



The Psychosocial Special Interest Group (SIG) aims to pursue didactic, research, policy, and operational excellence in international disaster preparedness, response, and recovery, including the prevention and mitigation of psychological stress, and the promotion of resilience.

PSYCHOSOCIAL SPECIAL INTEREST GROUP NEWSLETTER

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Issue Theme: *Psychological Support and Care for EMS Personnel and Other First Responders*

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Introduction

This is the second newsletter issued by WADEM's Psychosocial SIG. There will be two issues per year (March and September). It is being distributed, free of charge, to all WADEM members and to others known to us as having an interest or involvement in international psychosocial research and field work. Please feel free to forward it to people who may be interested.

Purpose of the Psychosocial Newsletter

The Psychosocial Section Newsletter has been developed as a medium to provide WADEM members and other interested academics, professionals, students, and organizations with useful information relevant to international psychosocial work. Each issue will have a theme; this issue's theme is that of "***Psychological Support and Care for EMS Personnel and Other First Responders.***" Research and project abstracts and journal references are provided addressing this issue's theme. In addition, each issue briefly identifies a different graduate school program or institute having a disaster mental health graduate level track, organizations providing a variety of psychosocial resource information, a journal with psychosocial emphasis articles, and upcoming conferences or events of likely interest.

Guest Editorial

Dear Friends and Colleagues,

I am pleased to have the responsibility of editing this second issue of the WADEM Psychosocial Section Newsletter, covering the psychological challenges and extended support of EMTs, and the past history and current refugee/migrant situation in Greece. I have been a part of WADEM since the late 1990's; I was approached by various WADEM members at that time who recognized the need for the organization to include psychosocial factors in Congress papers, workshops, and other activities. The Psychosocial Task Force (later SIG) was formed in 2003 along with other WADEM task force groups, each focusing on particular disaster challenges.

My research interests have focused on the study of stress and coping in extreme environments, including Chernobyl power plant operators and affected populations, and polar expedition teams living and working over extended periods in isolated, confined, and extreme environments. An overriding finding from the Chernobyl studies was the marked deleterious psychological and physical health impact of the uncertainty about one's long-term health status in a context in which there was disbelief in the information provided by the government. This situation has parallels with other human-made disasters such as Fukushima in which long-term health implications simply are not known, or are minimized by institutional agencies.

While the motivations and goals of expedition teams are in many respects different from that of EMTs, examination of team composition and processes can be informative. The studies I conducted have been quite consistent in demonstrating personal and social values of self-determination, benevolence (interest in and empathy with other people), stimulation, and boldness (adventure-seeking). Would EMT groups be much different in values??? I don't think so, but it is an empirical question. An interesting issue that came up in a study of Danish military personnel living and working for an extended period on a remote station in Greenland related to team conflict resolution; that is, a personal decision by a group member when/if to take sides when two members of the group disagree with each other. Clearly, conflict resolution can have significant ramifications on the effectiveness of EMT groups as well.

While EMT groups may only operate in a disaster area for a relatively short period of time, psychological support while in the disaster area and during the reintegration back into one's usual life following a period of high stimulation and stress can be a challenge. The articles in this newsletter by Eyal Fruchter and Karen Ginat, Gordy Dodge, and Erin Smith address different aspects of providing psychological support and care to EMTs and other first responders. In addition, Jeffrey Levett's account of the history of migration to Greece and its past and current public health ramifications provides a perspective on how a disaster process impacts both the refugees/migrants and the local population.

Psychosocial SIG members, many of whom currently or have served in EMT roles or in other psychosocial capacities, can be helpful in disseminating information to enhance the support of disaster teams and the affected populations. I trust the articles in this newsletter will be useful in furthering these aims.

Gloria R. Leon, PhD

Psychological Support and Care For EMS Personnel and Other First Responders

Mental Health in Disaster Areas

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Background

Any disaster- natural or man-made, carries an urgent medical need. Historically, the medical focus in disaster preparedness has been on injury, infection, and exposure-related illness, although clinicians have been interested in post-disaster mental health interventions since the middle of the 20th century. Unlike physical injuries, adverse mental health outcomes of disasters may not be apparent at the first phases, and therefore often overlooked or under reported, but mental outcomes due to exposure to a disaster are common.

One-third or more of individuals severely exposed may develop mental disorders- new or exacerbated. A systematic approach to the delivery of timely and appropriate disaster mental health services may facilitate their integration into the emergency medical response and better their overall outcome. Among the mental disturbances other than PTSD, individuals might suffer from disorders such as adjustment disorder, major depression, psychotic breakdown, as well as behavioral manifestations such as substance abuse, violence, helplessness and suicidality.

The responders, professional and non-professional, working for their communities or in humanitarian delegations and field hospitals, are also a community at risk for mental disorders. Posttraumatic stress disorder (PTSD) and depression were the most studied diagnoses, with prevalence of PTSD ranging from 0%-34% and depression from 21%-53% across studies.

Psychiatric outcomes are not the only mental ramification of trauma. Symptoms and unpleasant emotions not meeting criteria as a psychiatric disorder are referred to as psychological distress. Distress, at some level, is nearly universal after disasters and is far more prevalent than psychiatric disorders. The distinction between these two entities is critical for effective disaster response because different interventions are needed. The integration of psychosocial care into emergency and medical disaster response must occur prior to the disaster itself, and will depend on effective collaboration between medical and mental health care providers.

This commentary focuses on the role of a mental health provider in the community and in the team's engagement in humanitarian missions, based on our experience in many such missions with the Israeli Defense Force to different places of disaster. The psychological intervention schemes of treatment are multi-variable. The first question is the exact nature of the disaster and in terms of the local remaining infrastructure and treating capabilities. The flow of decision is dictated by moral obligation. The following description will be presented in accordance with the three parts of the mission: prior, during and after.

Prior to the Mission

From our experience, the three major reasons that people function in an altruistic mission are: a capable and reliable leadership, a strong sense of camaraderie, and understanding the meaning of the effort. Therefore, the initial effort while preparing for a mission should be dedicated to strengthening these three principles by active team building, psychoeducation, and transparency of information.

During the Early Phases of the Mission

This is a crucial phase for the success of the mission as well as the psychological outcomes of the entire group. As a rule of thumb, the emergency teams do not tend to suffer from ASD (Acute Stress Disorder) or any clinical sequelae. The teams are usually well prepared for the mission and have knowledge and readiness to perform. Problems may arise in the teams at the early phase primarily when their physical needs are not met or when the mission causes frustration or helplessness. The mental health professional role at this phase should focus on

making sure the commanders consider meeting physical needs such as sleep and food, and that any sign of frustration and helplessness is talked about and met within the teams.

Mental Health Professional's Role with the General Population

The primary line of duty in EMTs (emergency medical teams) is to understand what the population needs and how it can be provided to appropriately meet the local needs. Intervention in the population should be exponential; for example, working with local teachers, first aid responders, critical workers etc. who can each reach and affect many different longitudinal waves of people and alleviate suffering in a widespread manner.

The literature suggests that persons/communities struck by disaster will generally pass through four phases of response: the heroic phase, honeymoon phase, disillusionment phase and reconstruction phase. One must be familiar with the different stages every society might go through after a huge traumatic event in order to provide the help needed for the particular phase, along with readiness for the next phases. In addition, the mental health professional must provide treatment to all casualties of the traumatic event including the worsening of known and the emergence of new psychiatric illnesses.

During the Mission

When the treating facility is built and operational, the EMTs face hardship from three different directions; 1. Working long hours in a challenging surrounding; 2. Seeing traumatic sights and having to take difficult moral decisions; and 3. Being far away from home and normality. All three types of hardships are true for the hospital personnel as well as the supporting or rescue teams, and usually more severe in Third World countries. Since the work in the field hospital is a long distance struggle, one should make sure the EMT gets some rest, a place and time during the day for refilling resources, and a place to share thoughts about the traumas seen and the moral questions that arose.

The best tools to be used against these three aspects are to have a rigid daily structured timetable including a start, food breaks, and most important, an end with a structured closure at a debriefing talk to share and learn from each other and build plans for improvements for the next day.

The field hospital should have a "relaxation zone" where the members can have some sugar refill, something hot and cold to drink and even play cards or backgammon for a few minutes with others. The hospital should also have an ethical board to make sure difficult decisions are been made together and not upon the decisions of one specific person. This would enable sharing and lowering the individual burden. If the mission is a long one, it should include a "day off" plan in which personnel from each team would get time off for refreshing and taking some time to tune down.

Although not all of the above are the mental health professional's role, they are the ones who should be working with the commanders to make it happen. If these procedures are not taken, burnout would be accelerated and might cause later post-mission PTSD.

The mental health professional should also be a part of the ethical committee, take part in as many debriefing sessions as possible, and know when it is most important for them to participate. For example, they should be informed if a delivery of a baby failed and join the labor team for the talk that day. It is crucial that the mental health professional would "live the hospital" all the time.

Before Coming back Home

Usually, this is an easier phase for most teams. Sometimes ethical questions might arise about our contribution in the face of a major trauma, aspects of leaving a needful society, and caring for the patients that need ongoing care. These issues should be discussed at the morning talks as well as at the team's reviews. The commander should consider a hospital talk to provide closure to unresolved issues and to share information with everyone so rumors will be minimal. The mental health professionals at this point should help the team leaders to close the mission in a positive and optimistic manner, building a positive narrative for each and every participant. This is the story they go home with, so difficult occasions should not be ignored but rather reframed into a more positive and "mindful" manner. Before departing, the mental health professional should remind all participants

of the possible delayed outcomes of such a mission and to emphasize that sometimes it is hard to readjust and that traumatic sights sometimes comes back.

Returning from a Mission

The process of returning home and returning to "normal" is very important professionally and in terms of mental health. The switch from the high adrenaline felt in a mission to mundane routine work necessitates proactive building of a return process. This can include ceremonies, operational investigations and cognitive processing. It should be dealt with as a mission within itself. In addition, the unique characteristics of each mission should be considered separately. The differential impact of the team characteristics, their job specifications and feelings of pride and adequateness (as opposed "to insufficiency") need to be addressed. As a rule, cognitive processing should be carried out by the commander with the guidance of a mental health professional. The processing should be organized as a mission taking place a few days after return home. The mission's organizer should not include the mental health officers who were part of the mission. Now is the time to care for the caretakers.

We recommend that the talks should take place within organic groups of approximately 10 to fifteen people who comprised the organic group of the mission. The talk should be led by the commander, with a mental health officer present. In this way the mental health professional can also identify those in need of further mental assistance. The talk is then carried out in a modified "debriefing" manner. Each participant can only speak for oneself and is limited to a certain amount of time in order to enable everyone to participate. Judgmentalism is prohibited, and the participants are encouraged to help their comrades with positive reframing of the issues they brought up in the group. The discussion is divided into three different stages:

1. Opening - The opening should be about 5 to 10 minutes long and consist of defining the purpose and rules of the discussion. If this is not the first team discussion that a specific organic team has gone through, then a quick reminder of the rules is usually enough.

2. The Mission - This section of the team discussion is divided into three separate rounds of participation by all members of the group. A. Fact phase: The purpose is to build a clear, realistic and integrative picture of the overall situation in chronological order. Each participant describes factually, using the description of all five of the senses, what they experienced. B. Thought phase: In this phase each participant describes what they thought throughout different situations in the mission. It is important to remain in the domain of thought and not feelings or emotions which encourage blood flow to the lower brain areas. C. Reaction phase: Each participant describes their new reaction to the integrative picture drawn by the group and the commander.

3. Recruitment of Strengths and Summaries - At this point each participant should leave with pride and a feeling of relevance in the mission. The last question which each of the participants answers in turn relates to the personal meaning of the mission and the cohesive and protective factor of the group. For example, "What are the important things that you did for the team and for the mission?" If a participant finds difficulty in answering, help them out. Positive reinforcement of purpose and being an integral part of a team is imperative. Summary: The commander should summarize the talk with the purpose of building positive expectations for the future.

In Conclusion

The mental health professional in a humanitarian mission has multiple hats to wear; therapist for the team, working with hospital patients, and keeping vigilant for possible opportunities to help outside the field hospital mission. They should be active in the daily routine of the hospital, in touch with all the teams, making sure to be aware of all negative situations or ethically questionable interventions, and maintain vigilance regarding undercurrents between the commanders and the teams.

What is Helpful to EMS Providers Following a Critical Incident or a Disaster

Gordy Dodge, PhD, LP

Introduction

Over the course of my professional years as a psychologist I have had the honor of providing diagnostic and therapy clinical services to EMS service providers as well as other public safety personnel such as firefighters and law enforcement. More importantly, for many years I coordinated a regional critical incident response team, and also worked as a volunteer first responder. In addition, as a disaster psychologist I have gone out with a rescue and recovery team in response to the Gujarat Earthquake, provided services to a similar team following the Korean Airline Crash in Guam, and to various personnel shortly after 9-11.

These and related experiences allow me to comment on what I have observed in myself as well as in other responders over the few days following critical incidents and disasters, what is helpful at those times, and what residual effects often occur regardless of whether interventions were provided or not shortly after a critical incident.

Examples of High Risk Incidents

First, it is important to note that most EMS personnel handle a whole range of stressful work experiences without experiencing serious or lasting effects. Secondly, there is a wide range of individual differences in response among responders. There are, however, several high risk incidents that are more likely to precipitate severe and troubling responses of concern. These include when the patient/victim is a peer, a child, a friend, a personal acquaintance, or someone who reminds the responder of a friend or family member. Also, mass casualties, a patient demonstrating prolonged acute pain, and severe child or sexual abuse all often affect the responder more deeply. An understandably overwhelming experience for many responders that is taking place as I write this article is the desperate sustained effort being expended in trying to retrieve children from the ruins of their school building that collapsed because of the earthquake in Mexico.

One type of incident that does not readily come to mind but is mentioned by EMS personnel is when they arrive at the scene but are helpless to do anything. An example of this is of a wintertime drowning of a child who was too deeply in very cold water so that the local first responders were not able to retrieve the child until personnel with cold water diving equipment arrived, which was too late. Similarly, if the responder is convinced that they made a mistake that resulted in the death or serious injury to another, this often has immediate as well as lasting effects. Lack of training or equipment failure also can affect outcome.

Examples of Short Term Effects

First it is important to note that many short term effects of concern often ameliorate on their own, some morph into other "symptoms" and a few may continue and become more permanent and damaging. Secondly, the same incident may affect the responders quite differently. Effects may be seen in behavior, thought, and emotion, and change in relative portion of these over time. Also, experienced EMS personnel will typically react differently than a lay person who has just experienced their first critical incident or disaster.

With these cautions and qualifications in mind I will now indicate the primary short term reactions of possible concern that I have observed in EMS personnel as well as in myself. Fatigue, detachment, waves of sadness, and irritability are often observed shortly after a critical incident. Questioning one's own competence and that of the other responders can be common and disturbing if things didn't go well. Nausea, loss of appetite, headaches, and muscle aches are a few of the more common physical responses. Somewhat later, but usually within the first 24-48 hours, and especially when alone and now off duty, flashbacks, sleep disturbance, nervousness, and spiritual struggles, such as, "God is punishing us for our sins", or "there must not be a God", and "why do bad things happen to good people" may occur.

What is Helpful

Now I will discuss what I have found to likely be helpful in easing some of the short term effects of concern, as well as what may be of help in preventing those effects from creating residual or cumulative problems. First the

most helpful characteristics that are the “natural and spontaneous” ones, for the individual as well as the organization. The extent to which these characteristics are present, maintained, and further developed will in turn often help diminish the serious and lasting effects of concern. Proper selection of EMS personnel, sufficient training, team development and cohesion, perceptive, responsive, and supportive leadership, self-awareness, good stress management skills and practices, and openness, trust, respect, and support among colleagues are all important. It is also important that EMS personnel know their department recognizes critical incident responses will occur, has a CISM program in place and supports the staff in availing themselves of those services.

Several critical incident response intervention methods have been developed for use by EMS organizations as well as other public safety, military, and disaster response NGOs for response especially in the first few days following a critical incident or disaster occurrence. The utility of any of the intervention methods will vary depending on many factors, and outcome research and evaluation studies are sorely lacking, so bear in mind my findings and recommendations are primarily based on my professional mental health and EMS experiences; and only secondarily on related literature. For a good review of critical incident response methods I recommend *Post Traumatic Stress (The Facts)* (Regel & Joseph, 2017).

A peer-based critical incident response team model has been found to be useful, at least for organizations that are large enough to maintain support for initial training and periodic team review and advanced training, management, on-call staffing, and in some cases, additional compensation. The strengths of this model are that “defusing” type crisis interventions are provided by personnel familiar with and trusted by those needing an intervention, and that the initial contact can occur on scene, or shortly after. This also allows for a knowledgeable and trusted means for follow-up and referral if indicated.

Participation by an EMS organization in an interagency, regional, critical incident stress management (CISM) program is a common model, and is usually based on Jeffrey Mitchell’s work. The strengths of this model are that it is peer based with professional mental health support, has several intervention strategies depending on specific needs, and is cost efficient because it often relies primarily on voluntary member teams. It also can work well in rural areas where no one department can support its own team.

The limitations of this model are that it was developed without sufficient outcome research, parts were too structured, and some departments mandated participation. In addition, it was and still is used with some inappropriate populations, at counter-productive times, confidentiality violations can occur, and sometimes its interdisciplinary structure inhibits group discussion. Overall, however, the establishment of or participation in a critical incident stress management program based on the several components of a Jeffrey Mitchell model (defusings, debriefings, demobilizations, etc.), with certain modifications and limitations, still provides a likely range of useful services to have available for EMS personnel and other emergency and public safety personnel (Mitchell, 2004).

Another or an additional service model is that of an employee assistance program (EAP). Such programs provide a range of short term information and counseling services to employees of firms and organizations holding contracts for those services. Most EAP contracts will provide for individual and group counseling as well as management consultation at a work site following a critical incident, as well as educational programs such as stress management and team development. A difficulty however is that many EMS programs do not have EAP contracts, they can be expensive to purchase, and for small EMS agencies who rely on volunteer responders, those personnel usually are not covered under EAP contracts.

There are other potentially useful resources to consider for the few days following response to critical incidents or disasters. Some departments have chaplains who make themselves available at short notice and who have had training in critical incident response counseling. Some community or non-profit counseling agencies will provide counseling at short notice at least in their offices and often at reduced or no cost. If EMS personnel are responding to a major disaster, the American Red Cross as well as other organizations typically have disaster mental health staff on scene or readily available who are trained in crisis counseling work. Red Cross and many other disaster response NGOs have incorporated Psychological First Aid (PFA) models for crisis response staff care as well as for survivor care. Unfortunately, although PFA has good face validity it too has not been evaluated well with respect to effectiveness (Deltjens,2014).

What Specifically do EMS Personnel Need Shortly Following a Critical Incident or Disaster Response

Removal from the scene to a safe and confidential setting allows the responder a realization that he or she is “off duty” and can attend to his or her own needs. Ideally a calm, quiet, and reasonably comfortable place can be found. Defusing and psychological first aid steps apply at this early stage. Brief educational material is often provided at this time, a short term self-care plan is developed, possible referrals, and follow-up arrangements are made. Usually multiple agencies are involved in responding to a critical incident, and a more formal group peer-based debriefing may be in order. If so, this usually is scheduled within a few days of an incident.

This allows for better timing in processing the incident, better self-awareness, peer support, realization of the normalcy of the incident responses and reactions, education, and further development of a team and self-care plan. Depending on circumstances and needs some one on one and/or a later group debriefing may be in order. Education also regarding possible cumulative and residual effects is good to provide within a few days of a critical incident, indicating that specific triggers may remain for a long time. Explanation of what can be helpful given the possibility of this occurring should occur at this time, (e.g., self-care and therapy). For me, the image of a child’s stunned face from just after she had been hit by a trailer while riding a bike and whom I was the first to respond to before she died still comes back to me clearly many years later. Another memory, this being tactile, is left over from when I went out with a rescue and recovery team (recovery stage at the time I joined them) following the Gujarat earthquake in India. In response to the suggestion of the team leader I was instructed to reach into a hole in the rubble and feel the head of a young boy; this being helpful to the team in determining where to dig and the approximate age of the dead child.

Ever since then the practice of affectionately tussling some young child’s hair is not as appealing anymore. I have attended to other’s who were dying or dead but children obviously have a special place for me as well as with many other responders, and that tactile memories can be as lasting as visual, auditory, or olfactory. A firefighter EMT related to me once that the sound of a firefighter’s air pack being depleted inside a burning building, as was able to be heard in the coverage at 9-11, is a trigger that is deeply imbedded in his mind, something to which he could personally relate to as well as identify with fellow responders. The fear of dying from lack of oxygen, claustrophobic reactions, and the understandable doubt of being able to respond to another such incident that may cause such a debilitating response again all developed and needed further care.

What many EMS personnel find eases the emotional and psychological hurt that may be present right after a tough run is going back to their base, writing up reports, and more importantly cleaning up the rig and replacing supplies and equipment. This can provide a calm and confidential setting where mutual support, appreciation and reassurance can be felt and expressed. Often, however, the crew will be having a busy shift and this opportunity may not be available.

Well-meaning mental health professionals often chastise responders for adjourning to a local favorite drinking establishment after their shifts, especially after a difficult day or particularly difficult incident. Being off-duty and as stated by an emergency room nurse “Drink a few and unofficially debrief or drink enough (with a ride home) to help you forget about the sexual assault of a child or a child beaten to death by a parent.” This reminds me to always remember to first ask EMS personnel what is most helpful to them before trying to tell them what I think is most helpful.

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9/11 Sixteen Years On: Recounting the Ongoing Psychosocial Impact on the First Responders

Dr. Erin Smith

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The September 11th, 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 sixteenth 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.

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Migrants in Greece Over Time: People, Disease, and Development of European Schools of Public Health

Jeffrey Levett

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The next Nobel Peace Prize should go to the Grandmothers of the Aegean, having plucked migrant babies from Mediterranean waters and nurtured them. JL

Greece has never been a stranger to disruptive population movements or to manmade and natural disasters. At the end of the Bronze Age, Great Migrations of immense proportion took place. After population dispersal (circa 1200 BC), renewal came several centuries later (900-600 BC); written works of Homer, Hesiod (*Works and Days* with instructions for farmers on agricultural arts at a time of crisis), and Thales of Miletus (philosopher, scientist and entrepreneur). Descriptions of chaos passed down by folk singers and storytellers helped piece together the *Iliad* and the *Odyssey*.

Modern Greece unfolded to a background of horrendous infectious disease that took more lives than the Greek Revolutionary War occurring during this period (1821-1830). The Ottoman Empire was in collapse and refugee trails were long, suffering incredible; millions of people were homeless, undernourished, diseased, wounded and cold.

At the end of WWI, one and a half million refugees entered Greece from Turkey (circa 1922). This was a period in which there was the emergence of activities by the League of Nations and the Rockefeller Foundation. These organizations were convinced that good health is dependent on democracy, and were highly focused on disseminating the principles of public health organization. In Yugoslavia, they supported the establishment of the Zagreb or Stampar School of Public Health and the Belgrade Medical School; in Greece, they helped develop the Athens School of Public Health (1929), now called the National School of Public Health (NSPH) (1994).

The Athens School was first conceived at the beginning of the 20th century, but essentially was established in 1929 as a result of a bizarre pandemic of dengue fever introduced from the Middle East, which brought Greece to a complete standstill. The Athens School was a landmark in social policy, and it precipitated a revolution in European public health. With the advent of the Athens School, public health evolved, health status improved, and dramatic health gains occurred. The Athens School took a key role in eradicating endemic malarial disease, which held the country in a grip of underdevelopment, and in bringing tuberculosis under control.

In 1931, the Athens School was described as a post war-imposed necessity based on the conviction that first among all things, the Greek population must live and develop under healthy conditions. During the period 1930 to 1970, there was a 20 year increase in life expectancy and a dramatic reduction in infant mortality. However, during the dictatorship (1967-1974), the Athens School was manacled; in 1975, it again achieved a positive place on the political agenda, but it continues to be hampered by bureaucratic and legalistic obstacles.

Circa 1930, Greece saw health as a means to an end central to the nation's development. The first primary health care (PHC) attempt occurred with the commencement of the National Health System (1983), subsequent to the first international declaration underlining the importance of PHC (WHO, Declaration of Alma-Ata, Kazakhstan 1978). In the 2017 health sector, the Greek government is again attempting to implement PHC as an

integral part of the health system. However, psychosocial support and care are not at the same level of priority, and many hospital services are being stretched beyond the limit as in the case of cancer therapy and emergency medical services.

In my view, the WHO Declaration of Alma-Ata is to the global health sector what the Paris Climate Change Agreement is to global health (2016). Alma-Ata reaffirmed health as a fundamental right of all and defined it as a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity. It pointed to the gross inequality in health between developed and developing countries. Earlier (1966) Martin Luther King pointed to the disparities in the USA when he proclaimed that of all the forms of inequality, injustice in health care is the most shocking and the most inhumane.

Background: Halfdan Mahler (1923 – 2016), three times Director-General of WHO, shaped the primary health care agenda as an addition to the goal of Health for All. Of note, Mahler saw a great need for regional schools of public health as Centres of Excellence and Relevance within a new framework of public health policy and health for all in Europe. His successor, Jo Asvall, pressed on with this agenda. My own breaking news: plans are now underway in Belgrade for a regional structure in public health education in collaboration with American institutions.¹

Unfortunately, Greece is now a land of growing mental depression and suicide (where suicide previously was extremely low according to international epidemiological data), and with a growing number of hungry children and impoverished families. Unemployment in Greece runs close to 20%, while that of youth nears 60%. Many have lost homes, unable to meet loan payments as salaries and pensions have been slashed by more than 50%. Many families are now considerably subsidised by the pensions of grandparents. In addition, the presence of an extremely large number of migrants and refugees on Greek soil arriving so quickly has had its own impact on public health resources. (Prior to the current mass migrations, the percentage of the foreign born population living permanently in Greece was around 11-12%, mainly those with Greek roots emigrating from Albania).

The current flux of migrants have faced different types of conditions than migrants at other periods. Uncontrolled smuggling and criminal networks operate between the Horn of Africa, Yemen, North Africa, Italy and Greece. Concurrently, vulnerable migrants crossing the Mediterranean Sea face a terrible and deadly dangerous ordeal. In the first six months of this year, of the 100,000 refugees and migrants that arrived in Europe crossing the Mediterranean, 2,247 lost their lives or are missing. Over the past two decades, 20,000 have drowned.

At present, there are 60,000 refugees and migrants (Syrians, Afghans and Iraqis) stranded in Greece as a result of border closures in the Balkans, while the number of unaccompanied migrant children is rising. Since 2015, nearly one million people have passed from Turkey to the Greek Islands, trying to reach Northern Europe. So far this year, 11,000 refugees and migrants have crossed into Greece from Turkey, a number considerably lower than in 2016. This past winter, a naval asset was deployed by the Greek authorities to temporarily shelter migrants on the island of Lesbos, opposite Turkey. As of January 2017, only 11% of stranded children have been relocated to other European countries.

While facing an uncertain future in Greece, migrants are still trapped within an unwieldy bureaucracy and an inflexible Europe even though they face a much friendlier situation than experienced prior to their flight. To deliver water, food and clothing to migrants in a dignified manner under difficult circumstances is necessary, but insufficient. Preparedness, mitigation, and response to disaster with better rehabilitation must improve. It can be achieved by reinforcing public health and international relations instruments that strengthen security and counter misrepresentations. Moreover, greater attention must be given to the psychological and social needs of

¹ Halfdan Mahler was a recipient of the prestigious medal for excellence named after Andrija Stampar, a founding father of the World Health Organization [Geneva, 1948] established during my Presidency of the Association of Schools of Public Health in the European Region [ASPHER], The European Center for Peace and Development, Belgrade in collaboration with LIU, Brooklyn is in the process of establishing a regional school of public health.

this population, a difficult and complex requirement. Nonetheless, Greece, in spite of its limited infrastructure and poor governance, is still a hospitable host country!

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Upcoming Events

I.S.T.S.S. Annual Convention - "Trauma & Complexity: From Self to Cells." November 9-11, 2017 Chicago, Illinois, USA

Organizational and Informational Resources

This issue's feature: *Psychosocial Centre International Federation of Red Cross and Red Crescent Societies.*

Psychosocial Centre



International Federation
of Red Cross and Red Crescent Societies

The IFRC Reference Centre for Psychosocial Support (PS Centre) aims to create awareness regarding psychosocial reactions at a time of disaster or long-term social disruption, to set up and improve preparedness and response mechanisms at global, regional and local levels, to facilitate psychosocial support before, during, and after disasters, to restore community networks and coping mechanisms, to promote the resilience and thereby the rehabilitation of individuals and communities, and enhance emotional assistance to staff and volunteers.

The PS Centre develops training material, guidelines, handbooks and other materials to help Red Cross Red Crescent National Societies provide psychosocial support. The PS Centre also participates in knowledge development and research, and collaborates with the global MHPSS community. Read more and access materials at - www.pscentre.org.

Other Informational Resources

Disaster Research and Evaluation – Useful articles site

A nine-part series of excellent articles on Frameworks for Disaster Research and Evaluation prepared for WADEM can be accessed by the following link:

<https://wadem.org/publications/frameworks/>

Primary Relevant Journals – This issue's feature: *Journal of Traumatic Stress*

Journal of Traumatic Stress is published by the International Society for Traumatic Stress Studies; and is "an interdisciplinary forum for the publication of peer-reviewed original papers on biopsychosocial aspects of trauma. Papers focus on theoretical formulations, research, treatment, prevention, education/training, and legal and policy concerns. The *Journal of Traumatic Stress* serves as a primary reference for professionals who study and treat people exposed to highly stressful and traumatic events (directly or through their occupational roles), such as war, disaster, accident, violence or abuse (criminal or familial), hostage-taking, or life-threatening illness. The journal publishes original articles, brief reports, review papers, commentaries, and, from time to time, special issues devoted to a single topic." *Journal of Traumatic Stress* (Volume 30, #2, April, 2017).

Graduate Training Programs – This issue’s feature:



Institute for Disaster Mental Health at the State University of New York

Advanced Certificate in Trauma and Disaster Mental Health

The Institute for Disaster Mental Health at the State University of New York is now offering a 15-credit certificate program to provide specialized education for mental health professionals who desire intensive training in supporting survivors of disasters and other traumatic experiences. The program is intended for two groups:

- Professionals who have already earned a Master of Arts, Master of Science, or higher degree in counseling, social work, or a related field.
- Students who are currently enrolled in master's- or doctoral-level counseling or social work program and who can demonstrate completion of a graduate-level counseling theories and skills course.
- Courses are taught by a combination of SUNY New Paltz faculty members who are affiliated with the Institute for Disaster Mental Health and by adjunct instructors with expertise in treating trauma in specific populations. The curriculum includes three required core courses (Disaster Mental Health; Evidence-Based Assessment and Treatment for Trauma; and Assessment and Interventions with Children, Adolescents, and Families), plus two electives selected from three options (Assisting Veterans Populations; and Grief, Loss, and Bereavement).

Setting this program apart from others, all courses are entirely online with the exception of Disaster Mental Health, which involves one weekend on the New Paltz campus (about 100 miles north of New York City) during the summer to provide intensive practice opportunities. This distance learning approach makes the program accessible to working professionals from around the country and the world. Classes include a combination of these experienced professionals from various disciplines (i.e., social work, spiritual care, counseling), and current SUNY New Paltz Mental Health and School Counseling students, allowing all to learn from the experiences of fellow classmates as well as from the instructors. The certificate can be completed within one year, or extended over time to accommodate the student’s schedule.

Details about the program, including the course schedule and application information, can be found at - <http://www.newpaltz.edu/idmh/academic-programs/grad.html>. or by emailing the program director, Dr. Karla Vermeulen, at - vermeulk@newpaltz.edu.

Reader Comment

Comment from our newsletter readers is welcomed. The primary purpose of reader comment is to briefly address the issue’s theme writings (guest editorial and abstracts). Please include your name and email address.

Disclaimer

Please note: All views expressed in this newsletter are those of the authors of their respective writings, and do not necessarily reflect those of the editor of the newsletter or of WADDEM.

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