

studies/interventions attempt to list the various mental health problems and psychosocial consequences. There are very few studies which go beyond listing of consequences, to focus on implications of disaster mental health for long term disaster recovery. There is dearth of research based literature on the concept of community trauma, factors contributing to negative emotions and emotional distress/problems, community response (social and cultural) to disaster mental health issues, long term emotional implications of psychosocial consequences of disasters and the life course of individuals with mental health issues in the long run following disasters. The paper attempts to address the above mentioned issues in the context of 2004 tsunami. The paper is based on a study carried out in India two years after the disaster. A Case study approach was used and 177 case studies were collected from 104 villages in 14 affected districts of three states in India. The paper contributes to understanding the long term implications of disaster mental health for disaster recovery and reiterates the significance of integrating disaster mental health services within humanitarian services.

Prehosp Disaster Med 2011;26(Suppl. 1):s2–s3
doi:10.1017/S1049023X11000240

(A12) From a Helpless Victim to a Coping Survivor: Innovative Mental Health Intervention Methods during Emergencies and Disasters

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Crisis, disasters, terror attacks or any other traumatic event may cause among the survivors acute stress reaction (ASR). The main goal of the first responder in terms of mental health in the acute phase is to provide the victim the basic support that will stabilize the needed coping resources and re-establish the sense of control and safety (Kutz & Bleich, 2005). This process encourages the shift of the victim's perspective from a helpless victim to a coping survivor. The emergency mental health interventions are differentiated by the location: Location 1: The event's location: Pacing & Leading using varied communications channels. Re-establishing sequences of contingency. Regaining sense of control. Using the cognitive communication channel. Yes-set sequences. Location 2: Emergency rooms or Traumatic Stress First Aid Centers (TSFAC) Stress symptoms reduction using suggestive techniques Memory Structure Intervention (MSI). Psychological Inoculation (PI). Group interventions. Basic differential diagnosis: ASR-PTSD Patent release decision making. The higher the number of casualties, the more likely is the need for early interventions by non-professionals. This may be particularly true for a mega-terror attack, when the numbers of survivors with ASR can flood the hospital gates. The general principles for intervention by non-professionals, adopted by the Israel Ministry of Health (2002), are: a. Establish personal contact with the survivors and provide words of comfort or supportive touch. b. Encourage survivors to verbalize their experiences. c. Provide orienting information about what happened and what is about to happen in the hospital. d. Ensure physical needs such as hydration, food, and rest when appropriate. e. Enable contact with any significant other as soon as possible through phone or personal contact. During the presentation

the above subjects will be elaborated and demonstrated by case studies and short videos.

Prehosp Disaster Med 2011;26(Suppl. 1):s3
doi:10.1017/S1049023X11000252

(A13) Effective Proactive Outreach among Disaster Relief Workers (DRW) in an Emergency Mortuary (EM)

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Background: Following the Buizingen train-crash disaster on February 15, 2010, nineteen dead bodies were evacuated to the morgue of the Military Hospital. According to the hospital's emergency incident management system, the reception plan for the deceased was activated and an EM organized. Aim: To determine the psychological impact of exposure to current death and to evaluate the effect of proactive outreach in DRW deployed in an EM.

Methods and Results: For five consecutive days 62 hospital staff personnel were involved in the daily activities of an EM: disaster victim identification, autopsies, care for the dead, logistic support and reception and mental relief of the families. Besides a critical incident debriefing on day 5, a postal questionnaire survey of these 62 DRW was conducted, including the Davidson Trauma Scale (DTS) – detecting acute post-traumatic stress reactions/symptoms (ASR/S) – and the Symptom Checklist SCL 90 self-report inventory – measuring primary symptoms and global distress – administered 2, 4 and 7 months following the train-crash. Out of these, 35 (56%) initially responded (informed consent), followed by a return rate of 80% (28/35) and 68% (19/28) respectively. Six out of the 35 participants were identified suffering from acute psychological distress according to DTS and SCL 90 and subsequently followed up in the hospital's dedicated Military Centre for Crisis Psychology. In five of them, normalization of symptoms had occurred by the second inquiry and persisted. Ten months post-event, only 1 patient still needs psychological counseling, whereas 34 demonstrated psychological resilience.

Conclusion: Prevalence of chronification is low (1/35) compared to literature (5 to 10%). Timely detection of acute distress and proactive outreach may effectively counterbalance chronification in tertiary victims following a critical incident. Education and training should help hospital staff deal with ASR/S and improve coping. Hospitals should support professionals in the most disturbing situations.

Prehosp Disaster Med 2011;26(Suppl. 1):s3
doi:10.1017/S1049023X11000264

(A14) Psychosocial Support Services in Disasters - Indian Experiences

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India with 1.08 billion populations is vulnerable to earthquake (56%), floods (8%), cyclones (12%) and droughts (28%) every year. It is further compounded with refugees, riots, epidemic and endemic situations. Disaster psychosocial support and mental health services has consistently grown and standardized over