community-based interventions in the wake of terrorism

the overview

the balance between awareness and fear

citizens and resilience

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colophon

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1 introduction

preface

This overview of community-based interventions in the wake of terrorism is one of the four products of Impacts EU-project: Citizens and Resilience, the balance between awareness and fear. It offers brief descriptions of best-practice community-based interventions in the context of psychosocial care following a terrorist attack.
It is a structured document for policy makers and (mental) health professionals to support collective resilience and natural recovery of the affected population. It is aimed at increasing communal resilience and initiating immediate, medium-term and long-term psychosocial aftercare. The interventions often appeal to community-leaders, key persons in specific communities, to voluntary organisations, to GPs and to professionals working in the field of mental health. The material is written in a general way which means it has to be adjusted to the actual context and situation.

General
A terrorist attack has a major impact on the community affected. We speak of the community affected because the community as a whole has to try to deal with the consequences of a disaster and return to a more or less secure existence[1 2]. By the community affected, we mean those directly affected, the relatives of those who have died, the injured, those who have just survived the disaster, and the people who have lost everything they owned. But those indirectly affected, the people who sensed the attack, who became aware of it by hearing, seeing or smelling it, are also part of the affected community. Others indirectly affected are the emergency workers who helped victims of the attack and journalists who reported the event. And the authorities that have to support the community in a recovery phase are part of it too. The 'affected community' could be summarised as those unable to avoid the consequences of a disaster.
The consequences of a disaster may vary widely. The feeling of security and control has gone, people have lost faith in their fellow man, and many practical matters have to be dealt with. Often, people's social networks have been badly damaged, and they cannot give or be given adequate support.

Why community-based interventions?
One of terrorism's aims is to disrupt community life through violent actions. That is why it is important to put in place interventions aimed at the community as a whole (in other words, community-based interventions) to assist affected communities in their collective resilience. These interventions set out to reinforce social cohesion and social support in a community. In this way, the effects of an attack can be mitigated and the community's resilience can be increased.
One example is to think of ways of identifying and helping affected subgroups in the community who develop psychological and/or physical symptoms. Or of interventions in which people can be given proper information about an attack and its consequences, so that a great deal of the disquiet can be alleviated.
Major interventions are geared to key figures within a community, such as teachers, spiritual

carers, community workers, general practitioners and other first-line relief workers. They are often already familiar with existing needs in the community, and people in the community trust them. Social support in particular seems to be extremely important to people's health and psychosocial wellbeing[3].

Aim: a source of inspiration
The aim of this document is to give a brief description of a number of best-practice community-based interventions that can make a contribution to effective psychosocial care following a terrorist attack.
The way in which this role is interpreted will vary from one terrorist attack to another. Many factors may be of importance here, such as the nature of the terrorist attack, the number of people affected by the attack, the policy of local and national government, care-management aspects, finance and so on. Precisely because of the great diversity among the EU Member States with regard to these factors, this document does not set out to provide an overall plan or guidelines, but it can serve as a source of inspiration. The material is written in a general way which means it has to be adjusted to the actual context and situation. Every reader will be able to see which interventions can be of benefit in his or her situation.

Design of this overview
Community-based interventions are subdivided into six types, as follows: a one-stop shop for support, in which those affected can get help with questions of all kinds, is an essential facility (1). Many professional psychosocial relief workers are not familiar with providing care following disasters and terrorist attacks. Interventions designed to support them are described (2). Insufficient attention is often given to the role of volunteers, although they play a major supportive role. How can organisation of volunteer help and cooperation with the professionals be improved (3)? Communication with those affected is a psychosocial intervention and is described as such here (4). Social support is an important component of resilience, and makes a positive contribution to the natural recovery of those affected. Interventions are designed to reinforce this support, which is often already spontaneously available, or to give shape to it if it is lacking (5). Health research forms the basis of attuning the provision of care to demand (6). These six community-based interventions constitute the leitmotiv of this document. We determined these six types based on the results of about 80 international scientific publications combined with the results of the European site-visits and expert-opinions.

Another key theme running through this document is the staging of follow-up care. On the basis of the European policy paper 'Psycho-social support in situations of mass emergency'[4], we have chosen to make a distinction between short-term, medium-term and long-term follow-up care. It is not known precisely how long (days, weeks, months) each stage lasts. The staging of psychosocial follow-up care chosen here is dependent, rather, on arguments based on content, such as what problems people face and what symptoms they have. On the

basis of this, it would seem that certain interventions need to be introduced at particular time points after an attack. Other interventions are of value at all stages.

The field of work that deals with community-based interventions for the purposes of psychosocial care following disasters and terrorist attacks is still very new. Within it, more practical guidelines and consensus on best practice are gradually being developed. Within the EU, ever-increasing experience is being gained of community-based psychosocial interventions following terrorist attacks. Many different disciplines need to work together in order effectively to incorporate this know-how into relief work. This requires a more public-health-oriented vision, which is a good adjunct to the vision of regular mental healthcare, which is often geared to the individual.

Note for readers
This document discusses the various types of community-based intervention (6) for the various stages (4). This gives 24 topics, each of which begins on a new page. This overview is not primarily meant to be read from the first page to the last. The intention is that relevant bits en pieces can be used whenever it is relevant.
The heading of each page provides a brief summary of the content. If you read these headings in order, you will see that they form a single narrative, as it were. If you wish to know more about a particular intervention, simply read the rest of the page. Any comments or suggestions that may occur to readers will be most welcome to Impact.

stages of care

Care following a large-scale shocking event can be roughly divided into three stages.

Based on the characteristics of the affected community following an attack, the following division into stages is adopted. This is partly based on the European policy paper 'Psycho-social support in situations of mass emergency'. We have added the preparatory stage, since we wish to draw particular attention to the importance of good preparation.

The short-term stage
The medium-term stage
The long-term stage
The preparatory stage

The short-term stage
The short-term stage following a terrorist attack is understood as being the stage at which people react to the immediate consequences of an attack.
In the minutes after an attack, people may have varying needs for practical, emotional, medical and social assistance. Depending on the nature of the attack, people will have to take account of other aspects and add in the appropriate psychosocial care.
It is always important to carry out the following basic actions:

- Taking care of those affected in a safe and comfortable setting.
- Answering questions about where loved ones are and about the terrorist attack itself. The best way to do this will vary depending on the culture, the individual and the situation.
- Meeting practical and social needs, such as reuniting people with family members and friends. This group too may constitute a group with varying needs (somewhere to stay, transport, psychological and emotional support).
- Organising a care chain for those who develop psychological symptoms.

The medium-term stage
The medium-term stage is the stage in which people adjust to the psychological, social and practical consequences of the terrorist attack(s).
In this stage of transition, people in the following groups may make an appeal for follow-up care:

- Victims admitted to hospital.
- Slightly injured victims.
- Uninjured persons and eyewitnesses.
- Partners, surviving relatives and good friends of those affected and missing persons.

A varying pattern of needs in terms of psychosocial care is to be expected in these different groups.

The long-term stage
Following a disaster, 10-30% of those affected continue to suffer physical and/or psychological consequences of the event for many years. They may be in need of specialist help. Some 5% of those affected develop a psychological disorder. These symptoms may develop only at a later stage (delayed onset). The psychological effects are often apparent for longer after a terrorist attack than after a natural disaster. One explanation of this may be that terrorist attacks are man-made. Those affected are affected not only by the catastrophic consequences of the attack, but also by the purpose, evil intentions and hostility of the perpetrators in relation to those affected and their community. Ongoing physical symptoms or disability bring a need for many practical adjustments in their wake.
In terms of the community, support must be given to elements that increase resilience.

Preparation: preparatory stage
The above interventions will be more successful if the way has been prepared for them in the preparatory stage. 'If you fail to prepare, you prepare to fail.'

types of community-based intervention

Six types of community-based intervention are described for each stage.

The following main themes have been selected on the basis of research into the literature, in combination with the results of site-visits to various EU-countries and the USA and expert-interviews.

One-stop shop for support
In order for those affected to be provided with effective psychosocial support, a central support point serving as a one-stop shop is required. Here, those affected can get help with all kinds of specific questions about the disaster. People with psychological and practical problems are helped or referred elsewhere for help.

The professional relief work chain
To ensure that psychosocial follow-up care is as efficient and effective as possible, it is supported by well-trained personnel who can refer back, to the greatest possible extent, to experience set out in plans, guidelines, models of best practice and evidence-based methods.

Volunteers
Volunteers play a supportive role in post-disaster psychosocial care. In the first few minutes after an attack, professional reinforcements are not usually on the spot, and the first people to attend to those victims are often volunteers (e.g. passers-by or groups of victims themselves). Volunteer organisations can play a more structured part in relief work and provide their members with support via education, training and coaching.

Communication
Experience has shown that people involved in a terrorist attack have a fundamental need for information. It is crucial to provide clear and effective information, for example on the fate of loved ones involved and about the attack itself. Some people will be asking questions actually on the site of the attack, while others will raise them a bit later on in the relief centre or the hospital, or will contact agencies from home.

Giving shape to or reinforcing social support
In order to be able to support a community effectively, it is important to know what has happened, seen from the perspective of the community affected. Then people can acquire an insight into what kind of psychosocial support is needed. So it is advisable to work with people from within the community, who wish to and are able to play a leadership role in the community's recovery. Other forms of social support also need to be reinforced, such as support from family and volunteers.

Organisation of stocktaking and evaluation studies
Various aspects of follow-up care and of the problems and needs of those affected can be regularly evaluated. Experience gained in health research has shown that it is particularly important to be absolutely clear about what you are researching, in whom, and for whose benefit. For example, short research pathways can make a particularly valuable contribution to good planning and implementation of relief work.

list of concepts

To make the document easier to read, a number of concepts are briefly described here.

Community
In the event of a terrorist attack, it is important to realise that a community affected by an attack often experiences fundamental change. In fact, one could speak of pre-terrorist communities and post-terrorist communities.
A community comes into being when people have something in common with one or more other people. In particular, the term 'community' is used in the geographical sense – a village, people living together or a society can also be called a community. Characteristics may also be used to indicate a community, for example 'the Chinese elderly community'.

Community-based interventions
Interventions to be carried out by particular parties (who vary from country to country) for 1) prominent persons (key figures) in specific communities, 2) volunteer organisations, 3) general practitioners, and 4) various professional relief workers in the field of mental health. The interventions are for the benefit of the population of the district in which 1, 2, 3 and 4 operate, and are designed to be conducted after a terrorist attack. The interventions are designed to increase resilience within the community or to initiate or maintain acute, medium-term and long-term follow-up care.

Terrorism
Terrorism is a terrifying method of repeated violent action used by semi-clandestine, individual, group or national players for strong personal, criminal or political reasons, in which – in contrast to attempted murder – the direct targets of violence are not the main targets. Generally speaking, the people directly affected are chosen by chance (opportunistic targets) or clearly selected from a population (symbolic targets) and serve to transmit a message. Threats and processes of communication based on violence between terrorist (organisation), (threatened) victims and the main targets are used to manipulate the main target (onlooker), and to change it into a target of terror, a target of demands or a target of attention, depending on whether the intention is to achieve intimidation, coercion or propaganda.

Psychosocial care
Psychosocial care after a terrorist attack is geared to the psychosocial needs of people affected by a terrorist attack. These needs may be practical, emotional, social or psychological. Some of them arise in the acute stage and some at later stages after an attack, and they may persist for years. Care may comprise, among other things, practical help, social support and psychological support. Locations where there is a need for psychosocial care in the first instance may be the site of the attack, hospitals, central support points for the injured, survivors, friends/family, evacuees, information centres and mortuaries.

Social support
Social interactions that provide individuals with actual assistance and embed them into a web of social relationships perceived to be loving, caring, and readily available in times of need. Social support has a positive influence on natural recovery and positive implications for health. Research has shown that social support is a positive sign of psychosocial wellbeing.

2 the short-term stage

Those affected need one central support point after a disaster.

At this one-stop shop for support, those affected and others involved can find help with their psychosocial needs. Immediately after an attack, in the most acute emergency phase, the one-stop shop can be sited in or close to the relief centre for those affected. In the second stage, the one-stop shop should be housed in a separate, centrally situated location.
The precise way in which a one-stop shop is organised depends on a number of different factors (community, attack, culture, etc.).
Generally speaking, it is a central place where victims, surviving relatives, relief workers and others involved in a disaster or attack can obtain answers to their questions arising out of the disaster/attack. It comprises a 'front office' where people are received, and a 'back office', to which the various support bodies belong.

It can perform the following functions:

1 Information and advice function, i.e. informing, advising and/or referring disaster those affected, relief workers and the authorities. It may also be decided to allow this support centre to play a central part in dealing with the press.
2 Facilitating function, i.e., firstly, facilitating support processes helping to deal with the disaster (e.g. early social, psychological, cultural and religious support). Special attention may be given to the needs of vulnerable groups (e.g. children). Secondly, a facilitating role can be played in the compilation, storage, provision and administration of disaster-related data.
3 Coordinating function: i.e. coordinating provision of practical and emotional relief, and efficient referral of those requesting help.
4 Preparatory work for the medium-term stage.

Three examples of a one-stop shop for support that have now been put in place are the Information and Advice Centre (IAC), the Reception, Information and Support Centre (RISC), and the Family Assistance Center (FAC).

↳ NL Handreiking opzet Informatie- en AdviesCentrum (IAC) na rampen. The Hague, 2004, pp. 17-26.
http://www.rampenbeheersing.nl/contents/pages/9518/handreikingopzetiac.pdf
EN The RISC (Reception, Information and Support Centre) in 'Psycho-social support in situations of mass emergency'. European policy paper 2001; pp. 23-24, Annex 5.
EN Family Assistance Center. Pier 94. New York City, September 2001, American Red Cross Disaster Services.

A checklist for setting up an IAC is available on the following site. This list is tailored to the situation in the Netherlands.

↳ NL Handreiking opzet informatie- en adviescentrum (IAC) na rampen. The Hague, 2004, pp. 45-55.
http://www.rampenbeheersing.nl/contents/pages/9518/handreikingopzetiac.pdf

After an attack, relief workers helping those affected may well become affected themselves.

After an attack, psychosocial care is of immense importance from the outset. Those affected have a variety of needs, such as clear information, practical and emotional support, help to make contact with family members, friends and other networks. All this helps in regaining control, a key concept in post-disaster psychosocial care. Additional support may be provided by professionals and by trained volunteers.

In the first four weeks after an attack, psychological interventions may be needed. Often, those working in mental healthcare are not prepared for coping with providing care after a disaster or a terrorist attack. When they are suddenly confronted with this situation, they may have questions about how to proceed, for example what interventions are to be recommended and under what conditions, and what skills do professionals need in conducting psychological interventions? Shortly after 9/11, the National Institute of Mental Health in the United States issued a publication on early intervention.

↳ EN National Institute of Mental Health. Mental health and mass violence: Evidence-based early psychological intervention for victims/survivors of mass violence. A workshop to reach consensus on best practices. 2002.

Guidelines can offer a strong support for professionals. They are based on the last scientific findings in combination with systematically gathered best-practices.

↳ EN Post-traumatic stress disorder (PTSD): The management of PTSD in adults and children in primary and secondary care – National Institute for Clinical Excellence – Protocol National Institute for Clinical Excellence, London, 2005.

In the Netherlands there is a multi-disciplinary guideline available especially on early interventions. This guideline will be translated in English in 2008 to support the standardization of post disaster psychosocial care in Europe.

↳ NL Multidisciplinaire richtlijn vroegtijdige psychosociale interventies na rampen, terrorisme en schokkende gebeurtenissen – Impact & Trimbos – Amsterdam, 2007.

Experience has shown that, both in the acute stage of a disaster and in the long term, spiritual care can be an important adjunct to regular post-disaster care. With the aid of the options available to it (manpower, church buildings and places of worship, rituals and symbols, commemorations and funerals, pastoral care for people in their homes, support groups for those grieving and companions in adversity, diaconates and networks), it supports the resilience and vitality of those affected and affected communities.
When a disaster is caused by terrorism, it can be a particularly complex matter for spiritual leaders to work together on an intercultural basis to provide relief.

Positive experience was gained in this area both after 9/11 and after the 7 July attacks in London.

↳ NL De Ruyter AM et al. Rampenspirit. Gestructureerd improviseren. Impact, 2005.

In a terrorist attack, mental health professionals are not only relief workers, but also people indirectly affected. The nature of their work means that they run the risk of developing disaster-related symptoms. The organisations for which they work are responsible for arranging support for professionals who are exposed to shocking events. Some rules of thumb that may help not only professionals, but also other people affected, to reduce secondary traumatisation:

- Multidisciplinary cooperation.
- Supervision and intervision.
- Not working for too long and going home on time.
- Brief discussions of practical issues and the strategy to be followed.
- Regular breaks.
- Alternating between policy-related and relief tasks.

↳ EN Fostering resilience in response to terrorism: among primary care providers. Factsheet. APA.
EN http://www.apa.org/psychologists/pdfs/careproviders.pdf#search=%22fostering%20resilience%20primary%20care%20providers%22

Volunteers play an important part, which needs special support.

Right from the first moment after an attack, volunteers play an important part. They are often the first people to be on the spot – for example chance passers-by and fellow victims. It often takes some time for disaster relief organisations to be fully operational. In the meantime, people rescue and look after each other, offer consolation, take command of districts and communities, and open provisional relief centres, for example in churches.

→ NL Ruitenberg & Helsloot Zelfredzaamheid van burgers bij rampen en zware ongevallen 2004 COT Instituut voor veiligheids- en crisismanagement. The Hague

Sadly, valuable volunteers (with medical or public-health training) often seem to find it difficult to slot into acute-stage professional relief work. The following problems arise with volunteers who come forward of their own accord:

- Verification of accreditation (for example, checking on certificates or licences).
- Liability.
- Management and supervision of volunteers.
- In CBRN attacks, volunteers need particular attention because they may be less accustomed to working with formal protocols. They may find it difficult to accept the need for a formal working method, or may not be familiar with certain tasks.[5]

An attempt can be made to structure the input of volunteers into psychosocial follow-up care. This can help with the above-mentioned problems, and offers training opportunities.
See the 'Preparatory stage' section. Existing organisations with experience of this include:

- The International Committee of the Red Cross. www.icrc.org
- International Save the Children Alliance. www.savethechildren.org

In addition to follow-up care for professionals who develop symptoms, it should also be borne in mind that volunteers may need follow-up care.

For example, 10 months after 9/11, research was conducted in New York into the physical and mental status of 1,138 people (out of the total of 11,768 professional and voluntary rescue and recovery workers studied)[6]. It turned out that a substantial proportion of the workers (43.2%) qualified for a routine mental health evaluation, and 8% for treatment in connection with suicidal tendencies. On the basis of questionnaires, 43.9% needed to be referred for help, and 19.7% of those surveyed after 10 months proved to be suffering from PTSD.

Follow-up care is often arranged for volunteers working in organised fashion, but this is not usually the case with volunteers who come forward of their own accord.

The Reference Center for Psychosocial Support of the International Red Cross has compiled a lot of knowledge about supporting affected communities. The information is available through an open Psychosocial Document Database with important documents, manuals and training materials for volunteers.

→ EN http://psp.drk.dk

Communication from the authorities and via the media can provide strong support for those affected and relief workers.

Official media

It is essential for the authorities to have an effective media policy, in order to give those affected confidence that the authorities are capable of giving them solid support.

Erikson says of this: 'people's sense of injury becomes all the sharper and more damaging when …other human being respond to the crisis with what is seen as indifference or denial.'[7] The provision of clear, transparent information about the psychosocial, medical, financial and other relevant consequences of a terrorist attack is an essential task if the authorities are to retain citizens' trust [Becker SM, 2001]. If this is not done, it can be seen as a failure to take the disaster seriously, or the withholding of important information for political reasons. Involving the public is not a guarantee of success, but failure to involve the public virtually guarantees failure[8].

Information needs to be provided by key figures or experts within the community of relevance to the attack. Its aim and content can vary – general information, risk and crisis communication and psycho-education. The information must be easily accessible, geared to the target group, provided in an effective way, relevant and, if necessary, available in various languages. More information on communication in the various types of attack is given in the publication 'Terrorism and other public health emergencies: A field guide for the media'.

↳ EN Terrorism and other public health emergencies: A field guide for the media
EN www.hhs.gov/emergency/mediaguide/field/

Information campaigns will be most effective if they get across that:

- A particular kind of behaviour is required (vulnerability).
- This behaviour will prove to be effective (sense of control).
- Individuals have the necessary skills to behave in this way (ability to cope).
- Others expect the individual to behave in this way (standards).
- This behaviour shows that one cares about others (morale).

The degree of emphasis on the individual points will vary depending on the culture and situation.

↳ EN Omasundaram D et al. Natural and technological disasters. In: 'Trauma interventions in war and peace: prevention, practice, and policy' by Green et al., Kluwer Academic 2003.

Journalists have developed models of best practice and codes of behaviour among themselves in order to be able to report safely on shocking events. For example, they themselves may have to cope with problems such as physical and mental trauma and burnout, and may be exposed to toxic substances.

↳ EN Šindelářová B. Vymětal S. Tragedies & journalists. Ministry of the Interior of the Czech Republic 2006.

EN www.dartcenter.org

Terrorism and other public health emergencies: a reference guide for media

EN http://www.hhs.gov/emergency/mediaguide/PDF/09.pdf

Information

- Information and follow-up care projects can be identified by an umbrella name (+ logo) with a positive ring to it, to be as persuasive as possible in getting people to take advantage of the services.
- Advertisements on TV, radio, in the press, leaflets, in buses and on the underground. Internet: sites with specific information:

↳ EN www.projectliberty.state.ny.us

- General health-related sites:

↳ EN www.webmd.com

- Involvement of supportive knowledge centres that have up-to-date information on psychosocial care following attacks and can disseminate this direct.

↳ NL www.risicoencrisis.nl

EN www.impact-kenniscentrum.nl

EN www.krisberedskapsmyndigheten.se

EN www.fema.gov

EN www.safecanada.ca

Activities and networks that offer those affected social support should be established or reinforced.

In the short-term stage after an attack, those affected will want to make urgent contact with their families and friends. This is an essential source of social support.
Following an attack, however, existing social structures may disappear (possibly temporarily) as a result of losing loved ones, know-how, key figures and whole organisations.

Professionals and volunteers within and outside the central support point will try to compensate for this loss of social support to the greatest possible extent for a diverse group of people affected.

1 Injured victims in hospital, who may, for example, need emotional support, and whose psychological condition needs to be monitored.
2 Uninjured or slightly injured victims, who may have the same needs as the first group.
3 Relatives and friends of the dead and injured, who may be in need of social support. For example, a family may need someone with them when they identify the bodies of loved ones.
4 Groups requiring particular attention (e.g. children, the elderly, people with a psychological disorder).

↳ EN 'Psycho-social support in situations of mass emergency.' European policy paper 2001; pp. 22-23, Annex 5.

As voluntary or professional relief workers, people can play a part in discussions with citizens and key figures, looking jointly at how a community was organised, what human resources are currently available, and what bodies (e.g. religious denominations, pressure groups, schools) can, in the community's view, be involved in providing social support. Taking part in discussions about organising social support gives a sense of control, offers more hope, forms a source of resilience, and provides energy for rebuilding the community.

↳ EN Van Ommeren M. Wessels M. IASC Guidance on mental health and psychosocial support in emergency settings. Fourth working draft May 2006. Action sheet 5.

Immediately after an attack, people are often only too ready to offer each other help and support. People feel very close to each other, and donate money and practical items to demonstrate this. Initial conflicts within a community (social class, ethnicity) seem to be temporarily swept away. This is also known as the 'honeymoon' stage, and in this stage the community is an 'altruistic community'.
Care often proves not to be equally distributed among those affected. Its provision takes place in accordance with longstanding socio-political and cultural rules. In other words, the quantity of care is the result of complex interactions between the individual, the community and the attack itself. For example, it can happen that owing to their age or financial status, some people make less use of the beneficial aspects of the altruistic community.

↳ NL Gersons B et al. De psychosociale zorg na de vuurwerkramp in Enschede; lessen van de Bijlmer-vliegramp. Ned Tijdschr Geneeskd 2004; 148(29): 1426-30.
EN Kaniasty K. Norris FH. Social support in the aftermath of disasters, catastrophes, and acts of terrorism: altruistic, overwhelmed, uncertain, antagonistic and patriotic communities. In: Bioterrorism. Psychological and public health interventions by Ursano et al. 2004. Cambridge University Press. pp. 217-222.

With the aid of health research, care can be better attuned to the needs of those affected.

Aims of health research

1 To identify possible exposure and/or health impact at individual level. To provide those affected with clarification regarding possible exposure to harmful substances.
2 To identify possible exposure (at community level), for example in order to provide a basis for a risk assessment.
3 To take stock of the affected population, for example insight into the population's composition, identification of groups at high risk.
4 To take stock of the health status, e.g. identification of the effect of specific interventions or more community-based interventions (evaluative research).
5 To gain more knowledge, e.g. about the relationship between exposure and psychological and physical symptoms.
6 To respond to questions, concerns and pressures from the affected community and/or politicians.

In the Netherlands, it is recommended that research under headings 1, 2, 3, 5 and 6 should be addressed as soon as possible after the disaster. It can be useful to repeat these stocktaking and evaluation exercises, in full or in part, in later stages of follow-up care. The latter is known as setting up a monitor. Careful attention must be paid to ethical (e.g. informed consent, privacy, data protection) and cultural standards, which may be important in carrying out research with those affected.

↳ NL Franssen EAM et al. Handreiking gezondheidsonderzoek na rampen CGOR, RIVM pp. 65-70
www.rivm.nl/cgor/kennis/publ/index.jsp

Recently developed techniques for collecting samples and compiling data have speeded up the performance of quantitative research. For example, Random Digit Dialling (RDD) is a way of obtaining a probability sample from a community prior to telephone surveys. The first three digits are fixed and represent a particular area, and the remaining digits are selected randomly in accordance with a particular system.

↳ EN Schlenger WE, Silver RC. Web-based methods in terrorism and disaster research. J. of traumatic stress 2006; 19(2): 185-93.

Stocktaking is often conducted by means of questionnaires. When studying the international literature, one must bear in mind that the use of valid and reliable questionnaires from other countries does not guarantee good validity and reliability in one's own country. It is difficult to produce a translation that is culturally acceptable, comprehensible, relevant and of equivalent semantic value, and as a result the reliability and validity often need to be re-examined.

↳ EN Ommeren M van. Validity issues in transcultural epidemiology. British journal of Psychiatry 2003.

3 the medium-term stage

There is a partial change in the function of the central support point.

During the short-term stage, the central support point organises and provides various activities. In the medium-term stage, this changes to some extent. The support point acquires more of a facilitating function with regard to normal structures within healthcare and the community that fulfil the psychosocial needs of those affected.

Specific role

1 A central contact point that champions the needs of those affected (in dealing with the authorities and the media, with insurance companies or business undertakings involved).
2 Continuing documentation and evaluation of the needs and psychosocial care of those affected.
3 Assistance for self-help groups, pressure groups, reunions, meetings and get-togethers of various parties. Self-help groups may benefit from professional support.
4 Facilitation of access to healthcare.
5 Cooperation with specialised services with experience of the long-term consequences of attacks (e.g. screening of those affected or risk groups for psychological symptoms, and identification and onward referral of this group).
6 Cooperation with services involved in the continuing search for missing or unidentified persons.
7 Attention to the needs of hospitalised victims (belated need for information about the attack, social isolation).
8 Facilitation of rituals, ceremonies and commemorations.

Support organisations may be:
Medical services
Educational institutions
Social services
Insurance companies
Housing associations
Spiritual carers, churches, religious denominations
Research and knowledge centres
Embassies

Translation agencies or VETC. VETC stands for Voorlichting over gezondheid en opvoeding in de Eigen Taal en Cultuur (information on health and education in one's own language and culture). In the Netherlands the Netherlands Institute for Health Promotion and Disease Prevention (NIGZ) is involved in this.

↳ NL Handreiking opzet Informatie- en AdviesCentrum (IAC) na rampen. VNG uitgeverij The Hague 2004; pp.17-26. http://www.rampenbeheersing.nl/contents/pages/9518/handreikingopzetiac.pdf

EN The RISC (Reception, Information and Support Centre) in 'Psycho-social support in situations of mass emergency'. European policy paper 2001; pp. 27-32.

NL Information about VETC: http://www.nigz.nl/index.cfm?act=dossiers.inzien&vardossier=14

Professionals obtain a better idea of the risk groups and the care provision needed.

In the medium term, it becomes clear which people are having problems dealing with everyday matters and adjusting to the new situation. A professional can help people:

- to join self-help groups or pressure groups;
- to adopt an active problem-oriented attitude (this reduces the feeling of helplessness);
- to take realistic steps;
- where possible, to put things into perspective and to adopt the most positive attitude to the future possible;
- with treatment for complex grief reactions and psychological disorders; it is advisable to follow guidelines such as the NICE PTSD Guidelines and the brief eclectic psychotherapy (BEP) model.

↳ EN Fostering resilience in response to terrorism: Among primary care providers. Factsheet, APA.
EN http://www.apa.org/psychologists/pdfs/careproviders.pdf#search=%22fostering%20resilience%20primary%20care%20providers%22
EN Post-traumatic stress disorder (PTSD): The management of PTSD in adults and children in primary and secondary care – National Institute for Clinical Excellence – Protocol National Institute for Clinical Excellence, London, 2005.
EN http://kennisbank.impact-kenniscentrum.nl/doczoekenfull_nl.php?id=1000011941&type=4#
EN Lindauer RJ, Gersons BP et al. Effects of brief eclectic psychotherapy in patients with posttraumatic stress disorder: randomized clinical trial. J Trauma Stress. 2005 Jun; 18(3): 205-12.

Extra training may be needed for regular relief workers within a community. Here, it may be appropriate to involve trainers for their experience of and expertise in training professionals who have to deal with those affected. If international advisers/trainers are used, the ISTSS guidelines are relevant.[9]
Two examples of training in cognitive behavioural therapy for trauma-related symptoms are:

↳ EN Neria Y (ed.), Gross R, Marshall RD, Susser ES. Mental health in the wake of terrorist attacks. Cambridge University Press 2006.
EN Basoglu M et al. A brief behavioral treatment of chronic post-traumatic stress disorder in earthquake survivors: results from an open clinical trial. Psychological Medicine, 2003, 33, 647-654.

It is also important to be able to recognise alcohol- and drug-related problems. Training in screening, prevention and short-term treatment will be found in the following documents:

↳ EN www.who.int/substance_abuse/activities/en/
EN Young BH et al., Disaster mental health training. Guidelines, considerations, and recommendations. In: Interventions following mass violence and disasters: strategies for mental health practice. Richie et al., 2006.

Training for key figures
General practitioners and other first-line healthcare providers may need extra training and training in disaster-related symptoms and referral options.
Spiritual carers, teachers and other key figures in a community derive benefit from training, opportunities for consultation, and flexible referrals.

Volunteers may be given a monitoring function and be supported by means of training and supervision.

Within the community itself
Volunteers within a community can play an important monitoring and supportive role in a 'buddy system'. A volunteer (buddy) is assigned to an attack victim. He or she offers the victim practical and emotional support and gradually involves him in everyday activities. If a victim has psychological symptoms, a buddy can raise the alarm. Buddies are trained and given professional support. If the buddy already knew the victim before the attack, he is able to assess what behaviour gives grounds for concern.
In the Netherlands, this system was used after the disaster in Volendam. It is based on experience gained following the disco fire in Göteborg (Sweden).

↳ NL Beernink MK. Support in Volendam. De kracht van de gemeenschap na een ramp. Bohn, Staflieu, van Loghum, Houten 2006.

Volunteer organisations play an important part in supporting those affected. Some examples are

Warchild/World Child Kosova offers support to children in coping with traumatic experiences of war by means of creative workshops and sporting activities. For more information about these organisations, see:

↳ EN www.worldchildkosova.com
EN www.warchild.com

The International Red Cross
For example, support for the needs of families of missing persons in the acute and medium-term stages.

↳ EN www.icrc.org/Web/eng/siteeng0.nsf/htmlall/5CBDZG/$File/ICRC_TheMissing_082002_EN_4.pdf

The Reference Center for Psychosocial Support of the International Red Cross has compiled a lot of knowledge about supporting affected communities. The information is available through an open Psychosocial Document Database with important documents, manuals and training materials for volunteers.

↳ EN http://psp.drk.dk

Religious denominations often play an important part in coping with traumatic experiences such as a terrorist attack. The publication 'Rampenspirit' [disaster spirit] covers this topic. In the Netherlands, religious denominations do not yet always have a fixed place in disaster planning – this varies from community to community.

↳ NL de Ruyter AM et al. Rampenspirit. Gestructureerd improviseren. Impact, 2005.

Volunteers and those affected can also join pressure groups or self-help groups. The missions and activities of pressure groups vary.

Here are some examples

United Kingdom: Disaster Action

↳ EN www.disasteraction.org.uk

France: S.O.S Attentats

↳ EN/FR/ES www.sos-attentats.org

Spain: e.g. AAV11M (Association of aid to the victims of 11 March)

↳ ES www.ayuda11m.org

USA: Peaceful tomorrows

↳ EN www.peacefultomorrows.org

Factsheets with information about how people can help themselves to cope with a traumatic event/disaster

↳ EN www.ncptsd.va.gov/facts/disasters/fs_self_care_disaster.html

EN www.istss.org/terrorism/self_english.htm.

Communication serves to give attention, provide information, and refer people for expert help when necessary.

In the medium term too, it is important for the media to continue to devote attention to the terrorist attack and the consequences for people and their community. There will be commemorations (especially one year after the attack), details of which will be published in many newspapers, magazines and radio and television broadcasts. The authorities can play an active part in this, by organising or facilitating commemorations. If necessary, the authorities can respond to questions still arising within a community.
Below we give two examples of designing effective communication:

A public information section in a one-stop shop for support in the Netherlands initiated a large number of information products for its affected community:

1 The Bewoners Nieuwsbrief [residents' newsletter] was a paper that came out once a week. This newsletter contained important information, often the successful adjustment of individual customer contacts. This gave many people affected a sense of recognition, and for doctors and many social organisations, it was a valuable source of information. The residents' newsletter was also published in a fixed advertising page in the weekly free local paper.
2 A service heading in a local radio programme in which various topics were discussed. Part of the programme was interpreted and transmitted in Turkish and Moroccan.
3 The local authority commissioned a film of the district affected. This film was initially given a private showing with support from aid to those affected. Subsequently it was possible to order the video in 6 languages.
4 A relief workers' magazine was brought out for the many emergency workers who had helped during the disaster.
5 An informative website was developed and expanded further to include a digital shop.

↳ NL Informatie- en adviescentrum. Jaarverslag 2000. Gemeente Enschede March 2001

This is an international site on which people can obtain information in 15 languages about the emotional consequences of the tsunami. Scientific research is being conducted via the site into the effects of the disaster. This is done by means of structured questionnaires (web survey). By logging in for the web survey, people can request an e-Consult online. In this system, participants can put questions to experts in a safe way and receive advice within 24 hours. The e-Consult is not intended as therapy.
The site also includes a forum, an open online discussion platform where experiences can be shared with people affected.

↳ www.tisei.org

Social support needs to be an integrated part of the community.

In the medium-term stage, there will be a marked decrease in social support in a community as a result of various negative influences. The social network within a community may be damaged by a terrorist attack (death, injury, relocation of those affected). This may have consequences for the amount of social support experienced and perceived by a victim.
Terrorism has a negative effect on social activities when places that people previously used for them have been destroyed or are perceived as unsafe. This in turn affects fellowship with friends, family or the community as a whole.
A third effect may ensue from the fact that stressed people have a negative influence on one another.
Fourthly, the fact that a terrorist act is man-made (as opposed to 'nature-made'), may lead to divisions within the affected community (e.g. on the basis of religion, social status and origins).

↳ EN Kaniasty K & Norris FH. Social support in the aftermath of disasters, catastrophes, and acts of terrorism: altruistic, overwhelmed, uncertain, antagonistic and patriotic communities. In: Bioterrorism: psychological and public health interventions. Ursano et al. Cambridge University Press 2004.

In this stage, mutual support within a community can be additionally empowered by

1 enabling a community to grieve collectively and facilitating shared activities;
2 leaving people in their natural groups if there is an enforced need for rehousing;
3 organising social activities for and with members of new communities;
4 organising group meetings to brainstorm on various aspects of rebuilding the community. Citizens can play an active part in this.

↳ EN Norris FH et al. Psychosocial resources in the aftermath of natural and human-caused disasters: A review of the empirical literature, with implications for intervention
EN www.ncptsd.va.gov/facts/disasters/fs_resources.html

Note on 1. A particular repertoire of rituals has been observed in the Netherlands since the 1990s. This repertoire is coherent and well organised, and includes:

- Holding of silent processions
- Appropriate forms of collective mourning within a community
- A lasting monument as a memorial
- Annual commemoration

↳ EN Post P et al. Disaster rituals; Explorations of an emerging ritual repertoire. Peeters 2003, Leuven, Belgium.

Monitoring for the purposes of evaluation and guidance.

Starting points in the Netherlands

The following investigations can be conducted in the first three months after an attack. They supplement the research in the short-term stage and study the various topics in depth.

1 Screening or individual research. Exposure, other risks and consequences for health are identified for individuals affected.
2 Research at group level. The nature and extent of what was experienced in the terrorist attack are established, risk groups are identified, and the demand for care and care needs in respect of follow-up care are assessed. This study may be repeated, since needs and the demand for care change over time.
3 Socially based research. This is research that helps to combat disquiet in society and to rebuild trust, and/or to identify unanticipated effects on health.

Three to six months after an attack, it is important to chart the health status of those affected. Information is needed on:

1 The incidence of somatic, psychological and/or social problems.
2 The health problems to be anticipated and their likely course in order to attune the provision of care to demand.
3 The effects of interventions: evaluation and monitoring.

↳ NL Franssen EAM et al. Handreiking Gezondheidsonderzoek na rampen. CGOR/RIVM 2006 pp. 65-70.

4 the long-term stage

The one-stop shop is adapted in line with the community's needs.

The after-effects of a disaster or terrorist attack can linger on and continue for years. A one-stop shop for support remains useful in the long term. For example, it can coordinate care in areas where there are still problems (e.g. financial claims) and support specific groups and individuals who are vulnerable and need more help.

It is assumed that a one-stop shop will remain in existence for some four to five years, in a limited and appropriate form. It is important to run down a one-stop shop gradually. In the Netherlands, the checklist for the running-down stage can be used.
This contains useful tips on dealing with networking partners, those affected and the media. It refers to the fact that documents containing knowledge acquired must be housed with the right bodies. And evaluations of the psychosocial interventions in the various stages should be used in preparing for and planning care in future attacks.

Description of a support centre

↳ EN The RISC (Reception, Information and Support Centre) in 'Psycho-social support in situations of mass emergency'. European policy paper 2001; pp. 33-37

NL Handreiking opzet Informatie- en AdviesCentrum (IAC) na rampen. The Hague 2004 pp.17-26.
http://www.rampenbeheersing.nl/contents/pages/9518/handreikingopzetiac.pdf

Checklist for running-down stage

↳ NL Handreiking opzet Informatie- en AdviesCentrum (IAC) na rampen. The Hague 2004 p. 57.
http://www.rampenbeheersing.nl/contents/pages/9518/handreikingopzetiac.pdf

Examples of a one-stop shop over the long term

↳ NL http://www.crnhetanker.nl 5 years after the café fire in Volendam.

EN http://www.projectliberty.state.ny.us 5 years after 9/11.4.

Professionals may find themselves dealing with a group of people with chronic psychological symptoms.

The long-term consequences of terrorist attacks may be just as serious as or even more serious than the incident itself[10]. These less visible long-term consequences may be expressed as physical and mental suffering, disability, loss of one's job, home, possessions, local environment and trusted networks, and loss of cohesion in the affected community. This 'post-disaster disaster' is also known as a 'secondary disaster'. Following the Chernobyl disaster (1986), the nine psychosocial help centres set up after the disaster proved to be still in operation in 2001.
Relief workers may find themselves dealing with a wide range of psychological symptoms in those affected. Extra training and supervision may be required in the fields of supportive counselling, working with families, complex mourning, suicide prevention, dealing with inexplicable physical symptoms, managing substance abuse and referral in this connection, anxiety disorders, mood swings, and the diagnosis and treatment of PTSD.
Having a family member on the missing list also has serious long-term consequences for the health of surviving relatives. Sometimes the surviving family members form new communities in which they help each other with many issues.

↳ EN Boss P. Ambiguous loss in families of the missing. The Lancet 2002; 360: 39-40.

Policymakers in the mental healthcare field will have to work towards appropriate national legislation, policy and implementation in the area of psychosocial care after a terrorist attack.

↳ EN Mental health of populations exposed to Biological and Chemical Weapons, WHO, Geneva, 2005.

Volunteers: an inflation-proof investment.

Within the community itself
Volunteers within a community can play an important monitoring and supportive role in a 'buddy system'. A volunteer (buddy) is assigned to a victim. He offers that person practical and emotional support and gradually involves him in everyday activities. If a victim has psychological symptoms, a buddy can raise the alarm. Buddies are trained and given professional support. If the buddy already knew the victim before the attack, he is able to assess what behaviour gives grounds for concern. In the Netherlands, this system was used after the café fire in Volendam. It is based on experience gained with psychosocial support in Göteborg (Sweden) following the disco fire.

↳ NL Beernink MK. Support in Volendam. De kracht van de gemeenschap na een ramp. Bohn, Staflieu, van Loghum, Houten 2006.

Volunteer organisations continue to be of great importance in supporting those affected.

The Reference Center for Psychosocial Support of the International Red Cross has compiled a lot of knowledge about supporting affected communities. The information is available through an open Psychosocial Document Database with important documents, manuals and training materials for volunteers.

↳ EN http://psp.drk.dk

Communication about the attack and its consequences remains important.

The support centre remains in existence in a limited form, and continues to be a contact point for those affected, professionals and volunteers who want more information.

Here is an example of designing effective communication
The public information section in a one-stop shop for support in the Netherlands initiated a large number of information products for the affected community in the medium-term stage. In the long-term stage, it conducted extensive research into the impact of these information resources on recipients:

- On the basis of this, the Bewoners Nieuwsbrief (residents' newsletter) was continued in the form of a monthly magazine. The content was expanded to include representatives of healthcare, interest groups made up of individuals, artists and entrepreneurs from the rebuilding project office. This expansion meant that various information flows could be incorporated.
- The website containing information was expanded into a Q&A site on which not only those affected but also interested parties could find information or request it by email.
- There turned out to be a great need for information on the part of schoolchildren and students. Accordingly, an information package was compiled.
- Contact with the press was both active and passive. The media were kept informed with the aid of press lunches and press releases. Reports were also regularly borrowed from the monthly magazine. In this way, the media were able to fulfil their function of keeping the public informed.

↳ NL Informatie- en AdviesCentrum. Jaarverslag 2001. Gemeente Enschede. May 2002.

Over the long term, a great deal of communication is also taking place as a result of the health(care) research carried out. Various parties, such as knowledge centres and universities, are involved in this. Their findings are being reported at national and international level, orally and in writing. Versions for the public need to be written in order to make these reports more accessible.

Social support is a structural component of the community.

Social support continues to be of great importance over the long term. Terrorism has serious psychosocial consequences. Disruption of the community threatens (isolation, scapegoating, loss of confidence in the authorities and relief organisations). These consequences can in their turn lead to new conflicts, prejudices and stigmatisation.
However, good outcomes have also been reported in the literature. Studies in two communities showed no reduction in social support and cohesion following a large-scale shocking event. The explanation given was that these communities had sources of social, financial and psychological protection at their disposal.
If the right measures are taken after a disaster or an attack, they can help to improve the structure of the everyday surroundings of an affected community.

↳ EN Gunter VJ et al. Toxic contamination and communities: using an ecological symbolic perspective to theorize response contingencies. The Sociological Quarterly, 40, 623-40.
EN Kaniasty K, Norris FH. Social support in the aftermath of disasters, catastrophes, and acts of terrorism. In: Bioterrorism: Psychological and public health interventions. Ursano et al. Cambridge University Press 2004.

Rituals and commemorations also remain important over the longer term.
The question arises of how long the authorities and other official bodies must continue to take responsibility for this.
Memorial committees often assume responsibility for organising the annual commemoration. Those affected often play an important part in this. For them, it can be a way of finding a balance between the energy this demands of them and the benefit they receive from it in terms of the bond with other people affected, consolation and recognition/remembrance.

Pressure groups and organisations of fellow sufferers continue to be a great support to those affected over the long term in particular, as does support from churches, religious denominations and other organisations involving a philosophy of life.

Research is still in full swing and new research is being begun.

Starting points in the Netherlands
The following investigations should be conducted over the long term following an attack, or can be repeated.

1 Stocktaking of the affected population. An example:
- Research into factors that may play a major part in the occurrence, severity and duration of long-term effects.

2 Stocktaking of the health status of those affected, since there is an ongoing need for information on:
- the incidence of somatic, psychological and/or social problems;
- anticipated health problems (type, number of people) and their course, in order to attune care provision to demand;
- the effects of interventions need to be evaluated or monitored.

3 In order to increase the scientific knowledge available, the following investigations can be initiated:
- Investigations gathering information on the etiology of attack-related disorders.
- Investigations gathering information on the consequences of exposure to disasters.
- Investigations designed to increase understanding of the (possible) link between exposure to harmful factors and health.
- Investigations providing an insight into the anticipated nature and extent of health problems in relation to future attacks.
- Investigations studying the validity and reliability of measuring instruments used after the attack.

↳ NL EAM Franssen et al. Handreiking Gezondheidsonderzoek na rampen. COGR/RIVM 2006 pp.65-70.

5 preparation; the preparatory stage

The dormant central support centre.

Preparations that can be made in the preparatory stage to give shape to a one-stop shop for support have been clearly described. The preparations cited here are tailored to the situation in the Netherlands.

An Information and Advice Centre can be prepared at local or regional level. In the Netherlands, this is arranged in such a way that local authorities are responsible for setting up an IAC. A checklist has been developed, and shows step by step how to work on preparing an IAC. The checklist for the preparatory stage begins with points relating to the external environment that require particular attention.
A scan of the surrounding area and issues needs to be commissioned, to be carried out in relation to the external parties of relevance to the IAC. In this way, one finds out not only which parties are relevant (scan of surrounding area), but also what their relationship with the IAC is (scan of issues). Might they be cooperation partners for the IAC, or do they have an interest in the IAC? Do they need to be kept informed, or do arrangements need to be made with them at an early stage? It is useful to record this in the preparatory stage, so that advantage can be taken of this information at the time of a disaster.
Subsequently, the checklist is drawn up on the basis of the following operating functions:

- Primary process.
  For example, draw up a description of target groups and the primary process of the IAC, arrange for financing.
- Personnel.
  For example, appoint people to be responsible for the process and a team to prepare the IAC.
- Information & registration.
  For example, tips on developing a registration system.
- Communication/public information.
  For example, guidance on information officers and translators it might be possible to employ.
- Accommodation/facilities.
  For example, plan to site the IAC in the middle of the affected community, with the possibility of a front and back office.

↳ NL Handreiking opzet Informatie- en AdviesCentrum (IAC) na rampen. The Hague. 2004 pp.11-13 & 37-44.
NL http://www.rampenbeheersing.nl/contents/pages/9518/handreikingopzetiac.pdf

Professionals: initiative is worth its weight in gold.

The position of the professional: chain of command
Many professionals are brought in to help in connection with shocking events in general, and terrorist attacks in particular. It often proves not to be easy to involve professionals and volunteers efficiently, so that thanks to their expertise they can provide victims with effective support. In the short-term stage in particular, a clear structure is required in terms of management and responsibilities. Often it is not clear who is in charge, there are communication problems at various levels, and too many people and relief workers come to the site of the disaster[1]. It can be helpful to practise repeatedly in the preparatory stage, and to evaluate the practice properly.

Recommendations and models of best practice were published at the time of the Oklahoma bombing, and they constitute good preparation for an attack.

1 Development of a plan specific to terrorist attacks, and a plan for long-term psychosocial follow-up care. Irrespective of the administrative level involved, it is important to:

- have a plan
- test the plan
- share the plan with the relevant colleagues
- practise the plan regularly
- update the plan regularly
- enter into relationships as part of the planning
- prepare a list of service providers.

2 Development of a strong network between mental health professionals themselves and between mental health professionals and first responders. Encourage the mental health community to sign up as a participant in an organisation geared to psychosocial care after a terrorist attack.

3 Information on potential funding geared to psychosocial care after a terrorist attack.

4 Preparation of framework conditions for research.

This document is published by the MIPT (National Commemoration Institute for the Prevention of Terrorism). This is an organisation primarily engaged in compiling and disseminating information about preventing terrorism and reducing its consequences.

↳ EN Oklahoma City – Seven Years Later: Lessons for other communities. MIPT 2002
http://www.mipt.org/pdf/MIPT-OKC7YearsLater.pdf
www.mipt.org

Potential volunteers need to be known in advance as far as possible.

As we said earlier, problems can arise with volunteers who come to help of their own accord. There can be problems as regards accreditation, responsibility, liability and supervision. An attempt can be made to structure the efforts of volunteers in psychosocial follow-up care. This would help to deal with the above problems and offer opportunities for training.

Examples are

1 Organisations that rely primarily on volunteers, such as:
The International Committee of the Red Cross.

↳ EN www.icrc.org

International Save the Children Alliance.

↳ EN www.savethechildren.org

2 National networks launched among volunteers, operating at local level, such as:

- Medical Reserve Corps (active since 2002) is a network comprising 30,000 volunteers and 230 local subdivisions. The local subdivisions have teams of medical and public (mental) health professionals from within the community. The advantage of the emphasis on local subdivisions is that the training package can be attuned to specific characteristics of the community (e.g. experts in geriatrics if there are many elderly people).

↳ EN www.medicalreservecops.gov

EN Hoard ML, Tossato RJ. Medical Reserve Corps: Strengthening public health and improving preparedness. Disaster Management & Response 2005; 3(2): 48-52.

- Citizen Corps: a national network of volunteers who want to aim to prepare their families and the community for terrorism, criminality and disasters.

↳ EN: www.citizencorps.gov

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↳ EN http://psp.drk.dk

Thought must be given to how communication will be organised and what will be communicated following an attack.

In the preparatory stage, it is a question of communication about the risk, the aim of which is to prepare people for the possibility of a transition from risk to crisis. Two ways of communicating can be distinguished:

- Informal information:
  In the preparatory stage, it is as yet not a matter of a crisis as the result of an attack, but of a perceived risk of a crisis if the necessary measures are not taken. In the preparatory stage, it must be ensured that information about this risk does not lead to disquiet among the population. By means of communications about the risk, citizens and other target groups are informed of new potential risks in a way that is tailor-made for them.

- Specific information:
  In this stage, the preparatory and planning activities are geared to limiting the extent of a disaster as far as possible, and to organising relief work as well as possible.
  At this stage, the measures have a 'what if?' character. Elements of the preparatory stage include drawing up a plan and holding practices, developing crash kits and designing specific measures to encourage the desired behaviour and retain public confidence.

↳ NL Risico en crisis gecommuniceerd; naar een verbeterde risico- en crisiscommunicatie. Werkgroep Voorlichtingsraad. Rijksvoorlichting, Ministry of General Affairs.

In order to provide a community with information quickly after an attack, 'silent websites' can be maintained. These are immediately actively furnished with information in the event of an attack. The community itself is told in the preparatory stage of the existence and value of the 'silent website'.

↳ NL www.crisis.nl

The Dart Center is an organisation working on the topic of journalists and trauma. Here, journalists who intend to involve themselves in reporting on attacks can obtain useful guidance. For example, tips are given on the best ways of bringing particular traumatic events out into the open, and the best ways of interviewing those affected. Journalists are also informed about the risk of traumatisation and the opportunities for follow-up care.

↳ EN www.dartcenter.org

Social support, whom should you support and how?

It is useful

1 To be aware of the 'human capital' in a community.
- What different subcultures exist?
- What key figures can be approached?
- What vulnerable groups exist within a community?

2 To know how people interact with one another. Are there central meeting points? Who uses them?

3 To gain an understanding of the possible effects that an attack may have on social support within a community.

4 In the event of a (bio)terrorist threat, for the community to learn to get used to the threat and the hazards of (bio)terrorism, to counter the potential risk of a loss of social cohesion.

↳ EN Kaniasty K, Norris FH. Social support in the aftermath of disasters, catastrophes, and acts of terrorism: altruistic, overwhelmed, uncertain, antagonistic and patriotic communities In: Bioterrorism Psychological and public health interventions. Ursano et al. Cambridge University Press 2004. pp. 217-222.

Networks are an important means of obtaining social support and effective information. Networks are also of importance to relief workers. Networks among the various partners involved in relief work and within a particular type of relief work can be an important source of support and information. Within the EU, for example, there are various ways in which psychosocial support is provided following an emergency or a disaster. A publication that discusses this and also briefly sets out the structure of civil protection on a country-by-country basis is that of Wood-Heath & Annis.

↳ EN Wood-Heath M, Annis M. Working together to support individuals in an emergency or disaster. Project Final Report. British Red Cross 2004.

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↳ EN http://psp.drk.dk

Community Stress Prevention Center (Israel)
An example of a centre working to increase resilience within a community is the Community Stress Prevention Centre. Within this Centre, Professor Lahad has developed a model known as BASIC Ph. This model incorporates various coping styles and teaches adults to avoid stress and/or to learn to cope with stress. It is applied with parents and children, but also in schools for the benefit of teachers and their students. This latter project has two goals:

- To train teachers to conduct interventions and use follow-up techniques that help them to prepare themselves at times of a terrorist threat. This enables them to provide better support for their classes in a stressful security situation.

- To train students to assume a supportive role in a crisis situation. Active participation had beneficial effects on their coping skills.

↳ EN http://icspc.telhai.ac.il/material/articles/stress_settlements.htm

Evaluation and research require a vision geared to the long term.

Across the world, various organisations have been set up to help to prepare for research after a terrorist attack. The aims may range from support for and partial implementation of post-terrorist research to training of researchers. Researchers can be trained in the latest research techniques, methods for taking stock of needs and psychological problems, reliable and efficient data gathering, and effective interventions. Practical advice can also be sought in respect of specific projects, and the support of mentors can be requested.

Some examples are

↳ EN Disaster Research Training Grant (DRT). www.nctsnet.org

EN Disaster Research Education and Mentoring (DREM) Center. www.disasterresearch.org

EN Research Education in Disaster Mental Health (REDMH). http://www.redmh.org/

In making preparations for health research, it is important to prepare at both administrative and organisational level. For example, an administrative decision can be made that post-disaster health research is a core task in combating disasters and crisis management.
In organisational terms, it is important, for example, to be clear about who will be commissioning the research, who, in principle, will be taking up the research, and who will be involved in carrying it out. In addition to the administrative and organisational aspects, the content aspect is also important. If those affected are carefully listened to when study questions are drawn up, research can play an important role in supporting the authorities and relief work. A checklist for preparing to conduct post-disaster research is available for the situation in the Netherlands.

↳ NL Franssen EAM et al. Handreiking Gezondheidsonderzoek na rampen. COGR/RIVM 2006 pp.21-26.

6 appendix

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(Endnotes)

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A lot of care and attention was given to content, design and quality of this product.
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