U3-patients, and non-injured are given to the authorities or to the press, on the condition that it is **anonymous**.

  Lists with the **names** of dead, injured, missing and other affected people, containing a general notice on the gravity of their health situations (e.g. life in danger or not) should be handled with utmost care. Only persons or agencies authorised within the psycho-social plan should collect, review, or create any aggregate list. This information should be used strictly for purposes of disaster victim identification or when required for adequate medical and psycho-social care (triage, appropriate care and services).

  There is no valid argument for giving nominal lists of deceased, injured, non-injured or missing persons to authorities who have no operational task that serves the direct interest of those involved in a major incident. Personally identifiable information, handled in the context of mass emergencies should never be shared with third parties, commercial entities or for profit organisations.

- The way of communicating information to people involved in mass emergency should take into account the psycho-social impact. This is one of the reasons why the whole process of managing information concerning the identity and status of victims, as well as organising the notification and communication should be an integral part of the specific functional discipline that is psycho-social support.

CHAPTER 4

Managing Psycho-Social Support during the ACUTE PHASE of mass emergency situations

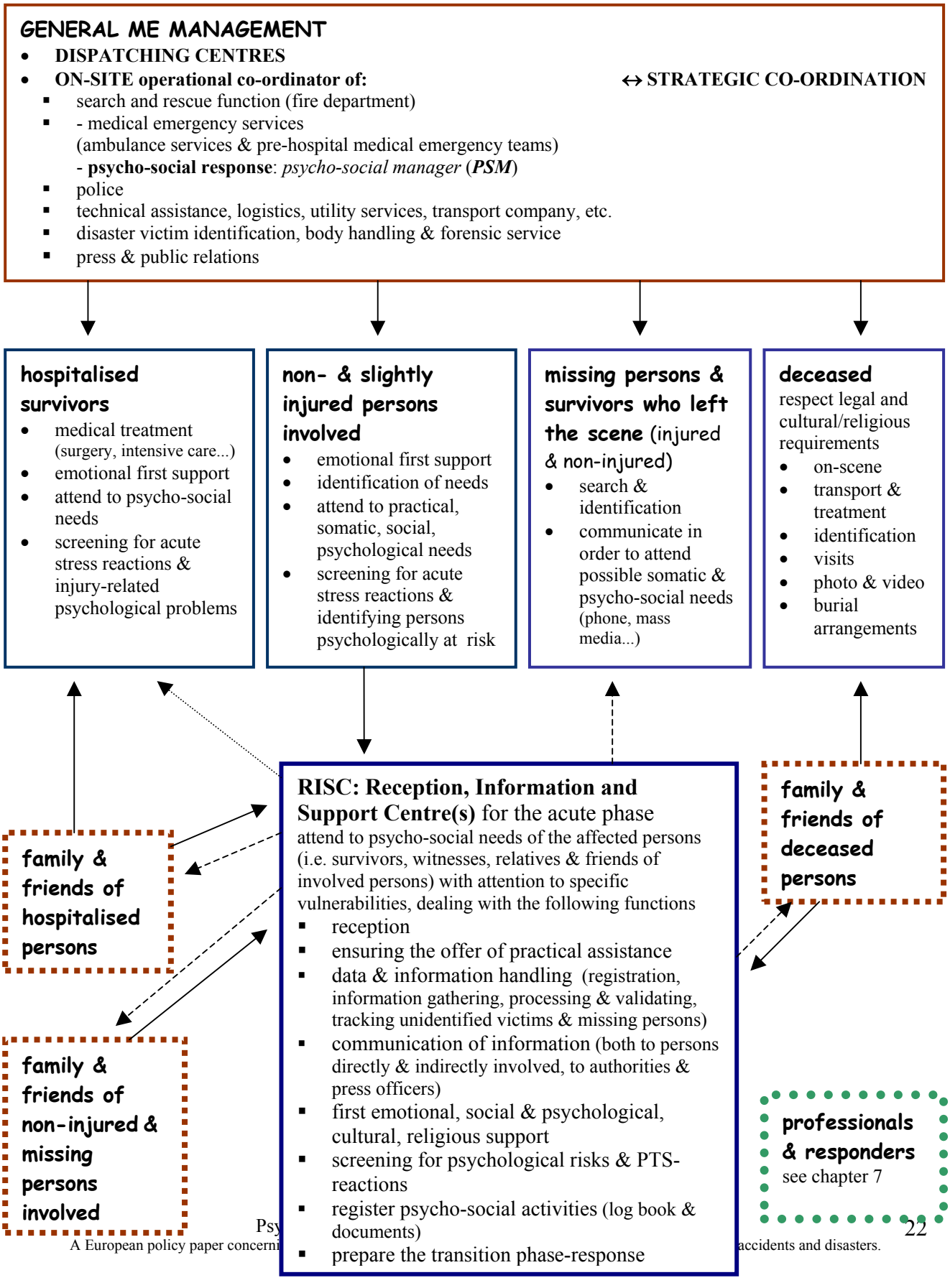
Depending on the nature and extent of a mass emergency, the taking and the regulation of emergency calls at the **emergency dispatch centre** are followed by a process of mobilising the usual emergency services (fire department; ambulance services, pre-hospital medical teams, accident and emergency departments of hospitals; police). The process of scaling up resources can include mobilising extraordinary resources, such as teams of psycho-social workers and special units for technical assistance and logistics (civil protection, local authorities etc.). At a certain point there is the need for a formal **co-ordination at the site** of the incident of the operations of all services and functional disciplines involved. Some major accidents, and certainly disasters also require another type of co-ordination (at a higher tactical or strategic level, including administrative and/or political authorities), mostly in some kind of crisis centre at a distance from the scene. Procedures, hierarchy and a mechanism for this interdisciplinary co-ordination are in most European countries pre-established in the form of **general emergency** or contingency **plans**. Tasks and responsibilities assigned to the different agencies and services, and the way of co-ordinating, tend to vary within Europe, according to country and regions. The same goes for the involvement for NGOs, charitable and voluntary organisations (e.g. Red Cross).

The psycho-social response (co-ordinated by the PSM, or lead agency) should be integrated into the medical emergency response. The PSM should co-ordinate with other functional disciplines, and act as an interface with other agencies and the authorities. A PSM not only leads the activities of the specific teams of psycho-social workers, but should function as an advocate and interpreter, analysing the psycho-social needs of the people affected, and advising those in charge of the general operational management regarding the interface between psycho-social needs and specific technical and logistical responses (i.e. practical requirements such as food, accommodation, fax- en telephone lines, need to be considered within the context of the psycho-social impact of the ME).

Although the PSM may have the final responsibility of providing information to friends and relatives, the gathering of information on injured survivors for example, requires the collaboration of the medical chain of triage, first treatment, transport and hospitalisation. Burial Services, death certificates, disaster victim identification (DVI) and investigations are co-ordinated by specialised agencies and authorised bodies, such as forensic services or the coroner's office, and again the role of the PSM will consist in advising on the psycho-social aspects. The psycho-social response to immigrants or travellers from other countries, involved in a ME, will require liaison and advice to foreign affair departments, embassies, religious, cultural and/or community organisations.

The flow chart in Figure 1 illustrates the way in which the psycho-social response should integrate with the general operational management of the response to a ME.

Figure 1: General Mass Emergency Management in the ACUTE PHASE



Psycho-Social response in the ACUTE PHASE

The Reception, Information and Support Centre: RISC

Establishing a Reception, Information and Support Centre (RISC) function gives an organisational framework to the psycho-social response in the acute phase that facilitates the co-ordination of an effective response. The RISC concept however, does not prescribe the different psycho-social activities to be concentrated in one central place. The single focal point for data collection, information handling and call centre can be organised separately from the family reception centre or the place where people directly involved are accommodated, and also it may be at a different location from the press centre. In addition, when there is a long distance between the scene of the accident and the nearest facilities (hotels, railway stations, and airport) or between the different hospitals where injured have been taken, it can be necessary to establish satellite RISC centres. A detailed summary of the specific functions of RISC is given in Annex 6.

In the immediate aftermath of a ME the RISC provides a structure for co-ordination of the response to a wide spectrum of practical, medical, social, emotional and psychological needs of all those involved. It is the role of the Psycho-Social Manager (PSM or leading agency) to decide, whether there is a need for special task co-ordinators for the various functions. This decision will depend on the nature and extent of the ME.

The main focus of the work of the RISC is during the acute (immediate) phase. The staff working in the RISC will be drawn from agencies that are part of a pre-established psycho-social network. There is no specific time-limited border between the acute and transition phase, it will depend upon the characteristics of the ME, including the number of affected persons. The decision may be taken to close the RISC when the immediate needs of the affected population are dealt with, or it may be appropriate to transfer some of the functions (and some of the staff) to another structure appropriate to the needs and response required during the transition phase. For example the Psycho-Social Follow-up Co-ordination, PSFC, described in more detail in the next chapter, is a structure that enables co-ordination in response to the psycho-social needs emerging during the transition and long-term phases.

Responding to and considering the needs of different subgroups

Abstract categories can be helpful in analysing the psycho-social needs, although it is recognised that people affected by a ME can belong to different categories at the same time (a person can be both hospitalised and a relative of somebody deceased). It is also recognised that using a classification system that relates to the degree of physical injury is not the only method that could be used, and that other variables need to be considered when analysing the needs of the whole population that may have been affected. For example, there is a need to consider specific demographic factors that may lead to increased vulnerability (i.e. children, people from different ethnic backgrounds), or indeed psychological variables or factors specific to the ME that may lead to increased vulnerability (i.e. proximity to the event, intensity and duration of involvement in the event, lack of social support). These variables are considered further in the chapters that review the transition and long-term phases.

In the acute phase there are some core needs and responses that need to be considered for all people affected. The following section outlines those needs and issues in relation to the psycho-social response.

Core issues and responses

In the immediate aftermath of a ME, people involved can have a wide spectrum of practical, medical, social, emotional and psychological needs. Some of the core issues that need to be considered in the response are as follows:

- There is a consensus that the emphasis of psycho-social support in this phase should be on offering safe and comfortable surroundings; adequately answering questions about the whereabouts of loved ones, or about the ME itself; attending to practical and social needs such as reuniting family and friends.

- Relatives, partners and close friends can form a large group with a wide range of needs including: practical arrangements (food, place to sleep, transport etc.), information, emotional and psychological support. If carefully planned and co-ordinated, many of the relatives' and friends' needs could be dealt with by the RISC function.

- Screening for the purpose of identifying people who may be at risk of developing psychological disturbances is important, and a process for screening should start within the first week. All people affected by the ME should be included in the screening process. Screening instruments/measures should be well validated, brief and as non-intrusive as possible. It is recommended that instruments and measures be selected on the basis that they can be used to evaluate the reaction as a process over time. The general professional consensus is that the following measures fulfil the above criteria, although this is not an exhaustive list and other measures may be useful for specific groups (i.e. children); The General Health Questionnaire, The Impact of Events Scale, The Post-traumatic Symptom Scale – PTSS-10. In addition, measures for specific subgroups can be found in "Assessing Psychological Trauma and PTSD"

- The psycho-social manager is responsible for ensuring the co-ordination of the psycho-social response throughout the acute phase but also in preparation for the transition phase. This is particularly important in relation to the organisation of follow-up for those people who develop psychological and/or social difficulties, and who may need specific referral on to specialist services. It is important that people are made aware of the PSFC arrangements and know-how, and when they can access this service.

These core issues are likely to apply to the needs of non-hospitalised, slightly or non-injured people, and family and friends of non-hospitalised survivors or missing people. For other groups, in addition to core issues there may be specific issues that need consideration.

Hospitalised persons

Emergency rescue workers and medical personal prioritise survivors according to their immediate medical needs and available resources, and some physical traumas such as serious burns, haemorrhages, fractures, etc. require urgent treatment in hospital. But ME-induced

stress can also trigger acute myocardial infarction or even obstetrical problems that require hospitalisation.
In addition to physical injuries, some of these people may need emotional first aid as well as assistance with specific practical or social needs, and hospitals may not be able to provide this. Finding and informing their relatives and friends, assisting in practical arrangements for visits (e.g. transport facilities) should be done in co-ordination with the RISC. Dependent on the numbers of injured people, it may be helpful to establish a local satellite linked to the central RISC or to install different RISCs. If survivors are severely injured, it may be better to postpone psychological screening until the transition phase. Consideration also needs to be given as to how the follow-up care is organised so as to ensure that seriously injured people are given the same access (during the transition phase) as those who were uninjured or had minor injuries.

Missing persons and survivors who leave the ME-scene

In most mass emergencies, experience has shown that people do not passively wait to be triaged or to follow pre-established mechanisms of response organisations. They act spontaneously and/or get help from bystanders. A certain proportion of non-injured or even injured survivors will leave the scene of the incident without coming into contact with any of the rescue service or other organisations. Some of them, needing urgent medical care, may present to a hospital hours or days after the event. While it is difficult to ensure that all those involved in major accident or disaster are included in an organised response, the following measures could be taken in order to reach most of those who disappear:

- appeal via mass media to contact the RISC using a toll free telephone number
- pro-active contact by staff in the RISC to try to contact persons involved in the ME who left without passing through the formal response channels
- registration & identification of people affected, assessment and comparison of lists of people (supposed to be) involved, search activities for missing persons and for witnesses

Deceased

Each country has legislation for handling bodies, on-scene, during transport or within the morgue and/or treatment facilities. Body handling, but also identification (DVI), video & photo opportunities, mourning and burial arrangements should take into account ethical values, as well as the cultural and/or religious diversity (for example, Islam and Jewish religious rules prescribe time limits for burial).

Family and friends of hospitalised survivors/Family and friends of deceased

Relatives and friends may need practical assistance, facilities for communication, transport, travel and accommodation in order to be able to contact and visit hospitalised persons. Information as well as practical, emotional and other psycho-social support services should be provided within the hospital, by the hospital staff or by a hospital based satellite RISC. Relatives, partners and close friends of persons deceased, during or in the aftermath of a mass emergency, may need a different approach concerning information and support. Experience suggests that staff should attend to their needs during the acute phase, separately from survivors and their relatives. The bereaved should have the opportunity to see the bodies of

their deceased relatives together with support personal or other family members. Viewing the body can be very important in the process of mourning the deceased.
The following table gives a summary of the needs, responses and general principles underlying the acute phase. It is not an exhaustive list but it highlights the main issues.

Table 1: ACUTE PHASE Psycho-Social response

Psycho-Social NEEDS of people involved	RESPONSE to needs of affected people	ORGANISATION of the response	VALUES & PRINCIPLES of approach
▪ safety (away from danger & devastation), minimal comfort (dry, clean & warm), tranquillity and privacy	▪ evacuation/relocation at a certain distance from the scene, protection from intrusions & unwanted attention	▪ reception centre (RISC) & accommodation	⇒ concentrating on the needs & rights of people affected as individuals and as a group
▪ to know for sure that loved ones are well, safe or taken care for	▪ adequate information	▪ information focal point (RISC)	♦ sensitive attitude & empathy of all responders
▪ consideration & human interpersonal contact	▪ empathy & emotional first aid	▪ RISC	♦ integrate multi-component Psycho-Social approach
▪ to hear, see, notify family, friends, workplace; visit hospitalised survivors	▪ facilitate reconnecting with social network	▪ telephone & fax lines; call centre (RISC); transport	- pro-active - multidisciplinary - collective
▪ thirst, hunger, personal hygiene, substitute for dirty or destroyed personal effects, minor medical needs...	▪ practical assistance (drink, food, toilets, washing facilities, new clothes, glasses, medical exam, medication, …)	▪ reception centre (RISC) , logistic support & event. medical consultation	- offer (comfort, support, understanding, advice) & facilitate access to services (liaison & referral)
▪ expressing fear, anger, blame, guilt…	▪ supportive environment & emotional support	▪ RISC	- continuity
▪ reassurance about one's own emotions	▪ inform about common reactions to ME (e.g. leaflets)	▪ RISC	★ respect privacy & confidentiality
▪ to know what has happened and why, what is going to happen, …	▪ adequate information	▪ information focal point (RISC)	★ Psycho-Social Support – not treatment
▪ control and empowerment	▪ social and psychological support	▪ RISC	
▪ recognition	▪ information & social support	▪ RISC & ceremonies	★ avoid victimisation & pathologising
▪ unresolved or unidentified needs	▪ evaluate needs & screen for risk factors; follow-up in transition phase	▪ prepare Psycho-Social Follow-up Co-ordination (PSFC)	
Religious/cultural needs			
• specific food, spiritual needs, religious beliefs and practices, performance of rituals	• religious/culture-sensitive response; contact spiritual leaders if desired	• RISC & specific organisations, religious/community leaders	• respect socio-cultural diversity
Specific vulnerabilities			
• children • people of old age • people with disabilities • foreign language	• child support • elderly support • disability support • translation, international	• RISC with specific logistic & skills • specific services,	• consider specific vulnerabilities

speakers, tourists… • people who have lost relatives in ME	services • emotional first aid as separate group	embassies • facilitate group of bereaved persons	• do not mix bereaved with relatives of survivors

CHAPTER 5
Managing Psycho-Social Support during the TRANSITION PHASE

In most instances, the needs of affected people decrease over time, from the acute through to the transition phase. Nevertheless, many people might have unresolved needs from the acute phase, and/or issues that were not a priority in the acute phase, but arise later in time and now require attention.

Psycho-Social Follow-up Co-ordination in the transition phase (PSFC)

While the most prominent features of the acute phase are those of immediate medical, practical and emotional first aid, the features of the transition phase may be very different and focus on **adaptation** to the psychological, social and practical consequences of a ME. Whereas in the acute phase the RISC centre organised and directly provided a lot of psycho-social activities, the PSFC does not have a direct operational function. The PSFC has more of a co-ordinating function, to ensure that the normal structures within health or social services, respond to the psycho-social needs of the different groups of people involved. Figure 2. illustrates the central role that the PSFC takes in the overall process. In addition, in order to advise and facilitate liaison and access to the people involved, the PSFC has a function of interface with a range of people and organisations that are detailed in Annex 7.

The PSFC should promote the reactivation of social networks and co-operate to strengthen existing structures and strategies used by the individuals, groups and communities that have been affected. The focus during the transition phase, is on assisting people to return to daily activities and routines. Self-help or actions groups are often established in this phase. The PSFC can offer assistance to group gatherings, reunions and meetings of different people involved and also facilitate the organisation of burials, rituals and memorial ceremonies. The PSFC can play a role in stimulating healthy reactions and discouraging pathological reactions in self-help groups, as experience has shown that in some cases the groups can focus on the detail of the ME to the extent that they are unable to positively move forward with their lives.

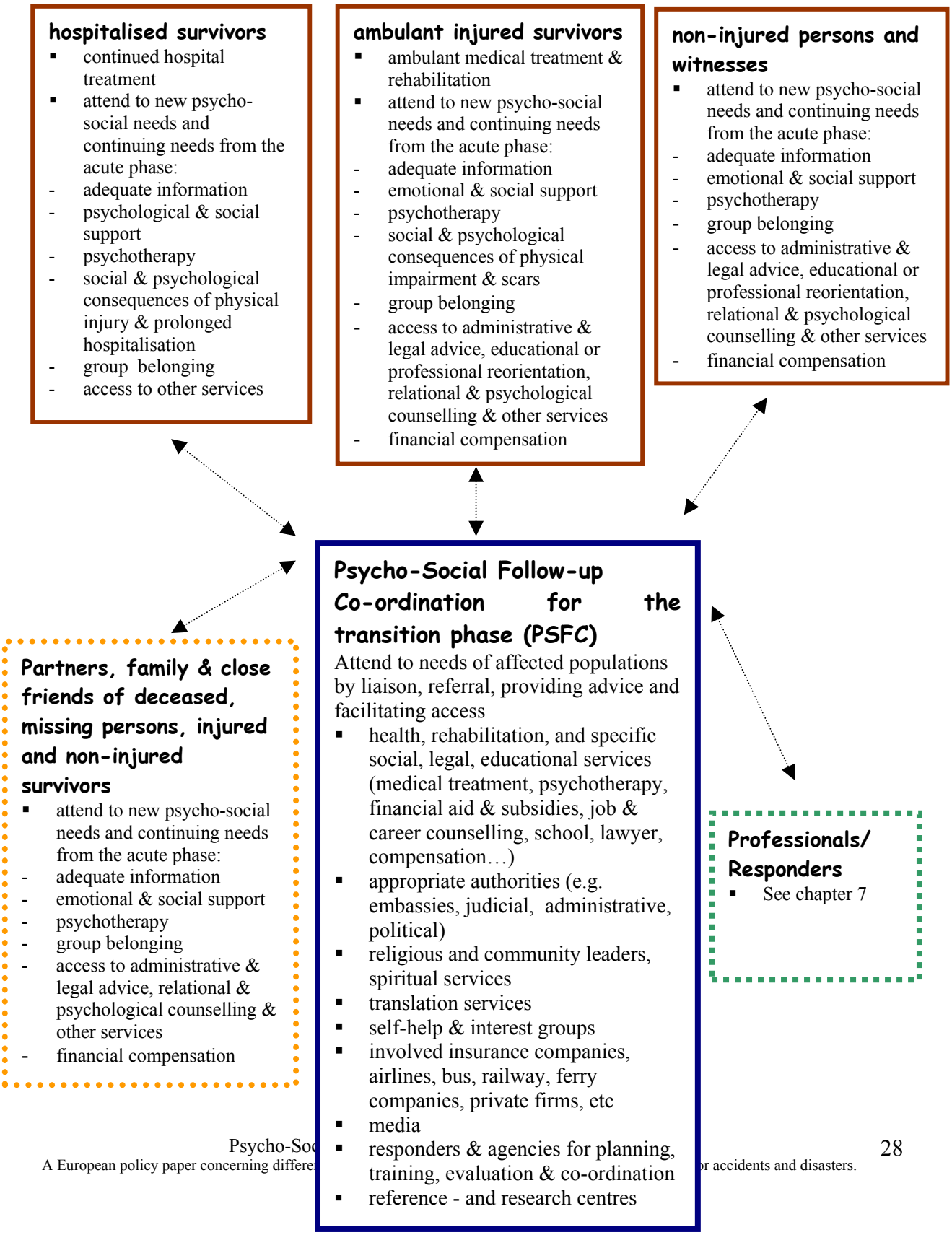
The role of the PSFC is also to offer advice and facilitate access to specialised services and agencies that have the necessary expertise concerning longer-term ME issues. This requires the PSFC to have an inventory and details about a range of resources. In some cases co-operation with other services or authorities will also be required in relation to the continuing search for missing persons or with identification (i.e. hospitalised people in coma). The PSFC should however be pro-active, anticipate possible needs at the beginning of the transition phase, and not wait to react until a specific problem arises, or an individual or agency seeks assistance.

The PSFC has a special role as a central agent and advocate for the needs and interests of people involved (considering collective issues, and intervening on behalf of the group). This

can be considered in relation to the interface with authorities or the press, with insurance companies, or private enterprises involved in the ME.

The PSFC has a crucial role in further documenting and evaluating both the needs of the affected people, and the psycho-social response during the transition phase.

Figure 2: Transition phase



Responding to and considering the needs of different subgroups

In the transition phase there are some core needs and responses that need to be considered for all people affected. The following section highlights those needs and issues in relation to the psycho-social response.

Core issues and responses

The psycho-social needs of non-injured survivors and witnesses will by and large be the same as for ambulant injured survivors, with the exception of those who have enduring physical impairment.

- Emotional and social support from within their usual environment (family, friends, neighbours, work) is important and can assist in social and psychological adjustment.

- Some people will need professional/ career advice and reorientation, or access to administrative services advice about special subsidies or social benefits. It is not uncommon to see different patterns of health behaviour, divorce and loss of jobs as a longer-term consequence of being involved in a mass emergency.

- Insurance and legal issues, compensation and financial matters are important, and may become a contributing factor for psycho-social problems if not attended to in an appropriate and timely manner. This requires access to the appropriate administrative, social, legal, and other services.

- Some people who are receiving ambulant medical treatment & rehabilitation services may also have to deal with the practical, social and psychological consequences of physical impairment. This might include adapting the infrastructure of their home and car (e.g. for using a wheel chair), but also may require assistance in coping with further surgical procedures (i.e. plastic surgery).

- The need for group belonging, getting more information on what happened, or contacting other survivors or responders will probably grow during the transition phase. This can also be an element in the development of self-help or pressure groups.

- Some people will require onward referral to psychotherapy or specialist psychology services. The transition phase is a time when the needs of the group can be considered in the context of identifying those people who are most at risk of developing psychological problems. Analysis of data gained from psychological screening and the use of criteria that help predict current or future psychological disturbance is important at this stage (see Annex 8 for details of risk factors).

These core issues and responses are likely to apply to the needs of ambulant injured survivors, non-injured survivors and witnesses, however specific vulnerabilities may also require the

facilitation of specific interventions during the transition phase (e.g. for children, older adults, people with physical disabilities, immigrants, tourists, foreign language speakers…). For example, young people with relationship or learning problems may require special attention. A certain proportion will be in need of trauma treatment by experienced and skilled therapists. Specific attention is needed for the post-traumatic reactions that children can present with, as these may be different compared with the reactions of adults.

Hospitalised survivors

People who still require hospitalisation for physical injuries may have specific needs for administrative or social services, advice and information. Some (e.g. those who have been in a diminished state of consciousness) need to be updated on what happened. There may be the need to make contact with other people affected or some of the responders (group belonging). Social and psychological consequences of prolonged hospitalisation and of physical trauma may require specialist social and psychological support (e.g. risk of social isolation from home and work, coping with a situation of physical impairment). The results of screening for post-traumatic stress symptoms, earlier psychiatric disorders, lack of social network (done in the acute phase or in case of severely injured, postponed until the transition phase) should be dealt with. Some may need specialist psychological treatment. It is the role of the PSFC to ensure that the needs in the transition phase are attended to by hospital services, or where appropriate, access to other services is facilitated.

Partners relatives and close friends of deceased, missing persons, injured and non-injured survivors.

During the transition phase, family and friends, after getting over the initial shock of learning that a loved one was directly involved in a ME, may still be coping with the consequences. They may be coping with the loss of someone close (or uncertainty if someone is still missing), and with the socio-economic and psychological consequences of that. Or, they may be coping with psycho-social needs of a loved one who survived the ME, but may be more or less changed by the ordeal (physically, emotionally, mentally…). They may require access to administrative, social, legal, psychological and other services available to the survivors and in addition, they may have other specific needs:

- Special needs for burial and memorial ceremonies that are related to cultural, philosophical and religious particularities. Children and young people who are bereaved of their parents may need specific attention.

- Sometimes the search for missing persons (i.e. hospitalised people in coma) continues and family and friends who have been bereaved in a situation where the body cannot be recovered may have special needs.

- Emotional and social support from other family members, friends, neighbours, colleagues etc. is an important variable in helping people cope with what has happened. There may also be a desire to link up with family members of other people affected, to have contact with responders, or a desire to participate in support groups.

- Some families and friends will also have to deal with the practical, socio-economic, financial, emotional and relationship consequences of living with somebody with physical impairment, or problems of professional, psychological, etc. nature.

- The needs of people indirectly involved in a ME can sometimes also include the need for specific psychological treatment.

The following table gives a summary of the needs, responses, and general principles underlying the transition phase:

Table 2: Transition phase Psycho-Social Support

Psycho-Social NEEDS of affected people	Psycho-Social RESPONSE to these needs	ORGANISATION of the response	VALUES and PRINCIPLES of approach
• new & non-resolved needs of the acute phase	• re-evaluate individual & collective needs - postponed screening of seriously injured - organise the follow-up of individuals & group	• **RISC → PSFC** - scale down RISC - establish Psycho-Social Co-ordinating Group (**PSFC**) - prepare long term (including evaluation, research, planning)	★ continuity ★ pro-active ★ co-ordination individual & collective
• information - update on what has happened and perspectives - search for missing & unidentified persons - place & time of ceremonies and group reunions	• organise provision of adequate information - contact hospital, search & rescue, DVI, police, authorities, religious & community leaders - assist other services to respond and survivors to find access	▪ inventory of possible and adequate resources ▪ interface between affected people and	★ balance between individual, social & institutional responsibilities ★ offer (advise)
• advice - administrative & legal procedures	• knowledge base & referral to specialised services		★ facilitate self-empowerment, social reintegration & referral to adequate services
• access to local health and social services	• referral, facilitate access, and assist other services & networks to provide adequate and timely response	- public health services (primary and secondary) - local social services	▪ promote autonomy & self-esteem
• attend to consequences of physical impairment (disability, unaesthetic scars) and of prolonged hospitalisation (isolation)	• facilitate access to adequate medical treatment (e.g. plastic surgery), rehabilitation & re-adaptation (infrastructure, job,…); social benefits & subsidies; encourage Psycho-Social Support	- public & private trauma centre, psycho-therapist, counselling - specialised health and social services	▪ strengthen coping capacity and existing adaptive mechanisms & strategies of individual, group & community ▪ prevention & punctual individual treatment of chronic PTS-disorders
• serious psycho-social problems, psycho-logical disorders, psycho-somatic diseases	• treatment - psychotherapy - counselling - medical treatment		
• returning to daily routines	• facilitate - social and emotional support by daily living environment - social reintegration (job, school…)		▪ facilitate reactivating social network
• need to contact other persons involved, group belonging, rituals	- facilitate contact & spontaneous actions - stimulate healthy (re)actions - discourage psycho-pathological or destructive (re)actions	- self-help, interest & pressure groups	▪ respect cultural, religious, philosophical diversity
• socio-economic needs	• financial compensation	- involved insurance & private companies, appropriate authorities…	▪ collective & pro-active
▪ specific vulnerabilities - of bereaved relatives - children, impaired & old people, immigrants, foreign language speakers…	• facilitate - respectful body handling, funerals - age-specific responses, translation, etc.	- cultural, religious & community leaders, embassies, translation services, …	▪ specific

CHAPTER 6
Managing Psycho-Social Support during the LONG-TERM PHASE of mass emergency situations

The needs of affected people tend to stabilise and continue to decrease from the transition through to the long-term phase, and this means that the level of response and organisational efforts of the PSFC will diminish. Nevertheless, a certain proportion of those originally affected by the ME, may continue to experience difficulties in relation to physical impairment, they may develop psychological or psychiatric disorders, or may continue to have minor problems but of a more or less chronic nature. Dependent on the nature of the ME, and the population affected, research has shown that between 10 to 30 % of those originally involved could go on to develop post-traumatic stress disorder (PTSD) or other mental health disorders. Individuals involved in a ME who had previous mental health disorders, or who have a poor social network are more at risk (more details about risk factors are given in Annex 8.). The psychological effects for survivors of man-made mass emergencies (i.e. transport or industrial accidents, acts of terrorism), seem to be more persistent than those caused by natural disasters such as floods or earthquakes.

Psycho-Social Follow-up Co-ordination during the long-term phase (PSFC)

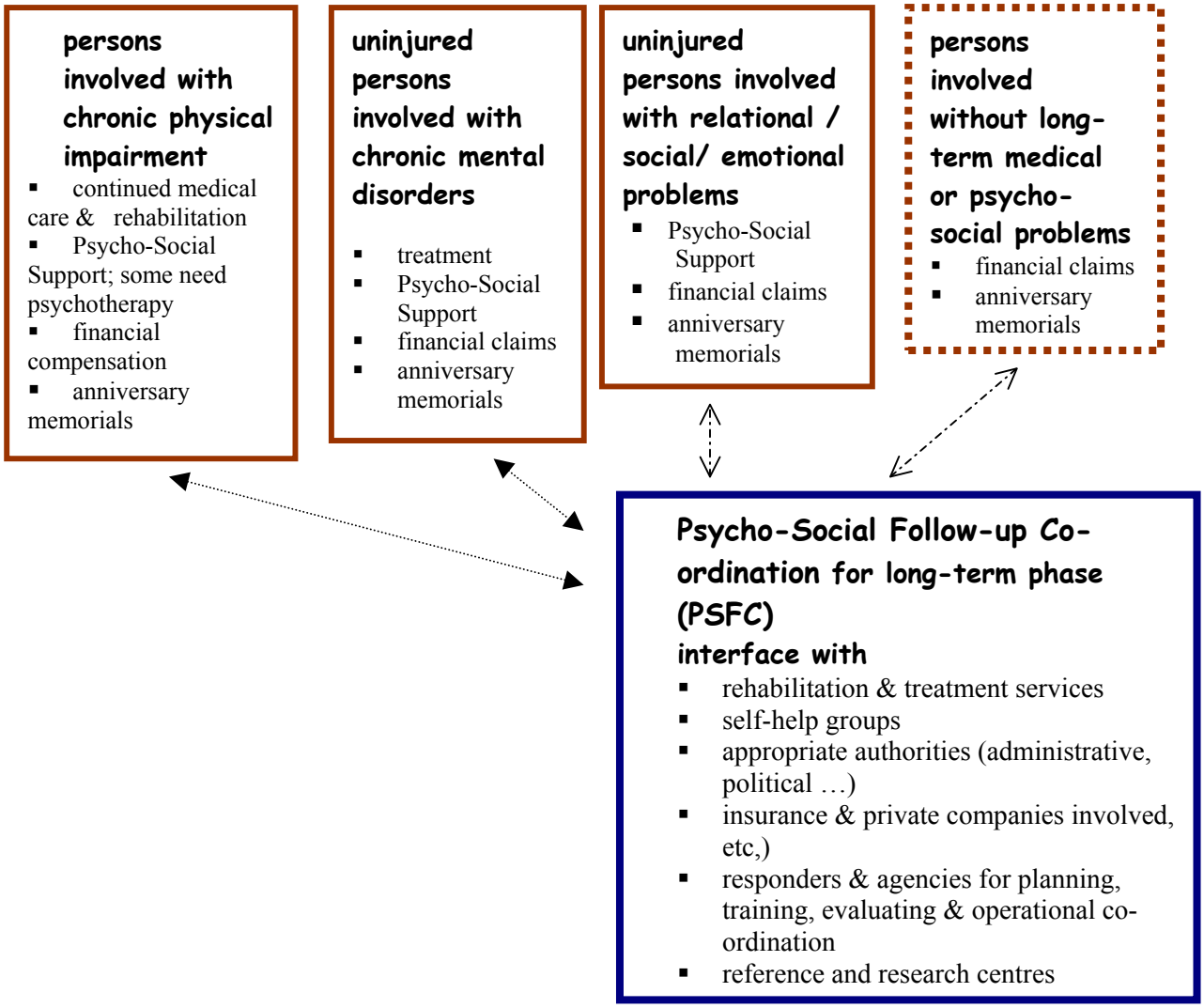
With diminishing psycho-social needs, there is also a change in the co-ordinating role of the PSFC compared to during the transition phase. The PSFC started by essentially having a pro-active advice, referral and facilitation function, with a focus on co-ordinating access to specialised resources, facilitating reintegration into usual life and stimulating self-empowerment. At this point in time, local health and social services, or specialist agencies will for the most part, have taken over the provision of psycho-social support, and life for most affected people will be gradually returning back to normal. The focus of the PSFC at this stage, should be on specific areas where there are continuing issues and difficulties, and with specific subgroups who may be more vulnerable and in need of ongoing assistance.

In order to ensure its co-ordinating function during the long-term phase, the PSFC has a function to interface with a range of people and organisations and these are listed in Annex 9. The PSFC in the long-term phase also has a continuing role as an advocate for the collective needs and interests of people involved. As long as there are administrative, legal, insurance or financial issues unresolved, the PSFC could be an interface between people affected by the ME and the authorities, the media, or private companies involved in the ME.

Finally the role of the PSFC is crucial in documenting the activities of the final phase, ensuring longer-term archiving, co-ordination of the final evaluation, and linking up with relevant agencies for review of response planning, training, evaluation, and ongoing development of reference and research centres.

The flow-chart in Figure 3. illustrates the way in which the PSFC plays a central role in continuing to co-ordinate the psycho-social response.

Figure 3: Long-term phase



At some point, the PSFC will close its activities concerning a specific ME. The PSFC must make a final evaluation of the whole psycho-social intervention process (acute, transition, long-term phase) and also review the preparation and planning for MEs. It should transfer all information and documents to the competent authorities and/or reference and research centre(s).

It is the responsibility of the competent authorities and policy makers to take and effectively implement the necessary measures to incorporate lessons learned from the evaluation. These need to be incorporated into revised plans and preparation for future mass emergencies.

Responding to and considering the needs of different subgroups

In the long-term phase there are some core issues/needs and responses that need to be considered for some of the people affected. The following section highlights those needs and issues in relation to the psycho-social response.

Core issues and responses

- While most people involved in a ME will have unusual emotional reactions during the acute phase, only a small proportion will continue to experience problems and develop significant difficulties during the transition phase. In the long-term phase, the majority of people initially affected by the ME are likely to have relatively few social and psychological problems. They should nevertheless have access to the PSFC especially where administrative, legal issues, litigation or financial compensation remain unresolved in the longer term.

- The need to identify with other people involved in a ME, to meet or participate in self-help groups and memorials, may be as important in the long-term phase as it is in the transition phase. However, during the long-term phase, many people will find the need for meetings/reunions diminishes. Some people, especially those who have experienced the bereavement of somebody close, or those people who have a poor social network, may need specific psycho-social support on special occasions, such as anniversaries or memorials.

- The chapters on the acute and transition phase already referred to the concept of psychological, social and environmental risk factors and these are outlined in more detail in Annex 8. However, in the long-term phase specific consideration still needs to continue to be given to these factors. For example, if an accident or disaster is experienced as seriously life threatening and traumatic, than the ME in itself may result in the development of a significant psychological/psychiatric disturbance, without there having been any previous vulnerability. People involved in a ME, with previous mental health disorders, with earlier traumatic experience, or with a poor social network are also more at risk of developing psychological problems. Unresolved financial claims can also have an adverse impact on the mental health of people involved, partly because the process often involves having to talk about the events in detail and on numerous occasions, and this in itself can be experienced as re-traumatising.

- Individuals developing psychological and psychiatric disorders (including PTSD) as a result of the ME should have access to appropriate specialist psychological and pharmacological treatments. It is not the remit of this paper to outline in detail the specific treatment approaches, however there is a growing evidence base for effectiveness of both psychological and pharmacological treatments for specific disorders such as PTSD.

These core issues and responses are likely to apply to the needs of most people who have been affected by a ME. Specific consideration should however, be given to people with long-term physical impairment (outlined in the following section), and also for example, to specific subgroups such as children and young people, and people from different ethnic backgrounds.

Persons involved in ME with long-term physical impairment

There is a limit to what even the best medical care can finally achieve, and a number of survivors will be confronted with physical disabilities (i.e. paralysis, blindness, chronic pain, scars). Some people with physical impairment, or who require chronic medical care in order to stabilise their situation (dialysis, medication, pacemaker…), may continue to be dependent on practical assistance from other people or rehabilitation services.

Ongoing medical problems or impairment may lead to functional adaptations being necessary to allow the individual to adjust (i.e. adaptations to house, car, workplace). Educational or professional reorientation that have been made during the transition phase will not always totally compensate for the loss of autonomy, self-esteem, social life, and income. Coping with this not only requires psycho-social support from family, friends and colleagues, but also financial compensation that may be critical in assisting some people to regain as normal a life as possible. In addition, the traumatic experience of the ME itself, added to the psychological consequences of physical impairment, contribute to the risk of developing mental health disorders that may require specialist therapy.

The following table gives a summary of the needs, responses, and general principles underlying the long-term phase:

Table 3. LONG-TERM phase Psycho-Social Support

Psycho-Social NEEDS of affected people	Psycho-Social RESPONSE to these needs	ORGANISATION of Psycho-Social Response	VALUES and PRINCIPLES of approach
• non-resolved needs of the transition phase and new needs created by new life situations	• organise the follow-up of psycho-social activities or therapies and the global results	• **PSFC** ▪ adapt Psycho-Social Co-ordinating Group	★ continuity ★ pro-active & reactive
• punctual questions - information update - place & time of ceremonies and reunions - administrative procedures - attend to consequences of physical impairment or requiring chronic medical care - psychological disorders	• adequate punctual response - information - contact, authorities, religious & community leaders - knowledge base & referral to specialised services - assist other services to respond and survivors to find access - follow up treatment & results	- inventory of possible and adequate resources - interface between affected people, (individually and also on behalf of the group) with adequate services, authorities, self-help & interest, involved insurance & private companies, cultural, religious & community leaders, ME-response agencies	★ individual & collective ★ preventive & therapeutic ★ co-ordination ★ global & specific follow-up ★ punctual intervention ★ balance between individual, social & institutional responsibilities ★ feedback & integration of lessons learned into future response to ME
• reintegration in society & turning to daily routines - social & economic needs - legal issues (liability, compensation) - specific vulnerabilities (children, impaired & old people, immigrants, refugees)	• follow-up of social reintegration & punctual intervention - rehabilitation & re-adaptation - socio-economic situation, school & job situation,, social benefits, pension - financial compensation & court case (eventually joint claim) - adapted solutions & responses		
• ME that may happen in the future	• final evaluation & organising links with future response - documenting long-term phase activities - archiving - feedback to ME-response management - link with reference & research centres	prepare long-term memory, evaluation, research, planning with adequate agencies, authorities, reference & research centres, policy makers	

CHAPTER 7

Stress management and psycho-social support for emergency responders and other staff who respond to mass emergencies

Traditionally **emergency responders** have neglected their own need for emotional ventilation after critical incidents. Feelings of guilt, sadness or other strong emotions have been considered to be a sign of weakness or even unsuitability for rescue work. The ability to control emotions during a rescue is crucial. But that does not mean that what one sees, hears or experiences during an incident has no psychological impact. Those who respond to the psycho-social needs of people affected by a ME will include not just emergency responders, but also the psycho-social workers and hospital/community-based medical staff who will respond in the days, weeks and months after the event. This second group may for example, include personnel from hospitals and non-statutory organisations, psycho-social workers in RISC centres or in the PSFC, as well as mental health professionals, social services staff, etc. These staff will have different but no less important, needs for support. This chapter aims to highlight the general principles in relation to the provision of support for both groups of staff. These principles directly relate to identified needs based on professional consensus, previous experience of staff involved in MEs, and evidence from research literature.

General Principles – emergency responders:

- It is important to recognise the difference between **emergency responders** and those directly involved in a ME (and their families). Emergency responders have chosen to participate at rescue scenes and are trained professionals. They are an homogeneous group, who have high levels of training that provide them with good coping skills, high levels of motivation and the ability to monitor and manage their own stress levels.

- Emergency responders in most countries are used to intervening as part of a team, and training regularly as a group. This provides them with a strong peer support network. In addition, rescuers usually have some time for mental preparation prior to arriving at the scene of an emergency, and they will have had training and resources available to them that allows them to have a sense of control and ability to manage the situation. As a result, emergency responders will have a better understanding of what is going on at the scene of the ME (comprehensibility) and be able to influence the outcome (manageability). Being part of emergency operations also provides them with purpose and meaning (meaningfulness). These factors mean that emergency responders are likely to experience considerably lower levels of stress, compared with people who respond in a voluntary capacity (who may be unorganised, and mentally and physically unprepared).

- There is evidence however, that emergency responders (i.e. those who attend the actual scene of the incident) are more likely to report post-traumatic and other stress symptoms than those responders in hospitals. In some situations, usual coping skills will not be sufficient, and responders may feel both emotionally and physically overwhelmed. The evidence about prevalence of post-traumatic stress in emergency services staff is inconclusive. In one study up to 80% of rescue personnel (Fire fighters, Police etc.) had at least one post-traumatic symptom e.g. following an explosion at an apartment building.

The most common symptom (intrusive thoughts about the disaster) was experienced by 74% of those staff. In a different longitudinal study, 30% of fire fighters had some acute psychiatric symptoms 4 months after responding to a major incident. In contrast, a different study assessing psychiatric morbidity in police officers involved in body recovery duties showed no significant post-traumatic stress symptoms.

- Certain factors and situations are particularly stressful for **emergency responders** and may make them more vulnerable to developing psychological/psychiatric disturbances. These factors might include:
  - large scale incidents that last for a long time, with many dead or injured victims
  - incidents where there are dead or seriously injured children
  - death or serious injury to other emergency responders
  - serious mistakes during the rescue
  - accidents or events for which they were unprepared
  - conflict with existing world view and beliefs
  - negative criticism in press and media
  - lack of respect or recognition, negative criticism coming from people directly involved

- It is the responsibility of the employer to make the adequate preparations beforehand, to provide on-scene support so as to reduce the exposure to trauma, and to offer specific support to assist with physical as well as psychological recovery in the longer term.

- Professional consensus suggests that emergency responders (as individuals and as a group) have different psycho-social needs, and will require different strategies for dealing with traumatic incidents. It is recommended that organisations develop specific psycho-social interventions for **emergency responders**, and that they should **not** be included in interventions aimed at the general population who have been affected by a ME.

- Critical Incident Stress Debriefing is one type of support intervention that has been used by emergency service organisations. It has been the focus of much debate in the scientific research, and the outcomes of the research have been largely equivocal. The Cochrane Review (1998, 2001) is probably the most comprehensive meta-analysis review of the studies, however this review included mostly studies that had used critical incident debriefing with individuals (as opposed to rescue workers) who had been directly affected by a traumatic event. In addition to some serious methodological flaws in the studies reviewed, it is difficult to generalise outcomes for an intervention used with directly affected people, to the use of the intervention with a professional emergency responder group. One of the recommendations of the review however, is that critical incident stress debriefing should **not** be compulsory for people involved in traumatic events. Professional consensus suggests that this should also be the case in relation to its use with professional responder groups.

General Principles – psycho-social workers and other responders

- **Responders** who do **not** intervene **at the scene** of the accident may have different needs for psycho-social support. It is widely recognised that work that focuses on the relief of physical and emotional suffering of those affected by traumatic events necessarily includes absorbing information about that suffering. Experience has also shown that staff working therapeutically with trauma-affected people is vulnerable to vicarious traumatisation.

- **Psycho-social workers** providing a service to people involved in a ME may be vulnerable to vicarious traumatisation because of the following factors:
  - The process of "empathising" may help the responder to understand the affected person's experience, but in the process they may become traumatised as well.
  - Responders may have experienced traumatic events in their own life history. Subsequent work with people affected by trauma may be re-traumatising.

- There is professional consensus that **mental health staff** working therapeutically with trauma-affected people should have access to appropriate clinical supervision. Pearlman and Saakvitne 1995, suggest that there are specific aspects of trauma work that need to be considered in the context of what would be considered appropriate supervision;
  - a supervisor who has a theoretical grounding/ understanding of trauma therapy and responses to trauma
  - attention within supervision to the conscious and unconscious aspects of the therapeutic relationship and the treatment process
  - attention to countertransference and parallel process
  - education and attention to vicarious traumatisation and other effects on therapists

Good practice guidelines - Preparation and planning of stress management support for emergency responders

The following tables and text present different methods and procedures that can be used at different levels (management, group leaders, groups and individuals), and at different time points, prior to, during and in the short- and long-term phases following a ME. This is by no means an exhaustive overview of possible methods and procedures, but aims to be a source of information and inspiration for those who commission and provide stress management programmes for primarily for emergency responders. In addition, there may be some elements of this type of programme that could be adapted for use with other groups of responders (i.e. hospital based staff in Accident and Emergency services). Similarly, the basic principles could be adapted in situations where responders do not usually work within a team (i.e. management principles for providing support to staff).

General principles underlying the Management response

To succeed in a stress management project with a group of emergency responders, it is of vital importance that leaders at all levels support the programme. Leaders must be seen to demonstrate and lead by their actions, otherwise the groups and individuals will not see the benefits of the program. Members of management and staff should receive training in stress management to be able to recognise these needs. Table 4. gives a summary of the key tasks and issues that should be considered by management.

Table 4.

Preparation and planning	During traumatic incident	After incident, short term	After incident, long term
Selection criteria for rescue workers and leaders Management training EAP-program Peer support group training Network (other org. and experts) Action plan (when, who, how, what)	Practical support Rotation Identification Support group deployment Press and media contact Information within department Info outside department Assessment of incident and level of stress	Practical support (transport, food, safety) Information Defusing Debriefing Relatives and spouse support Give recognition Press management and protection Mental health consultation	Evaluation Update or change plans Long-term follow-up for individuals and groups Support research

Preparation and planning

The emphasis in selection criteria when recruiting emergency responders is often on physical abilities. The ability to endure stress and have emotional stability is just as important. The employer is not only responsible for stress management during and after an incident, but should also ensure that stress management principles apply to more general staff policies and procedures.

Many rescue service organisations prefer to take responsibility for stress management work by creating an in-house peer support group. A peer support group should receive advanced training in stress management techniques. Usually a mental health professional responsible for training, supervision and follow-up leads the group. Advantages of a peer support group are that they are usually well accepted within the groups, they have first-hand knowledge of the conditions during an incident, and they can usually be deployed quickly when needed. Disadvantages are that they sometimes are to "close" to colleagues and incidents to perform objectively. They may also lack experience and knowledge in being able to accurately assess stress levels and symptoms of mental health problems. They should therefore, work closely with mental health professionals and receive supervision and advanced training.

It is a good idea to build a network with other organisations within the community. This way, rescue organisations can support each other after difficult accidents and disasters. After a ME, support may be needed from outside to enable the organisation to respond effectively. It is also advisable to have a list of people who have expertise in trauma both for the provision of treatment where appropriate, and also for training and supervision purposes.

An action plan regarding measures for acute stress management should consider the following:

- A list of examples of situations when the action plan should be used
- Who has the right to put it into action
- Procedures for deployment of the support group
- Available external and internal resources for stress management

During an incident

It is very important to correctly identify the affected group and recognise that within the larger group, there may be people who have different levels of exposure to the ME and that these people may have different needs for support. During an incident the stress management work should be focus on practical support with the aim of reducing levels of stress at the scene. Examples of such activities are:

- Effective management of press and media
- Distribution of food, drinks and snacks
- Distribution of dry and warm clothing
- Information about the objectives of the rescue and time schedules
- Offering of telephones to be able to call home during large scale or prolonged incidents
- Rotation of staff to prevent them becoming both physically and emotionally drained

It is a good idea to deploy the support group as early as possible. The task of the support group should be to identify the involved rescuers, assess the level of exposure to trauma and to prepare the different stress management strategies after the incident.

After an incident – short and long term

Support after a traumatic incident should start with responding to basic needs such as transport to safety, shower, dry clothes, food, phone home and information. If the basic needs are not fulfilled, stress management will be less effective. Some families of the rescuers may need information and support in order for them to understand what their partner has been through. Managers should also recognise the importance of giving recognition for the work. It is also wise not to allow press and media access to rescuers before they have been debriefed and had an opportunity to operationally and emotionally process what has happened.

Although stress management activities seem to work, and if well planned and prepared, are often highly appreciated by the staff, the scientific evidence for effectiveness of some activities (i.e. critical incident stress debriefing) is equivocal. Management has a responsibility to ensure that they are kept appraised of the issues and emerging evidence in this field. There is a need for more scientific research into the effectiveness of early stress management interventions, and management should support and co-operate with researchers both in evaluating support systems and in relation to long term follow up studies on the effect the traumatic incident may have on the rescuers. Evaluation is always necessary but often neglected.

It is recognised however, that even where good support systems are in place, some individuals may develop significant psychological problems and it is therefore very important for the organisation to be able to provide access to specialist professional treatment for those who need it. Management should also be prepared to consider the provision of specific support in situations where legal matters arise (i.e. where staff is involved in official investigations).

General principles underlying the role of operational group leaders

Group leaders have a range of issues to consider in relation to training, education, operational assessment and leadership of the groups that they work with. Table 5. summarises some of the key issues.
Table 5.

Preparation and planning	During traumatic incident	After incident, short term	After incident, long term
Education of leaders in stress management (situations, stress symptoms, stress management action)	Operational assessment of level of stress for group and individual Rotation within group Information to group Information to Management and /or Staff Encouragement Direct contact to mental health professionals	Assessment Active support for stress management techniques Recognise stress symptoms for group and individuals Encourage emotional ventilation Include mental health experts when needed	Watch out for change in behaviour of group and individuals

Preparation and planning

The leadership style of the group leader will reflect on the way the group operates. Thus, if the group leader is positive and believes in the principles and practice of stress management procedures, so will the group. It is therefore of great importance for group leaders to have training in stress management. Group leaders should after training be able to:

- Recognise potential traumatic situations.
- assess stress levels within the group during and after an incident
- implement basic stress management procedures for the group
- know when and how to refer to additional support when needed

During an incident

It is the responsibility of the group leader to:

- Assess the impact that the incident has on the group.
- Be sure to rotate the shift to ensure that the staff are protected from physical and emotional exhaustion
- Consider factors such as experience, number of years in service and general physical and emotional health when selecting staff for extremely difficult tasks.
- Recognise acute stress symptoms within a group or an individual and take them out of duty if necessary
- Report back to headquarters and ask for rotation and stress management support if involved in a potential traumatic incident.

It should be noted that leaders are also sometimes directly involved in the incident and can be reluctant to ask for rotation and support. Therefore headquarters should take a pro-active approach to monitoring and supporting group leaders.

After the incident – short and long term

Group leaders should encourage emotional ventilation after critical incidents. This can be done in many ways. One is by attending and being supportive of the stress management activities. Another might be to give time to, and encourage informal group meetings after the incident. There is a need to be alert to signs of negative coping strategies, such as scapegoating and blaming. It is also important that group leaders are aware of and acknowledge that people have different ways of coping after incidents. Group leaders should monitor how the group deals with the incident. It is important to assess whether there are any individuals who show significant change in their behaviour (i.e. irritability, sleep disturbance, inability to stop talking about the incident/ inability to talk about the incident) as these may indicate that the person is experiencing significant emotional disturbance.

General principles underlying the response for groups of staff

Confident groups where the members feel safe to express their needs and opinions, both physically and emotionally, have a far greater potential to handle post-traumatic stress after difficult situations. Based on this principle, Table 6. highlights some of the key issues for groups of staff.

Preparation and planning

Teambuilding techniques are an effective means of increasing group confidence and cohesion, and can be used to strengthen the group and help people to be more mentally prepared for traumatic situations. Groups should also get basic stress management training and victim support information and education. If they feel confident and have basic knowledge of victim support on the scene they will also reduce their own stress levels.

Table 6.

Preparation and planning	**During traumatic incident**	**After incident, short term**	**After incident, long term**
Team building Education in stress management (when, why, how) Education in crisis management and victim support. Stress inoculation training Defusing training Role model support	Informal group support activities Victim support on scene	Within group support Accept individual differences in coping strategies Participate in stress management work	Accept differences in time for managing trauma. Meet and support directly involved persons

During an incident

Informal group support (i.e. a pat on the shoulder, a smile or a joke) can be very helpful within a group and assist individuals to keep the emotions under control and continue work during difficult rescues. Rescuers can also make a considerable contribution by giving comfort and both physical and emotional support to those directly affected on the scene. A lot of the stress that rescuers experience at a scene comes from watching bereaved or distressed people, and not being able to do something to help. With proper training in providing emotional support and by showing empathy, rescuers also help themselves.

After an incident – short and long term

More experienced staff should act as role models for those with less experience. They can do this by encouraging attendance at debriefings and by being open about their own feelings and thoughts. By doing so they set standards for the whole group and can lead the group towards a closing of the incident. Groups need to accept that individuals have different coping strategies and that for some, emotional healing can take a considerable time. If the group can acknowledge, accept and manage these differences in a supportive and understanding way, the group can be of real help. But negative group processes can also lead to projections where one individual carries the trauma for the group. This of course can be very destructive and harmful to both the group and the individual.

Sometimes there is a need from those directly affected by an incident to meet with the rescuers. It might be to say "thank you" or to get a first-hand account from rescuers of how they perceived the situation. These meetings give the rescuers an opportunity to contribute long after the actual rescue. Rescuers sometimes feel dubious about the value of such meetings, because they are afraid of being blamed or accused of doing the wrong thing. These situations very seldom occur. Often these meetings provide a step towards "closing" for the affected people, and this can give the rescuers a feeling of doing something really positive and important. However, meetings should be well prepared and led by someone who was not directly involved in the rescue. It is usually a good idea to use someone from the support group and a mental health professional.

General principles underlying the response of individuals

The key issues for individual rescue workers are highlighted in Table 7.

Table 7.

Preparation and planning	**During traumatic incident**	**After incident, short term**	**After incident, long term**
Stress management training Self-knowledge (strength and weaknesses)	Self-support and encouragement Self-monitoring	Accept reactions Participate in stress management activities Inform spouse and relatives	Self-help relaxation methods Accept help when needed

Preparation, planning and during the incident

Individuals should consider training in the use of self-help techniques to help monitor and manage their stress levels during an incident. Self-awareness regarding personal strengths and weaknesses is also helpful in managing stress. Individuals trained in stress management techniques can become very effective at managing their own stress levels.

After the incident – short and long term

Individuals need to take responsibility for their own emotional responses. If they experience emotional difficulties or physical reactions they need to be able to share this information with other colleagues. The organisation can provide support, but if individuals are unable to share what is happening for themselves, they will be less able to access support. Rescue workers should also try and share information and their experience with partners and other family members. It is not always advisable to go into graphic detail about the incident, because partners and other members of the family may not be prepared or able to cope with details for which they have no experience or training. However they are entitled to get sufficient information to help them understand the reactions of the rescue worker. Rescue workers also need to acknowledge and be aware of the fact that emotional recovery sometimes takes time, and will vary between individuals. They should also accept that there may be circumstances in which it is appropriate to seek and accept professional help.

Annex 1.

KEY WORDS

For a common understanding of concepts and terms, the paper established some pragmatic operational definitions, which are - without pretending to be the only sacred ones - based on a large consensus in the scientific literature and in the world of emergency services, medicine and psycho-social work.

Major Incident	A 'Major Incident' is any emergency situation that requires the implementation of special arrangements by health authorities and/or by medical emergency services. Within the category of Major Incidents a distinction is made between a 'Public Health Crisis' and a 'Mass Emergency'.
Mass Emergency	A 'Mass Emergency' is a major incident with a large number of people involved, causing an exceptional disproportion - in size or in time - between on the one hand the medical and psycho-social needs (in numbers and nature) and, on the other hand, the response capacity (the available resources and their organisation). Within the category of Mass Emergencies a distinction is made between Major Accidents and Disasters.
Major Accident	A 'Major Accident' is a mass emergency situation in which an exceptional insufficiency of resources in medical care and psycho-social support can be rapidly overcome by reallocation and/or extra-ordinary mobilising of resources. Also, by implementing specially modified procedures, this may result in a temporary lowering of the normal quality standards of individual care.
Disaster	A 'Disaster' is a mass emergency situation where disruption of facilities, infrastructure and/or services causes a huge and long lasting disparity between the needs and the medical and/or psycho-social capacity to respond to those needs.
Public Health Crisis	A 'Public Health Crisis' is a situation that presents an unusual serious health risk to a community (or which is perceived as such), requiring swift action, extraordinary decision-making and/or extraordinary measures by health authorities, but without the immediate need for mobilising medical personnel and material resources. Rather than an acute disproportion between needs and resources, a public health crisis is characterised by a lack of information, scientific uncertainty and/or public worry about causes, character or dimension of an unusual health problem.
People Affected	Every person who is directly or indirectly involved in a mass emergency can be affected or may need Psycho-Social Support. Major accidents or disasters not only carry with them a direct potential for death, physical injury, violence, destruction and property loss, but are also associated with mental/emotional stress. Mass emergencies can also have an impact on family members and friends of those directly involved in a ME. Witnesses and those who respond to the ME (responders) can also be affected.
Psycho-Social Support Workers	Trained personnel who respond to practical, emotional/psychological and social needs of people involved in mass emergencies, in the context of strengthening the existing coping strategies of the individual or community that has been affected, are called 'psycho-social support workers'.
Rescue Worker	The term rescue-worker is used in this document for professionals, semi-professionals and trained volunteers who intervene directly at the scene of an accident. Rescue Workers interpreted in this larger sense can be for example; fire fighters, paramedics, nurses, doctors, Red Cross personnel, police, etc.

Responder	All staff whose task or duty it is to respond to a mass emergency are described as Responders, independently of the phase in which they intervene after the incident. Members of emergency search and rescue organisations (i.e. fire service); staff of emergency medical services (ambulance services, pre-hospital medical teams); psycho-social support workers; people working in emergency dispatching centres; police and personnel belonging to agencies for technical/logistic assistance; those who respond in the framework of other health and social services; all belong to the category of responders.
RISC	The term RISC or Reception, Information and Support Centre is used for the various psycho-social functions, set up in the immediate aftermath of mass emergencies, whereby people involved are offered reception/shelter, information and/or support, whether this is organised in one or different centres.
Debriefing	Like other people affected by situations of mass emergency, the responders also have needs for psycho-social support. For professional groups it is important to involve the whole group in any support programme. Debriefing is a structured meeting which aims to assist the group in coping with the psychological aspects of a traumatic incident. Debriefing can be carried out using different types of models and approaches. In Europe, the most common approaches are "Critical Incident Stress Debriefing" (J Mitchell), and "Reconstruction and Integration of Traumatic Stress" (A. Holen). It should be noted that the term "debriefing" in this context, refers exclusively to dealing with psychological issues.

Annex 2.

Glossary		Page number
ME	Major Emergency	1
Psycho-social intervention	sum of all actions taken to support people affected via psychological and social means	2
Victim	Every person, suffering as a result of the disaster, the word victim is related to pathology. Therefore it should be replaced by "people affected," which stresses the self-help capacity of people…	2
Preventive approach	efforts to reduce rate of illness in the long term	2
Psycho-social workers	trained personnel, who respond to psycho-social needs of people affected	3
PSM,	Psycho-Social Manager - co-ordinating person of all activities related to a disaster handling.	9
Responder	rescue workers, police, medical emergency service psycho-social workers	12
Vicarious traumatisation	psychological term to describe the traumatic reaction of mental health personnel treating traumatized patients	15
Psychotraumatology	psychological category to describe the whole field of trauma reaction, trauma support and treatment, comprises research, practice and theory)	16
Compassion fatigue	– see vicarious traumatisation	16
Salutogenesis	psychological theory by A. Antononovsky, stressing the potential of individuals to stay healthy.	16
Hardiness	psychological theory, stressing the capacity of individual to cope with distress.	16
Pathologising	concept, stressing the negative effects, when people affected are only perceived as a sum of symptoms	16
Victimisation	concept stressing the danger of making victims out of people who survived	16
DVI	disaster victim identification	21
RISC	Reception Information and Support Centre,	23
PSFC	Psycho-social Follow up co-ordination	27
EAP-Program	employee assistance program, set of techniques to provide health and social support for employees.	38

Annex 3.

Evaluation – a case example

As part of a larger planning group, the lead-agency that would have responsibility for coordinating psycho-social support in the acute, transition and long term phases, are thinking about how they might evaluate the use of an **information leaflet**. The specific question is: "is an information leaflet outlining common stress reactions, helpful for people affected by this major incident?" The group considered the following issues/ questions:

- What are the specific aims of the intervention that we are interested in (i.e. it may be to help people "self-refer" in order to access additional support)

- Planning the evaluation at the same time as thinking about using the information leaflet is helpful – we might modify the leaflet to include something that will help with the evaluation

- Do there exist any published studies or other similar evaluations in the past that can be helpful in thinking about the approach and ways of collecting data?

- Who do we want to ask to carry out the evaluation – how will we make that decision?

- What measures are going to be used? We need to know e.g. the total number who received the information leaflet and how many did self-refer in the months following the intervention. We may want to know more about specific characteristics of those who received the information but who did not self-refer (– are they different in some way?).

- Which organisations are involved in using this information leaflet, and how are they involved. How is the responsibility for and input to the evaluation going to be shared across agencies?

- Is the perspective of the "user" important in answering the question – and if so how are you going to access those views in a systematic way?

- How is the outcome of the evaluation going to influence the way in which an information leaflet might be used in the future?

Annex 4.

INFORMATION MANAGEMENT

.

Conflicts concerning information management

There are conflicts of *time* whereby authorities need to gather and assess information before they speak to the media, who themselves have to consider deadlines and competition. Authorities, wanting to influence public behaviour, prefer to see the official message to be presented as the only "correct" one, while the media may need several *sources* and different perspectives. The *responsibility* and liability of authorities concerning accuracy of information are not the same as for the media, who can leave a lot of the interpretation of information up to the public. A conflict of *knowledge* can exist between official experts and the media, in presenting the complexity and uncertainties of a mass emergency, and the tendency to simplify and popularise. Contradictions in objectives and judgement can also lead to conflicts of *priorities*. Management errors can result in the media questioning the *credibility* and the authorities skills in emergency management. We can add the fundamental issue of partial convergence/contradiction in socio-economic and political interests between state institutions and commercial press agencies. This can contribute to explaining the ongoing need to confront tendencies for sensationalism, manipulation, cover up or censorship by democratic control, citizen emancipation, investigative journalism, etc.

different types of information management:

- as to the **object** of the information:
- related to the identity, the fate and perspectives of injured or non-injured survivors, and of missing persons
- related to the identity of the deceased or disaster victim identification DVI, which can including forensic services (but which is different from investigating the cause of death and the legal responsibilities)
- concerning the disposition of personal effects
- in relation to the mass emergency itself, the general context and evolution (what happened/is going on/will or may follow; why and how; etc.)

- as to the **destination**
- the individual involved him/herself.
- in order to address the concerns of partners, family members or close friends of the accident victims, including the process of notification
- relevant and necessary for an adequate ME-response management (e.g. the RISC-centres or PSM; general operational or strategic management, authorities including foreign offices and embassies; technical services for logistics, translation,...; agencies and services involved in follow-up)
- for public information, press or public relations
- for scientific purposes (e.g. to be collected blinded regarding the case/control status) or for documenting/preserve/archiving/evaluating the Psycho-Social Intervention itself

- as to the **characteristics**:
- accuracy, impartiality, acceptability, credibility, timing, amount of detail, completeness, relevancy …
- local, thematic, factual, general, truthful, emotive…
- authoritative, informal, official, commercial, legal, …
- private, confidential, public…

- as to the **means**, circumstances and technology of information handling
- direct personal contact, physically present or by telephone,
- indirect means of handouts, postal letters, fax, E-mail
- public radio, television, printed press, …
- using written documents, computers, video, photographs, slides, digital information carriers…
- at the scene, in hospital, RISC-centres, offices, public places, at home…

Annex 5.

Psycho-social response in the ACUTE PHASE

RISC-functions

- **reception** and practical arrangements, at first for those directly involved (and maybe for witnesses and bystanders), and later also for their families and friends

- shelter, protection from unwanted attention (e.g. from the media)
- food, drinking, communication facilities (phone, fax, E-mail), replace shoes or clothing, repair or replace broken spectacles, money, place to sleep while at the location, etc.
- specific assistance for children (baby food, toys…), for older adults or people with disabilities (mobility aid e.g.), translations for foreign language speakers, etc.

- establishing a single **focal point** for **information handling**:

- **multi-disciplinary** co-operation in collecting **data** on those involved (between emergency services on the scene of the ME), during transport, within hospitals and gathering necessary information on the causes and consequences of the ME itself
- **registration** and **data collection** via reception centres and call centres (e.g. publicising a reliable toll-free telephone number and adequate staff to handle calls from family members)
- **centralising**, **processing**, **verifying**, **updating** and **assessing** information on those involved (lists of deceased, injured, non-injured, missing)
- adequate and timely **communication** of accurate information **to those involved** about the situation (what happened/will happen) and on their loved ones (in person, by telephone or via other services)
- keeping a **logbook** of psycho-social activities, archiving documents and preserving valuable information related to the disaster (long-term memory of what occurred)
- periodic briefing of the **psycho-social staff** and management
- providing **press** and public relation officers, **other agencies** and **authorities** with relevant information, gathered during psycho-social activities

- **social** and **psychological support**

- wording and approach are very important: we 'offer' psycho-social 'support' - not 'care' or 'therapy'; we speak of 'people affected' by a ME- not 'victims'
- offer social support to people involved in the reception centre(s), during hopeful, joyful or painful tasks, on visits to the scene, to hospitals, to the morgue, etc.
- pro-actively provide information (e.g. by handouts) about possible reactions that can be considered as normal in the context of ME-situations, like state of emotional shock, sleeping disturbances, nightmares, frustration, restlessness, etc), being careful, however, not to create expectations about such reactions (not everybody will have these reactions)
- create an atmosphere of safety & confidence, protect from unwanted attention & external pressures, providing structure and orientation in order to minimise feelings of loss of control
- provide emotional support (i.e. if there is bad news or no news at all), but not treatment (i.e. affected people are not psychiatric patients)
- stimulate self-empowerment (minimise feelings of helplessness but avoiding victimisation)
- activate individual and collective resources of those involved, assisting in re-establishing contacts with their social networks and their local community, with special attention towards cultural and religious diversity (e.g. contact with community representatives or spiritual leaders, utilisation of religious belief and practises, if affected people desire such intervention; support grieving survivors in case of a first fare-well ceremony)
- assure consultations with partners and relatives concerning the disposition of victim remains or personal effects
- a telephone help-line can be provided for people involved at long distances or staying at home, offering emotional support and advise

- **pro-active screening** and identification of persons at risk for **posttraumatic stress reactions**
  - earlier traumatic experiences, prior psychiatric disorders, poor social network, etc. are factors that predispose to possible posttraumatic disorders
  - this psychological screening can be started within the first day

- **preparing** the **follow-up** for the transition phase.
  - liaison with usual health and local social services before the RISC is closed
    - the principle of informed consent of the survivor
    - inform the general practitioner (GP) or family doctor about the ME and the health situation of affected persons
    - provide access to appropriate mental health and support providers for those individuals that have been identified as at risk of severe posttraumatic reactions
  - serve as a basis for further evaluation

- access to **non-emergency medical service**
  Offering people involved access to a medical examination can be part of providing practical assistance, like providing routine medication for chronic illness (diabetes or hypertension e.g.). Medical attention can also be given concerning minor, event-related somatic needs, like psychosomatic problems (sometimes needing tranquilisers or antispasmodics e.g.) or disorders that are exacerbated by psychological stress (including atopic dermatitis, herpetic keratitis, endogenous uveitis e.g.).

  Others suggest that physical examination by a medical doctor or nurse, performed in a supportive way, can provide considerable emotional support, or even be part of the screening process for acute stress reactions and psychological risk factors.

Annex 6.

Psycho-social response in the Transition Phase

The PSFC has a function to liaise with the following people and organisations:

- all categories of affected persons, eventually with self-help and interest groups
- the RISC-centres and the hospitals
- the local public health, rehabilitation and social services which attend to the medical and psycho-social needs of people affected in a ME
- specific services that deal with administrative, legal, technical, educational, job issues of people involved in a ME (adaptation, job, school, subsidies, lawyer, compensation, translation, job adaptation, learning problems, …)
- authorities, religious and community leaders, media (burials, collective rituals, memorial services, utilisation of religious belief and practises)
- insurance companies, and airlines, bus, railway, ferry companies, private firms, etc that were involved in the ME (on behalf on the whole group of people affected)
- occupational health & safety department and management of responders organisations
- agencies for planning, training, evaluation
- reference - and research centres

Annex 7.

Psychological, social and environmental risk factors

- Early prediction of psychological difficulties can be based on:

1) Risk exposure:
   - intensity and duration of threat to life
   - type of physical injury
   - witness experiences
   - attack on integrity

2) Individual risk factors:
   - lack of competence (education, training and experience)
   - pre-morbid psychological problems
   - difficult life situation
   - lack of social support

3) Individual risk reactions:
   - disturbed disaster behaviour (panic, paralysis)
   - lack o relief reaction
   - resistance to outreach
   - severity of shock reaction
   - severity of post-traumatic stress reactions
   - no improvement first week post disaster
   - severe sleeping problems
   - maladaptive coping strategies (alcohol, social isolation etc.)

- Early prediction of social and environmental risk should include analysis of specific groups and factors as follows:

  - Age
  - Culture
  - Place they are (location)
  - Culture
  - Subgroup (heterogenous – homogenous)
  - Kind of loss (material – family)
  - Degree of dislocation
  - Gender
  - Language
  - Original country
  - Religion

Annex 8.

Psycho-social response in the Long term Phase

In order to ensure its co-ordinating function during the long-term phase, among others, the PSFC has a function to interface with:

- all categories of affected persons, eventually with self-help and interest groups
- all public health, rehabilitation, social and specialised services which attend to medical, administrative, legal, technical, educational, occupational, religious, cultural, relational, social, psychological needs and interest of people affected in a ME
- self-help and pressure groups
- authorities, religious and community leaders, media, insurance companies, airlines, bus, railway, ferry companies, private firms, etc that were involved in the ME (on behalf on the whole group of people affected)
- agencies for ME-management, planning, training and evaluation; reference- and research centres