



## WADEM Oceania Newsletter. October 2016

Welcome

To a slightly new look newsletter, following a committee discussion the newsletter will have a 'themed' focus for each issue. This issue it is mental health, a topic so important in resilience and recovery from major events. Research work and lessons learnt from experience are included, all important to improve knowledge of the requirements of psycho-social responses.

Reports from health service here in Christchurch, yet again, are included. These highlight the ongoing strain on mental health services and the effect on the population some 5+ years post- earthquake.

I also want to highlight the coming elections for the Oceania Chapter committee please consider joining the committee and contributing to the WADEM organisation in our region. Along with committee members, a new newsletter editor is required as I will be relinquishing that role after many years. The creative juices are drying up. We are also losing John Coleman from the Committee, sadly John is not in a position to continue due to his health. John was a foundation member of the Chapter Committee.

Cheers

**Graeme**

### Guest Editorial by Professor Sarb Johal

#### **Does the concept of recovery serve us well?**

In traditional models of disaster management, the stage that follows response is usually labelled recovery. In a social context, recovery is typified as following a trajectory, including Heroic and Honeymoon phases, as well as the Disillusionment phase with obstacles, followed by that has been terms the Reconstruction phase. This whole sequence has been characterised as a pathway to recovery. . I would gently suggest that this doesn't reflect reality very well at all. I have lost count of the times that I have heard with a cynical tone words to the effect of, '*Am I recovered yet?*' Because calling this recovery implies that there may be an end-point, and I think this does not do us or the communities we serve any favours.

A dictionary definition of recovery offers many definitions, a couple of which include; (a) a return to a normal state of affairs, and (b) the action or process of regaining possession or control of something stolen or lost. Are either of the ideas encapsulated in these definitions realisable after a disaster? I believe it is questionable to raise expectations according to these lay understandings of what recovery might mean.

A more technical definition is offered by the Ministry of Civil Defence and Emergency Management in New Zealand, where recovery is defined as: 'The coordinated efforts and processes to effect the immediate, medium and long term holistic regeneration of a community following a disaster'.

Furthermore it offers that, 'Recovery is a developmental and a remedial process encompassing the following activities:

- Minimising the escalation of the consequences of the disaster;
- Regeneration of the social, emotional, economic and physical well-being of individuals and communities;
- Taking opportunities to adapt to meet the social, economic, natural and built environments future needs; and
- Reducing future exposure to hazards and their associated risks.'

Though this is a more precise yet broader definition of the scope of recovery in a disaster context (as one would expect), I would argue that it does not necessarily reflect lay understandings of recovery or how the concept is talked about in everyday life. In addition, I believe it misses some key components.

For example, the concept of 'Destierra' might give us a clue as to what might be going on underneath the 'hood of what we might mean by recovery. Destierra is a Spanish word that refers to the psychological effects of being uprooted, displaced or dispossessed from a loved place. There appears to be no direct equivalent for the concept in the English language. However, immigrants often experience mental health issues arising from grief associated with forced and often hurried removal from homes, land and culture, with often limited opportunities to return 'home'. This can also be seen to be mirrored in the experiences of many indigenous peoples, and is accentuated and exacerbated through the loss of a decisive say in how these lands are subsequently managed.

So, if we follow this though, in a sense, we perhaps have no words in modern English-language based societies for this loss of sense of place, and our selves in it. Could it be that the loss of place also results in the loss of part of our selves and also the loss of agency in managing the place in which we find ourselves? In this sense, recovery is not possible, and has no end.

I wonder if we would not be better of perhaps thinking about adaptation to post-disaster environments? That is, rather than recovering, we think of adaptation, defined as the process of becoming a better fit for one's environment. However, it is critical to also think about one's agency within this. Not agency in the sense of Government departments or NGOs doing things for us, but fostering and supporting a sense of agency and purpose in the place where we find ourselves, so we can exert meaningful influence in our own adaptation pathway.

One of the issues that has emerged in my thinking about agency is the ability to be able to determine one's own outcome – so this is self-determination. But, determination also means the ability to persist in the face of great difficulty.

So we have the elements in place for re-storying the post-disaster environment of adaptation – a process of change by which one becomes a better fit with one's environment. This isn't giving up or becoming resigned to a process of *fait accompli*, but needs to be considered in the light of increasing the opportunities for self-determination and the exertion of real agentic influence in the post-disaster environment – to be able to change that too.

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### **9/11 fifteen years on: Recounting the ongoing psychosocial impact on the first responders**

The September 11, 2001 terrorist attacks (9/11) on the World Trade Center (WTC) killed nearly 3,000 people, including 413 Emergency First Responders, and caused profound human suffering, physical destruction, and economic loss (1). Whilst New York rebounded strongly following 9/11, one of the painful legacies of the disaster is the lasting effect on the mental health of thousands of individuals who survived the attacks— including the first responders. The fifteenth anniversary this year marked an important milestone in our collective remembrance of 9/11, with countless television specials, documentaries and articles all focusing on what happened on that single day. However, a deeper understanding of what truly happened and the ongoing impact of the terrorist attacks requires us to delve deeper and consider the ongoing, long-term consequences on the first responders.

Early health and psychosocial assessments following 9/11 tended to focus on firefighters and indicated that sleep issues, mood changes, feelings of detachment, and flashbacks were common problems for Fire Department of New York (FDNY) responders (2). Published reports on the health and psychosocial impact of 9/11 on medics (paramedics and emergency medical technicians) are scarce. One study indicated that medics who had been directly involved with the 9/11 response reported ongoing psychosocial impact five years after the disaster (3). They reported problems sleeping, mental health issues such as anxiety and depression, extreme moods, addictive behaviour such as smoking and drinking, and negative impact on relationships, with some reporting the breakdown of marriages.

Long-term research on a cohort of 54 9/11 medics highlights that the terrorist attacks were experienced in a very personal and individual way, bearing long-lasting impacts on not only themselves, but also on their family and friends (4). When medics reflect on their initial response to 9/11, the words come slowly. Recollections bring back a range of emotions. Mass atrocity can overwhelm the ability of language to fully describe the devastation that has been witnessed. Many medics recalled sights, feelings and smells, but often paused, apologising mid-sentence as memories flood back and they find themselves right back there, in a pile of dust and debris.

Study participants reported problems sleeping, mental health issues such as anxiety and depression, extreme moods, addictive behaviour such as smoking and drinking, and negative impact on relationships. Some reported the breakdown of marriages, and marriages and ongoing strain on significant relationships. Most participants reported that their respective employers had been supportive in providing ongoing health and mental health care to 9/11 responders, however, almost half were not actively accessing support at the ten-year milestone. This number had increased at the fifteen-year anniversary, with all medics reporting some sort of access to support services. Reasons for not seeking support earlier included a belief that “there were others worse off than them” and that “they would be seen as weak” if they admitted they needed help.

The medics who responded to 9/11 are still impacted by ongoing physical and mental health consequences of that day. Medics continue to be traumatised by 9/11—because what they

experienced has not ended. The trauma of that day continues to affect the psychosocial health and well-being of many medics, with new cases of 9/11-related illness diagnosed regularly. In many cases, the ongoing impact of 9/11 has shattered families and destroyed lives in a never-ending reverberation of pain and suffering. These findings indicate the need for ongoing, targeted support services for 9/11 medics and their families. The reality is that while the physical wounds may have healed, the emotional scars remain for many medics fifteen years after 9/11.

#### References

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- (2) Fire Department, City of New York: Bureau of Health Services WTC Medical Monitoring and Treatment Program. World Trade Center Health Impacts on FDNY Rescue Workers.
- (3) Smith E. Paramedic perception of risk and willingness to work during disaster. PhD Thesis. Monash University, Melbourne, Australia December 2009.
- (4) Smith E, Burkle FM Jr. Are you OK? 9/11 medics 15 years on. Presented at the Australian and New Zealand Disaster and Emergency Management Conference, Gold Coast, Australia, May 2016

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#### **Canterbury DHB pleased increased mental health need recognised**

Released Monday March 21, 2016. (Accessed at [www.CDHB.health.nz](http://www.CDHB.health.nz) website 29 August 2016)  
Canterbury DHB chair, Murray Cleverley, is pleased with today's announcement by the Minister of Health, Dr Jonathan Coleman, which acknowledges the increased demand for mental health services Canterbury DHB has experienced since the series of earthquakes that have rocked the region since 2010.

"It's fantastic to see the increased demand recognised, as our staff and those providing care in the community are certainly feeling it, and our data is still showing high numbers of new people being admitted into the acute inpatient service," Mr Cleverley says.

He says the additional funding will allow the DHB to continue to provide the services people in our community need.

"It is recognition to those at the sharp end of providing care that their work is highly valued. This is the work that is being carried out every day in the community, through primary care and non-government organisations, in schools, in the police watch-house, in prisons and across the specialist mental health service.

"The fact this funding is spread over a three-year period means that we can take a longer-term view. We will continue to adjust our services to meet the changing demand patterns over time.

"At the moment we are seeing really high demand for Child and Youth services. This funding means we can continue to invest and strengthen these services," Mr Cleverley says.

*Six years' post-earthquakes the increased demand for mental health services is an ongoing cost and an example to be factored into any disaster response plans. Graeme*

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### **Post-quake pressures on Canterbury continue to shake the health system**

Tuesday, 23 February, 2016 (Accessed at [www.CDHB.health.nz](http://www.CDHB.health.nz) website 29 August, 2016)

The latest national health target results show a Canterbury health system that is continuing to deliver for its population despite being under increasing pressure. David Meates, Canterbury DHB chief executive, says the health system continues to be operating in a very fragile state and there's no sign of it easing anytime soon.

"While I'm incredibly proud of what we've achieved in the past five years – it's been nothing short of remarkable – five years on we are still operating in an environment that is a long way from being business as usual. This health system continues to strive to do the best for its community despite the very disrupted environment that we work within," he says.

Mr Meates says Canterbury's integration efforts with primary and community organisations remain key to ensuring it can deliver world class care to Cantabrians.

"It is impressive Canterbury continues to achieve the Emergency Department (ED) health target with 95 percent of people admitted, discharged or transferred from ED within six hours, despite growing demand."

Younger adults, particularly those non-enrolled aged 25-29 years, are driving demand with ED attendances increasing 46 percent for this age group since 2014.

"This reflects the rebuild population. The DHB is not funded for the workers who have come in from overseas to help with the rebuild. We have an increased focus on capturing home addresses and ensuring this group is provided with appropriate information about where to seek primary care, rather than defaulting to ED."

### **Research/ Evidence Corner**

#### **Could an Australian Resilience Officer impact better mental health outcomes following a disaster?**

Anthony Bergin and Paul Barnes, from the Australian Strategic Policy Institute, wrote the following article titled *How Australia needs to adapt to face the inevitable disruptions heading our way* for *Sydney Morning Herald* on 24 August 2016 and co-authored *Working as One: A road map to disaster resilience for Australia*. While not directly related to mental health, the article raises an intriguing suggestion that could contribute to mental health outcomes. With Melbourne and Sydney appointing two Resilience Officers through the Rockefeller Foundation, Bergin and Barnes suggest that, an Australian Chief Resilience Officer, answerable to the Prime Minister, might 'help ensure our communities, metropolitan and regional areas, and nation can better withstand, nimbly respond, recover, and adapt to the inevitable disruptions heading our way'. In the face of increasing disasters, such an appointment may well promote resilience to improve mental health outcomes.

*Australia may be a land of sweeping plains and rugged mountains ranges but it's increasingly a land of densely urbanised populations living on the coast. Our identity may be less well defined as our people travel to and from other lands and our economy becomes integrated into global markets.*

*We face different and significant challenges including managing border threats, such as pandemics and animal and plant diseases. We rely on international maritime and aviation based supply chains for a range of essential products.*

*We face more extreme weather events across our region as climate variability continues.*

*Research released this week by German-based [Climate Analytics](#) has given fresh insight into [what global warming is likely to mean for Australians](#) if it is not curbed.*

*The report suggests southern Australia would have longer heatwaves and dry spells, and intense rain storms would be 2 to 3 per cent heavier. The change in northern Australia is much more dramatic, according to the study.*

*We confront uncertainties from global economic volatility and transnational terrorism. All these shocks can occur with limited warning, or their onset not noticed.*

*In short, we face many events or situations which may threaten our welfare, environment, economy, national security and identity. Just like droughts and flooding rains, how serious these disruptions are, depends on the likelihood of them happening and on the consequences or impacts that people and the economy will feel if they do occur.*

*In the face of these disruptive events we need to feel that our people are not only resilient but that they will pull together and bounce back stronger. It's about our capacity to persevere and adapt when we're faced with challenges.*

*Our communities and businesses can thrive only if the systems and networks that underpin our daily lives, whether physical, technological or social, are able to better withstand, recover from, and adapt to the inevitable shocks and disruptive events we're likely to see.*

*Confidence could be boosted at a national level by better integrating national security, social and economic policy so that thinking about resilience becomes everyone's business. There are a couple of initiatives that should be considered.*

*First, Australia should develop an aggregated national risk assessment that would evaluate our national risk exposures in terms of their impact, plausibility and likelihood. This would aid preparation for all kinds of emergencies and help the development of state, local and city-based resilience plans.*

*Such an assessment would set out the capabilities required to meet a range of likely threats from, for example, natural hazards, pandemics, major accidents, failures of essential services, terrorism and cyber-attacks.*

*By examining how these emergencies compare in terms of likelihood, and the scale and extent of the consequences, we can anticipate the future capability needs of governments. It would ensure we're better able to prevent, mitigate, respond and recover from disruptive challenges.*

*In essence, this is 'behind the scenes' work by state and federal agencies and experts, albeit with levels of broader consultation.*

*Second, and to give this work a public face, we should establish a Chief Resilience Officer for Australia. An Australian Chief Resilience Officer, could help break down 'silos' between national agencies responsible for infrastructure planning, energy, social cohesion, housing, healthcare, education, economic development, social welfare, disaster management and environmental protection, and will help ensure our communities, metropolitan and regional areas, and nation can better withstand, nimbly respond, recover, and adapt to the inevitable disruptions heading our way.*

*We have seen such [people appointed for short periods](#) when a major disaster occurs – think Cyclone Tracy or Australia's involvement in East Timor. It is now time to establish a permanent role so that we are pro-active rather than re-active.*

*An Australian Chief Resilience Officer, answerable to the Prime Minister, will help ensure our communities, metropolitan and regional areas, and nation can better withstand, nimbly respond, recover, and adapt to the inevitable disruptions heading our way.*

*It's about finding the synergies and nurturing the shared capabilities to enable the nation and our communities to face significant challenges that can disrupt the way we normally live. The tasks are so many and varied that a single national focus point for resilience thinking and coordination will yield the results.*

*At the start of the Turnbull government's three-year term there are few more important imperatives to progress than bolstering national resilience.*

**From Dr Caroline Spencer, Monash University Disaster Resilience Initiative.**

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## **Kiwi surgeon saves Fijian woman's sight after botch-up**

**This news report highlights that it is not only post-disasters where less-than-competent 'tourists' arrive to provide aid. It can happen during regular poorer nation 'aid' assistance.**

STACY SQUIRES/FAIRFAX NZ

A Fijian woman faced losing her eye after a foreign surgeon's botched operation.

An American medical aid organisation botched cataract surgery on Sarifa Begum in Fiji, leaving her in extreme pain and blind in one eye. Without the help of a Christchurch surgeon, she would have lost the eye.

Begum's niece, Farisha Naaz and nephew, Shiraz Ali, who live in Auckland contacted Christchurch surgeon Dr Sean Every, who agreed to perform the necessary procedure free of charge.

Normally, a cataract, or cloudiness of the natural lens, is removed and a new lens is put in. "Instead of extracting the cataract it was knocked down to the back of the eye," said Every. That requires the skills of a vitreoretinal surgeon. They didn't have a way to deal with that, so they just sent her home."

Naaz contacted various eye surgeons around New Zealand asking for help, and found out the operation might have cost between \$7000 and \$15,000. "I just had a letter come across my desk describing the scenario to me and saying 'can you help?'. And I thought, 'you know, I think we can actually'," Every said.

The board of directors at Christchurch Eye Surgery agreed Begum's was a deserving case and donated the theatre time and consumables. A New Zealand charitable trust called Volunteer Ophthalmic Services Overseas (VOSO) paid for Begum's flights. She is staying with a relative in Ashburton. She will remain in New Zealand for a few more weeks so Every can monitor any inflammation and remove the stitches.

Begum does not speak fluent English, but through her sister-in-law, Nazima Ali, she said she was grateful that Every restored her sight and relieved the pain. "She can smile now after the operation," Ali said.

Every called into question the professionalism of the surgeon who did the operation in Fiji. "It just raises a lot of questions about useful aid in these countries. Useful aid in my opinion involves upskilling locals." He liked to think that a New Zealand aid team in a similar situation would do whatever it took to rectify the situation. "These aid teams arrive in, hopefully do

more good than harm, bugged off, then someone like her is sort of left holding all these pieces and trying to sort something out."

He said aid surgeons might not necessarily have a lot of experience. "Overall they might have done some good... but you know, this person fell through the cracks a bit." Every said Begum was lucky her niece was willing to help. "It's thanks to her family, really, that they showed some initiative."

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An interesting report in the Fiji Sunday Times of 18 September, highlighted a health problem for Children in parts of Fiji affected by cyclones earlier this year. The cyclones damaged the reef eco system, which in turn drastically reduced the fresh fish catch, and it felt that this reflects nutritional problems for children as their diet now involves canned rather than fresh fish and a drop in the amount of fresh fish in their diet.

### Professional Development

#### Australian Risk Management Conference

#### Melbourne from November 16-18, 2016

This conference offers a **full program** of National and International Speakers including:

- Mike Utsler - Chief Operations Officer, Woodside Energy, BP Deepwater Horizon Response & Recovery
- Nicole Grantham - Chief Risk Officer, SAI Global
- Shannon Sedgwick - CEO, Global Media Risk
- Simon Madden - Director, Essendon Football Club

The Risk Management Institution of Australasia (**RMIA**) is the professional institution and industry association for Risk Leaders in the Asia Pacific region.

*RMIA members are involved in every sector of the community and economy.*

Our purpose is to **promote recognition and reward for our Members** and deliver:

Cutting edge education and professional development

- Recognised certification of professional standards, competency and ethics
- The opportunity to network with the Australasian and global risk management communities
- Value added services which benefit Members' careers, businesses and personal development
- *We can all learn from adapting the principles in risk management, building*



*resilience in our businesses and communities*

<http://rmiacconference.com.au/>

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**CALL FOR PAPERS**

**'Mobile Cultures of Disaster' Conference  
22-24 March, 2017  
University of South Australia  
Adelaide, Australia**

According to a growing body of literature, the dangers and hazards that people around the world face in the 21<sup>st</sup> century are in many ways unparalleled. In order to confront these problems, there is a growing recognition that disasters and other social disruptions are cultural matters.

This has stimulated research across the Asia-Pacific on the cultural determinants and consequences of disasters. However, the extent to which these concepts differ or intersect between various social contexts has remained less well-explored. Additionally, there is a need to further investigate how disasters cultures are mobile, in that culture is a phenomenon that circulates, as acutely evident in the rise of social media.

The aim of the conference is to bring together prominent academics, specialists and policy analysts across the world to investigate the cultural and mobile aspects of disasters. The conference principally seeks to stimulate research on how disasters are mobile and cultural phenomena. It asks participants to consider how disasters circulate around various parts of the world. This refers to the ways in which disasters involve movement and cultural exchange in terms of how they are managed, experienced and socially constructed.

Further information about the conference can be found at  
[www.unisa.edu.au/disastersconference2017](http://www.unisa.edu.au/disastersconference2017)

**Lessons Learnt**

**'THREE TIPS' Experts provide advice based on their experiences.**

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Gordon R. Dodge, Ph.D., LP  
Disaster Psychologist

Dr. Gordon Dodge is the clinical director for Lakes Area Human Services, Inc., Forest Lake, Minnesota. He has over 45 years of experience as a psychologist in clinical, consultative, and educational services, and he also heads up a consulting firm that addresses workplace and community crises and trauma.

As a disaster psychologist, Dr Dodge has extensive experience working with private industry, emergency services personnel, and other public agencies on a local, national and international basis.

Dr Dodge has had numerous international assignments: in the former Yugoslavia during their war (staff care); Kosovo (psychosocial evaluation team leader); Albania; the Burmese-Thai refugee camps; the Gujarat earthquake in India (psychosocial assessment and planning team leader); the KAL plane crash in Guam; development of the Worker Care Program for the Canadian Red Cross; two consultation and training assignments to Nairobi in follow-up to the embassy bomb blast; two psychosocial missions to Pakistan in response to the Kashmir earthquake; a consultation and training assignment in Guyana in response to civil conflict, mass murders, and neighborhood violence, and two missions to Haiti.

Domestic assignments have included an Oklahoma City bombing hotline; Red River Valley floods; Hurricane Katrina; San Diego Wildfires; and several other natural disaster responses in the U.S. for the American Red Cross, serving on their Critical Response Team; was assigned in a leadership position in New York following the World Trade Center attack; is an instructor in Coping with Deployment; Coming Home Series; Psychological First Aid; and Critical Incident Stress Management.

Dr Dodge has written, lectured, and provided training extensively on many other aspects of trauma and disaster psychology nationally and internationally.

A full curriculum vitae and description of services available may be obtained by writing to: Gordon R. Dodge, Ph.D., LP, PO Box 485, Center City, MN 55012 USA, +1-651-303-2355, [gordydodge@cs.com](mailto:gordydodge@cs.com)

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**THREE LESSONS LEARNED  
GORDY DODGE, PH.D., LP  
WADEM PSYCHOSOCIAL SECTION CO-CHAIR**

These are three of many lessons learned are based on my 25 years of experience in responding to domestic and international disasters and complex emergencies.

**1. Know yourself and know how to take care of yourself, whether on a short-term or a long-term assignment.**

- Have a self-care plan and stay with it.
- Pace yourself.
- Know what you are getting into.
- Stay in touch with home.
- Know what “bugs” you.
- Be patient and flexible.
- Have some fun, take time to relax each day, even if it is just for 15 minutes.
- Monitor yourself.

- 2. At least for psychosocial interventions, we are most effective not only by working in cooperation with the other responding functions and local resources, but through the services they provide.**

Have a local counterpart trusted agent pair up to work with you.

Identify and work with and through the affected populations' natural and spontaneous healing social systems and activities.

Not only have a good grounding in clinical psychology but also know how to maximize those methods by their application through community psychology principles.

- 3. Effective psychosocial interventions require accurate and thorough needs assessments.**

Draw not only on the advisement of other function responders but also representatives of the affected populations.

Involving the affected populations in assessing needs on an on-going basis not only improves assessment accuracy but doing so can, in itself, be a healing empowering activity.

Needs assessment should be an on-going activity.

Assessment should be conducted jointly with local mental health resources, as well as in cooperation with other NGO psychosocial respond.

**LESSONS LEARNED, UNLEARNED, AND RELEARNED  
REFLECTIONS FROM TWENTY YEARS OF INTERNATIONAL WORK AS A DISASTER  
PSYCHOLOGIST**

**GORDON R. DODGE, PhD, LP**

**PRESENTED AT THE WADEM CONGRESS**

**CAPETOWN, SOUTH AFRICA, APRIL 23<sup>RD</sup>, 2015**

**INTRODUCTION**

In this workshop I will briefly present best practices approaches and conclusions I have developed from my international disaster psychology work. These have evolved from complex emergency and disaster assignments in 18 countries over the past 20 years. This is a workshop, so questions and comments are welcome.

**INTERVENTION PREMISES**

"I realize I have very little understanding of how a people handles being at war, with the enemy just 20 to 30 miles away. I've seen neither patriotic rallies or signs, nor protests. It is like they try their best to live a normal life, spending a few hours now and then in the bomb shelters."  
(excerpt from my journal, Zagreb, Croatia, July 1995)

Community psychology

Social structures

Phases make a difference

Dependency vs denial

### **PSYCHOSOCIAL ASSESSMENT**

“About 5 kilometers outside of Kukes we came across a truck full of armed KLA, apparently trying to recruit additional men from among the refugees”. “I have been bothered much by the effects of the rain on the refugees; and the long lines (usually children) at the bread trucks, water trucks, and at public phones is saddening. Seeing a boy steal a smaller boy’s loaf of bread and the smaller boy chasing after him with a rock was also disturbing.” (excerpt from my Kosovo Crisis journal, April, 1999).

- Protocols and methods
- Community strengths focus
- Cooperative assessment
- Intrusiveness and epidemiology
- Reassessments

### **PROGRAM PLANNING AND DEVELOPMENT**

“I enjoy observing my feelings when starting an assignment. In some ways I am more labile than at the end of a mission when I am fatigued and satisfied; but not much more. Now I am confident, excited, curious, only a little apprehensive, and less patient than I will need to be when I get there.” (excerpt from my Kenya journal, August, 1999)

- Organizational capability/culture
- Local counterparts
- Flexibility/delays/approvals/priorities/revisions

### **TEAM SELECTION AND DEVELOPMENT**

“I guess I didn’t learn my lesson in Guyana; that is, to know and select your team members before going out on an assignment.” (excerpt from my Haiti journal, August, 2010).

- Option to choose team members
- Hidden agendas/organizational expectations
- National staff vs expats
- Professional/team/organizational growth

### **CAPACITY BUILDING**

“A quote from one of the Indians I worked with captures some of their primary characteristics: ‘Think positive, stand up, be bold, and face the problem like a lion’ “. (excerpt from my Gujarat, India earthquake journal, March, 2001)

- Competence, plus consultation
- Organizational and community development
- Awareness building and training options

### **ADMINISTRATION AND MANAGEMENT**

“The individual and inter-organizational power struggles had escalated since I was here a few months ago, and I had to be careful not to get caught up in those, but rather to focus on specific program improvements.” (excerpt from my Kenya journal, January, 2000)

- Competence plus consultation
- Organizational structure, policies, culture
- Supervisory skills
- Technological skills

## **PROGRAM EVALUATION**

“This assignment has given me the opportunity of improving on the basic evaluation design we developed in Pakistan, but I will need to stay involved to see to its fruition.” (excerpt from my Haiti journal, 2010)

- Initial design or after the fact
- Internal and/or external
- Organizational and donor methods
- Clinical-functional-community
- Ethics-training-supervision
- Time crunch/too ambitious
- Pit falls/ response bias/focus groups/hidden agendas

## **STAFF CARE**

“When I somewhat naively asked a Croatian social worker if thoughts and memories about assaults, killings, burning of homes, and shellings that she and her acquaintances had experienced were what mainly debilitated her, she said those took their toll but being on assignment by herself for months, not having sufficient supplies or administrative support, power outages, and no hot showers for weeks wore her out much more.” (excerpt from my Balkans journal, 1994)

- Individual/peer/supervisory/organizational responsibilities
- Critical incident/cumulative/organizational stressors
- Short term vs long term stressors
- Ex-pat vs national staff variables
- Selection/monitoring/exit protocols

## **COLLEAGUES/COMRADES/FRIENDSHIPS**

“Over the years since this assignment we have worked together several more times, and have developed a pleasant long-lasting friendship.” (excerpt from Kosovo journal, 2001)

- Loyalty/esprit de corp/movement dynamics
- Ex-pat vs national staff relationships
- Supervisory ethics
- Interpersonal unmet needs/dangers
- Local customs vs having fun

## **SELF-CARE**

“The rescue and recovery group’s leader located a body in the rubble and let me put his gloves on and reach in to identify the body as that of a young boy. I have a few emotional scars and triggers from my work, and since this incident it is no longer a pleasurable affectionate experience for me to reach out and tussle a young child’s hair.” (excerpt from my Gujarat earthquake journal, March, 2001)

- Have everything in order/ read organizational advisements
- Have a self-care plan developed
- Know yourself/pace yourself
- Know what you are getting into
- Stay in touch with home
- Have some fun/take time to relax
- Monitor yourself

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## WADEM INTERNATIONAL NEWS



The banner features the WADEM logo (World Association for Disaster and Emergency Medicine) at the top left, the Sunnybrook Health Sciences Centre logo, and the CBRNE Collaborative logo. Below these is a silhouette of the Toronto skyline with the word 'Toronto' written in a script font. At the bottom left, it says 'WADEM Congress on Disaster and Emergency Medicine 25-28 April 2017'.

**Registration and Accommodation** for the WADEM Congress on Disaster and Emergency Medicine 2017 are now open. The Congress will be WADEM's 20th biennial meeting of global experts to exchange knowledge and best practices on disaster and emergency health. Co-hosted by the [Sunnybrook Health Sciences Centre](#) and the [CBRNE Collaborative](#), the Congress will convene from 25-28 April 2017 in the vibrant city of Toronto, Canada.

For full Congress registration rates, please visit - <https://wadem.org/congress/toronto-2017/registration/>.

**REGISTER FOR THE CONGRESS**

## WADEM OCEANIA NEWS

### Chapter Committee Elections

Details of the Committee election will be circulated by Andrew Lavelle in the near future. Positions are:

- Chair
- Deputy Chair
- Secretary (Graeme standing down)
- Committee members

Self-nominations are required and are to be submitted to Andrew at [alavelle@wadem.org](mailto:alavelle@wadem.org)

Also required is a **Newsletter editor**, someone with fresh ideas to promote WADEM knowledge and experiences to members. Enthusiasm required fine editing is volunteered by Liz Noble who has had years of experience working with Frank Archer and Graeme.

\*\*\*\*\*

**Minutes of 3<sup>rd</sup> WADEM Oceania Chapter Committee Meeting**

**1pm Tuesday 30 August 2016**

## via Gotomeeting

### Welcome and Apologies

- Present: Graeme McColl, Caroline Spencer, Erin Smith, Sarah Weber, Penny Burns, Andrew Lavelle,
- Apologies: Joe Cuthbertson, Peter Aitken, Rowena Christiansen

### Minutes of previous meeting 26<sup>th</sup> May 2016

- Accepted ES – Seconded GM

### Newsletter review

- Current suggestions for template items and themed quarterly newsletters agreed on. Suggestions of encouraging all to contribute to each Newsletter as part of being on the Committee to lessen the work of the editor.
- SW agrees with progressing with this. It looks great. Additional inclusion of Conference details is a great idea.
- Request by PB, SW to have cameos from Auntie. SW suggestion of introducing a new 'character' if Graeme and Peter have exhausted Aunty's personality...
- Suggestion to contact Sarb Johal to contribute to next Newsletter.
- Andrew mentioned the templates across WADEM and volunteered their graphic designer to set up a template for the Newsletter so items could be dropped in to make the process easier for the editor.

### Blog submission

- Accepted as is by the Committee and AL to post up
- Explanations about blogs, forums and webinars on WADEM site from AL, and discussion about linking each Newsletter with a forum on the same topic led by an interested Committee Member PB.

### Committee position drafts

- Comment from SW: read these and somewhat concerned not living up to my end of the deal!! But as others said, coming into a position is a little daunting and not necessarily clear of expectations. Adding in specific things to do is a great idea - and would certainly give ability to contribute. Adding to the Newsletter or forums is great.
- Each member to contribute some editing to their particular job description and CS to head up the General Committee one and send back to PB for distribution to all for comment before the next meeting.

Conferences and other business

- Upcoming Resilience Conference Finland 2016 - CS attending.
- Futures Conference plan for July 2017 in Fiji – possibility for WADEM promotion PB.
- GM Comment on Hawkes Bay NZ gastro outbreak by GC and the effect it has had on the local community, closing schools and infecting ½ to 1/3 of the population.

Next WADEM Oceania Committee meeting date.

Doodle poll for 2 months' time.

Special thanks to Andrew for hosting it.

### Useful Resources

The views of a Doctor working in a tent near the major building collapse following the Christchurch earth quake.

<http://www.stuff.co.nz/national/85318229/rural-gp-reflects-on-training-reality-check-in-christchurch-earthquake>

This link won't stay active for long, I have the full transcript for anyone interest.  
Graeme.

Contributions and links to material that would provide assistance for our members required.

### Up Coming Courses

UNSW Short Course

#### **Health Aspects of Crises, Emergencies and Disasters**

##### **What is Covered?**

This course addresses the epidemiological, clinical, population, systems and service management aspects of crises, emergencies and disasters. Using a multi-disciplinary approach, it examines the role of healthcare professionals and managers within local and international emergency settings of different scales and durations, including natural disasters and civil emergencies. Students will be involved in scenarios and case studies drawn from major biological, chemical, radiation and natural disasters. Expert input will come from Faculty, including international experts who have been actively involved in managing crises in the field.

##### **How much does it cost?**

\$1500 for the full 5-day course or as an elective within the Masters program. Discounts for multiple participants from the same service organisation.

##### **When is it?**

November / December. Dates to be confirmed.



### Where is it?

The course will be held at the University of New South Wales, Sydney Campus.

### Further information?

[https://sphcm.med.unsw.edu.au/sites/default/files/sphcm/Current\\_Students/PHCM9662\\_Flyer.pdf](https://sphcm.med.unsw.edu.au/sites/default/files/sphcm/Current_Students/PHCM9662_Flyer.pdf)

## A FINAL THOUGHT

We are now at, hopefully, the end of the influenza season so this thought forwarded by a daughter-in-law might interest some. I must point out that it totally ignores statistical evidence from the 1918 pandemic when more men than women died, thus proving that men are more susceptible to influenza than women.

*Did it start with 'I think I'm coming down with a cold'? Don't forget, even medical experts recommend self-diagnosis, and ALL men are experts at recognising the early stages. You will be expected to sympathise; any flippant comments now such as "Oh, I expect it's Man Flu is it?" will cause immediate deterioration. Preferred responses will be along the lines of "There, there, can I get you some chicken noodle soup and put your favourite Police! Camera! Action! DVD on"? This stage can last from one to three days. He must be barely able to lift his fingers to work the remote control.*

*There will be dramatic displays of coughing and chest holding. He will present a red and sniffly nose, and a phantom fever. Do not mention <begin sarcasm> Man 'Flu <end sarcasm>. Instead, continue to serve comfort food and provide him with a selection of magazines and books to take his mind off the illness ravaging his poor body. You may also be required to gently dab his forehead with a lightly dampened sponge or massage his feet. This life threatening stage may last from three to five days. After 3-5 days it will not be completely gone.*

*By now he will be physically exhausted. He will have spent the previous seven days teetering on the brink of death only to have pulled through. However, he will start to feel less 'achy all over', and begin to move short distances away from the sofa. Hang in there with your pampering, you're nearly done. This stage can typically last from six to ten days. Please be aware that any sarcastic references to Man Flu at this stage can render the hapless victim straight back to the life threatening stage 2. He should be allowed a suitable period of convalescence (the length to be suggested by him) prior to being tasked with household tasks.*

The beloved Auntie is on a sabbatical at present, a recharging process she says, as an alternative she offers the 'daughter-in-law's' views as above.

## REQUEST FOR MATERIAL

Material is required for any of the sections listed, or under a new category, if that is appropriate. Personal experiences, case and research reports are especially welcome and we ask that these are limited to no more than 1,000 words. The subject matter can be aspects of a disaster or response that is unusual because of its type, location or effects. Material is welcome from WADEM members and even non-members internationally.

**Any suggestions regarding material for content, or to improve this Newsletter, are welcome.**

Please forward contributions to Graeme McColl at [ilsogno@snap.net.nz](mailto:ilsogno@snap.net.nz)

**DISCLAIMER**

The comments, opinions and material in this newsletter are those of the respective authors and not necessarily those of WADEM or the WADEM Oceania Chapter.