Annex 1: Visibility and Dissemination, Participation in Conferences

<table>
<thead>
<tr>
<th>THW (CB)</th>
<th>CoP (AB1)</th>
<th>Impact /arq (AB2)</th>
<th>BBK (AB3)</th>
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</thead>
<tbody>
<tr>
<td>23rd of August 2011: EU-CREMEX Lessons Learnt Seminar, Tallin, EE</td>
<td>14th annual meeting of German Society for Psychotraumatology (DeGPT) in Hamburg on the 10th of March 2012</td>
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<td>4th-6th of October 2011: 14th CBRN Symposium, Shrivenham, UK</td>
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<td>2nd International Conference on Preparedness and Response to Emergencies and Disasters (IPRED II)’ in Tel Aviv/Israel from January 15th to 19th, 2012</td>
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<td>26th-28th of March 2012: Formation “Assurer le secours psychologique des Sapeurs-Pompiers”, Charbonnières-les-bains, FR</td>
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<td>Problems of psychological consequences after radium catastrophes and other incidents ’ Moscow/Russia ,May 22th to 26th, 2012</td>
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<tr>
<td>22nd-24th of October 2012: 2nd International Symposium on Development of CBRN-Defence Capabilities, Berlin, DE</td>
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Annex 2: PUBLICATIONS

Publications related to the topic of CBRN and/or PSS:

- EU- CBRN Action Plan
- NATO Guidelines for First Response to a CBRN Incident
- NATO – The International CBRN Training Curriculum
- Impact: „Richtlijn psychosociale ondersteuning geüniformeerden”, Amsterdam (NL): Impact, 2010

Project own publications/brochures:

- Project flyer 'Psychosocial Support for Civil Protection Forces Coping with CBRN' (DE): THW, 2011

THW Newsletter articles (monthly internal newsletter):

- THW (2011), Erstes Treffen des EU-Projektes Psychosoziale Unterstützung, THW Newsletter April 2011
  Title in English: First Meeting of the EU-Project Psychosocial Support
Co-Financed by the European Commission

  **Title in English:** Post-Disaster Psychosocial Support (→ Announcement of the Berlin Conference in July 2011)

- THW (2011), Interdisziplinäre Konferenz zur psychosozialen Notfallversorgung, *THW Newsletter August 2011*
  **Title in English:** Interdisciplinary Conference about Post-Disaster Psychosocial Support

  **Title in English:** Psychosocial Support after CBRN-incidents: First Pilot Trainings of the EU Project

**THW Kompakt (biannual THW Newspaper for internal and external use):**

  **Title in English:** Psychosocial Support for Civil Protection Forces Coping with CBRN incidents’ – a European Project.

Additional information on the project has been published on the internet under: [www.thw.de](http://www.thw.de).
Annex 3: Annotated literature survey, Impact/Arq

Search strategy for literature search EU project CBRN and PSS

Search in databases of: Pubmed, PsycINFO and Embase:

(CBRN or CBRNe or NBC or WMD or chemic* or biologic* or radiologic* or radioactive or nuclear) AND ("disaster worker*" or "emergency service*" or "rescue service*" or "rescue worker*" or responder* or "life guard*" or police or officer* or "fire brigade" or "fire department*" or "fire fighter*" or firemen or ambulance or paramedic* or military or soldier* or veteran* or uniformed or "hospital staff*" or nurse* or doctor* or clinician* or physician*) and (terror or terrorism or attack or attacks or attacked or accident or accidents or disaster or disasters or calamity or calamities or emergency or emergencies or crisis or crises or war or wars or battle or battles or combat or confrontation or confronted or exposed or exposure) and (prevent or preventive or prevention or prevented or protect or protected or protection or protective or detect or detection or detected or identify or identified or screening or screen or screened or reduce or reduction or reduced or mitigate or mitigation or mitigated or ameliorate or amelioration or ameliorated or monitor or monitoring or monitored or track or tracking or tracked or training or trained) AND ("psycho social" or psychosocial or psychological or social or emotional)

Limitations:
- English language only;
- Humans;
- Publications with abstract;
- Published between 1st of May 2001 and 31st of May 2011

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Ref ID: 254
Abstract: Little is known about contemporary physicians' sense of preparedness for bioterrorism, willingness to treat patients despite personal risk, or belief in the professional duty to treat during epidemics. In a recent national survey few physicians reported that they or their practice are "well prepared" for bioterrorism. Still, most respondents reported that they would continue to care for patients in the event of an outbreak of "an unknown but potentially deadly illness," although only a narrow majority reported believing in a professional duty to treat patients in epidemics. Preparing physicians for bioterrorism should entail providing practical knowledge, preventive steps to minimize risk, and reinforcement of the profession's ethical duty to treat.

Ref ID: 308
Abstract: Study 1 examined whether 9/11 deployment was a risk factor for canine
search and rescue handlers. Eighty-two deployed handlers were compared to 32 non-deployed handlers on measures of PTSD, depression, anxiety, acute stress, and clinical diagnoses. Deployed handlers reported more PTSD and general psychological distress. Prior diagnoses and peritraumatic reactions were associated with distress whereas social support and training were protective. More extensive screening and prophylactic interventions for individuals with prior mental illness could be beneficial. Future research should examine identified risk resilience factors prospectively to inform training and intervention. Study 2 examined the utility and mechanisms of expressive writing interventions for rescue workers. Thirty-nine deployed canine search and rescuers were randomly assigned to one of three writing conditions: cognitive restructuring, emotional processing, or a combination. Essays were coded for factors hypothesized to be related to outcome. Handlers in the cognitive restructuring condition reported fewer symptoms of PTSD and depression after writing than those in the emotional processing conditions. Negative emotional arousal and writing about dissociation mediated the effects of writing condition on symptoms. Rescue workers may benefit more from focusing on positive emotions and beliefs about deployment than from expressing negative emotions. Long-term follow-up suggested that the deleterious effects of focusing on negative emotions may endure and that a career in emergency work contributes more to risk than any single, stressful deployment. Study 3 examined rescue workers' biological response to stress. Morning and evening cortisol levels of deployed canine search and rescuers from study 2 (n = 37) were compared to non-deployed handlers (n = 15). The relationship between psychological distress and cortisol levels in deployed handlers was also examined. Deployment may produce lasting changes in rescue workers' biological stress response. Chronic exposure to stress and trauma in rescue work may lead to progressive hypersensitization of the HPA system, particularly in those experiencing psychological distress. Future studies should further investigate the relationship between sleep, distress, and HPA alteration and monitor biological markers prospectively and longitudinally. Low cortisol levels may be a useful marker for intervention to counteract the effects of chronic stress and avoid more severe psychological disturbances. (PsycINFO Database Record (c) 2010 APA, all rights reserved)

Ref ID: 185
Abstract: One of the most innovative aspects of NCRP Report No. 138 (Management of Terrorist Incidents Involving Radioactive Material) was the high priority it accorded to psychosocial and communication issues. While previous discussions of radiological and nuclear terrorism had occasionally referred to these topics, NCRP Report No. 138 was the first report of its kind to recognize the profound challenges posed by these issues and to place them at the heart of preparedness and response efforts. In the years since the report's release, a host of important developments have taken place in relation to psychosocial and communication issues. This paper reviews key changes and advances in five broad areas: (1) training exercises, (2) policy and guidance development, (3) findings on hospital and clinician needs, (4) survey research on public perceptions of radiological terrorism, and (5) risk communication for radiological and nuclear terrorism situations. The article concludes with a discussion of continuing psychosocial and communication challenges, including critical areas needing further attention as the nation moves to meet the threat of terrorism involving radioactive materials

Ref ID: 284
Abstract: The United States has not suffered significant psychosocial or medical
consequences from the use of biological weapons within its territories. This has contributed to a “natural” state of denial at the community level. This denial could amplify the sense of crisis, anxiety, fear, chaos, and disorder that would accompany such a bioterrorist event. A key part of primary prevention involves counteracting this possibility before an incident occurs. Doing so will require realistic information regarding the bioterrorism threat followed by the development of a planned response and regular practice of that response. 

Unlike in natural disasters or other situations resulting in mass casualties, emergency department physicians or nurses and primary care physicians (working in concert with epidemiologic agencies), rather than police, firemen, or ambulance personnel, will be most likely to first identify the unfolding disaster associated with a biological attack. Like community leaders, this group of medical responders must be aware of its own susceptibility to mental health sequelae and performance decrement as the increasing demands of disaster response outpace the availability of necessary resources. A bioterrorist attack will necessitate treatment of casualties who experience neuropsychiatric symptoms and syndromes. Although symptoms may result from exposure to infection with specific biological agents, similar symptoms may result from the mere perception of exposure or arousal precipitated by fear of infection, disease, suffering, and death. Conservative use of psychotropic medications may reduce symptoms in exposed and uninfected individuals, as may cognitive-behavioral interventions. Clear, consistent, accessible, reliable, and redundant information (received from trusted sources) will diminish public uncertainty about the cause of symptoms that might otherwise prompt persons to seek unnecessary treatment. Training and preparation for contingencies experienced in an attack have the potential to enhance delivery of care. Initiating supportive social, psychotherapeutic, and psychopharmacologic treatments judiciously for symptoms and syndromes known to accompany the traumatic stress response can aid the efficient treatment of some patients and reduce long-term morbidity in affected individuals. Preventive strategies and planning must take into account the idea that specific groups within the population are at higher risk for psychiatric morbidity. First responders comprise one group at psychologic risk in this situation, and healthcare providers comprise another. These and other high-risk groups will benefit from the same supportive interventions developed for the community as a whole.

DiGiovanni C: Pertinent psychological issues in the immediate management of a weapons of mass destruction event. [References]. Military Medicine 2001, Dec-60. Ref ID: 325

Abstract: This paper discusses some pertinent psychological issues in the immediate management of a weapon of mass destruction (WMD) event. Decisions made and actions taken by crisis and consequence managers during the initial stages of a domestic terrorist incident that involves a WMD will influence the ultimate psychological toll of the disaster. Exploring, in advance, the feasibility of quarantine, participating in training exercises that force decision makers to confront the consequences of their decisions on the behaviors of a population at risk from a WMD agent release, and critically examining the capabilities of mental health crisis intervention teams that might respond to a terrorist event are some of the suggestions offered to crisis and consequence managers to help them prepare for their roles. Other suggestions deal with the media, public education, first responder and staff education and training, use of personnel, communications security, processing the dead, maintenance of records, debriefings, and military medical readiness. (PsycINFO Database Record (c) 2010 APA, all rights reserved)

Ref ID: 3
Abstract: A nuclear detonation in a US city would have profound psychological, social, and behavioral effects. This article reviews the scientific literature on human responses to radiation incidents and disasters in general, and examines potential behavioral health care provider (BHCP) contributions in the hours and days after a nuclear detonation. In the area directly affected by the blast, the immediate overarching goal of BHCP interventions is the support of lifesaving activities and the prevention of additional casualties from fallout. These interventions include 6 broad categories: promoting appropriate protective actions, discouraging dangerous behaviors, managing patient/survivor flow to facilitate the best use of scarce resources, supporting first responders, assisting with triage, and delivering palliative care when appropriate. At more distant sites, BHCP should work with medical providers to support hospitalized survivors of the detonation. Recommendations are also made on BHCP interventions later in the response phase and during recovery.

Ref ID: 101
Abstract: Most hospitals' disaster plans are extensive and effective at establishing an incident command center, directing material and personnel resources, and triaging patients. However, few organizations have assessed caregivers' needs and fears related to disaster response. When nurses have been interviewed on this topic, findings indicated complex concerns involving fear of loss (e.g., loss of order in their work environment, loss of safe work conditions, loss of freedom to come and go at will, and loss of trust in their hospital's commitment to their best interest). The sobering result of anticipating these losses is fear of abandonment. The purpose of this article is to address factors identified by hospital-based nurses that contribute to their fears of abandonment in a bioterrorism emergency. Hospitals that choose to respond to these concerns will exemplify best practice toward care of the community and care of their own nurses.

Ref ID: 2
Abstract: The hallmark of a successful response to a nuclear detonation will be the resilience of the community, region, and nation. An incident of this magnitude will rapidly become a national incident; however, the initial critical steps to reduce lives lost, save the lives that can be saved with the resources available, and understand and apply resources available to a complex and dynamic situation will be the responsibility of the local and regional responders and planners. Expectations of the public health and health care systems will be met to the extent possible by coordination, cooperation, and an effort to produce as consistent a response as possible for the victims. Responders will face extraordinarily stressful situations, and their own physical and psychological health is of great importance to optimizing the response. This article illustrates through vignettes and supporting text how the incident may unfold for the various components of the health and medical systems and provides additional context for the discipline-related actions outlined in the state and local planners' playbook.

Ref ID: 245
Abstract: Chemical warfare agents are toxic weapons and emergency prehospital medical care providers should be well prepared, trained, and equipped to give response. Personnel need to be aware of the following medical issues regarding
prehospital management of a chemical attack, event recognition, incident medical command and control, safety and protection, decontamination, isolation of the incident area (hot zone, warm zone, and cold zone), sampling and detection, psychological management, communication, triage, treatment, transportation, recovery activities and fatality management. During prehospital response, healthcare responders should provide self protection by wearing proper protective equipment and ensuring that the casualty is thoroughly decontaminated. Medical first responders are also responsible for performing triage in each zone of the incident area. Victims are triaged into four categories based on the need for medical care; immediate, delayed, minimal, and expectant. Finally, a medical emergency planning should be completed, and exercises conducted to test the system before an event occurs.

Ref ID: 301
Abstract: Civilian emergency response personnel who assist at chemical or biological disaster scenes are likely to be novices at functioning in chemical-biological (C-B) protective clothing (CBC) meant for use on contaminated battlefields. Such teams must be aware that CBC imposes numerous physiological, psychophysiological, and biomechanical effects on performance, and significant declines in individual and group performance effectiveness can be anticipated. Cumbersome protective suits, gas masks, rubber gloves, and protective overboots worn to clean up chemical spills or to respond to terrorist use of weapons of mass disruption, produce performance slow-downs requiring up to 30% more time to accomplish tasks, compromise communications, and raise the risk of dehydration, heat injuries, and other environmental and psychological stresses that impinge upon task completion. First-response workers who will wear cumbersome CBC need realistic, confidence-building, mission-related training in the C-B uniforms, clothing, and equipment available to them.

Ref ID: 179
Abstract: Evidence in the disaster mental health literature indicates that psychosocial consequences of terrorism are a critical component of chemical, biological, radiological, and nuclear (CBRN) events, both at the clinical level and the normal behavioral and emotional levels. Planning for such psychosocial aspects should be an integral part of emergency preparedness. As Canada and other countries build the capacity to prevent, mitigate, and manage CBRN threats and events, it is important to recognize the range of social, psychological, emotional, spiritual, behavioral, and cognitive factors that may affect victims and their families, communities, children, the elderly, responders, decision makers, and others at all phases of terrorism, from threat to post-impact recovery. A structured process to assist CBRN emergency planners, decision makers, and responders in identifying psychosocial risks, vulnerable populations, resources, and interventions at various phases of a CBRN event to limit negative psychosocial impacts and promote resilience and adaptive responses is the essence of our psychosocial risk assessment and management (P-RAM) framework. This article presents the evidence base and conceptual underpinnings of the framework, the principles underlying its design, its key elements, and its use in the development of decision tools for responders, planners, decision makers, and the general public to better assess and manage psychosocial aspects of CBRN threats or attacks.

Lemyre L, Johnson C, Corneil W: Psychosocial considerations for mass...

Abstract: Mass exposure to explosions, infectious agents, foodborne illnesses, chemicals or radiological materials may require mass decontamination that have critical psychosocial implications for the public and for both traditional and non-traditional responders in terms of impact and of response. Five main issues are common to mass decontamination events: (i) perception, (ii) somatisation, (iii) media role and communication, (iv) information sharing, (v) behavioural guidance and (vi) organisational issues. Empirical evidence is drawn from a number of cases, including Chernobyl; Goiania, Brazil; the sarin gas attack in Tokyo; the anthrax attacks in the USA; Three Mile Island; and by features of the 2003 severe acute respiratory syndrome pandemic. In this paper, a common platform for mass casualty management is explored and suggestions for mass interventions are proposed across the complete event timeline, from pre-event threat and warning stages through to the impact and reconstruction phases. Implication for responders, healthcare and emergency infrastructure, public behaviour, screening processes, risk communication and media management are described.


Abstract: During a public health emergency such as an influenza pandemic or a bioterrorism attack, nurses may be at risk for exposure to lethal infectious diseases when caring for victims. The aim of this study was to identify interventions nurses believe will support their ability to cope during public health emergencies. A qualitative research design was used with 33 nurses from designated bioterrorism-receiving hospitals. Nurses recommended adequate protective equipment, education, drills, accessible information and available content experts, and available administrators. Other recommendations included increased security to protect nurses, emotional and physical support, communication with nurses’ families, and commitment from institutions to care for ill or injured nurses. Preparations for emergencies should include assessments of nurses’ and other stakeholders’ concerns. These nurses proposed specific measures to improve safety, reduce anxiety, increase trust in hospitals, and provide physical and emotional support.


Abstract: BACKGROUND: Since the events of September 11, 2001, subsequent anthrax mailings, world political events, and natural disasters such as Hurricane Katrina and the recent tsunami, public health emergencies including bioterrorism events are viewed as realistic possibilities. Public health emergencies would stress the current health care system. OBJECTIVE: The objective was to identify beliefs and concerns of nurses who work in hospitals designated as receiving sites during public health emergencies. METHODS: A qualitative study using focus groups with a total of 33 hospital nurses in 2003 was used. Audiotapes were analyzed, and codes, categories, and a theme were identified. RESULTS: Fear of abandonment was the overarching theme. Nurses believed that clinical settings would be chaotic, without a clear chain of command, and with some colleagues refusing to work. Limited access to personal protective equipment, risk of infection, unmanageable numbers of patients, and possibly being assaulted for their personal protective equipment resulted in the sense that they would be in unsafe clinical environments. Loss of freedom to leave the hospital and fears that hospitals would not provide treatment to nurses who become ill as a result of caring for patients contributed to the sense of abandonment. CONCLUSION: Although these nurses worked in hospitals with comprehensive public health emergency plans, they believed that they would not have readily accessible material and human resources to cope with a bioterrorism
event. Readiness plans should include a systematic assessment of nurses' concerns. Health care readiness plans should incorporate focused interventions to improve safety, a sense of control, and facilitate coping in public health emergencies.

Ref ID: 192
Abstract: The events of 9/11 highlighted the limitations of the United States health care system in responding to large-scale public health emergencies. The key for an effective response to any mass casualty event is preparedness; thus, the education of medical students has become a priority. The Association of American Medical Colleges (AAMC) recommended that the nation's medical schools should thoroughly educate students about the public health and emergency services systems to ensure coordinated responses to weapons of mass destruction or other public health threats. In response, The Texas A&M University System Health Science Center College of Medicine, partnering with the Defense Institute for Medical Operations (DIMO), developed a one-week block of required (but not graded) instruction, the "Leadership Course in Disaster Response," first given in 2003-04 to 72 second-year students and taught by six military experts from DIMO. The course goal is to (1) educate students on resources available for regional disaster response; (2) define principles of resource management in disaster response; (3) identify specific agents associated with bioterrorism; and (4) understand the psychosocial aspects of disasters. The course was well received, and the 2004-05 session was improved, based on student and faculty feedback. The authors describe the details of the course (specifically, how the course was tailored to fit the AAMC guidelines), changes in students' knowledge and attitudes, and how the course was improved.

Ref ID: 381
Abstract: Previously, the threat of bioterrorism was not taken seriously. Today, in the aftermath of 9-11, Americans know this threat can no longer be ignored. The effects of terrorism can be covert and can catch unsuspecting individuals off guard. In the event of an attack, Americans will look to hospital emergency departments as the first responders for all levels of care. Therefore, helping professionals such as physicians, nurses, and social workers employed in these departments must be prepared to assist with formulation and delivery of these plans. This implementation will require quick and accurate assessment and intervention strategies reflecting multiple levels of disaster preparedness. Suggestions are made for how to identify the threat related to bioterrorism and guidelines for plans to address this threat are postulated in an attempt to avoid further crisis and trauma toward all involved. Recommendations for future improvements in service delivery are made. (PsycINFO Database Record (c) 2010 APA, all rights reserved) (journal abstract)

Ref ID: 220
Abstract: INTRODUCTION: The nursing profession is developing educational resources to improve their response to victims of nuclear, biological, and chemical terrorism. Future nurses may differ from practicing nurses in their perspective of what is critical information. The purpose of this study was to identify student nurses' major concerns in relation to working with victims of terrorism. METHOD: A descriptive study was used to identify how future nurses might practice as caregivers for victims.
of terrorism. The study population consisted of a convenience sample of 95 junior and senior baccalaureate nursing students at a mid-south state university. The students were given an anonymous questionnaire regarding their concerns and how their lives had changed after September 11, 2001. The questionnaire consisted of 19 major items that identified demographics and perceptions and concerns regarding preparedness, willingness to work, expectation of future terrorism events, effect on lifestyle, and other fears related to terrorism or caring for victims of terrorism. A Cronbach alpha coefficient of reliability on standardized items was .745. RESULTS: Students' primary concern was for the safety of themselves and their families. They were primarily concerned about having adequate protection for all types of terrorist agents and indicated they would not be willing to care for victims if there was a lack of protection for both themselves and family. Although the nursing school faculty had provided self-education information about terrorism, students did not demonstrate an accurate understanding of the pathogenic nature of many agents.
This leaflet provides information about the EU-Project ‘CBRN Incidents and Psychosocial Support for Civil Protection Forces’ and the conference taking place in Berlin as an essential part of the project.

THE PROJECT ‘CBRN INCIDENTS AND PSYCHOSOCIAL SUPPORT FOR CIVIL PROTECTION FORCES’

The risk regarding CBRN situations has increased in almost all EU Member States. Civil protection forces deployed in emergency and disaster response operations under CBRN conditions are exposed to additional risks and pressures that are likely to cause heavy psychological strain. However, psychosocial crisis management is in most EU Member States not yet part of the training programme of specialists in CBRN.

The EU-Project ‘Psychosocial support for civil protection forces coping with CBRN’ (Acronym: ‘CBRN Incidents & PSS’) has been initiated to address this deficit. The project is co-funded by the European Commission, DG Humanitarian Aid and Civil Protection (ECHO).

THE OBJECTIVE OF THE PROJECT

Improving the preparedness of first responders in matters regarding psychosocial support (PSS), the long-term effects of psychosocial stress could be minimised and the overall efficiency of the crisis management could be enhanced locally, regionally, nationally and across the EU.

THE PROJECT GROUP

Partners in the Project are:
- German Federal Agency for Technical Relief (THW) (DE)
- Centre of Psychotraumatology, Alexianer Krefeld GmbH (DE)
- Impact – Dutch Knowledge & Advice Centre for post disaster psychosocial care (NL)
- Dirección General de Protección Civil y Emergencias, Ministerio del Interior (ES)
- German Federal Office for Civil Protection and Disaster Assistance (BBK) (DE)

Members of the Steering Committee are:
- German Fire Services Association (DE)
- British Red Cross and Red Cross EU-Office
- NOFER Institute of Occupational Medicine (PL)
- THW Regional Office for Bremen, Lower Saxony (DE)

EXPECTED RESULTS FROM THE PROJECT:
- Study of the current situation in the EU Member States regarding CBRN and Psychosocial Support (PSS)
- Study of the interface between first responders and hospital staff
- Curriculum and teaching material for a training course including exercises (for first responders and hospital staff respectively)
- Documentation of lessons learnt
- Guidelines
- Recommendations
- Two international conferences
- Information brochure

PURPOSE AND AIMS OF THE CONFERENCE:

- Gain an overview on the current state of training issues for first responders who have to cope with CBRN incidents in the EU
- Share expertise and examples of good practice
- Gather valuable advice and ideas for the development of pilot training courses for first responders in civil protection and in hospitals

The discussion and conclusions will contribute to the further development of the pilot training courses for first responders and hospital staff and to the other key deliverables of the ‘CBRN Incidents & PSS’-Project.

STYLE OF THE CONFERENCE

The conference will bring together a wide range of expertise from across the European Union (EU MS / EEA) who are active in the domains of CBRN incidents and/or psychosocial support:
- Civil protection
- Fire brigades
- Police
- Rescue services
- Medical/psychological services and hospitals,
- Volunteer organisations
- Private sector
- Academics
- Media

There will be working groups and plenary sessions held during the conference. Additionally, presentations will be given by experts dealing with CBRN and/or PSS issues. The language of the conference will be English.
CONFERENCE VENUE
The conference will take place at the Mövenpick Hotel, Berlin, Germany from Tuesday 12th to Thursday 14th July 2011 at:

MÖVENPICK Hotel Berlin
Schöneberger Strasse 3
10963 Berlin
Germany
Tel: +49(0)30-23 00 60
Fax: +49(0)30-23 00 6199

E-Mail: hotel.berlin@moevenpick.com / www.moevenpick-berlin.com

PARTICIPATION IN THE CONFERENCE
The EU funding allows us to pay for each participant’s travel, subsistence and conference costs. Participants are being invited to contribute their advice and expertise. Therefore there is no attendance fee.
Tuesday 12 July 2011

08:30-12:00 Arrivial of participants and registration
12:00-13:00 Lunch
13:30-14:00 Opening
   Rainer Schwierczinski (Vice President), German Federal Agency for Technical Relief (THW)
   Ralph Tiesler (Vice President), German Federal Office for Civil Protection and Disaster Assistance (BBK)
   Pilar Gallego (General Director of Civil protection), Dirección General de Protección Civil y Emergencias, Ministerio del Interior
14:00-14:30 Introduction to Conference
   Presentation of the 'CBRN Incidents and PSS'-Project and conference objectives
14:30-15:00 Opening Keynote by Prof. Dr. Richard Williams
   Prof.of Mental Health Strategy, University of Glamorgan, Wales
15:00-15:15 Coffee / Tea Break
15:15-15:45 'CBRN Incidents and Media and Crisis Communication' – Michael Granatt,
   Lutherpendragon - communication consultancy, London
16:00-17:30 Working groups on 'Media and Crisis Communication'
   (4 parallel sessions)
17:30-18:00 Presentation of the results of the working groups and conclusions of first conference day
18:30 Departure to shipping pier (Meeting point: Hotel Lobby)

Wednesday 13 July 2011

07:30-08:30 Breakfast
08:30-08:45 Introduction to second conference day
08:45-09:15 'CBRN Incidents and Psychosocial Support: Training for Hospital Staff' – Prof. Dr. Lars Weisaeth, Norwegian Centre for Violence and Traumatic Stress Studies, University of Oslo
09:15-09:45 'CBRN Incidents and Psychosocial Support: Training for First Responders' – Mario König, Analytical Task Force, Fire brigade Mannheim
09:45-10:15 Coffee / Tea Break
10:15-12:00 Working groups on 'Training for Hospital Staff'
   (2 parallel sessions)
   Working groups on 'Training for First Responders'
   (2 parallel sessions)
12:00-13:30 Lunch
13:30-14:00 'Lessons Learnt from the EU CREMEX' – Stella Polikarpus,
   Estonian Rescue Board, Dep. for ‘Rescue Works’, Tallinn
14:00-15:30 Working groups on 'Training for Hospital Staff'
   (2 parallel sessions)
   Working groups on 'Training for First Responders'
   (2 parallel sessions)
‘CBRN Incidents and Psychosocial Support for First Responders
– Improving Resilience through Training’
European Conference in Berlin, 12th – 14th July 2011

Wednesday 13 July 2011

15:30-16:00 Coffee / Tea Break
16:00-16:45 Presentation of results from working groups on 'Training'
16:45-17:15 Summary and conclusions of second conference day
19:00 Dinner (Hotel Mövenpick)

Thursday 14 July 2011

07:30-08:30 Breakfast
08:30-08:45 Introduction to third conference day
08:45-09:15 'The Impact of CBRN Incidents on First Responders, Volunteers and Hospital Staff' – Prof. Dr. David E. Alexander, Global Risk Forum, Davos
09:15-10:45 Working groups on 'Impact of CBRN Incidents on First Responders, Volunteers and Hospital Staff'
(4 parallel sessions)
10:45-11:00 Coffee / Tea Break
11:00-11:15 Presentation of results from working groups on 'Impact of CBRN Incidents on First Responders, Volunteers and Hospital Staff'
11:15-12:00 Conference Wrap-up and Closing
Farewell Address by Norbert Seitz (General Director of Civil protection), German Federal Ministry of the Interior, Department 'Crisis Management', Berlin
12:30 Lunch and Departure

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European Conference on ‘CBRN Incidents and Psychosocial Support for First Responders - Improving Resilience through Training’ (Berlin, 12-14 July 2011)

Annex 5: Results of the Evaluation forms

Participants: 71  (whereof 12 working groups leaders)  
Completed evaluation forms: 48

1) What were your expectations for this particular event? (the most mentioned answers)

- to learn more about PSS in CBRN situations / how it is dealt with in other EU countries: systems and procedures
- to get new contacts and new input / ideas with regard to PSS and training
- sharing and comparing experience and opinions with colleagues from other EU countries

2) How were your expectations met? (46 of 48 completed questionnaires)

<table>
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<th>Number</th>
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<td>Completely</td>
<td>11</td>
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<tr>
<td>Well</td>
<td>32</td>
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<tr>
<td>Partly</td>
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<tr>
<td>Not very well</td>
<td>1</td>
</tr>
<tr>
<td>Not at all</td>
<td>0</td>
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Q2: How were your expectations met?

3) The overall preparation (invitation, registration, travel arrangements etc.) of the conference was...

<table>
<thead>
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<th>Degree of satisfaction</th>
<th>Number</th>
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<tbody>
<tr>
<td>Excellent</td>
<td>34</td>
</tr>
<tr>
<td>Very good</td>
<td>12</td>
</tr>
<tr>
<td>Good</td>
<td>2</td>
</tr>
<tr>
<td>Average</td>
<td>0</td>
</tr>
<tr>
<td>Poor</td>
<td>0</td>
</tr>
</tbody>
</table>

Q3: The overall preparation (invitation, registration, travel arrangement etc.) of the conference was...
4) The realisation (organisation, accommodation, food etc.) of the conference was...

<table>
<thead>
<tr>
<th>Rating</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>41x</td>
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<td>7x</td>
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<tr>
<td>Good</td>
<td>0x</td>
</tr>
<tr>
<td>Average</td>
<td>0x</td>
</tr>
<tr>
<td>Poor</td>
<td>0x</td>
</tr>
</tbody>
</table>

Q4: The realisation (organisation, accommodation, food etc.) of the conference was...

5) What are your comments concerning the programme?

<table>
<thead>
<tr>
<th>Subject</th>
<th>Very relevant</th>
<th>Relevant</th>
<th>Of little relevance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subjects (46 of 48)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Content covered (45 of 48)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very relevant</td>
<td>26x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relevant</td>
<td>20x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Of little relevance</td>
<td>0x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Length of event (46 of 48)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Too long</td>
<td>0x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>About right</td>
<td>45x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Too short</td>
<td>1x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of working group / plenary session (47 of 48)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Too much plenary</td>
<td>1x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>About right</td>
<td>44x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Too much working group</td>
<td>2x</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

First conference day (12th of July 2011)

6) How relevant was the presentation given by Prof. Dr. Richard Williams to you? (1 of 48 noted ‘did not attend’)

<table>
<thead>
<tr>
<th>Relevance</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very relevant</td>
<td>22x</td>
</tr>
<tr>
<td>Relevant</td>
<td>24x</td>
</tr>
<tr>
<td>Of little relevance</td>
<td>1x</td>
</tr>
</tbody>
</table>

7) How relevant was the presentation given by Mr. Michael Granatt as stimulus for the working group ‘Media and Crisis Communication’ to you? (1 of 48 noted ‘did not attend’)

<table>
<thead>
<tr>
<th>Relevance</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very relevant</td>
<td>28x</td>
</tr>
<tr>
<td>Relevant</td>
<td>17x</td>
</tr>
<tr>
<td>Of little relevance</td>
<td>2x</td>
</tr>
</tbody>
</table>

8) How useful were the discussions within your working group for you on this conference day? (1 of 48 noted ‘did not attend’)

<table>
<thead>
<tr>
<th>Usefulness</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very useful</td>
<td>13x</td>
</tr>
<tr>
<td>Useful</td>
<td>23x</td>
</tr>
<tr>
<td>Average</td>
<td>9x</td>
</tr>
<tr>
<td>Of little use</td>
<td>2x</td>
</tr>
<tr>
<td>Of no use</td>
<td>0x</td>
</tr>
</tbody>
</table>

Second conference day (13th of July 2011)

9) Which working group did you attend at the second conference day?

<table>
<thead>
<tr>
<th>Working Group</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>9a) WG ‘Training for Hospital Staff’</td>
<td>20x</td>
</tr>
<tr>
<td>9b) WG ‘Training for First Responders’</td>
<td>28x</td>
</tr>
</tbody>
</table>

If 9a), how relevant was the presentation given by Prof. Dr. Lars Weisaeth as stimulus for the working group ‘Training for Hospital Staff’? (41 of 48 completed evaluation forms)
If 9b), how relevant was the presentation by Mr. Mario König as stimulus for the working group ‘Training for First Responders? (45 of 48 completed evaluation forms)

<table>
<thead>
<tr>
<th>Very relevant</th>
<th>Relevant</th>
<th>Of little relevance</th>
</tr>
</thead>
<tbody>
<tr>
<td>22x</td>
<td>19x</td>
<td>4x</td>
</tr>
</tbody>
</table>

10) How useful were the discussions within your working group for you on this conference day?

<table>
<thead>
<tr>
<th>Very useful</th>
<th>Useful</th>
<th>Average</th>
<th>Of little use</th>
<th>Of no use</th>
</tr>
</thead>
<tbody>
<tr>
<td>16x</td>
<td>21x</td>
<td>9x</td>
<td>2x</td>
<td>0x</td>
</tr>
</tbody>
</table>

11) How relevant was the presentation given by Mrs. Stella Polikarpus to you? (46 of 48 completed evaluation forms whereby 1 noted ,did not attend”)

<table>
<thead>
<tr>
<th>Very relevant</th>
<th>Relevant</th>
<th>Of little relevance</th>
</tr>
</thead>
<tbody>
<tr>
<td>16x</td>
<td>28x</td>
<td>2x</td>
</tr>
</tbody>
</table>

Third conference day (14th of July 2011)

12) How relevant was the presentation given by Prof. Dr. David E. Alexander as stimulus for the working group ‘Impact of CBRN Incidents on Volunteers, First Responders and Hospital Staff”? (44 of 48 completed evaluation forms)

<table>
<thead>
<tr>
<th>Very relevant</th>
<th>Relevant</th>
<th>Of little relevance</th>
</tr>
</thead>
<tbody>
<tr>
<td>27x</td>
<td>15x</td>
<td>2x</td>
</tr>
</tbody>
</table>

13) How useful were the discussions within your working group for you on this conference day? (42 of 48 completed questionnaires)

<table>
<thead>
<tr>
<th>Very useful</th>
<th>Useful</th>
<th>Average</th>
<th>Of little use</th>
<th>Of no use</th>
</tr>
</thead>
<tbody>
<tr>
<td>17x</td>
<td>18x</td>
<td>7x</td>
<td>0x</td>
<td>0x</td>
</tr>
</tbody>
</table>

14) In your opinion, the overall design of the working groups (structure, clarity of assignment, material provided, time at hand etc.) was… (47 of 48 completed evaluation forms)

<table>
<thead>
<tr>
<th>Excellent</th>
<th>Very good</th>
<th>Good</th>
<th>Average</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>8x</td>
<td>25x</td>
<td>9x</td>
<td>5x</td>
<td>0x</td>
</tr>
</tbody>
</table>

Q14: In you opinion, the overall design of the working groups (structure, clarity of assignment, material privded, time at hand etc.) was...
Q15: Your overall rating of the conference:

Excellent □ 21x  
Very good □ 19x  
Good □ 7x  
Average □ 0x  
Poor □ 0x

16) Other comments on any aspects of this event:
- Good speakers
- more time for Working Groups
- Many thanks
- Very good organisation
- Very nice conference venue
- Key Questions: clearer

Suggestions:
- list with the names of the participants in a Working Group
- smaller Working Groups
- more operational staff (among participants)

(Responses to Open Questions No. 1 and No. 16)

Q1: Expectations (feedback forms 1-48)

1. - To get an overview about PSS in relation with CBRN incidents in other countries in the EU
   - To get new contacts
2. -
3. - To understand how other countries deal with CBRN and PSS
   - To provide professional input into this project from a hospital perspective
4. - Sharing science, experience and opinions with colleagues and peers
5. - Wider understanding of preparation and need for PSA/PSS across EU
6. - That it would be informative
   - Develop ideas and an understanding of other good practice
7. - This was an ideal opportunity to compare CBRN theory that I studied during my masters degree in Civil Protection with the experience of some first class experts from a variety of different organisational and cultural backgrounds
8. - To see the psychiatric perspective of CBRN operation and understand if they are aware of the peculiarities of these category of event have.
9. - Learn more about PSS in CBRN situations
   - Learn from other countries in the EU - Protection of the first responders (mental and physical)
10. - Share expertise, familiarize with PSS systems and solutions in other countries/services
11. -
12. - I had no real expectations.
   - I believe I anticipated it would be a general exchange of views on psychosocial support and its place in a CBRN incident
13. - Learn more about specific PSS requirements in CBRN incidents
14. - exchange with other CBRN-PSS experts
   - learning about implementation of PSS in CBRN
15. - My expectations are covered by the event
16. - To meet people who work in the same fields like mine; to earn experience; to improve my skills
17. -
18. - Setting guidelines
19. - Gain more knowledge about how to prepare my team better on how to deal with CBRN threats.
   - Be clear about the difference to what I have experienced in my regular work so far.
   - Understand the limits of what can be done by teams of volunteers.
20. - To see what goes on in Europe very much, especially seeing how in different countries provisions and organisations prepare for the case
21. - To get some information how other organisations (other countries) deal with the problems of psychosocial support for first responders.
   - To compare the methods and the system of help with these of the German Armed Forces.
22. - Meeting participants mixed-up of people from the operational and strategic level,
   - topics on CBRN and PSS,
   - more relation to the experience of Fukushima nuclear power plant in Japan
23. - Knowing systems PSS in the other countries, procedures, guidelines etc.
   - Understanding of people which deal with PSS.
   - Pumping of knowledge from presentations.
24. - To exchange experience with colleagues.
   - To get news on PSS field.
   - To present news about PSS in Slovakia.
25. - New information; experiences in other countries
26. -
27. - Useful technique, how to work with firefighters;
   - how to organise trainings;
   - what knowledge they should have;
28. - I expected to learn more about psychosocial behavior of first responders, victims and hospital staff
29. -
30. - To learn more about CBRN incidents and their management
- To increase my knowledge concerning psychological aspects of CBRN incidents and solution in each EU countries.
- Meeting colleagues from other countries in Europe in order to exchange ideas and experiences;
  - giving input
- I got a task to make a presentation, so I was waiting to get that done. But I was surprised how much I could learn from other presentations and group work discussion. So my expectations are met and I am surprised!
- I want to see how can we help these people who try to handle these difficult situation such as CBRN incidents.
- Sharing experience and best practice + learn from it;
  - opening of CBRN PSS-topic;
  - networking
- I kept an open mind.
- Exchange of information, expertise etc.
- No expectations: came with an open mind
- Support for volunteers on a long term if CBRN attack? Is it different? Primary psychosocial care after the CBRN attack. --> consequences for support. Is it different than 'normal' Psychosocial case?
- to learn something new in sense of exchanging of experiences;
  - to inform myself with examples of good practice
- High level of quality,
  - relevant topics,
  - good organisation
- networking;
  - getting knowledge about the systems in different countries
- Get some information what it is all about!
- To understand psychosocial support specifics in the context of CBRN events
- Theoretical and practical knowledge and networking opportunities
- share experience and raise new questions
- be a part on the process of forming a system for psychological preparation for first responders;
  - get the confidence to go on with the teaching materials I have used and
  - get some new approaches

Q16: Comments

1. -
2. -
3. - Excellent venue - left wanting for nothing
  - Good facilitators for Working Groups
  - Good selection of speakers with a wealth of experience
4. -
5. -
6. -
7. - Really enjoyed the range of experience and knowledge - one phrase remains with me: 'Training is best form of Communication'
  - Maybe we should run an exercise on PSS with this group when we meet in Madrid?
8. In the introductory phase one or two presentations on CBRN agents and what happens at the incidence site were mandatory because the audience was not solely CBRN first responders.

9. - a first step is done! We have to go on.

10. - Great summary by Mr. Facilitator :-)

11. -

12. - The humidity of the conference facility did not aid concentration.
- The conference room with pillars was not ? to a good event.
- Better audio system required i.e. smaller radio
- Not enough time for workshops for the questions asked.

13. -

14. -

15. - I hope this group will continue the work in this field till something concrete (guidelines, ...) will be ready.

16. -

17. -

18. -

19. - The way the moderator being native English speaker dealt was difficult to appreciate, especially the way Dr. Weisaeth was introduced. This was embarrassing.
- Some of the questions were not cut clear enough and led to some confusion whether the group was talking about victims or about first responders.

20. - Q9a (Prof. Dr. Weisaeth): excellent;
- Giving a bit more time between and of workshops and reporting would have improved reports!

21. - Q6 (Prof. Dr. Williams): verwissenschaftlicht; schnelles, sehr schwerverständliches Englisch; Keine 'Message' erkennbar (für mich);
- Q11 (Mrs. Polikarpus): sehr gut zu verstehen und zu folgen

22. - Working groups: clarity of assignment improved during the days, but a clear structure and briefing of moderators and participants when workshops started would have been appreciated.
- Presentation about facts&figures of CBRNe incidents on the first day would have prepared a better common ground, especially for the 'felt' majority of psychosocial support experts here (best: presentation of David E. Alexander).
- More participants from the 'operational level', especially more CBRN first responders speaking up;
- Suggestions: more and smaller working groups representing CBRN experts, PSS experts, science, strategic level, etc.

23. -

24. - Thank you for this useful meeting to theme PSS.

25. - Materials (presentations, conclusions...) maybe given on CD; USB key...

26. -

27. -

28. - The project could probably have benefited from having a draft product at this time for the delegates to comment on. Also the questions in the workshops could have been more specific.

29. - Probably it would be a good idea to organise groups in a more uniform way, and not with so many different fields of expertise.

30. - The whole questions should be reworked: there were too long, complex and need differentiation (more concrete)

31. - Thanks for the possibility to join the conference, it was useful for my profession and I have got many new ideas!
- Great conference: however the outcomes of the workshops depends highly on the input of the workshop leaders.

- Q2 (Expectations): (Completely) and more; Thank you so much for great, fruitful and comprehensive conference! I enjoyed every moment of it. :-)

- Q12 (Prof. Dr. David E. Alexander): Great! Structured clearly! :-)
  - Presentations from real incidents are welcomed!
  - to involve more people from hospitals and from the military (for Workshops);
  - Psychology of shelter, evacuation, displaced inhabitants, isolations, DVI (?);
  - Israeli experience can be inspirative related to CBRNe; see comments on extra sheet

- Q12 (Prof. Dr. David E. Alexander): Super!
  - Many thanks

- Very good organisation (hotel excellent, boat trip...);
  - nice atmosphere, good networking;
  - didn't learn a lot of new things, but it was interesting to hear other opinions or approaches;

- Q11 (Mrs. Polikarpus): Of little relevance; but very well done;
  - Workshop: it is very important that the leader of the WS has experience. His role is to open the debate and not necessarily to follow the questions;
  - Conclusion for social support on long term for volunteers: to give more attention to volunteers and their relatives. How to organise it? Needs of more support for volunteers.

- I hope that PPT Presentations will be available (and also the results of the working groups). Thank you very much for excellent organisation of the event.

- Thanks to the organisers for their efforts during the conference.

- Swedish representative from MSB and specialist would like to participate in coming pilot course, work with standard checklist ('Guidelines') and so on!
  - 'Need all documentation'.
  - Please contact me.

- The English wasn't easy to understand (the facilitator, some keynotes, in the working groups...);
  - to be prepared better it would be much better to get the key questions earlier;
  - I missed a list of names in the workshops: whom I am sitting next;
  - too short time in the breaks, 1 1/2 hour lunch was excellent;
  - the questions for the working groups were too big and large in context and confusing;
  - Thanks a lot for taking this effort; the conference was very good and very well-organised; I hope you will recover very well now!

- Great work, great conference

- The importance of getting together, sharing the knowledge, experience, information would become smaller and easier to understand working together /teamwork; Thank you!
Annex 6: Results from the interviews with experts

Report interviewed experts

M.W.Rooze
December 2012

The CBRN incidents

Italy

The experts in Italy report that the majority of the accidents where CBRN is involved are industrial accidents and transport accidents, mainly chemical hazards. And the size of the accidents is limited until now. No large scale disasters. Examples which are mentioned are train accidents, one accident with a trainwagon carrying liquefied petroleum gas (LPG) at the station of Viareggio in 2009 with sixteen wagons, where only one wagon exploded, causing 14 victims, 50 injured, with 38 seriously burned for 80-90% and 1000 people to be evacuated. So a high risk accident which resulted in relatively limited damage, because only 1 trainwagon of the 16 exploded. A fire in a factory where a toxic cloud was released. Large amounts of toxic waste, piles of litter which pollute the lakes in Italy and which are dead because of the toxicity of the litter. Venezia Porto Marghera is one of the largest and most contaminated sites in Italy, for example, situated in the lagoon of Venice, few kilometres from Venice’ historical centre.

In Italy there is no real risk of terrorism with CBRN material. Since Italy is for 70% seismic, the risk for earthquakes is substantial. Every few years Italy is confronted with an earthquake. Combined with the fact that Italy has 4 reactors and 1 experimental one, this means a heightened risk for nuclear incidents.

France

In France they consider CBRN not only related to terrorism, as many people think. Industrial and transport accidents with toxic agents are considered a CBRN incident. But in the France they speak
about CBRN emergencies in fact only when it is a large scale incident. And in that sense Fukushima qualifies as a CBRN incident. The incident of course happened in Japan but the effects were also noticeable in France. The other incident which can be considered a large scale CBRN incident is that of the explosion in Toulouse of the chemical plant AZF on September 21st in 2001. So the emergency management status makes the difference between one case and another. Looking at the case of Alexander Litvinenko can be considered an act of terrorism, in fact of murder. But it became an emergency because of the widespread contamination. A very specific issue regarding the contamination was that a lot of the affected were concerned about the stigma they would get being contaminated than that they were concerned about the cleaning. The bar Litvinenko visited is an example of this phenomenon. A unique case which makes clear that stakeholder involvement is important in these kind of emergencies.

United Kingdom

Experts in the United Kingdom and Scotland stress the importance of the definition of a CBRN incident. In the U.K. and Scotland a CBRN incident refers to a deliberate act, and CBRN is then associated with terrorism. The response to these incidents is coordinated by the police. Incidents with hazardous materials (HazMat) are coordinated by the Fire and Rescue Service. Many incidents in the U.K. and Scotland are transportation accidents, fires in plants with toxic gases, spills of chemicals and nuclear material. Examples of these kinds of incidents are for example the Sellafield site. This site was to produce materials, principally plutonium, for nuclear weapons. The site has been subjected of much controversy because of discharges of radioactive material, mainly accidental but some alleged to have been deliberate. People’s perception is that these are only small incidents.

One expert mentioned the outbreak of the plague in Surat, India where 52 people died causing a large internal migration of 300,000 residents. There where a lot of rumours about the cause of the death, since the authorities were unable to culture Yersina pestis. There was great concern that it could be a CBRN attack and half the city left. In fact an example of a confusing picture of the nature of the incident, being a pandemic outbreak or a CBRN attack. The effects of such an incident are immense looking at the evacuation stream that was caused.

The Chernobyl disaster with the a nuclear plant in the Ukraine in 1986 was also mentioned by the British experts, because of the international effect. 100,000 km2 of land was contaminated, with slight levels of contamination all over Europe. The same holds for the Fukushima Daiichi nuclear disaster in 2011, it has led to trace amount of radiation being observed around the world. It had it’s effects in the Scottish mountains and the Wales mountains as well. After the incidents ‘ funny lambs’ were born. An interesting category is mentioned by one of the experts, where CBRN incidents can happen with flooding. When there is a combination with pollution by toxic agents you have to deal with this. Another example is a fire in a container in Petershead, which produced a huge cloud. Where in transportation accidents, where the HazMat triangle is used on the vehicles, indicating what they are carrying, in these kinds of incidents it is often unclear what substances are released. It is important to
alert the population very quick, and reassure people especially what it is not! In isolated areas one should make use of local radio stations, televisions etc. It is important to realize that reassurance only works when it is based on accurate information.

Storage of toxic material can be a risk, although legislation in the U.K. is very tight on when and how things are stored. The biggest problem with storage is storage of nuclear waist. There are 2 installations in Scotland for example. Transportation of the nuclear waist is one of the risks, the other one is that the nuclear plants are ageing, which heightens the risk of leakage.

Looking at the CBRN incidents according to the definition of a deliberate act, the Litvinenko case may be seen as a murder, but in the response handled as a CBRN incident. Alexander Litvinenko died of radiation poisoning November the 23th 2006 in London. At first it caused a lot of confusion and many theories about poisoning and death were put forward. In a urine sample the radioactive polonium-210 was found. Since Litvinenko served as an officer in the Russian KGB, the later Federal Security Service (FSS) it was supposed to be an assassination because of his KGB past. This case is an interesting case because of the public reaction. Since the public tends to stereotype events, this caused not much public concern.

Other incidents are powder incidents, for example with antrax, ricine incidents deliberate induced chemical suicides for example with hydriusulphate, this produces a gaz and is dangerous also for the responders, incidents with crystalmeth with the risk of explosions because of the wrong mixes, and incidents with heroine, where antrax got in, people, mainly heroine addicts, died of this combination. The risk for a terrorist attack with nuclear material is considered low. An attack with a dirty bomb is seen as more likely, with the risk of active radiological dirt, or the scenario with suicide bombings.

**Germany**

In Germany not many incidents happen, the training is in fact the most important experience the responders have. Training of first responders exists in every ‘länder’, every year there is a training event. Also the psychosocial care workers are trained. A German wide training was held on a nuclear threat on Berlin, and a nuclear threat scenario on an airport. Also a terrorist attack on 2 big cities was exercised. In total a 1000 first responders were trained. But in fact it was too big to be effective. The objective was to train on the higher level, especially the communication procedures. In Cologne 500 players were playing in real time.

The firebrigade is trained to respond to chemical incidents. Monitoring after an incident is important to follow-up if there are any toxic agents involved, because it is not always clear from the first moment on. Monitoring is not the standard procedure in case of an incident, but it is strongly recommended for example in case of a car incident when there is no indication, fire fighters should be trained to monitor. In general CBRN incidents are rather seldom, because of this there is no real experience.
Poland

In Poland there are no real large CBRN incidents. False alarms with bombs from World War II are known. CBRN incidents are exercised. The majority are industrial incidents where firefighters are involved, some 100 incidents a year with transportation of chemicals by truck or by train. An example is mentioned at the end of 2011 where there was a big fire where large amounts of rubber were burnt, this caused a thick, dark toxical smoke. It cause a lot of anxiety among the population. In the beginning of 2012 a huge fire at a shipyard, where plastic materials and chemicals burned. This was in the middle of the city. In Warshaw some large magazines were set on fire where rubber shoes burned, and a plant which produced cosmetics a.o. sprays. Experts from the police mention the outbreak of the birdflew as a biological incident, where the task of the police was to protect the area. Also in the case of counterterrorist acts the police is involved: fighting the terrorist, disarm dirty bombs. A special category where toxic agents are involved, and which is not easily considered a CBRN incident is suicide or poisoning. Poisoning with mushrooms, alcohol, narcotica and new developed pois like methodron. The main issue to be able to respond effectively to these kinds of incidents is being aware of new trends in drugs. The problem of not having a method to identify the drugs is prominent.

Romania

There are not many incidents with CBRN in Romania and it is not considered a big risk in general. Chernobyl had an effect in Romania, but Fukushima didn’t. If e is included CBRN-e (explosives) In the North East bombs are found coming from World War II. There is 1 nuclear plant ‘Cernovoda’, a big one with 5 reactors, this nuclear plant is less than 200 km from Bucharest and in that sense it is a risk for the city. In Bulgaria there is a nuclear plant near the border of Romania, there were incidents with radiological spills, and measurements were taken. In Hungary there was the incident with the Red Mud, via the Danub this came into Romania. Incidents with transportation of chemicals, are known, although not too many. 2 years ago in the South East there was an incident, where nobody knew what the agent was. They used water to control the fire but in fact it stoked up the fire. Law is in general very strict about transportation of chemicals. Transports are being monitored when they travel through Bucharest, and they have to be registered to the fire fighters. In the country this is not always the case. Fires in factories are not common, and they are well-prepared since they all have their own firebrigade.

U.S.A.

CBRN incidents are mainly about large scale incidents. The rest is falling under the category of HazMat. From the responders side the issues are the same. Probably 90% overlap with basic responders issues as to CBRN and/or HazMat issues.
Anthrax attacks 2001
Ricin attacks by fringe groups
The risk that bio material is easy to get your hands on
‘Mother nature’ itself
Local chemical leaking, rather frequent
Natural disasters, for example floodings where toxic agents are being released and pollutes the water, for example in Washington State on the upperwest coast where agricultural agents were released.

The Anthrax attacks in the U.S.A. happened in the wake of the 9/11 attack. So the main attention went to the consequences of 9/11. In an incident like the Anthrax attacks the first responders are a different group, in fact the medical professionals are the first responders in an incident like this. People show up at the hospital by themselves. This meant that the emergency room had to respond to the incoming of many people worried about being exposed. Triage is then an important matter. Special in this case was the many politicians coming in and VIP’s as patients, demanding treatment. A different group in comparison what is seen most of the time. The people believed they have been exposed and they have a strong fear to be exposed. And these people have to be taken seriously, they cannot just be send away. In that sense the term ‘worried well’ doesn’t cover the load of what is happening and what these people need. It is a psychological issue and there is a problem if they are being trivialized.

After 9/11 the government improved the preparedness, fire fighters and police were equipped with radiation detectors for example. There is higher level of vigilence. In general the first responder community is better prepared. Compared to the Oklahoma bombing where it lasted 3 days before things were measured.

Other CBRN incidents are:

Ricin attacks by fringe groups
The risk that bio material is easy to get your hands on
‘Mother Nature’ itself
Local chemical leaking, which is rather frequent
Natural disasters, for example floodings where toxic agents are being released and pollutes the water, for example in Washington State on the upperwest coast where agricultural agents were released.

Sometimes incidents become a health issue which are not a health issue. Like for example when cemeteries are being flooded. This is not a health issue, dead material is not a threat for the health of people. It is more like a psychological issue.

Conclusion

The majority of the incidents in the different countries are industrial, chemical incidents. Incidents during transportation and release of toxic agents in plant fires. Fore these incidents one is in general well prepared and it is most of the times well contained.
Some experts mentioned certain incidents which are not easily seen as CBRN incidents, for example the toxic risk of the eco-mafia in Italy, floodings in combination with pollution of chemicals or otherwise, deliberate induced chemical suicides where gas is released, this forms a risk for the responders.

Smaller terrorist attacks like incidents with anthrax and ricine. The problem with storage of nuclear waist and transportation and plutonium spills.

The 2 major incidents which are mentioned are Chernobyl and Fukushima.

Biological incidents were hardly mentioned.

**Preparation**

**Italy**

At the national level many plans are made by different organizations, including the Ministries of Health, Interior Affairs and Environment. Transport guidelines are made by the Instituto Superiore per la Protezione e la Ricera Ambientale (ISPRA). ISPRA is the supervising authority for nuclear safety and radiation protection and the technical body of support to civil protection authorities for nuclear and radiological emergencies. ISPRA works under the Ministry of Environment. Chemically, there is a big synergy with the crisis centre of Venezia Porto Marghera. This centre provides information about the characteristics of chemicals that are being transported. It is owned and paid by industrial companies and provides information about the risks.

Italy has seismic risks and every few years Italy is confronted with earthquakes. Risk sites are being monitored. For nuclear hazards there is a national monitoring network for radioactive activity at ground level.

On the local level the CBRN-equipment is stockpiled in fire depots in big cities like Palermo and Bologna. And it is not linked to the 109 provinces, there is no provincial unit with CBRN-equipment for decontamination. There is not much expertise and experience on these levels. One could say that if an emergency occurs they have to start reading the manual.

In the context of preparation there has been a terrorism exercise at Leonardo da Vinci - Fiomicino airport on communication with mobile phones, and making use of symbols to support the communication. But in Italy the preparation is fragmented. There are 10 or 12 places of expertise. The expertise is mainly developed after a disaster.

There is no real general strategy in preparing for CBRN incidents. Every local organization follows its own strategy and it should be taken more seriously. Recent embassy bombings, now increased the pressure on dealing with CBRN.

As to the psychosocial aspect there is no special preparation. There is no emotional backup for uniformed services while in fact there should be one. There is no support by the authorities. Since 1977 there are psychosocial teams. There is minimal training, for example in Lombardi there is a basic course for psychologists, with a practical part on situations and scenario’s for example in case of a toxic cloud.
France

France is in general well prepared, especially the preparation for a nuclear incident is at a good level. After the incidents on 3-Mile Island and Chernobyl there was a raised awareness that such things can happen. The Nuclear Energy Agency (NEA) of the OECD was initially working with the focus on the short term. After 2001 consequence management became the focus. This means the measures taken to protect public health and safety, restore essential government services, and provide emergency relief to governments, businesses, and individuals affected by the consequences of a chemical, biological, nuclear, and/or high-yield explosive situation. The stakeholders in this process are very important: people, organizations, governments, NGO’s etc.

NAE is an intergovernmental organization advising governments. In 2005 the French government adopted a policy on how to deal with installations and ‘works’ who need a special intervention plan, like nuclear plants. They formulated a drafting policy: ‘le Plan Particulier d’ Intervention (P.P.I.), A plan which foresees in the risk analysis, monitoring and response on the local level, the level of the ‘Prefecture’ in case of an emergency. This plan was subjected to an international peer review. It formulates the measures in the hotzone (zone 1) and the zone around it (zone 2). According to psychosocial care, this is not included in the preparation plans. In France the psychosocial care in case of emergencies is organized in ‘Cellules d’urgence médicale-psychologique (CUMP). They operate in the framework of the ‘Service d’aide médicale urgente (SAMU), this is the emergency medical centre of a health care region and the ‘Aide Médicale Urgente (AMU), this is the prehospital care. The CUMP is formed by psychological specialists: psychiatrists, psychologists, nurses, all specially trained in emergencies.

Also the Red Cross, with 60.000 volunteers exploits activities in the area of civil protection: rescue services, support telephone service, psychological support, first reception and support, registration, emergency in situation of exception, link with tracing service.

United Kingdom

At the level of the government there is a National Security Strategy, to ensure a secure and resilient U.K. the highest priorities are:
- International terrorism
- Natural hazards
- Cyber attacks
- International military crisis

The Government’s community resilience programme aims to increase individual, family and community resilience against all threats and hazards; To support and enable existing community resilience, and raise awareness and understanding of risk and local emergency response capability in order to motivate and sustain self resilience.
The National Risk Assessment identified the Top Three Domestic Risks:
- Unconventional terrorism (CBRN)
- Major flooding
- Influenza pandemic

Policy:
- Increase information for responders
- Community resilience
- Arrangements for warning and informing
- Arrangements for response and crisis management

The response team, especially the Hazardous Area Response Team (HART) teams are in a high skilled state. There is a lot of training, the fire and rescue service has nearly 70 decontamination ambulances. HART is the Hazardous Area Respons Team. It is a national team and it exists since 2005. It is developed from the CBRN work, in the U.K. this means developed from the terrorist CBRN work. For example in Mumbai 26-28 November 2008, 10 terrorists in pairs, killed 174 people with automatic weapons, among others IED’s (Improvised Explosive Devices). The HART teams have a programmatic approach:
1. Identification, Mobilisation, Scene Assessment, and led by the police
2. Casualty Management, led by the Department of Health
3. Fire Hazard, led by the Fire and Rescue Service

The CBRN approach is a flexible approach, not getting operational paralysed, waiting for that extra bit of information. There is a Standard Operational Protocol (S.O.P.), to learn how to deal with ambiguity, minimizing the risk. The issue of safety, is understanding the risk, mitigating the risk. There is a special training programme “Stay Safe” for unarmed responders. It is important to Investment in the commanders, because they are the key persons in leading the operation and take care of their men. According to CBRN incidents is the biggest shift change to be focused on what is released (based on scientific expertise) so then you know what to do: decontaminate or not. In CBRN incidents scientific advice is needed as soon as possible.

Employers have a ‘duty of care’, this is a legal obligation. As to the preparation for psychosocial support for first responders this is more on an organizational base than country-wide. In many of the cases there is a contract with an organization that provides counselling and psychosocial care for the first responders. The majority of this occupational health to provide for this ‘duty of care’ is thus commercially contracted. So there is no real supervision on the quality of care.

Besides the support by private, commercial organizations peer support is introduced. (Trauma Risk Management - TRIM and Critical Incident Stress Debriefing - CISD).

http://www.fife.police.uk/pdf/sop_TRiM.pdf

For the police organization existing of 8 constabularies (police forces) in Scotland thist means that they can choose it’s own system. So, there are differences between services and regions. The military they have their own system: aftercare for the military as an ‘inhouse provision’. There are 15 military
Departments of Community Mental Health (DCMHs) across the UK, as well as sites in other countries including Cyprus, Germany and Gibraltar. They offer specialised psychiatric services similar to NHS community health teams, and include psychiatrists, community psychiatric nurses, clinical psychologists, mental health social workers and occupational therapists.

http://www.nhs.uk/Livewell/Militarymedicine/Pages/Mentalhealth.aspx

Main problem with peer support for the uniformed services is the stigma when we are talking about seeking help or support after incidents. Therefore peer support is favorable. You need a top-down approach, communicating in a positive way about peer support. The highest levels must be included, management in that sense is important for a positive culture.

Germany

The national emergency response system is effective. Within the Civil Protection system, the Federation, which is responsible for civil protection, and the states (Länder), which are responsible for disaster protection, work closely with aid organizations and fire services. A new Federal Office of Civil Protection and Disaster Assistance (BBK) was created which went into operation on 1 May 2004, this as a result of the experiences of 11 September 2001 and the flooding in summer 2002. Germany’s emergency response system is based on volunteer commitment: more than 1.2 million volunteer firefighters, five volunteer organizations (the German Red Cross, ASB, DLRG, the Johanniter Unfall-Hilfe, and Malteser Hilfsdienst) with another 500,000 volunteers, together with the 76,000 volunteers of the Federal Agency for Technical Relief.

The structural framework of Germany is a two-track system of emergency preparedness on the one hand, civil protection as a federal responsibility, a kind of annex to federal defence tasks; on the other hand, “peace-time” disaster protection as a responsibility of the states.

The psychological and -social support system consists of three main elements: support for survivors and witnesses, for relatives and for emergency responders. The care or treatment of emergency victims and relatives in the immediate phase is dealt with by Crises Intervention Teams or Emergency Pastoral Care Teams. Post-event care of responders is dealt with by Critical Incident Stress Management Teams and psychologists.

Organisations responding to emotional and practical needs of individuals include:

- The Federal Office of Civil Protection and Disaster Assistance (BBK)
- Non-governmental Humanitarian Organisations (Arbeiter-Samariter-Bund, Deutsche-Lefensrettungsgesellschaft, German Red Cross, Johanniter Unfallhilfe, Malteser Hilfsdienst)
- The Federal Agency for Technical Relief (THW)
- The German Foundation of International Critical Incident Stress Foundation
- The Protestant and Catholic Churches
- The Police/Federal Border Guard
- The Fire brigades (counsellors to support the firemen and women in the case of a disaster or emergency).
**Poland**

Each fireman is trained to identify the risk in case of an incident where chemicals are involved, he has knowledge about the risk and there is a strong internal cooperation at the scene, combined with a well-developed strategy for the external communication with the mass media. The fire fighters treat the mass media as a tool for informing and calming society. It is very important providing information that is well-checked. The information should be communicated in a consistent way by all actors, for this aim institutions who are involved should communicate with each other. Information should be given without any delay, and provided as soon as possible. It time passes without information to the people, rumours start to be spread around. There are several procedures to stream information: press agency, radio information agency and via television information 24-hours via running labels. There is a strong example being mentioned by one of the experts, where in the response to the earthquake in Haiti a team from Poland was send. They used the mass media as a kind of psychosocial care for the families of the responders.

The advantage of the organization of fire fighters in Poland is that they themselves have the experts. This makes the information more easy to manage.

In case of large emergencies also the foreign media come in, they also need information, and the fire fighters learned how to provide this information for the international journalists.

In Poland the fire fighters are trusted by the people because of the many years of their professional work. In communication this is an important element.

The Center of Crisis management in Warsaw prepares for a proper flow of information in case of a crisis or potential crisis. They collect the information from different services, ministries and local authorities. This is crucial in large crises. The Center ensures that society is provided with the necessary information. They are the leading institutions on the national level.

**Romania**

Since CBRN is more dangerous, preparation should be different, more specialized. When fire fighters see a fire, they know what to do. In case of CBRN there is a lack of knowledge. Also the population has a lack of knowledge. There are plans who prepare for incidents like this and there are exercises on the level of the city, not on a national level. There are cross-border exercises.

- Danub 2008-2009 with Bulgaria, exercising the scenario of floods and CBRN
- On a regular basis there are exercises in the West, with Hungary and Moldavia
- With Ukraine less exercises, since there is a natural border between the two countries by a river and the mountains
- Exercises around the Black Sea
- In Romania a special unit is formed for the Civil Protection Mechanism, there will be an authorization probably next year, so they can be operational.
The level of preparedness is extremely variable. Looking at the different levels of the Federal State, the State and the Local Government. In general one could say that the urban areas are better prepared than the isolated areas.

Much of the preparedness depends on the funding of the government. The major urban areas are well funded and well prepared. New York is a special case. This is ‘another world’. Now during the economic crisis the maintenance becomes a problem. Everything that has been put in place costs money to maintain, because of funding is being cut down, this makes that the maintenance comes under pressure.

General radiation is better prepared and is cheaper to monitor, in comparison to nuclear, since this is a lot more complicated.

A specific topic is when there are many victims, for example the task of picking up the remains. After 9/11 all the remains were to be identified and this work goes on, until today. We have to think about what this means for the people who have to do this work. So the management of the fatalities after an event is an important issue. ‘Who are helping, who are harming’. With forensic identification we are not going to stop, but what does this mean for the coronor. In other words, science outpaced us. This is a large psychological issue. The answer probably lies in the spiritual community. For example with the Estonia disaster, the large ferry which sank in front of the coast in Norway, Lars Weisaeth has advised not to lift the ship to cover all the bodies.

The sight of a disaster is very important, and how it is memorialized, for example with the pandemic flu. Behavioral health has to have a voice. For first responders having meaning for their actions. The consequences for first responders are probably cumulative.

But the key point is that we never measure what lies in between, meaning after the incident and the final outcome for the affected. Why do we do all this kind of stuff, what is the effectivity, that’s in fact the biggest issue. If we measure what is effective than we can move forward.

There is a very strong example of an explosion in a school in Wyoming, years ago, where the parents were the first responders. Bob Pynooss was the expert advisor. We should learn from this kind of experiences.

Conclusion

From the interviews with the different experts we get a picture of different systems and different levels of preparation for CBRN incidents. For the smaller incidents the local levels are more in place and
often well trained. The larger incidents are more under the attention of the government, but then the connection with provincial and local levels might be too much at a distance.

In general one can say that at a central level plans are made by different responsible authorities and many different organisations. The risk is that the result will be a fragmented picture, where the regional level lacks connection with these plans.

Looking at the CBRN concept as a whole one has to conclude that there is in fact not one concept what works for policy and response and professional organisations. The different types of incident are the responsibility of different authorities and different response and professional organisations.

The response organizations are often well trained and fit for their duty, especially the smaller and daily routine incidents.

For high risk scenario’s like seismic and nuclear risks there often is a monitoring system in place at a national level.

Experts and Centres of expertise are often spread and and there are only a few on every specific subject.

Preparation for psychosocial care for uniformed services for CBRN incidents is not readily available. Psychosocial support in general is in often peer support, and contracted commercially. Quality of care is therefore hard to control.

Experts also mention the change in focus from solely on the acute phase to the longer term, with more attention for recovery and rehabilitation.

**Special preparation concerning psychosocial care**

**Italy**

It started with nuclear and chemical risks. At the level of the personal fire-fighter instructions and basic information is provided about risks and self-protection. Every fire-fighter is prepared to deal with CBRN-problems. Especially in the use of equipment and self-safety. At the operational level the leader of the teams is responsible. Every squadron of five teams has a leader. This leader is instructed how to deal with problems. The third level is an expert. There is at least one expert assigned to each command unit, usually there are two or three experts. In the country there are approximately 300 experts. In addition there are teams with special expertise. In Venice, for instances, for dealing with chemical emergencies. Other teams are stationed in Bologna, Rome and Palermo.
Psychosocial care in general is fragmented. There is psychosocial aftercare but it is patchy, ach occasion results in own institutions - or fabrics looking like institutions or groups. Psychosocial care is provided in combination with medical care. The question of the diagnosis is in the case of CBRN incidents very important. Psychosocial care consists of different sources:

- Health services at the regional level, this is a collection of 20 health services
- Small national health services
- Local health districts
- Involvement of volunteers: mostly medical volunteers, some psychologists, incorporated in the system, 3600 volunteer groups with legislative responsibilities
- Miserecordia, responsible for their volunteers
- Civil Defence, they work with secrecy rules, but are overshadowed by Civil Protection
- 2 big Milanese hospitals collaborate with civil defence and civil protection in CBRN
- Civil Protection is involved in 50% of Civil Defence activities
- Volunteers are well equipped, see for example their work after the l'Aquila earthquake
- Largest component in the care is medical but they have no CBRN training
- Psychiatrists have a role in training the response organization, training to incorporate it

The important question in case of CBRN incidents is the level of expertise that is available.

**France**

Although there are no specific guidelines on psychosocial care after an incident with CBRN agents, the NEA is very aware of the importance of a multidisciplinary response. They strongly promote preparedness for stakeholder involvement as a top priority. A holistic, all-hazards, public health approach to emergency management is recommended, particularly in the planning, response and conduct of the late phase activities of recovery and rehabilitation. Awareness of psychological principles like: people want to know that you care before they care about what you know, and that people have difficulty hearing, understanding and remembering information in stressful situations and the importance of uncertainty.

As for the responders, they risk their lives and they deserve to be protected. In Chernobyl 31 people died. In general in these kinds of incidents, you don't know what the responders will be encountering, they go in very quickly and it is dangerous.

In Fukushima they were dedicated, and exposed continuously. Based on scientific knowledge about nuclear power plants they will probably be okay. In Japan they have loyalty to the company, and they are fairly well informed. Fire fighters and police are less familiar with these kinds of incidents. They are trained to safe people's life's, that's their focus. They don’t worry about safety. So this is a matter of awareness training to increase their resilience in responding to CBRN incidents.
United Kingdom

The provision of psycho-social support is undertaken by a range of response organisations. When an emergency is declared, it is the responsibility of the local Director for Social Services to ensure proper psycho-social responses. Local authorities will set up rest centres for individuals evacuated as a consequence of an emergency or disaster and will work in conjunction with the police to set up reception centres for survivors and relatives and friends. The intention is to provide a one-stop-shop for survivors and families but there have been teething issues to date.

A range of voluntary organisations will staff these centres, including:
- British Red Cross Society – a range of practical and emotional support
- Faith community members – spiritual support
- Salvation Army – clothing and emotional support
- St Andrew’s Ambulance – first aid
- St John Ambulance – first aid
- WRVS – a range of practical and emotional support

Police Family Liaison Officers (FLOs) undertake a range of support roles as part of their prime investigative responsibility. The FLOs’ involvement will include dealing with the family’s questions about the progress of the investigation and the law, facilitating attendance at key venues and assisting the family to deal with the media. The police will also provide the Casualty Bureau facility for collating information on individuals involved in the incident, or reported to be involved. They will inform relatives and friends when an individual has been identified as a casualty or deceased.

As the response moves to the intermediate and long-term phases, the local authority will take a leading role by facilitating the rehabilitation of the community and restoration of the environment and co-ordinating the caring response, working closely with health professionals.

Health and Safety at Work legislation places significant responsibilities on all response organisations to ensure that their employees/volunteers are prepared adequately and that there are no avoidable risks to the individuals they are supporting.

Appeals may be set up to provide financial assistance to the individuals affected by the incident. The British Red Cross provides advice for setting up Disaster Appeal Schemes.

The Foreign and Commonwealth Office has taken responsibility for assisting survivors and families involved in incidents overseas.

There are no special actions taken in psychosocial care after a CBRN incident. In case of a major CBRN-incident victims will leave if they can and find access to primary care or other professionals. Those who can’t leave the site themselves must be helped. Dealing with victims in these areas and responders, that is the challenge and proper training is necessary. Particularly regarding front-line triage of people suffering from CBRN-consequences. Ambulance, police and fire fighters in protective gear should be trained in triage. In recognizing and prioritizing of problems. Psychologically they must
be made aware that some people cannot be saved. That is what we need to think about. On the longer term we need to develop supportive approaches and means for our staff. Some need no support but others will. The trick is to find out which person needs which level of support.

You can think of a lot of different categories. First we have the immediate responders and their families. If responders are absent for a long time in dealing with a major crisis, families are worried. They contact the service and they must let them know their loved ones are save. Furthermore there is a need to communicate throughout the organization, and politicians should not to be forgotten. Government becomes a hungry beast' in a crisis situation, craving for each type of information. So communication has to be aimed at all types of organizations and agencies involved and to the general public, according to the principle “warning and informing”. Information provided by the media can provide stress, because of the reporting of the situation. Work with the media so they can create the right story.

Psychosocial support for first responders is important, even more for CBRN incidents then other incidents, there is more unknown, and then it comes back to fear; maybe you know the toxic agent, but not if you are exposed.

**Germany**

The psychosocial support in case of a CBRN incident should be a mixture of psychological and medical care. In fact doctors there is a shortage of doctors with expertise in this field and often they are not included in training and exercise. Germany has only 5 or 6 specialized doctors. We need these specialized doctors to give information. Psychosocial care should go hand in hand with medical care. There is for example a need for health checks over a longer period of time, especially with people who are very anxious and worried. You have to offer these people this service.

Psychosocial care for first responders should not only be provided on the local level, but it should be included on the strategic level, this means on the national level. You have to set a standard so to be sure that there is a good available quality of care.

Expertise should maybe not only be made available on the national level, but also on a European level. The big countries can manage by their own to create the necessary resources, but smaller or poorer countries may find this difficult. Also training on a EU level can support the development and harmonization of expertise.

**Poland**

There are no specific measures concerning psychosocial care. The insecurity is a major issue and for this there is a 24-hours support phone at the NOFER Institute. There is an open toxicology base with information of the composition of the substance. Information is very important.
Romania

Looking at psychosocial support in general, the most important principle is bringing people together and make a network, to be connected. The direct colleagues are the first to see if a colleagues has a problem. Psychoeducation is important to deliver the information on the level of the fire fighters, not the scientific abstract information, but the information which works for the fire fighters, this is not an easy job to do. Teaching the formal leaders the techniques of ventilation, how to listen to the fire fighters after an incidents what they have to say, this is not a debriefing as in a formal debriefing, but it is helpful to share the information. The sharing of feelings of fear and giving social support to each other in this way. The culture of the fire fighters is a military culture. Part of this culture is wearing a uniform, the signs, the structure, the feeling of ‘we are military, we are different’, the structure makes the fire fighters strong as a team. These principles are effective, there are no specific actions in case of CBRN.

U.S.A.

90% is probably the same, but in case of a CBRN incident the health impact is very strong, there is a great mental health task. The issue of uncertainty is psychologically a difficult task. Looking at the methodology versus science, then in planning science is not adequately used. Planning is based on intensified fear, it influences the quality of planning.

- motivation and content based on bad science, for example panic as a myth
- there is a psychological factor in planning itself, a psychological factor plays a role for the planners
- in the command center one is confronted with scary situations
- the process has a psychological cost

Conclusion

No specific measures are known concerning psychosocial care in relation to CBRN incidents, but all the experts stress the importance to pay attention to this and they formulate some important principles. Psychosocial care should be given in combination with medical care. This has directly to do with the kind of incidents where exposure to toxic agents and the worry about ones health plays a major role. To be able to formulate a diagnosis and differentiate between stress reactions and consequences to the exposure of toxic agents is essential. For this same reason the importance of information is stressed: warning and informing throughout the organisation, and the availability of experts and expertise. Also in planning science and evidence based information should be the base, the psychological factor in planning, i.e. fear, is underestimated.
**Difference between CBRN and ‘normal’ disaster –related psychosocial care**

**Italy**

The operational strategy and command structure are similar in case of CBRN and ‘normal’ disasters. For CBRN one works with specific equipment, in line with international standards. The scale and intensity of the actual response depends on the nature of the event. Train response organisations to understand the key issues in a CBRN incident and incorporate psychologists and psychiatrists in this planning. There is a huge logistical problem, for instance when it comes to dead bodies. A lot of psychosocial issues have to deal with logistics. Get professionals in the right teams and at the same place. What is needed is a process-oriented approach with a long-term perspective. The Sarin attacks in Japan resulted in 12 dead. Roughly 1,000 were injured. People are overwhelmed and worried about their health.

**France**

One should absolutely address the specificity of, in this case, a radiological incident. One should be cautious about the fact that ‘nuclear guys’ are not trusted, especially after Fukushima. We know from information about Chernobyl and Fukushima that levels of radiation are small, and that there will be no health effects in the future. But it is all about credibility, and this is the issues we should deal with. The first two years people will be very worried. Experts are not trained in this matter, and when communication is not clear, theories of hiding information arise. We need a group of good communicators. The situation is so sensitive in itself, for example the protective suits itself already scare people.

**United Kingdom**

Psychosocial care should be different for CBRN incidents. The high uncertainty on the long term is one of the key issues. The question is also to what level do you inform people about CBRN issues. Too much knowledge may scare people, finding the right balance is the challenge to support people in an adequate way in their resilience. A great concern is the willingness of the ambulance service to respond, part of the psychosocial support should be the support for the family of the responder.

**Germany**

The problem is especially with non-visible toxics, it is very emotional. Very difficult to communicate about their life-time risk. When you hear about contamination, people get very worried. We need precise information about the facts of contamination. Again this is difficult to communicate. We need to communicate the basic facts, but this is hard for scientists. We were not very successful in fact in the last 20 years.
Psychologists need additional training in CBRN. They need to know the basic facts. So not train fire fighters in psychology, but train psychologists in CBRN.

About family: first responders are not willing to go there. This is not a psychological problem, but it is lack of information. They don’t have the material and the information to take a good decision. The authorities are not trusted in these cases, experts are. Or anybody other trusted by the public: teacher, a medical doctor. CBRN experts are biased, also organisations, they have a tendency to hide.

**Poland**

On the national level the main general rules should be developed, on the regional level they need more detailed information. The guidelines should be specific in case of a CBRN incident. For example in case of a radiological threat, different actors are involved, they all have a different approaches according the information they want to communicate. The information is very fragile because of the idea of causing a panic. All involved actors have a common task to provide information, the correct information at the proper time. The safety ad security of the people is crucial, this asks for direct communication with the people. Trust is crucial.

**Romania**

Thinking about psychosocial support in case of a CBRN incident the difference is mainly the lack of knowledge. One has to give information in a proper way to the population and as quick as possible. Since in most cases it are not the CBRN experts who go in, the fire fighters are the ones who are first on the spot, they should have basic knowledge about CBRN to be prepared. When you cannot answer and when you don’t know you are not prepared for the job. Psychologists can play a role preparing them and that they are aware of their lack of knowledge, this to improve their resilience, making them understand the risk and stay together. Many develop a personal resilience, working for many years, they develop a coping mechanism. Personal resilience shows that we all come with our own resources. This personal mix makes the personal resilience. Psychosocial support in relation with personal resilience is finding the personal resources.

**U.S.A.**

The consequences are different for different kind of responders: fire fighters, police, ambulance. We have to look at the type of role of the responder to understand his position. If they deal routinely with it, it’s different for somebody who never deals with it. The awareness of the risk is important. CBRN incidents cause special stressors. Provide leadership and command that influences people.
Conclusion

The approach of psychosocial care after a CBRN incident is different from ‘normal’ disaster related psychosocial care. In the sense that the high uncertainty is the central issue. High uncertainty can lead to very emotional reactions and high stress levels. It means that the consequences of the incident can be very unclear: exposed or non-exposed, the type of toxic agent, the duration of the consequences, the uncertainty also about family.

So communication and information should be at the heart of the psychosocial care. But this is also a challenge since to communicate about uncertain issues is not easy. Credibility is also an important issue, experts (including doctors) should be trained to communicate in the way that they can ‘warn and inform’.

Lessons learned

Italy

People have to be informed but a difficult relation exists between awareness and fear. We need guidelines to deal with social awareness.

A great challenge lies in the social and political management of risk perceptions. It is difficult to communicate risks towards a population. We made an attempt to inform the public about a plan we made, based on an assessment of risks of the last 40 years. Instead of reassurance the result was an increase in the level of concern. People became worried. Be careful with what you communicate. Different parts of the population, moreover, require a different approach. A big problem is that an acceptable risk level has not been defined. This depends on social circumstances and varies through time. Many factors are related to risks.

9/11 New York. The risk of asbestos contamination made it important to identify who were at the scene. Nobody held a record of the people who were there. ‘Disaster bureaucracy’ is an important issue. In the aftercare, it is important that people who deserve compensation will get it. Insurance companies are interested in registration. A register is prove for compensation.

France

The importance of preparedness is central. Japan was not well prepared, since Fukushima was ‘new’ with a release of 3 weeks. So it was about evacuation, sheltering and stakeholder involvement.

Sheltering was foreseen for 2 days, so 3 weeks sheltering was very much improvised.

So preparedness is about:

- Planning
- Consequence management aspects
- Structural readiness in organizations
- Stakeholder involvement
- The solutions come from the people
- It is all about choices
- Information and responsibilities

United Kingdom

The obvious lessons concern providing information and reassurance to staff in the wake of an attack concerning issues over their exposure. Lack of information creates anxiety and concerns, the information should be limited to those to areas which are real and providing detailed information on how best to mitigate the effect. Part of that information should come from past case studies, like Chernobyl and Fukushima.

Also relevant to all disasters and CBRN in particular is facilitating ‘resilience’. There should be enough resources, people and equipment.

Organizations should work similarly in terms of command structures, communications, and operating procedures. What we learned from the London bombings is that police, ambulance and fire fighters should be able to talk to each other on radio, and not up and down within their own organizations.

Also, everyone should be familiar with each others procedures.

Robust training is needed, continuity in training, developing skills, not only refreshing training.

Continuity of care is needed at this moment it is most of the time patchy, short term and underfunded.

The long term care will be inadequate, because we don’t know the long term consequences. Special target groups are children and women, especially pregnant women.

Germany

Education is the key issue here, not only in times of crises but earlier. Start in school, ad approach the issue as that it is part of our environment, these things can happen.

CBRN is about risk and capabilities. Understanding the risks and facilitate self-help and resilience can mitigate the effects of the disaster.

The capabilities have to be available on the local level, together with the local people. Communication and advice! Then you reduce the effects. This is the key:
- deal with the population
- strategy
- include stakeholders.

Poland

Cooperation between institutions and mass media is a key issue. This cooperation should be build on trust, not only during incidents but in a longer lasting relationship.

Publish articles in the papers is an effective way to spread information. Mass media fulfill in this way an information task. But also via news bulletins in different medical institutions, universities and normal
hospitals. It shouldn’t be the journalists, but an expert. Also people from the government are not the right people to function as the messenger. Doctors should be prepared to talk with the mass media, not everybody is willing or capable of doing that. It should be a specialized doctor. In case of large scale incidents we need local consultants and general consultants.

It is important to educate society through the mass media. People in general are not educated and not prepared on the topic of CBRN.

Psychosocial support is important for families and first responders.

**Romania**

Psychosocial support should be practical, the scientific knowledge should be translated into concrete, understandable terms. We do not need only books, we should go to the people and see what works for them. Psychologists should be effective. What makes psychology an added value, what makes it work for them. To understand the importance of the network, the connection, manage the relation and find a way to manage the relation, working together makes them better. Fire fighters have no name, people see a fire fighter, they don’t see for example John, fire fighters are a team, and they have to become part of the team, to stay outside the team is not possible. This principle seems even more important in case of a CBRN incident, because the high levels of stress, anxiety and unsecurity.

**U.S.A.**

- Include the context
- Family is important
  - Katrina
  - Guidance for the federal workers
  - Reassigned people
  - Companion piece for the family
  - Flow of stress prevention
- Pre-event
  - Organizational culture: if the organization cares for you
  - Job description, like informed consent medicine
  - Employer selection – we don’t ask about stress related issues (trauma history, coping strategy)
- Post-event
  - Non-stigmatizing service
  - Having options; psychotherapy, peer support, counseling, spiritual care
  - Evaluatie usage/ efficacy
The CBRN Stress Response Model

Based on current knowledge on stress response reaction in case of crisis management, we will focus on the question: What are the differences between general disaster situations and stress response in CBRN incidents?

Therefore, we created a model that clarifies the interface between stress response and CBRN incidents, and focuses on differentiated knowledge about CBRN specialties. The CBRN stress response model focuses on the psychological impact as a framework for addressing the emotional, cognitive and behavioral effects. We conclude that the model serves as a basis for modifications of disaster plan management in hospitals.

Background:
The psychosocial effects at the emotional, psychological and behavioral levels that result from CBRN incidents have been shown to be more widespread and long lasting than the direct physical effects, in terms of their impact on society and the general health of the population. However, it is clear that even small-scale CBRN incidents can cause widespread confusion, fear and psychological stress that have lasting effects on the health of the affected communities and on a nation’s sense of well-being. Research evidence clearly demonstrates that fear and anxiety are normal protective behaviors that are part of much broader set of psychosocial reactions to CBRN threats and attacks.

Approach:
First, we introduce a model that is vaguely based on Loewenstein et al. (2001), which emphasizes the psychological aspects while experiencing a dangerous situation. Second, we will differentiate the aspects according to specific conditions of a CBRN incident (cf. Loewenstein et al. (2001), Raphael & Stevens (2008), and BBK (2011)). The psychological components of various disaster situations will be represented.
1. Responses in threat situations

The model (figure 1) exemplifies the psychological aspects while experiencing a threatening situation (cf. Loewenstein et al. (2001)). Disaster causes psychosocial responses on the emotional, cognitive and behavioral levels. These stress and social reactions serve a purpose. An individual’s threat assessment process is activated, as well as attachment behavior (cf. Strauß et al., 2002). Attachment theory postulates a universal, human need for a close emotional attachment, which is an essential part of our survival instinct. According to Bowlby (ibid), an attachment behavioral system is triggered early on by perceived threats, in order to motivate people to move closer to attachment figures. This attachment system is defined as a goal-correcting behavioral system that is primarily activated by discrepant experiences, such as acute threats, particularly by unfamiliar situations or strangers. Attachment behavior includes all behaviors that serve the purpose of ensuring proximity or accessibility to an attachment figure. The phenomenon, the “secure base effect” describes an attachment pattern where, in the presence of an attachment person, comfort and reassurance are increased and fear is decreased (ibid).
Disaster

Threat

Perception
Source of danger

Physical Reaction
High or low activation

Emotional Reaction
Emotional distress, life threat, panic, anger,

Cognitive Reaction
Out-of-control and coping

Perception of threat activates attachment behavior:

**Secure base effect**: Attachment behavior

Threat Reduction

Fig. 1: Response in threat situations
2. Response in CBRN threat situations

The CBRN stress response model describes specific psychological aspects of a CBRN threat situation (cf. Loewenstein et al. (2001); Raphael & Stevens (2008); BBK (2011); and Strauß et al. (2002)). At the core of observations is the question whether factors from a psychological perspective are effective in a CBRN incident, and whether it is a confounding factor between experiencing stress and handling stress.

Two aspects are studied that act as confounding variables between threat and stress processing. Both aspects show up in CBRN incidents and contribute to an increased focus on threats that make it more difficult to handle a CBRN threat situation effectively.

In the following passage, we introduce both aspects: First, the psychosocial stress of those affected by a CBRN situation is increased, since the source of danger is difficult to define. Radioactive, biological and some chemical substance cannot be perceived via the senses like smell, sight, touch, taste and hearing (cf. BBK, 2011). With chemical disasters, the degree of endangerment is usually not able to be assessed by laymen. In a biological damage situation, the risk of infection cannot be initially estimated. With radiological/nuclear damage situations, it is essentially impossible to detect the source of danger with our sense. This “invisible enemy” leads to uncertainty and fear.

The second aspect can be seen in the activation of attachment behavior, which contributes to the perception of threat reduction. The attachment system is primarily activated through an acute threat as represented in a CBRN situation. The attachment behavior is influence, however, by mimic, tone of voice, gender characteristics, and bodily proportions. These aspects contribute to the secure base effect in the sense that comfort and reassurance increase in the presence of the attachment figure, and fear is reduced. If this system is disturbed, then a frightening-frightened collusion can develop, whereby no protection is provided. In a CBRN disaster situation, rescue teams as well as hospital personnel, e.g., in the emergency room and intensive care units, work in PPE (personal protective equipment). The protective suits change and prevent the perception of the so-called bodily characteristics that contribute to the activation of the attachment behavior. Since the suits change the attachment behavior, this creates a special challenge in the psychosocial support of those affected.

Hobfoll et al (2007) identified five empirically supported intervention principles that should be used to guide and inform intervention and prevention efforts at the early to midterm stages. These are promoting: 1) a sense of safety, 2) calming, 3) a sense of self– and community efficacy, 4) connectedness, and 5) hope. Regarding the CBRN disaster situations it might be difficult to promote a sense of safety and connectedness regarding the “invisible enemy”.

Several intervention strategies will promote a psychological sense of safety. If actual safety is not restored, reminders will be omnipresent and contribute to an ongoing sense of exaggerated threat (Hobfoll et al, 2007). The CBRN stress response model outline that first responders working under personal protective equipment could may prevent a psychological sense of safety. Research on disasters indicates that social support is related to better emotional well being and recovery following
Proposal: The CBRN Stress Response Model

Mass trauma. Connecting with others is a primary goal in disaster-related interventions but possibly causes the CBRN disaster situation the impact of social isolation.

We conclude that obstacles in the identification of threats and danger are confounded with attachment behavior and hereby a stress potentiation in the affected is created, which effects how those affected experience and react to the threat.

![Diagram of CBRN Stress Response Model]

**CBRN Disaster**

**Threat “Invisible Enemy”**

- **Perception**
  - of possibly nothing

- **Physical Reaction**
  - High activation or Low activation

- **Emotional Reaction**
  - Special fears focus on possible exposure and possible impact of isolation

- **Cognitive Reaction**
  - Limited information, belief that one has been exposed, prolonged uncertainty

**Threat assessment activates attachment behavior:**

Perceived safety aids in stress reduction

**First responder working in Personal Protective Equipment (PPE)**

Attachment security is limited:

Frightening - Frightened Collusion

**Threat Focus**

Fig. 2: Attachment behaviour model for CBRN threat situations
Proposal: The CBRN Stress Response Model

**Practical Implication:**
We outline a strategy for integrating psychological needs into the disaster plan under CBRN conditions. This helps us to improve hospital preparedness. We focus on the conditions of CBRN events under which first responders and hospital staff must work while using PPE. We conclude that working under PPE conditions while providing psychosocial support creates a complex dynamic that makes it crucial to optimize the psychosocial intervention.

**Limitations:**
Every CBRN scenario is different from another. It is impossible to outline each aspect of a hypothetical CBRN damage situation in one model. Furthermore, it should be tested to what extent the model not only refers to the perspective of those affected who are adults, but also whether it can be adapted to children and youth, while also considering developmental-psychological aspects.
Last, this model is generally a theoretical discussion, which has not yet been empirically tested.

**References:**


Center for Psychotraumatology /Alexianer Krefeld GmbH
Results of Interviews with Managing Directors of Hospitals Concerning Hospital Preparedness for CBRN Incidents
INTERVIEW QUESTIONS:

1. How are your employees/staff informed about new CBRN crisis incident?

2 a. What are the essential key positions in a CBRN crisis incident?

2 b. Do these positions require additional personnel?

3. Do employees receive concrete support when in the midst of dealing with emergencies that allow them to do their work quickly and efficiently (e.g., daycare centers for employees)?

4 a. What kind of personal protective equipment (PPE) is stored at the hospital?
4 b. For what occupational groups or positions are they reserved?
4 c. Are these individuals trained in wearing a PPE?

5. Are there any special programs that provide psychosocial support to employees during and after a crisis incident?
Ad 1) Information Process

- Hospital A: Alarm Chain of Command / Alarm Server, By telephone
- Hospital B: Red Fax, Telephone Chain, DAG Server
- Hospital C: Hospital Intercom, Telephone Chain
- Hospital D: Alarm Plan by Organigramm, Internal Alarm
- Hospital E: In-house Alarm System, Individual Phone Calls
Ad 2a) Key Positions

Multiple Answers for One Key Position

Number of Answers Selected (in Percent)

Key Position

- Medical Director
- Nursing Director
- Administrative Director
- Managing Director
Ad 2a) Key Positions in Detail

Hospital A: OP, Anästhesie

Hospital B: Internist, Coordinating Incident Manager, Head of Triage

Hospital E: ER, Security Head

Hospital D: Chief of Staff of various Clinics, Technical Head
Ad 2b) Additional Need for Personnel

- Hospital A: Starting with 20 People
- Hospital B: Decontamination Team
- Hospital C: None
- Hospital D: At the Interfaces (medical, Hospital security)
- Hospital E: Location Technical Manager
Ad 3) Programs to Help Employees Get to Work Quickly
Ad 4a) Type of Existing Personal Protective Equipment (PPE)

Except in Hospital B, PPE is not available in any other clinic

Cat. III Protective Suits
Ad 4b) Possible Candidates to Wear PPE

- Nursing Staff in the ER
- Physicians of Internal Medicine
Ad 4c) PPE Training

- Only Hospital B
  - Physicians of Internal Medicine
  - Nursing Staff
  - ER
    - Refresher Courses
Ad 5) Psychosocial Support Programs

Hospital A:
- Pastoral Care

Hospital B:
- Psychiatrists / Psychologists for Relatives of the Patients

Hospital C:
- Offer Individual or Group Therapy with Psychologists on Location

Hospital D:
- No alarm plan to date, but after revision of alarm plan, psychiatric clinics should be integrated

Hospital E:
- Supervisor discussions, Trauma therapists, BG
Conclusion

The majority of hospitals surveyed is not prepared for a CBRN crisis incident.
Annex 9

Literature research: CBRN incidents at the level of hospital staff

❖ English Literature:

1-Psychological / Psychosocial Consequences of CBRN incidents/ Terrorism (general, not specifically for hospital staff):


Hyams & Murphy, 2002: "Responding to Chemical, Biological, or Nuclear Terrorism: The Indirect and Long-Term Health Effects May Present the Greatest Challenge". Journal of Health Politics, Policy and Law, Vol. 27, No. 2, April 2002.


2-Psychological Consequences (and PTSD) (general, not specifically CBRN Incidents) for emergency doctors and medical staff:

of Psychiatry 2001 178: 76-81.


2005 The British Psychological Society.


3-Perspective of hospital staff members on CBRN incidents:


4-Emergency Plans for hospitals regarding CBRN incidents:


Als komplette pdf-Dateien leider nur online sichtbar, bspw. hier:


Tener Goodwin Veenema (Ed). „Disaster nursing and emergency preparedness: for chemical, biological, and Radiological Terrorism and Other Hazards“. 2007
* Chapter 5 „Understanding the Psychosocial Impact of Disasters. P 81ff“
Großteile online zu finden bei google books


**5-Focus on communication:**


**Special Measures for CBRN Emergency Situations**

(Mass Contaminations or Infections)

**Terminology:**

**CBRN (formerly ABC) Situation:** - Chemical, biological, radiological, and nuclear situations

**Decon:** - Decontamination, basic cleansing

**Spot-Decon:** - Prioritized decontamination of open wounds

**Basic life support (BLS):** - Life saving emergency care

**PPE:** - Personal protective equipment

**Sounding of Alarm**

CBRN (ABC) situations require a differentiated alarm plan.

Notify as few personnel as necessary.

**Partial alarm** is limited to alarming personnel from the following areas:

- **Hospital Crisis Management Team:**
  - Managing Director Tel.: 02171 – 334 - 3550/5100
  - Medical Director Tel.: 02151 - 334 - 7166
  - Nursing Department Tel.: 
  - Others? Tel.: 

- **Clinic for Internal Medicine** Tel.: 
- **Clinic for Anaesthesiology** Tel.: 02151 - 334 - 5155
- **ER/Outpatient Clinic** Tel.: 
- **Reception Desk** Tel.: 02151 - 334 - 0

- **Inpatient Clinics:**
  - M9 Tel.: 
  - M1 Tel.: 
  - IPS Tel.: 
  - OP Tel.: 

- **Patient Care** Tel.: 
- **Food Services** Tel.: 

**Full Alarm:**

Full alarm should be sounded in cases where a large number of injured patients are registered (mass injuries).
Alarm in the Emergency Room (Rescue point)

Krefeld fire brigade notifies the hospital about the type of mass contamination and number of injured, by fax.

- Forward emergency notification to the doctor on duty. (KoEL)
- The doctor on duty, from internal medicine / anaesthesiology sounds the partial or full alarm in the hospital, with the word “mass contamination”.

Alarm notified through a self-referring injured patient

- Patients come directly from a mass disaster incident, complaining about the same symptoms.
- Emergency room personnel ask about the location, type and any details about the incident.
- Doctor on duty asks Krefeld fire brigade (Tel: ) about the emergency situation (dangers for employees and hospital staff).
- Contamination incident is determined, and emergency room is closed off to other patients.
- Personnel puts on protective equipment (e.g., gloves, protective suit, mouth protection/oxygen masks (FFP 3 masks)
- On-duty doctor, internal medicine, sounds partial or full alarm in the hospital
- Set up second emergency room
Tasks of the Coordinating Incident Commander (KoEL)

- On-duty doctor of internal medicine/anesthesiology hands over the function of coordinating incident commander to the on-duty surgeon, who takes over all necessary duties in the hospital until the hospital incident response team arrives
  - Block off hospital from the outside
  - Block off contaminated areas
  - Prevent access of non-contaminated people to the contaminated areas
  - Maintain contact to police dispatcher
  - Forward information immediately

Further tasks of the Medical Director and/or On-Duty Doctor

The following process is performed under the assumption that the hospital alarm has sounded, e.g., by the dispatcher of the Krefeld fire brigade.

- Head of Triage reports to the CD of Anesthesiology and outside of regular work hours to the on-duty doctor of Internal Medicine.
- Set up decontamination site (Decon) and initiate triage, if necessary, get keys from the reception
- Set up decon team from trained, alarmed employees
- Order the set-up of the decon line, and supervise. This includes the following:
  - Get equipment from room [ … ]
  - Determine areas to be blocked off and separate it into protective zones (black/gray/white)
  - Determine access area of hospital, block off all other access areas, put up signs.
  - Inspect and approve decontamination area
- Ensure that the emergency suitcase for basic life support (BLS) is in the black zone
- Ensure that medical instruments in the black zone are protected from contamination
- Required personnel put on personal protective equipment Chemical Blue (on-duty doctor and four employees from the ER and Psychiatry)
- Head of Triage inspects all areas and ensures that all measures have been done, and reports this to the hospital incident management team
- One employee with PPE is designated to the hospital entrance who will direct incoming patients to the emergency decontamination area
- Patients are registered for further treatment in the hospital only after they have been checked for contamination
Tasks of Pastoral, employee medicine, social services and psychiatric staff

- Treat severely to mildly injured patients
- Treat family members of emergency patients in room [ ]. Communication with the hospital crisis manager maintained through Dect-Telephone, [Nr. …:]. Vests for these employees can be found in room […]
- If necessary, doctors and nursing staff from psychiatric units, together with hospital incident manager take over aftercare measure for hospital personnel. Doctor and therapy rooms in house […] are reserved for this.
- Any other measures will be ordered by the hospital incident manager

Tasks of Employees, e.g. from Technical Services

- Ensure technical service
- Help set up decontamination area (decon site, block off areas, put up signs)
- Block off hospital from outside, set up required “border patrol”
- Set up help for families of victims in the cafeteria
- Ensure that patients have food & drinks
- Remain ready to take on other necessary tasks

Tasks of the hospital incident management

- Contact crisis management by head of Krefeld’s
  - Fire brigade, Tel.:  
  - Crisis team, Tel.:  
- Ensure decon site has the necessary equipment (continuously)
- Ensure that exhausted employees receive breaks and are replaced with other employees (shift work)
- Public relations (Information for the press)
- Maintain an incident journal (see form)
- After emergency is over, keep decon site open for emergency personnel such as fire brigade
- Manage the process of returning the hospital to normal non-emergency conditions

Tasks of other employees

- In case of further incoming mass injuries, further employees of the hospital will be added to the team based on the rules of mass disaster incidents
## Process Emergency Decontamination

### Blocked-off zone: Blue Zone

Explain the patient’s situation. Convince the patient of the necessity of decontamination through psychosocial competence (eye contact, talking directly to the patient, and attending to the patient’s needs). Avoid spreading contamination in the hospital.

<table>
<thead>
<tr>
<th>Process</th>
<th>Personnel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entrance</td>
<td>Head Decon: Doctor in personal protective equipment (PPE)</td>
</tr>
<tr>
<td>Screen patients (Triage)</td>
<td></td>
</tr>
<tr>
<td>Calm down patients, provide information</td>
<td></td>
</tr>
<tr>
<td>Determine order of decontamination</td>
<td></td>
</tr>
<tr>
<td>Spot-Decon (random Decon)</td>
<td></td>
</tr>
<tr>
<td>Emergency care, BLS, and covering wounds, administering antidotes</td>
<td></td>
</tr>
<tr>
<td>Registration (Marker on skin)</td>
<td></td>
</tr>
<tr>
<td>Undress patients, do not pull clothing over the head (if necessary use scissors)</td>
<td></td>
</tr>
<tr>
<td>Put clothing and valuables in a plastic bag with registration number written on the bag</td>
<td></td>
</tr>
<tr>
<td>Ensure the care of patients until decon</td>
<td></td>
</tr>
<tr>
<td>Personnel changes gloves based on the situation</td>
<td></td>
</tr>
</tbody>
</table>

### Decon Area

<table>
<thead>
<tr>
<th>Black Zone (Contamination Area)</th>
<th>2 med. assistents in special equipment (PPE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct patients to decon site when it becomes available</td>
<td></td>
</tr>
<tr>
<td>Conduct decontamination, if necessary with accompanying medical treatment, water temperature ca. 28°C</td>
<td></td>
</tr>
<tr>
<td>1. rinse, starting with head going down, from clean to contaminated area 1 min.</td>
<td></td>
</tr>
<tr>
<td>2. Soap and wash with sponges: head to toe, carefully (avoid irritating skin), but thoroughly (skin folds, haired areas, etc.) 3 min.</td>
<td></td>
</tr>
<tr>
<td>3. Rinse with a lot of water, from head to toe 2 min.</td>
<td></td>
</tr>
<tr>
<td>Contamination control</td>
<td></td>
</tr>
<tr>
<td>Dry off</td>
<td></td>
</tr>
<tr>
<td>New sponges, brushes and towels for each patient</td>
<td></td>
</tr>
<tr>
<td>Transfer patient data to “white” employees</td>
<td></td>
</tr>
<tr>
<td>Avoid spreading residual contamination</td>
<td></td>
</tr>
</tbody>
</table>

### White Zone

<table>
<thead>
<tr>
<th>Triage</th>
<th>1 doctor 2 med. assistants/staff from hospital personnel (no PPE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communicate patient’s treatment data</td>
<td></td>
</tr>
<tr>
<td>Add any additional necessary data of emergency patients and register them</td>
<td></td>
</tr>
<tr>
<td>Further medical treatment, care</td>
<td></td>
</tr>
<tr>
<td>Provide patient with clothes</td>
<td></td>
</tr>
<tr>
<td>If necessary provide drinks</td>
<td></td>
</tr>
<tr>
<td>If necessary monitor patient</td>
<td></td>
</tr>
<tr>
<td>Check in to hospital or release from hospital</td>
<td></td>
</tr>
</tbody>
</table>

### Ending the Incident

| 2 employees with PPE (Tychem C, FFP3-Masks; protective goggles, taped up) |
|-----------------------------|---------------------------------------------------------------|
| Decontaminate personnel |
| Leave all contaminated material in the “black zone” |
| Maintain blocked off areas until further notified |
| Order decontamination of necessary areas/departments |
| Complete documentation |
Curriculum for Psychosocial Support for First Responders Coping with CBRN Situations
Table of Contents

1. Duration of training course
2. Training level
3. Target group and requirements
4. Purpose of training
5. Need for training
6. Overall learning objective
7. Assessment of learning success
8. Advanced training for skill / qualification maintenance
9. Summary Tables
   - Content
   - General learning objective
   - Individual subjects
   - Number of training hours
   - Type of training
1. Duration of training course
   A course duration of 3 ½ to 4 days is recommended, corresponding to 26 lessons of 45 minutes each. The course may also be completed in 2 ½ to 3 days, corresponding to 19 lessons. In both versions, a whole day should be reserved for practical exercises.

2. Training level
   Classroom-based training

3. Target group and requirements
   Training group size: 15-20 participants. The training course is primarily aimed at command personnel on CBRN operations (target group A) but also at psychosocial emergency support workers and specialists in psychosocial matters (target group B). The course includes both employed and volunteer specialists from both target groups. They act as multipliers; the course is thus particularly aimed at participants who work as instructors.

   **Examples of target group A:**
   CBRN platoon or squad leaders and specialist advisers for CBRN situations working for fire brigades, relief organisations (e.g. THW leaders) and the medical services.

   **Examples of target group B:**
   Leaders and multipliers in the field of psychosocial emergency support (emergency counselors, members of crisis intervention teams, emergency psychologists, etc.), specialists in psychosocial matters, specialist advisers and heads of psychosocial emergency care providers.
**Purpose of training**

The purpose of this training course is to integrate psychosocial aspects of crisis management and psychosocial emergency care into CBRN situations and to improve the overall crisis management during and after CBRN situations through basic psychosocial skills by:

1. making relief forces aware of the importance of psychosocial factors,
2. explaining that psychosocial skills improve operational procedures, e.g. by improving coordination during the operation,
3. enabling the participants to implement psychosocial skills in extremely difficult and unusual operational environments such as CBRN situations,
4. training the participants to consider the basic needs of those affected and to foster cooperation with them,
5. teaching them the principles of professional risk and crisis communication,
6. making relief forces aware of subsequent psychosocial stress and presenting appropriate concepts of critical incident stress debriefing for the relief forces.

The aim of this course is to have participants working as multipliers in their respective organisations and passing on what they have learned, and also to have them raise awareness about the importance of the course contents in general. If possible, participation in this course should be integrated into the regular training curriculum of the individual organisations.

The training course enables relief forces to implement psychosocial skills even in CBRN situations, which pose a particular challenge. Participants are trained to communicate while wearing individual protective equipment (IPE) in order to make communication more efficient, both within the team and while interacting with affected persons. Background knowledge and skills are taught and trained both in theory and in practice within the framework of an all-day training exercise. The basic assumption here is that the implementation of basic psychosocial skills contributes to the improvement of mission coordination and the reduction of the relief forces’ personal level of stress during the mission. Relief forces are made aware of the potential for subsequent psychosocial stress. Appropriate concepts of critical incident stress debriefing are presented to them.

The course is explicitly aimed at a mixed target group consisting of CBRN relief forces and leaders as well as specialists in psychosocial emergency care. It is the aim of this training course to improve the knowledge about the working methods of CBRN relief forces as well as psychosocial emergency support workers and specialists in psychosocial matters and to intensify the sharing of expertise in order to improve mutual understanding. The lessons for target group A therefore focus more on the subject of psychosocial emergency care, while target group B learns more about the operational and tactical basic principles of CBRN missions.

The participants are intended to work as multipliers in their respective organisations, raising awareness about the importance of the course contents and passing on what they have learned. The course contents include the following:

1. Basic concepts of psychosocial emergency care for target group A, basic concepts of CBRN situations for target group B
2. Specific stressors in CBRN situations
3. Strategies for action and communication methods (while wearing IPE) including basic skills in handling phenomena of group psychology
4. Principles of risk and crisis communication in CBRN situations
5. Critical incident stress debriefing after CBRN situations
### Need for training

Over the past years, the risk of potential CBRN situations and the number of CBRN missions in European countries were on the increase. During and after CBRN situations, directly and indirectly affected persons and the relief forces have been proven to suffer from extreme psychosocial stress. Relief forces (target group A) and psychosocial emergency support workers (target group B) who are deployed in CBRN situations are exposed to additional risks and stressors. The training course contributes to the reduction of psychosocial stress and its consequences for affected persons and relief forces and to the improvement of operational procedures.

### Overall learning objective

The participants are made aware of the reactions and needs of affected persons and to their own increased stress levels in CBRN situations (self protection). They study measures of Psychological First Aid in CBRN situations (while wearing IPE) and practise them in short practical exercises. By practising psychosocial skills while wearing IPE, this training course helps to develop the skills and confidence of action for deployment in CBRN situations. The participants are also instructed about the strategies of critical incident stress debriefing. Psychosocial emergency support workers and specialists in psychosocial matters (target group B) are made aware of operational and tactical basics in CBRN situations in order to be able to act according to specific challenges in such situations and to prevent threats to themselves and others.

### Learning Success Control

- none -

### Advanced training for maintenance of the capability / qualification

- none -

### Summary Tables
## Summary Tables

### Psychosocial Crisis Management in CBRN Situations training course

<table>
<thead>
<tr>
<th>Study segment</th>
<th>General learning objective</th>
<th>Individual subjects</th>
<th>Number of lessons</th>
<th>Type*</th>
</tr>
</thead>
</table>
| 01 Specific stressors | The participants are made aware of the specific stressors in CBRN situations. | ▪ Psychosocial risk factors in CBRN situations  
▪ Research results with regard to the consequences of psychosocial stress in CBRN situations, illustrated by specific examples | T |

### Training of Psychosocial Crisis Management in CBRN Situations

<table>
<thead>
<tr>
<th>Study segment</th>
<th>General learning objective</th>
<th>Individual subjects</th>
<th>Number of lessons</th>
<th>Type*</th>
</tr>
</thead>
</table>
| 02 Reactions of affected persons in CBRN situations (primarily for target group A) | The participants are aware of the behaviour of affected persons in biological, chemical and radiological situations. | ▪ Reactions of people under extremely stressful circumstances  
▪ Specific characteristics of reactions by those affected in CBRN situations  
▪ Critical situations within the hazard area as well as before and after decontamination | T |

* T = theoretical lessons / P = practical exercise
<table>
<thead>
<tr>
<th>Study segment</th>
<th>General learning objective</th>
<th>Individual subjects</th>
<th>Number of lessons</th>
<th>Type T / P</th>
</tr>
</thead>
</table>
| 03 Operational procedures in CBRN situations (primarily for target group B) | The psychosocial emergency support workers have a basic understanding of the dangers and operational procedures in CBRN situations. | ▪ Introduction to chemical, biological and radiological agents and their effects  
▪ Operational stages in CBRN situations, tasks and duties of relief forces  
▪ Basics of IPE  
▪ Endangerment of self and others  
▪ Particular characteristics of the information needs in CBRN situations: transfer of information concerning the current situation and relief efforts | | T |

<table>
<thead>
<tr>
<th>Study segment</th>
<th>General learning objective</th>
<th>Individual subjects</th>
<th>Number of lessons</th>
<th>Type T / P</th>
</tr>
</thead>
</table>
| 04 Skills in Psychological First Aid while wearing individual protective equipment (IPE) | The participants have developed skills and confidence of action when dealing with Psychological First Aid (also while wearing IPE). | ▪ Needs and requirements of people under extremely stressful circumstances  
▪ Key elements of psychosocial care in emergency situations  
▪ Basic rules of Psychological First Aid  
▪ Implementation of psychosocial skills while wearing IPE (training exercise) | | T / P |
### Psychosocial Crisis Management in CBRN Situations training course

<table>
<thead>
<tr>
<th>Study segment</th>
<th>General learning objective</th>
<th>Individual subjects</th>
<th>Number of lessons</th>
<th>Type</th>
</tr>
</thead>
</table>
| 05 Basic skills for dealing with group and mass psychological phenomena | The participants have developed skills and confidence of action when dealing with major groups of affected people (basic knowledge). | - Group-dynamic processes  
- Differentiation between fear and panic  
- The myth of "mass panic" put into perspective  
- Threat analysis  
- Factors contributing to escalation and factors preventing escalation  
- De-escalation of group tension  
- Fostering of prosocial tendencies  
- Psychosocial strategies for action when dealing with groups (training exercise) | | T / P |
| 06 Critical incident stress debriefing after CBRN situations (both target groups) | The participants are aware of the specific requirements after CBRN situations and the available structures and options of critical incident stress debriefing in CBRN situations. | - Stressors for relief forces during and after CBRN situations  
- Possibilities and limitations of conventional critical incident stress debriefing  
- Need for adequate critical incident stress debriefing following CBRN missions  
- Task and role of command personnel  
- Available structures | | T |
<table>
<thead>
<tr>
<th>Study segment</th>
<th>General learning objective</th>
<th>Individual subjects</th>
<th>Number of lessons</th>
<th>Type</th>
</tr>
</thead>
</table>
| 07 Training exercise (CBRN crisis scenarios with directly affected persons in the hazard area) | The participants have developed skills and confidence of action regarding the following situations:  
- dealing with directly affected individuals at the damage site,  
- dealing with major groups of affected persons at the damage site,  
- dealing with different groups of affected persons (e.g. children, elderly people, migrants)  
- implementing Psychological First Aid measures while wearing IPE,  
- implementing de-escalation strategies. | During each training course, one day is set aside to test and train the theoretical knowledge in practical exercises.  
The skills learned in study segments 04 and 05 – Psychological First Aid while wearing IPE / dealing with phenomena of group psychology – are directly applied.  
During the day of the exercise, 3 crisis scenarios are simulated, e.g.: an accident during the transportation of hazardous goods in a residential area; an industrial chemical accident; a dirty bomb with a radiological component. The average duration of the exercise is 20 minutes per scenario.  
The training exercise is assessed immediately after the completion of each exercise scenario, with all participants (mock patients, students and observers) reflecting on the exercise together.  
With the help of video recordings of the exercise sequences, strategies for action are once again discussed and evaluated on the following day. | | P |
## Psychosocial Crisis Management in CBRN Situations training course

<table>
<thead>
<tr>
<th>Study segment</th>
<th>General learning objective</th>
<th>Individual subjects</th>
<th>Number of lessons</th>
<th>Type</th>
</tr>
</thead>
</table>
| 08 Risk and crisis communication | The participants are aware of the basic principles of risk and crisis communication and can implement those in practice. | - Identifying the information requirements of those affected  
- Dos and don'ts of information transfer at the damage site  
- Options for information transfer at the damage site while wearing IPE  
- Dos and don'ts of risk and crisis communication |                  | T    |
| 09 Stress management (optional) | The participants are able to counteract or reduce stress reactions with the help of self-regulation mechanisms. | - Stress reactions before, during and after CBRN missions  
- Perception and assessment of individual stress reactions  
- Measures to reduce stress during a mission (theoretical instruction and practical exercise)  
- Measures to reduce stress during a mission (theoretical instruction and practical exercise)  
- Further support measures for those suffering from stress reactions |                  | T / P |
Annex 12: Lehrgangsbescheinigung

Herr/Frau XXX

hat am Pilotlehrgang

Psychosoziales Krisenmanagement in CBRN-Lagen

vom 17.04. bis 20.04.2012 teilgenommen.


Lehrgangsinhalte:

- Belastungsfaktoren und Reaktionen Betroffener in CBRN-Lagen (für Einsatzkräfte) / Einführung „CBRN-Gefahren“ (für psychosoziale Akuthelfer/innen und psychosoziale Fachkräfte)
- Einsatzbereiche in CBRN-Lagen (Aufgaben Einsatzkräfte und psychosoziale Akuthelfer/innen)
- Empfehlungen für psychosoziale Handlungskompetenz unter PSA in CBRN-Lagen
- Eigensicherung von Kriseninterventionskräften bei CBRN/PSNV Lagen
- Praktische Übung: Kommunikation (unter PSA) mit Betroffenen eines CBRN-Krisenszenarios an der Schnittstelle Gefahren-/Absperrbereich
- Einsatznachsorge nach CBRN-Lagen

Bonn, den 20.04.2012

Dr. Barbara Blanckmeister
Projektleiterin, THW

Claudia Schedlich
Lehrgangsleiterin, BBK
Evaluation Sheet for the Pilot Course
„Psychosocial Crisis Management in CBRN Situations“

Red = First responders
Blue = PSS personnel
Green = active in both groups
Black = Total

To begin with we would like to ask you to answer some personal questions. This information will strictly be used only for the evaluation of the course and will be treated with absolute confidentiality.

A  Personal questions

A.1 Name (optional): ______________________________________________________

A.2 Sex:  □ female  □ male

A.3 Year of birth: ______________________________________________________

A.4 In which domain do you work?
 □ operative disaster response (7)  □ PSS (6)  □ in both domains (5)

A.5 In which function? __________________________________________________

A.6 Do you have practical experience with CBRN response?
 □ No 6 4 1 (11)  □ Yes in: 1 6 (7)

<table>
<thead>
<tr>
<th>Chemical Incident(s)</th>
<th>Event __________________________ Year ______</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Event __________________________ Year ______</td>
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<tr>
<td></td>
<td>Event __________________________ Year ______</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Biological Incident(s)</th>
<th>Event __________________________ Year ______</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Event __________________________ Year ______</td>
</tr>
<tr>
<td></td>
<td>Event __________________________ Year ______</td>
</tr>
<tr>
<td></td>
<td>Event __________________________ Year ______</td>
</tr>
</tbody>
</table>
B Questions pertaining to the training course

B.1 How much did your personal state of knowledge improve because of the course in the following areas?

<table>
<thead>
<tr>
<th>Area</th>
<th>Effectively</th>
<th>Rather effectively</th>
<th>Somewhat</th>
<th>Hardly</th>
<th>Not at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>B.1.1 In regard to CBRN response operations</td>
<td>1 4 4 (9)</td>
<td>1 2 1 (4)</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>B.1.2 In regard to the psychosocial support of the afflicted (individuals and groups) in a CBRN situation</td>
<td>2 3 4 (9)</td>
<td>4 2 1 (7)</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

B.2 How much did your skills improve with regard to the following aspects?

<table>
<thead>
<tr>
<th>Area</th>
<th>Effectively</th>
<th>Rather effectively</th>
<th>Somewhat</th>
<th>Hardly</th>
<th>Not at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>B.2.1 In regard to CBRN response operations</td>
<td>3 3 (6)</td>
<td>1 2 2 (5)</td>
<td>4 1 (5)</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>B.2.2 In regard to the psychosocial support of the afflicted (individuals and groups) in a CBRN situation</td>
<td>1 3 3 (7)</td>
<td>4 1 1 (6)</td>
<td>1 1 1 (3)</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

B.3 How helpful were the different training units with regard to your work?

<table>
<thead>
<tr>
<th>Unit</th>
<th>Very helpful</th>
<th>Helpful</th>
<th>Rather helpful</th>
<th>Rather not helpful</th>
<th>Not helpful</th>
<th>Not helpful at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>B.3.1 Group 1 (First Responders): Reactions of the afflicted</td>
<td>2</td>
<td>6 2 2 (10)</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group 2 (PSS): CBRN-risks</td>
<td>3 2</td>
<td>3 2 3 (8)</td>
<td>1 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B.3.2</td>
<td>Mental stress factors in CBRN situations</td>
<td>123 (6)</td>
<td>421 (7)</td>
<td>21 (3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------------------</td>
<td>--------</td>
<td>--------</td>
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<td></td>
</tr>
<tr>
<td>B.3.3</td>
<td>Operational management in CBRN response (tasks of first responders and psychosocial first aid staff)</td>
<td>13 (10)</td>
<td>451 (10)</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>B.3.4</td>
<td>Personal safety of crisis intervention personnel in CBRN/PSS situations</td>
<td>31 (4)</td>
<td>412 (7)</td>
<td>22 (4)</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>B.3.5</td>
<td>Case Study Fukushima</td>
<td>343 (10)</td>
<td>111</td>
<td>21</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>B.3.6</td>
<td>Action Strategies: measures for psychological first aid under CBRN conditions</td>
<td>333 (9)</td>
<td>222 (6)</td>
<td>21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B.3.7</td>
<td>Communication wearing breathing protection, Mask, Respirator (Praxis)</td>
<td>132 (6)</td>
<td>232 (7)</td>
<td>3</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>B.3.8</td>
<td>PSS aftercare after CBRN incidents</td>
<td>121 (4)</td>
<td>432 (9)</td>
<td>11</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>B.3.9</td>
<td>Human Biology Monitoring</td>
<td>312 (6)</td>
<td>12</td>
<td>33 (6)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>B.3.10</td>
<td>Introduction to Personal Protective Equipment)</td>
<td>233 (8)</td>
<td>321 (6)</td>
<td>111</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>B.3.11</td>
<td>Practical Exercise</td>
<td>444 (12)</td>
<td>11</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

**B.3.11 Do you have any remarks with regard to the above mentioned units? (Please refer to the relevant unit (e.g. B.3.1-B.3.11)**

____________________________________________________________________________________
____________________________________________________________________________________
### B.4 How do you rate the methodological and didactical line of action with regard to the following points?

<table>
<thead>
<tr>
<th>B.4.1 Course structure</th>
<th>Very good</th>
<th>Good</th>
<th>Satisfying</th>
<th>Sufficient</th>
<th>Deficient</th>
<th>Insufficient</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4 2 3 (9)</td>
<td>3 3 2 (8)</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B.4.2 Organisation / implementation of the practical exercise</th>
<th>Very good</th>
<th>Good</th>
<th>Satisfying</th>
<th>Sufficient</th>
<th>Deficient</th>
<th>Insufficient</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3 3 4 (10)</td>
<td>4 2 1 (7)</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B.4.3 Scenarios of the exercises</th>
<th>Very good</th>
<th>Good</th>
<th>Satisfying</th>
<th>Sufficient</th>
<th>Deficient</th>
<th>Insufficient</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5 4 2 (11)</td>
<td>2 2 1 (5)</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B.4.4 Roles of the actors</th>
<th>Very good</th>
<th>Good</th>
<th>Satisfying</th>
<th>Sufficient</th>
<th>Deficient</th>
<th>Insufficient</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5 5 5 (15)</td>
<td>2 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B.4.5 Evaluation of exercises</th>
<th>Very good</th>
<th>Good</th>
<th>Satisfying</th>
<th>Sufficient</th>
<th>Deficient</th>
<th>Insufficient</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 5 3 (9)</td>
<td>6 1 (7)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B.4.6 Response to questions of participants</th>
<th>Very good</th>
<th>Good</th>
<th>Satisfying</th>
<th>Sufficient</th>
<th>Deficient</th>
<th>Insufficient</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2 5 4 (11)</td>
<td>5 1 (6)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B.4.7 Exchange with colleagues</th>
<th>Very good</th>
<th>Good</th>
<th>Satisfying</th>
<th>Sufficient</th>
<th>Deficient</th>
<th>Insufficient</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6 5 4 (15)</td>
<td>1 1 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### B.4.8 Do you have any remarks with regard to the points enumerated under B.4? (Please refer to point in question.)

_______________________________________________________________________________

### B.5 How do you rate the following aspects?

<table>
<thead>
<tr>
<th>B.5.1 Duration of the training</th>
<th>Much too short / little</th>
<th>Rather too short / little</th>
<th>Just right</th>
<th>Rather too long / much</th>
<th>Much too long / much</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>3 3 3 6 2 (11)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B.5.2 Size of group of participants</th>
<th>Much too short / little</th>
<th>Rather too short / little</th>
<th>Just right</th>
<th>Rather too long / much</th>
<th>Much too long / much</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>6 5 4 (15)</td>
<td>1 1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B.5.3 Time frame for theoretical input</th>
<th>Much too short / little</th>
<th>Rather too short / little</th>
<th>Just right</th>
<th>Rather too long / much</th>
<th>Much too long / much</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1 6 5 5 (16)</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B.5.4 Preparation for exercises</th>
<th>Much too short / little</th>
<th>Rather too short / little</th>
<th>Just right</th>
<th>Rather too long / much</th>
<th>Much too long / much</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1 5 4 5 (14)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B.5.5 Time frame for exercises</th>
<th>Much too short / little</th>
<th>Rather too short / little</th>
<th>Just right</th>
<th>Rather too long / much</th>
<th>Much too long / much</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>3 1 2 (6)</td>
<td>2 5 3 (10)</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B.5.6 Breadth of knowledge acquired</th>
<th>Much too short / little</th>
<th>Rather too short / little</th>
<th>Just right</th>
<th>Rather too long / much</th>
<th>Much too long / much</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 2</td>
<td>6 5 3 (14)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
B.5.7 Do you have any remarks with regard to the points enumerated under B.5? (Please refer to point in question.)

_______________________________________________________________________________

_______________________________________________________________________________

B.6 How do you rate the methodological and didactical approach of the trainers in the following fields? (on a scale of 1 - 6, 1 = 'very good', 6 = 'unsufficient')

<table>
<thead>
<tr>
<th></th>
<th>Trainer 1</th>
<th>Trainer 2</th>
<th>Trainer 3</th>
<th>Trainer 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vividness/ clearness of presentation</td>
<td>9 x 1</td>
<td>9 x 1</td>
<td>7 x 1</td>
<td>6 x 1</td>
</tr>
<tr>
<td></td>
<td>9 x 2</td>
<td>9 x 2</td>
<td>9 x 2</td>
<td>6 x 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 x 3</td>
<td>1 x 3</td>
<td>3 x 3</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2 x 4</td>
</tr>
<tr>
<td>Understandability of content</td>
<td>7 x 1</td>
<td>11 x 1</td>
<td>5 x 1</td>
<td>6 x 1</td>
</tr>
<tr>
<td></td>
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<td>2 x 3</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Way of presenting the content</td>
<td>10 x 1</td>
<td>8 x 1</td>
<td>6 x 1</td>
<td>4 x 1</td>
</tr>
<tr>
<td></td>
<td>7 x 2</td>
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<td>1 x 4</td>
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<tr>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Teaching material</td>
<td>9 x 1</td>
<td>8 x 1</td>
<td>7 x 1</td>
<td>5 x 1</td>
</tr>
<tr>
<td></td>
<td>7 x 2</td>
<td>6 x 2</td>
<td>7 x 2</td>
<td>6 x 2</td>
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<td></td>
<td>1 x 4</td>
<td>2 x 3</td>
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<td>3 x 3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1 x 4</td>
<td>2 x 4</td>
</tr>
</tbody>
</table>

B.7 What were your expectations regarding the training course and to what extent were they met?

_______________________________________________________________________________

_______________________________________________________________________________

B.8 Which aspects of the training (theoretical and practical) were the most helpful for your (volunteer) work?

_______________________________________________________________________________

_______________________________________________________________________________

B.8 Which aspects of the training (theoretical and practical) were the most helpful for your (volunteer) work?
B.9 Which aspects of the training (theoretical and practical) were the least helpful for your (volunteer) work?
_______________________________________________________________________________
_______________________________________________________________________________

B.10 What did you learn?
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

B.11 What did you not learn?
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

B.12 What suggestions for improvement do you have?
_______________________________________________________________________________
_______________________________________________________________________________

B.13 Would you recommend the course to colleagues? □ Yes □ No
Please explain:
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

B.14 What should be done to gain the acceptance of superiors for this training?
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

B.15 Any further remarks you want to add?
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

C Organisation of the Training
C.1 How did you appreciate the following aspects?

<table>
<thead>
<tr>
<th></th>
<th>Very good</th>
<th>Good</th>
<th>Not so good</th>
<th>Not good at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accommodation</td>
<td>5 4 2 (11)</td>
<td>2 1 3 (6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meals</td>
<td>3 2 2 (7)</td>
<td>4 3 2 (9)</td>
<td>1 1</td>
<td></td>
</tr>
<tr>
<td>Premises, rooms</td>
<td>5 4 4 (13)</td>
<td>2 2 15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organisation and support</td>
<td>6 6 5 (17)</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

C.2 Anything you want to add regarding the organisation?

_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

Thank you very much for your support!!
Center for Psychotraumatology / Alexianer Krefeld GmbH

Results of Hospital Personnel Survey: Knowledge about CBRN Crisis Incidents
Current Status of “CBRN” 
(n = 27)
Knowledge of the Alarm Plan

- Yes: 33%
- No: 67%
Preferred Degree of Information & Training

- 74%: Very detailed
- 26%: Limited to the most important points
- 0%: Not at all
Subjectively Estimated Emotional Stability

- Yes: 38%
- No: 25%
- Limited: 37%
Expected Usefulness of the Training

- Yes: 92%
- No: 8%
Need for Continuous Refresher Courses

- 42% Once a year
- 58% Every 2 years
Reasons for Limitations in CBRN Competence

![Chart showing reasons for limitations in CBRN competence](chart.png)
Surveyor’s own area of responsibility in crisis situations

![Graph showing own area of responsibility in crisis situations]

- Treat injured
- Coordinate processes
- No answer
- Follow orders
- Remain calm/De-escalate
- Maintain own protection
- Protect patients
- Minimize residual damage
- Increase speed of registering

Number of Responses (in %)

Technical Hilfswerk - Alexianer - impact - Gobierno de España - Ministerio del Interior - FODP - Civil Protection and Disaster Assistance
Who should be the one to deliver information about required measures in CBRN crisis incidents?

Source of Information in CBRN Crisis Incidents

- Don't know
- Management
- Disaster Workers
- Medical Direction
- Technical Dept.
- CBRN Project/Psychotraumatology
- Psychosomatic
- Organisation
- Head of Nursing
- External Experts
- Hospital In-patient Managers
- Lab, OP, Diagnostics
Feelings of Safety through PPE

- Very safe: 79%
- Somewhat safe: 5%
- Not at all safe: 16%
Work Ability (2 – 3 Hours) in PPE

Work Ability in PPE

48% Yes
52% No
Importance of One’s Own Health

- Very important: 0%
- Somewhat important: 13%
- Not important: 87%
Expected Emotionality in CBRN Crisis Incidents

- 52% Rational
- 37% Overly Emotional
- 11% Answer missing or neutral
Effectiveness of the Team

- Every team member can depend on one another (27%)
- Some information gets lost in the shuffle (24%)
- Team is action-oriented and effective (49%)
How to deal with overwhelmed colleagues in a CBRN crisis incident

Dealing with overwhelmed colleagues in a CBRN crisis incident

<table>
<thead>
<tr>
<th>Types of Coping Measures</th>
<th>Number of Responses (in %)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restructure/Time-Out</td>
<td>40</td>
</tr>
<tr>
<td>Talk to Colleague</td>
<td>35</td>
</tr>
<tr>
<td>Don’t know</td>
<td>25</td>
</tr>
<tr>
<td>Find Psychosocial Support for Colleague</td>
<td>20</td>
</tr>
<tr>
<td>Take over Colleague’s Work</td>
<td>15</td>
</tr>
<tr>
<td>Motivate/Relate Stressor</td>
<td>10</td>
</tr>
<tr>
<td>Remain Calm</td>
<td>5</td>
</tr>
</tbody>
</table>
Strengthening Psychosocial Competence of Hospital Personnel in CBRN Crisis Incidents

Type of Preferred Help for Entire Team

Help for the Team

Number of Responses (in %)

Practical Training
Access to More Information
Don't know
Make a Plan
Increase Personnel
Have Equipment On-hand
Practice Scenarios

Type of Help
Type of Aftercare

- Individual Therapy: 33%
- Group Therapy: 25%
- Training in Self-help: 12%
- Professional Follow-up Discussion about Event: 30%
Protection from False Information from External Sources

Number of Responses (in %)

- Don't know: 60%
- Official contact address: 20%
- Clear instructions: 10%
- Increase own responsibility: 5%
- There is no protection: 5%

Type of Protection
Types of Practical Exercises

- Watch videos: 30%
- Discuss case studies: 20%
- Psychoeducation: 18%
- Conduct role-playing: 32%
Further Suggestions

Further Suggestions/Ideas/Issues

- Establish trainings
- Informational brochures
- Talk about with family
- What to do when participation is impossible
- Where can I get information at night/weekends

Number of Responses (%)

0 10 20 30 40 50 60
Curriculum for Psychosocial Competence Development of Hospital Personnel in CBRN Emergencies
Table of Contents

1. Length of Training
2. Level of Training
3. Target Groups and Requirements
4. Task Descriptions
5. Training Need
6. Overall Learning Objective
7. Assessment of Learning
8. Competence/Qualification Training
9. Overview
   • Training Modules
   • Overall Learning Objective
   • Individual Topics
   • Number of Training Hours
   • Type of Training
1. **Length of Training**
   
   1 day (equivalent to 7 training units à 45 min.); can also be split into two mornings

2. **Level of Training**
   
   School-level training

3. **Target Group and Requirements**
   
   Class size: 10-15 participants. The course is primarily targeted to medical and nursing hospital personnel. The trainees of both target groups are encouraged to take on a multiplier function in their respective hospitals.

   **Examples of medical personnel (target group A):**
   
   - Medical doctors (Chief physicians, attending physicians and resident physicians)

   **Examples of nursing personnel (target group B):**
   
   - Head Nurse / Head of Nursing Services
   - Registered Nurses

4. **Task Descriptions**

   The purpose of the course is to ensure that psychosocial crisis management for medical treatment situations is integrated into CBRN emergencies, and that the overall crisis management is optimized during and after CBRN emergencies through basic psychosocial competencies, by:

   1. teaching participants to use psychosocial skills in extremely difficult and unusual treatment situations, such as CBRN emergencies;
   2. helping medical personnel understand how psychosocial competence can improve coordination of medical treatment;
   3. training personnel to consider the basic needs of patients and how to encourage their cooperation;
   4. teaching the principles of effective risk and crisis communication;
   5. sensitizing personnel to the potential post-traumatic psychosocial stresses that can occur in patients; and
   6. strengthening the confidence—and subsequently the competence—with which hospital personnel deal with patients, relatives and colleagues.

   It is strongly recommended that participants—in particular those in leadership positions—act as multipliers of what they have learned in the training and pass it on to their respective departments or groups in their place of work, and/or pass on general principles learning in the course. If possible, this course should become part of the regular training program of the respective organizations.
### Training Need

The danger of possible CBRN emergencies and actual CBRN incidents in the European countries has risen in the last few years. Psychosocial stress for directly (patients) and indirectly (hospital personnel) affected people during and after CBRN emergencies evidently high. Physicians (target group A) and nurses (target group B) working in CBRN incidents are exposed to additional risks. This course helps to minimize the psychosocial stress and burden on patients and medical personnel.

Recommendation: Learning effective risk and crisis communication, or learning stress management techniques require separate training units. In other words, these can only be effectively learned through the completion of separate trainings. The contents of the training units 07 and 08 mentioned below are covered in the training “Psychosocial Crisis Management in CBRN Incidents”, but not expansively. Media training and/or stress management training in addition to this training is highly recommended.

### Overall Learning Objective

The training participants will be sensitized to the reactions and needs of the affected patients and their own intensified stress burdens in CBRN incidents (self-protection). Furthermore, psychosocial first-aid measures will be learned and practiced. The participants of this training will also learn risk and crisis communication in order to ensure effective treatment. Treatment competence and confidence in CBRN emergencies will also be reinforced in this training. Goals are to a) reduce stress during emergencies, b) better coordinated work processes, and c) protection from long-term stress disorders.

### Assessment of Learning

**work in progress**

### Competence/Qualification Training

- **none**

### Overview
### Training Psychosocial Crisis Management in CBRN Emergencies

<table>
<thead>
<tr>
<th>Learning Module</th>
<th>Overall Learning Objective</th>
<th>Individual Topics</th>
<th>Number of Hours</th>
<th>Type</th>
</tr>
</thead>
</table>
| **01** Reactions of Affected People in CBRN Emergencies | Medical personnel have knowledge of the behaviors of affected people in biological, chemical, and radiological emergencies. | - Reactions of people in conditions of undue stress  
- Unique circumstances of situations and reactions of affected people in CBRN emergencies  
- Critical types of situations during medical treatment | | T |

<table>
<thead>
<tr>
<th>Learning Module</th>
<th>Overall Learning Objective</th>
<th>Individual Topics</th>
<th>Number of Hours</th>
<th>Type</th>
</tr>
</thead>
</table>
| **02** Competence in providing psychological first aid while using personal protective equipment (PPE) | The participants have competence and confidence in dealing with psychological first aid (also with PPE). | - Needs of individuals under extreme stress  
- Basic principles of psychological first aid  
- Introduction to wearing PPE  
- Practical training in psychosocial competence while using PPE (practical exercise) | | T |
<table>
<thead>
<tr>
<th>Learning Module</th>
<th>Overall Learning Objective</th>
<th>Individual Topics</th>
<th>Number of Hours</th>
</tr>
</thead>
</table>
| 03 Deployment and operations processes in CBRN emergencies | Medical personnel have basic knowledge of the dangers and operations processes in CBRN emergencies. | - Introduction to chemical, biological and radiological agents and their effects  
- Operations processes in CBRN emergencies, tasks for emergency personnel  
- Interface: emergency personnel –and hospital  
- Processes according to hospital-internal emergency defense plan  
- Dangers to self and others | T |

**Training Psychosocial Crisis Management in CBRN Emergencies**

<table>
<thead>
<tr>
<th>Learning Module</th>
<th>Overall Learning Objective</th>
<th>Individual Topics</th>
<th>Number of Hours</th>
</tr>
</thead>
</table>
| 04 Risk and Crisis Communication | Participants have knowledge about the basics of crisis communication and can apply these. | - Information needs of those affected  
- Do’s and don'ts of disseminating information at the disaster site  
- Do’s and don'ts of crisis communication  
- Possibilities of information dissemination | T |
<table>
<thead>
<tr>
<th>Learning Module</th>
<th>Overall Learning Objective</th>
<th>Individual Topics</th>
<th>Number of Hours</th>
<th>Type</th>
</tr>
</thead>
</table>
| 05 Applying What You’ve Learned | Practical application based on a CBRN crisis scenario Prepared scene: Contaminated individual simply shows up on his own at the hospital after a chemical accident (professional actor plays patient) | - Application of the learned skill in psychological first aid while using PPE in dealing with patients that have become victims of a CBRN incident (learning modules 01, 02, and 04)  
- Assessment of the practical exercise in the form of a de-briefing with all participants and observers, which is to be held directly after the exercise. |                | P    |
Evaluation Results from the Training in Hospital St. Hedwig, Berlin on 19.06.2012:
“Strengthening the competencies of hospital personnel in handling CBRN crisis incidents”
I. Relevance
Were the training units easy to understand?

Understandable

- Absolutely not: 0%
- A little bit: 0%
- Mostly: 7%
- Yes, completely: 27%
- No answer: 66%
Was the topic relevant to your own real-life experiences?

Real-life Relevance

- Absolutely not: 7%
- A little bit: 27%
- Mostly: 0%
- Yes, completely: 27%
- No answer: 9%
Were the contents supported with real-life examples?

Supported by real-life examples

- Absolutely not: 13%
- A little bit: 0%
- Mostly: 7%
- Yes, completely: 27%
- No answer: 53%
Strengthening Psychosocial Competence of Hospital Personnel in CBRN Crisis Incidents

Were the contents interactive? Were you able to ask questions?

Interaction

- Absolutely not: 0%
- A little bit: 7%
- Mostly: 7%
- Yes, completely: 86%
- No answer: 0%

Technisches Hilfswerk
Alexianer
impact
GOBIerno DE Espana
MINISTERIO DEL INTERIOR
Federal Office of Civil Protection and Disaster Assistance
European Civil Protection
II. Efficiency
Were the training units focused on the most important issues?

Concreteness

- Absolutely not: 47%
- A little bit: 0%
- Mostly: 53%
- Yes, completely: 0%
- No answer: 0%
Were there any overlaps?

Overlaps

- Absolutely not: 7%
- A little bit: 7%
- Mostly: 46%
- Yes, completely: 33%
- No answer: 7%
Did you learn what you had hoped to learn?

Learning Success

- Absolutely not: 0%
- A little bit: 0%
- Mostly: 47%
- Yes, completely: 53%
- No answer: 0%
Do you now feel knowledgeable about CBRN crisis incidents?
Knowledge after training

- Absolutely not: 0%
- A little bit: 0%
- Mostly: 20%
- Yes, completely: 80%
- No answer: 0%
Do you feel like you are better prepared act effectively in CBRN incidents?

Improved Competence

- Absolutely not: 47%
- A little bit: 0%
- Mostly: 0%
- Yes, completely: 53%
- No answer: 0%
Do you feel like your are better informed about working with personal protective equipment (PPE)?

Knowledge about working with PPE

- Absolutely not: 7%
- A little bit: 0%
- Mostly: 40%
- Yes, completely: 53%
- No answer: 0%
This leaflet provides information about the EU Project ‘Psychosocial support for civil protection forces coping with CBRN’ and the conference taking place in Madrid. The conference is the important and final milestone of the project.

THE PROJECT - PSYCHOSOCIAL SUPPORT FOR CIVIL PROTECTION FORCES COPING WITH CBRN

The risk regarding chemical, biological, radiological, and nuclear situations has increased in almost all EU Member States. Civil protection forces deployed in emergency and disaster response operations, under CBRN conditions, are exposed to additional risks and pressures that are likely to cause additional psychological pressure. However, in most EU Member States, psychosocial crisis management is not yet included in the training programme for CBRN specialists.

The EU Project ‘Psychosocial support for civil protection forces coping with CBRN’ (Acronym: ‘CBRN Incidents & PSS’) has been initiated to resolve this problem. The project is co-funded by the European Commission, DG Humanitarian Aid and Civil Protection (ECHO).

THE PROJECT - OBJECTIVE

The project aims to improve the preparedness of first responders particularly concerning psychosocial support (PSS). This should reduce the long-term effects of psychosocial stress and enhance the overall efficiency of crisis management locally, regionally, nationally and across the EU.

THE PROJECT - GROUP

Partners in the Project:
- German Federal Agency for Technical Relief (THW)
- Centre of Psychotraumatology, Alexianer Krefeld GmbH
- Impact – Dutch Knowledge and Advice Centre for post disaster psychosocial care
- Dirección General de Protección Civil y Emergencias, Ministerio del Interior
- German Federal Office for Civil Protection and Disaster Assistance (BBK)

Members of the Steering Committee:
- German Fire Services Association
- British Red Cross and Red Cross EU-Office
- NOFER Institute of Occupational Medicine, Poland

THW Regional Office for Bremen, Lower Saxony

THE PROJECT - EXPECTED RESULTS

- Study of the current situation in the EU Member States regarding CBRN and Psychosocial Support
- Study of the interface between first responders and hospital staff
- Curriculum and teaching material for a training course including exercises for first responders and hospital staff respectively
- Documentation of lessons learnt
- Guidelines
- Recommendations
- Two international conferences
- Information brochure.

CONFERENCE - PURPOSE AND AIMS

- Present the results of the project and the draft recommendations for discussion and review during working groups and plenary sessions
- Gather ideas for the next steps and follow-up of the Project.

The aim is for participants to share the project results with end-users, first responders and hospital staff, and to arrange for the integration of the training curricula into the education and training of their own personnel.

CONFERENCE - STYLE

The conference will bring together representatives from EU Member States, from a wide range of organisations and specialist areas such as emergency planning and response, medical and psychological services, hospital and research institutions. The conference will be interactive and delivered through presentations, working groups and plenary sessions. Conference participants will be selected from the following target groups:

- Participants in the pilot training for first responders - staff leaders of fire brigades, rescue organisations and THW, including psychosocial first aid helpers
- Participants in the pilot training for hospital staff - including chief executives, senior managers and chief physicians of hospitals as well as public health experts
Co-Financed by the European Commission

Psychosocial Support for Civil Protection Forces Coping with CBRN - Final Conference -
Madrid, Tuesday 25 to Thursday 27 September 2012

- Directors of National Fire Brigades, Rescue and Civil Protection training centres and schools.
- Experts interviewed by Impact for ‘Assessment of current situations regarding preparedness for CBRN incidents’.
- Participants at the first conference in Berlin in July 2011.

Participants will be invited to share examples of national and local practice, either as part of a plenary session or via a poster exhibition during coffee breaks and at lunch time.

The language of the conference will be English.

CONFERENCE - VENUE
The conference will take from Tuesday 25 to Thursday 27 September 2012 at the

National School of Civil Protection
Autovía A-3 Madrid-Valencia Km. 19
Camino Salmedina
28529 Rivas-Vaciamadrid
Madrid (Spain)
Tel: +34 91 537 30 72
Web: http://www.proteccioncivil.org/en/enpc

CONFERENCE - ACCOMMODATION
All participants will be accommodated in the:

AC Hotel Rivas Vaciamadrid
Avenida. Francisco Quevedo, 2
28522 Rivas Vaciamadrid
Madrid (Spain)
Tel: 34 91 4990700
Fax: 34 91 4990701

CONFERENCE - SHUTTLE SERVICE
Airport transfer as well as shuttle services between the conference venue and the hotel will be provided by the conference management.

CONFERENCE - COSTS
The Project funding will cover the costs for each participant’s travel, subsistence and conference costs. There is no attendance fee. Participants are being invited to contribute their advice and expertise.

CONTACT:
Conference Manager
Mr. Juan Pedro Lahore
General Directorate Civil Protection and Emergencies Ministry of Interior, Spain;
Email jplahore@procivil.mir.es;
Tel +34 91 5373304 (09:00-15:00CET)

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Tuesday 25 September 2012
(First Conference Day)

08:30-12:00 Arrival of participants and registration at the National School of Civil Protection, Madrid

12:00-13:00 Lunch at the School

13:30-14:00 Opening – in the Plenary Hall
Mr Luis Aguilera - State Secretary, Spanish Ministry of the Interior
Mrs. Biljana Zuber - Directorate General for Humanitarian Aid and Civil Protection (ECHO A5, Civil Protection Policy Unit), European Commission
Mr. Jürgen Weidemann – Head of Unit KM 3 ('THW; international Operations THW'), German Federal Ministry of the Interior
Mr. Volker Strotmann – Head of Operational Department, German Federal Agency for Technical Relief

14:00-14:30 Introduction to conference (THW)

14:30-15:00 Presentation of project results (THW, BBK) (plenary session)

15:00-15:30 Coffee / Tea Break

15:30-16:00 Presentation of project results (Impact, Alexianer Krefeld GmbH) (plenary session)

16:00-16:30 ‘CBRN and psycho-social aspects: a view from a radiation protection expert’
Dr. Wolfgang Raskob Dipl.Met. - Head of the Accident Consequence Assessment Group, Institute for Nuclear and Energy Technologies, Karlsruhe Institute of Technology (plenary session)

16:30-17:00 Summary of first conference day

17:00-18:00 Guided tour around the national civil protection school

18:00 Departure to AC Hotel Rivas Vaciamadrid by shuttle bus (meeting point: in front of the school’s main entrance) for hotel check-in

20:00 Welcome reception with dinner in AC Hotel Rivas Vaciamadrid (dress code: informal)
Co-Financed by the European Commission

Psychosocial Support for Civil Protection Forces Coping with CBRN - Final Conference -
Madrid, Tuesday 25 to Thursday 27 September 2012

Wednesday 26 September 2012
(Second Conference Day)

07:30-08:30 Breakfast at AC Hotel Rivas Vaciamadrid

08:30 Departure to school by shuttle bus
(meeting point: front of the hotel's main entrance)

09:00-09:15 Introduction to day (in the plenary hall)

09:15-09:45 Experience report by participants of pilot training course for first responders
Mrs. Monika Duderstadt, Mr. Marinus Anemaet
(plenary session)

09:45-10:15 Experience report by participant of pilot training course for hospital staff
Mrs. Katrin Lokmani
(plenary session)

10:15-10:45 Coffee / Tea Break

10:45-12:00 Three parallel sessions: Part I
Working group on recommendations regarding 'Training for First Responders'

Working group on recommendations regarding 'Training for Hospital Staff'

Working group on recommendations regarding 'Guidelines for the Psychosocial Support of Uniformed Services in CBRN-incidents' (three parallel sessions)

12:00-13:00 Lunch

13:00-14:00 Three parallel sessions: Part II
Continuation of Working group sessions on recommendations (same composition of working groups)

14:00-14:30 Coffee/Tea break

14:30-15:30 Results of working groups on recommendations (plenary session)

15:30-17:00 Working group on follow-up of the project developments/results
(three parallel sessions, inter-disciplinary groups)

17:00-17:30 Summary of second conference day

18:00 Departure to hotel by shuttle bus
(meeting point: in front of the school's main entrance)

19:00 Suggestion: Dinner in AC Hotel Rivas Vaciamadrid (dress code: informal) - evening at your own disposal
Thursday 27 September 2012
(Third Conference Day)

07:30  Breakfast and check-out of hotel
08:30  Departure to school by shuttle bus (with luggage)
       (meeting point: the hotel’s main entrance)
09:00-09:15  Introduction to day (in the plenary hall)
09:15-10:15  Results of working groups on follow-up of the project developments/results
               (plenary session)
10:15-11:15  Conference summary and feedback (plenary session)
11:15     Official closing ceremony
          Mr. Ralph Tiesler – Vice President, Federal Office of Civil Protection and Disaster Assistance
12:00-13:00  Lunch and departure from school to Airport (shuttle service)
EVALUATION FORM

TYPE OF ACTION: European Conference

TITLE: ‘Psychosocial Support for Civil Protection Forces dealing with CBRN’
– final conference -


Please indicate your views by ticking the appropriate response to each question or statement

1) What were your expectations for this particular event? (summary of most given and most critical answers)

- to meet and share experience on the state-of-the-art of psychosocial support with other EU experts especially with regard to CBRN incidents
- to meet and share experience with other training centres
- to share best practices of training programmes for first responders
- to receive recommendations for psychosocial support for first responders and training scenarios
- to receive ideas and practical tools for the training of First Responders with regard to PSS for the case of CBRN incidents
- international networking

2) How were your expectations met? (1x not ticked)

Completely □ 2x     Well □ 9x     Partly □ 9x     Not very well □     Not at all □

Q2: How were your expectations met?

3) What are your comments concerning the programme?

<table>
<thead>
<tr>
<th>Subjects</th>
<th>Very relevant □ 11x</th>
<th>Relevant □ 10x</th>
<th>Of little relevance □</th>
</tr>
</thead>
<tbody>
<tr>
<td>Content covered</td>
<td>Too much □ 1x</td>
<td>About right □ 17x</td>
<td>Too little □ 3x</td>
</tr>
<tr>
<td>Proportion of working group / plenary session</td>
<td>Too much plenary □ 2x</td>
<td>About right □ 18x</td>
<td>Too much working group □ 1x</td>
</tr>
</tbody>
</table>
Q3: What are your comments concerning the programme? Subjects

- Very relevant: 10
- Relevant: 11
- Of little relevance:

Q3: What are your comments concerning the programme? Content covered

- Too much: 1
- About right: 17
- Too little: 3

21 of 21 completed questionnaires

Q3: Proportion of working group/plenary session

- Too much plenary: 2
- About right: 18
- Too much working group: 1

21 of 21 completed questionnaires
4) In how far are the results of the ‘CBRN Incidents and PSS’-Project relevant for your (professional/volunteer) work/ field of interest? Please explain in more detail. (summary of most given and most critical answers)

- Very relevant for the education of own staff, for the development of training programmes for own staff (first responders, hospital staff), Peer courses, CBRN experts
- Very important in order to be able to create an effective supporting system for first responders and hospital staff
- As part of my job as team leader for CBRN reconnaisscance team, as a trainer for first responder dealing with CBRN incidents, as a volunteers providing PS-support to THW (operational) volunteers, as organiser of national training programmes, as director of a hospital, as member of the emergency planning committee at a national level
- The PSS training modules are relevant for the training courses for different target groups of First Responders in the field of CBRN protection, public health and PSS

5) Your overall rating of the conference:

| Excellent | 2x |
| Very good | 10x |
| Good | 9x |
| Average | |
| Poor | |

Q5: Your overall rating of the conference:

- Excellent
- Very good
- Good
- Average
- Poor

6) Other comments on any aspects of this event? (summary of most given and most critical answers)

- Lack of organisational aspects
- Information about flights and the conference received very late
- Service at the hotel was bad
- Bad acoustic in the plenary hall
- Nice conference venue
- Excellent exchange opportunity in an international context
- The conference participants covered the different relevant topics in excellent form. Many different aspects and points of view, perhaps it would be helpful to integrate more contributions from the evaluation of real incidents (Madrid, London…), very useful results in short time
- Trainings should be more realistic and start from basics, for example: a person should train i.e. supportive conversation while getting someone from point A to point B. Then try to do the procedure wearing a special suit. And only in the third step try to get a person from point A to B in a ‘Psychosocial’ way.
- Needed more information on what support we should offer to responders post-incident
- Would like to have seen a copy of the training course, the questions of the working groups, recommendations etc. prior to attending the conference for better preparation and more time for reflexion
- Excellent hospitality by the organisers
- Thank you
7) Your message to the project team with regard to the project follow-up: (all answers)

- maybe there is a chance to keep a yearly e-mail report on improvements in each country
- To pick up the important points – and not doss them as there has been some excellent work.
- The team was very sophisticated and motivated and achieved very good results I the working groups, excellent moderation!!
- A good basis for the continuation of this work.
- Thank you very much and much success for the future work.
- There seem to be a lot of options in regard to follow-up
- Interesting to bring the training closer to the basic First Responders by implementing opportunities for existing trainings
- When we have a CBRN-incident in Belgium, now I know who to call.
- Keep the good work going!
- Very high motivation of the German-Project teams (e.g. THW and Krefeld) to create a follow up EU project.
- Test the courses in the next 2 years and thereafter, evaluate once more
- Trainings in English language. Why not offering ‘supervision’ to countries that will implement trainings on their own.
- I still think training (of course with adapted content) should be offered to media / journalists as well. They have important role in communicating public. And we keep saying communication is one of the most important things.
- The creation of a network of PSS experts (not only for CBRN events) will be more than welcome.
- Congratulations, excellent work.
- Thank you so much – we had the occasions to make plans with our Polish, Portuguese, Luxembourgish, Austrian colleagues.
- It’s a beginning.
- I really hope that the recommendations that we came up with will be implemented in my country.
- Deliver products that are really usable for education and training programmes
- Create a tool box from which we can take what we think we can use.
- I would like to see a post revised copy of the recommendations and course when complete.
- I wish I could receive scenarios for trainings for first responders and final guidelines / recommendations for psychosocial support – a way to disseminated the project results is required
- Good first and second conference.
- Good use of experts for range of disciplines.
- Would be happy to be involved in future work
- Thank you for Berlin and Ahrweiler
- Keep up the good work. The project must be followed up and EU should decide to recommend the implementation of some policies by all the member countries. During the working group sessions it was obvious that every country has a very different way of meeting these problems than the others. We need a common language in order to build on it and improve it.
- The focus of the project should now be to bring the ideas to the basis of the first responders.
- First to congratulate the team for the excellent work done.
- I think that it is extremely important to ? on the guidelines (?) as well as what the knowledge and proposal presented.

Thank you very much for taking the time to complete this sheet.

Name (optional) ..............................................................................
Working group on recommendations regarding the Training for First Responders

“Psychosocial Crisis Management in CBRN Incidents”

Comments/Suggestions from WG in Madrid (in red colour)
Introduction

The following recommendations on psychosocial crisis management in CBRN incidents and the training concepts for first responders are based on several pillars:

1. The German Federal Office of Civil Protection and Disaster Assistance (BBK), established a multidisciplinary working group in 2007, with the main aim of developing up-to-date recommendations on psychosocial crisis management in CBRN incidents and training concepts for first responders and psychosocial acute helpers. The results were published in German and English in 2011 (BBK, 2011).

2. Since 2009, the German Academy for Crisis Management, Emergency Planning and Civil Protection (AKNZ), delivered and evaluated seven, national, three-day training courses on psychosocial crisis management in CBRN incidents.

3. The first conference within the European Project ‘Psychosocial Support for Civil Protection Forces Coping with CBRN’ in Berlin, 12th - 14th July 2011, included an intensive exchange of experts and a critical reflection of national recommendations.

4. As part of the European Project ‘Psychosocial Support for Civil Protection Forces Coping with CBRN’, two pilot training programmes were delivered and evaluated with the aim of disseminating the training concept at a European level. First responders, incident commanders and psychosocial acute helpers from Austria, Germany, Luxembourg, the Netherlands, Spain and Switzerland took part in the European pilot training in October 2011 and April 2012. An essential part of the training was the discussion about contents, methodology and didactic concepts. Suggestions for improvements from the first training session were implemented in the second session.
**Recommendations A: General aspects**

<table>
<thead>
<tr>
<th>Comments suggestions/ modification/ amendment/agreement</th>
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<tbody>
<tr>
<td>Psychosocial crisis management has to be part of the standard crisis management process in CBRN incidents.</td>
</tr>
<tr>
<td>Bureaucratic failures often hamper proper psychosocial crisis management. The provision of psychosocial support needs to be prepared in terms of bureaucratic requirements (personnel, technical and financial resources).</td>
</tr>
<tr>
<td>Psychosocial support in CBRN incidents is not ‘an add-on’ or ‘nice to have’ in the education of civil protection forces. It is a ‘must have’ and has to be a regular part of the crisis management education – training courses with regard to this respect therefore should become regular features in the education of operational personnel.</td>
</tr>
<tr>
<td>Information is an essential part of (psychosocial) crisis management, especially in CBRN incidents. Psychological and sociological findings have to be included in concepts for crisis communication in CBRN incidents.</td>
</tr>
<tr>
<td>Information is an essential part of preparing the larger population for CBRN incidents, to foster self-help-ability and self-efficacy. Psychological and sociological findings have to be included in concepts for risk communication for CBRN incidents.</td>
</tr>
<tr>
<td>It is essential to consider the cultural background and cultural differences of affected persons when dealing with them in CBRN crisis situations.</td>
</tr>
<tr>
<td>Families of first responders in CBRN incidents have to be included in the institutional psychosocial aftercare. This is vital in CBRN incidents because of the high level of uncertainty concerning acute harm and long-term effects on health.</td>
</tr>
<tr>
<td>Recommendations A: General aspects</td>
</tr>
<tr>
<td>-----------------------------------</td>
</tr>
<tr>
<td>Common training sessions for representatives of national and international civil protection organisations fosters the exchange of expertise beyond borders and consequently contributes to an effective collaboration on site in real (cross-border) crisis situations.</td>
</tr>
<tr>
<td><strong>Comments/Suggestions from Working Group of the final conference (Madrid):</strong></td>
</tr>
<tr>
<td>- To integrate ‘psychosocial crisis advisers’ in the board of crisis staff (PSNV-Fachberater in LuK-Stab)</td>
</tr>
<tr>
<td>Recommendations B: Learning objectives</td>
</tr>
<tr>
<td>----------------------------------------</td>
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<tr>
<td>Learning objectives of the training course ‘Psychosocial crisis management in CBRN incidents’ for civil protection forces</td>
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</tbody>
</table>

**The overall aim of the training is to strengthen the confidence to act and to enhance the skills and abilities of first responders who are confronted with exceptional situations and work under difficult conditions in CBRN incidents.**

**Reason**
- The competence and confidence to act effectively, even in CBRN incidents improve mission coordination and reduce acute, mid- and long-term psychological stress

**Sub-goals**
1. Awareness of the particular stress factors in a CBRN incident
2. Preparation for reactions of affected people and the population during a CBRN incident
3. Strengthening of psychosocial basic competences, including basic rules concerning the provision of information in order to promote the confidence to act and skills and abilities
4. Confidence in information management (above all for incident commanders in leading positions)
5. Confidence to act and the improvement of situational support efficacy and self-efficacy
6. Reduction of stress and pressure caused by the operation
7. To become aware of stress reactions and the provision of competence for stress management, self-regulation and self-reassurance
8. To strengthen the motivation to profit from rigorous medical aftercare (Human Biomonitoring) and the offer of psychosocial care.
**Comments/Suggestions from Working Group of the final conference (Madrid):**

- Medical counselling is indispensable (complementary to PSS)
  - also to be able to differentiate between physical and psychological symptoms
  - Inform first responders that there is the possibility of human biomonitoring!
- After CBRN missions, psychosocial acute helpers and psychosocial experts of mid and longterm psychosocial aftercare have to be *even more* present than in other large-scale disasters

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**Recommendations C: Methods and Didactics**

**Didactic recommendations for the training course ‘Psychosocial crisis management in CBRN incidents’ for civil protection forces**

<table>
<thead>
<tr>
<th>Comments suggestions/modification/amendment/agreement</th>
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</table>

1. Concerning the target groups of the training course ‘Psychosocial crisis management in CBRN incidents’ for civil protection forces, we recommend joint training for operational first responders (fire brigade, police, and rescue services) and psychosocial acute helpers.

**Reasons**

- Common training sessions for operational (CBRN) personnel (fire fighters, police, rescue services, NGO’s) and psychosocial acute helpers/psychosocial crisis intervention teams in CBRN incidents’ contribute to improving the relationships amongst the target groups and developing a mutual understanding for the working conditions of the other party.
- It can be assumed that common training sessions between these two groups of civil protection forces contribute to an effective collaboration on site at the interfaces (Hot Zone/Warm Zone) in real crisis situations.
**Recommendations C: Methods and Didactics**

**Didactic recommendations for the training course ‘Psychosocial crisis management in CBRN incidents’ for civil protection forces**

<table>
<thead>
<tr>
<th>Comments suggestions/ modification/ amendment/agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommendation: Common training sessions for representatives of a variety of civil protection organisations (Fire brigades, police, NGO’s, THW etc.) contribute to an effective collaboration between different civil protection organisations on site in real crisis situations.</td>
</tr>
</tbody>
</table>

2. **We recommend including both modules for the training of all participants together and then to train target group-specific modules (operational first responders and psychosocial acute helpers) separately.**

**Reason**

- This enables the development of target group-specific basic knowledge (e.g. psychological knowledge for uniformed services, mission structures for the psychosocial acute helper).

3. **We recommend including practical exercises (CBRN crisis-scenarios)**

**Reason**

- Testing and applying best practices for psychological first aid and crisis communication under PPE (Personal Protective Equipment) enables first responders to gain experience for real-life incidents and to be able to perform as effectively as possible under CBRN conditions.

4. **We recommend performing practical exercises using professional actors, not amateur actors**

**Reasons**

- Professional actors contribute to a very realistic portrayal of different reactions of the affected on scene in CBRN crisis scenarios.
- The realistic portrayal leads to a much higher learning effect.
**Recommendations C: Methods and Didactics**  
Didactic recommendations for the training course ‘Psychosocial crisis management in CBRN incidents’ for civil protection forces

<table>
<thead>
<tr>
<th>Comments/Suggestions from Working Group of the final conference (Madrid):</th>
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<tbody>
<tr>
<td>- Two main tasks for first responders on site:</td>
</tr>
<tr>
<td>1.) taking care of the affected</td>
</tr>
<tr>
<td>2.) dividing tasks among the team of first responders for the CBRN mission</td>
</tr>
<tr>
<td>- A specific training curriculum for commanders is needed because of the different tasks of commanders + other team members</td>
</tr>
<tr>
<td>- Different groups of first responders (fire brigade, police, ambulances) → different tasks in the CBRN missions = different training needs to be covered by the curriculum</td>
</tr>
<tr>
<td>- Training needs from all crisis management levels have to be accounted for in the curriculum: operational + tactical + strategic level</td>
</tr>
<tr>
<td>- Target group-specific sessions on the working field of the other crisis management units working at the interface of the hot and warm zone</td>
</tr>
<tr>
<td>- very important for being able to understand what the others are doing</td>
</tr>
<tr>
<td>- to be able to concentrate on own tasks</td>
</tr>
<tr>
<td>- Also commanders and ambulance staff and medical emergency doctors should know the tasks and challenges of the working field of PSS staff</td>
</tr>
<tr>
<td>- Such trainings for commanders are also a good opportunity to inform them about the training needs of their team members as preparation to CBRN operations</td>
</tr>
<tr>
<td>- Include different providers of PSS staff → depending on the national structures of PSS provision → they also become aware of the special stress factors of CBRN responders</td>
</tr>
</tbody>
</table>
**Recommendations C: Methods and Didactics**  
**Didactic recommendations for the training course ‘Psychosocial crisis management in CBRN incidents’ for civil protection forces**

<table>
<thead>
<tr>
<th>and the basics of operational CBRN crisis management steps</th>
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</thead>
<tbody>
<tr>
<td>• The training modules have to be kept flexible enough to be easily tailored to the specific needs of the respective PSS providers and first responder organisations (fire brigade, police etc.)</td>
</tr>
<tr>
<td>• Also include recommendations for how to prepare layman to play the different roles and realistic reactions → depending on the scenarios (e.g. large-scale) to be played and the resources that are available</td>
</tr>
<tr>
<td>• Include real experience, examples of good practice/lessons-learned in the curriculum e.g. also analyse well documented CBRN missions by means of pictures, videos and crisis management reports together with the participants (or in smaller working groups) → could be included as an extra teaching unit</td>
</tr>
<tr>
<td>• → Also possible in form of table-top exercises e.g. on crisis management (decision-making) of commanders of past CBRN missions</td>
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<tr>
<td>• Integrate different agencies in the training</td>
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<tr>
<td>• Include also children as actors and maybe elderly people</td>
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<tr>
<td>• Switch professional roles (for the time of the exercise)</td>
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</table>
## Recommendations D: Contents

### Contents of the training course ‘Psychosocial crisis management in CBRN incidents’ for civil protection forces

<table>
<thead>
<tr>
<th>Comments suggestions/modification/amendment/agreement</th>
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</table>

### 1. Factual knowledge related to hazardous material

**Reasons**

- It is important for first responders to gain insight into possible effects of hazardous material and CBRN-related toxicological agents and the possible (long-term) impact on health. Knowledge about these issues may contribute to the willingness and motivation of first responders to work under CBRN-conditions, also with regard to family concerns (caring for safety of one’s family).
- For psychosocial acute helpers it is important to know and understand the possible impact on health of the affected and their legitimate fears in CBRN incidents.
- For peer support professionals and psychosocial professionals for first responders, it is important to know and understand the possible impact on first responders’ health that an operation under CBRN conditions might entail and consequently possible stressors or worries for operational (CBRN) experts before, during or after such an operation.

### 2. Basic knowledge of operational crisis management procedures/command structure in CBRN incidents

**Reason**

- For psychosocial acute helpers and professionals working in the field of post-disaster psychosocial care, it is important to understand the crisis management steps during and after a CBRN-incident, and the command structure for understanding the special conditions/stressors the affected and operational forces might be exposed to in CBRN incidents. It also will assist the effective collaboration between the first response on site and the reception of affected/first responder in the zone of psychosocial acute help (Hot Zone/Warm Zone);
<table>
<thead>
<tr>
<th>Recommendations D: Contents</th>
<th>Comments suggestions/ modification/ amendment/agreement</th>
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</thead>
<tbody>
<tr>
<td>Contents of the training course ‘Psychosocial crisis management in CBRN incidents’ for civil protection forces</td>
<td></td>
</tr>
<tr>
<td>3. Basic knowledge about specific stress factors in CBRN incidents</td>
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<tr>
<td><strong>Reason</strong></td>
<td></td>
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<tr>
<td>▪ The knowledge of specific stressors in CBRN incidents strengthens the understanding and the awareness to the reactions of those affected and also the stress reactions of first responders.</td>
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<tr>
<td>4. Basic knowledge about the behaviour of human beings during and after CBRN incidents</td>
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</tr>
<tr>
<td><strong>Reasons</strong></td>
<td></td>
</tr>
<tr>
<td>▪ For operational forces it is vital to be aware of the typical human reactions that can be expected from those affected by CBRN incidents.</td>
<td></td>
</tr>
<tr>
<td>▪ Knowledge about possible (stress) reactions of those affected by a CBRN incident, and also the reactions of oneself, helps preparedness for CBRN related operations.</td>
<td></td>
</tr>
<tr>
<td>5. Recommendations for actions for how to communicate and to deal with the affected in CBRN incidents (Psychological First Aid, de-escalation, panic prevention, panic reduction, strengthening cooperation)</td>
<td></td>
</tr>
<tr>
<td><strong>Reasons</strong></td>
<td></td>
</tr>
<tr>
<td>▪ Providing first responders with recommendations for actions how to communicate and deal with affected of CBRN incidents fosters their motivation and self-confidence to perform under CBRN conditions and their experience of self-efficacy.</td>
<td></td>
</tr>
<tr>
<td>▪ Control is key to the ability to perform effectively during CBRN incidents. Having the feeling of control during such deployments is very important for first responders leading to a capability to perform effectively.</td>
<td></td>
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</tbody>
</table>
### Recommendations D: Contents

**Contents of the training course ‘Psychosocial crisis management in CBRN incidents’ for civil protection forces**

<table>
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<tr>
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</thead>
</table>

| 6. **Information about medical (Human Bio Monitoring) and psychosocial aftercare for first responders**<br><br>**Reason**<br>  - Knowledge about possibilities and structures of the post-disaster psychosocial care for first responders sensitizes consciousness, and the possible need for psychosocial support for self and/or for colleagues that may arise after a difficult deployment. In case of CBRN incidents, knowledge about possible long-term effects on health (including mental health) is extremely valuable (see also recommendation on CBRN impact and Human Bio Monitoring) → It is important to inform first responders properly on the structure of PSS offered by the institution (or of an external institution) (Berlin conference) |

| 7. **Complementary contents for separate training include stress management, guidelines for risk and crisis communication and intercultural competences**<br><br>**Reason**<br>  - Stress management, guidelines for risk and crisis communication and intercultural competences should not be neglected. To deal adequately with these issues, additional trainings should be offered. |

**Comments/Suggestions from Working Group of the final conference (Madrid):**

- First responders have to trust the colleagues of the white zone (at the interface of the decontamination area) to take over for the psychosocial support of the affected → they have to concentrate on their operational tasks → they have to know about the tasks of the working field of PSS staff → this knowledge minimises the stress for first responders during CBRN operations on site (because they know they can concentrate on their own tasks)
### Recommendations D: Contents

**Contents of the training course ‘Psychosocial crisis management in CBRN incidents’ for civil protection forces**

<table>
<thead>
<tr>
<th>Information management:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.) First responders (at the operational and tactical level) need also information about the CBRN incident to be communicated to the affected (not only for themselves) → information management (basic rules of crisis communication, e.g.: ‘If you don’t know something, say so – say that you don’t know it at the moment – don’t lie to the affected!’) → could be supported by using pocket cards! → of course it is not the task of first responders to do crisis communication vis-à-vis witnesses on site or the wider public!</td>
</tr>
<tr>
<td>2.) Also, we have to develop crisis communication guidelines for large-scale CBRN scenarios: → for the wider public, press officers and politically responsible persons → e.g. with help of pocket cards</td>
</tr>
</tbody>
</table>

- Include European standards for training (be aware of the newest European training standards in this field)
- Account for different situations in the EU member states → for the different state of knowledge or practice with regard to basic knowledge concerning PSS and the provision of PSS

### Comments

**suggestions/modification/amendment/agreement**

### Topic II: Project Follow up

**Recommendations E: Project Follow up and implementing psychosocial crisis management in CBRN incidents**

| Staff leaders and directors of civil protection and fire brigade schools as well as the police |

**Comments**

**suggestions/modification/amendment/agreement**
**Recommendations E: Project Follow up and implementing psychosocial crisis management in CBRN incidents**

<table>
<thead>
<tr>
<th>Description</th>
<th>Comments suggestions/ modification/ amendment/agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>need to be convinced</td>
<td></td>
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<tr>
<td><strong>Concrete ideas how? E.g.</strong></td>
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<tr>
<td>➢ invite them to participate in the training themselves (not only as observers, but as participants of the theoretical and practical exercises)</td>
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<tr>
<td>➢ offer a version of the training, e.g. only for staff leaders or only for police officers</td>
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<tr>
<td>➢ participants report on their experiences to the directors of training schools</td>
<td></td>
</tr>
<tr>
<td>Other strategic and key authorities involved in crisis management should participate in training concerning psychosocial crisis management in CBRN incidents, e.g. public health authorities, mayors.</td>
<td></td>
</tr>
<tr>
<td>Include national level CBRN experts as lecturers in the training course.</td>
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<tr>
<td>Developing target group-specific ‘information leaflets’</td>
<td></td>
</tr>
<tr>
<td>➢ staff leaders: training course and project results → disseminating the information brochure/flyer at various civil protection schools in Europe at publishing it on the official websites of civil protection schools etc.</td>
<td></td>
</tr>
<tr>
<td>➢ first responders: stress factors in CBRN incidents, psychosocial support after missions, possibilities for psychosocial education</td>
<td></td>
</tr>
<tr>
<td>➢ public: risk awareness, preparedness, self-help and community help strategies</td>
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</tr>
<tr>
<td>Promotional presentations with special emphasis on the particular conditions of CBRN incidents</td>
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</tbody>
</table>
Recommendations E: Project Follow up and implementing psychosocial crisis management in CBRN incidents

Comments/Suggestions from Working Group of the final conference (Madrid) with regard to follow up and further tasks/projects:

- Development of specific training tools for police, medical doctors and rescue services.
- Development of short protocols / recommendations for incident commanders in which kind of CBRN incidents (concrete situations) they have to ask for psychosocial acute help on scene
- Development of guidelines for risk and crisis communication for large-scale CBRN scenarios for press officers and political authorities
- Development of dark sites
- Development of different ‘pocket cards’, e.g.
  - Pocket cards for first responders to support communication with the affected on scene
  - Pocket cards for incident commanders for CBRN incidents to inform when PSS is needed
- Propose a ‘European network and exchange project’ with European experts, practitioners from the different organisations of emergency response and scientific experts in the field of CBRN and PSS – sharing experience, examples and best practice
- Propose a research project to evaluate different PSS measures in CBRN incidents
- Compare the different situation/structures in the EU member states and adapt possibilities for implementing PSS
- Development of recommendations / standards for implementing a head of psychosocial support – acute, mid- and long term
  - a psychosocial advisor in the administrative and operational crisis staff (e.g. S7 in Austria) and
**Recommendations E: Project Follow up and implementing psychosocial crisis management in CBRN incidents**

- A head of PSS on scene
- A psychosocial manager in each department / at federal state level (Länder) / at community level
- Psychosocial coordinator in different organisations

- Integration of knowledge about psychosocial needs in CBRN incidents in the education of such personnel (head of psychosocial support/psychosocial coordinator)

- Compare different PSS-leading structures in the European member states (e.g. Belgium, France, Portugal, Germany)

- Invite staff leaders, directors of civil protection authorities, of fire brigade schools as well as of police academies to the trainings

- Other strategic and key authorities involved in crisis management should participate in training concerning psychosocial crisis management in CBRN incidents, e.g. public health authorities, mayors

- Implement modules ‘PSS in CBRN incidents’ into basic CBRN-training for first responders

- Organise information days for fire services, members of relief organisations, directors of training centres, incident commanders

- Inform the EU training coordinator about the different training modules to disseminate the results

- Include European standards into the training modules

- Develop short information leaflets for incidents commanders and members of the crisis management board (LuK-Stab) about the project results and the training modules → dissemination of the information / flyer at various civil protection schools in Europe in different languages
### Recommendations E: Project Follow up and implementing psychosocial crisis management in CBRN incidents

**Comments**

- Suggestions/modification/amendment/agreement

| Inform about the results on the official websites of civil protection schools etc. (e.g. the final project report or the executive summary thereof as download) |  |
Working group on Recommendations regarding the Guidelines for Psychosocial Support for First Responders in case of a CBRN incident
Abstract

The guidelines for first responders in case of a CBRN incident were prepared in the context of the European project ‘CBRN and Psychosocial Support’ of the Directorate General Environment of the European Commission. These guidelines are based on the guidelines for Psychosocial Support for Uniformed Workers who were prepared at the request of the Dutch Ministry of Security and Justice. They were developed by Impact, the Dutch knowledge and advice centre for post-disaster psychosocial care. The quality control bureau of the Netherlands Society of Occupational Medicine, and the Trimbos Institute provided methodological support during the development.

To understand the relevance of and support for the guidelines within a European context, three methods were used: an international conference, a questionnaire distributed amongst experts and a literature review. This discussion and consensus is used as a starting point for the guidelines for first responders in case of a CBRN incident. Development of the guidelines in the specific context of CBRN included a complementary literature review (PubMed, PsychINFO, Embase 2001-2011), sitevisits to 7 different European countries to interview experts; workshops and conferences to reach consensus with the relevant stakeholders.
**Topic I: Guidelines for Psychosocial Support for First Responders**

<table>
<thead>
<tr>
<th>A) Recommendations and dilemma’s on information</th>
<th>Comments suggestions/modification/amendment/agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>• create awareness about CBRN: different perceptions lead to different conclusions, preparation and response</td>
<td></td>
</tr>
<tr>
<td>• give information: warning and informing, precise information about facts of contamination, in case of lack of information first responders might not be willing to go in;</td>
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<tr>
<td>• good communication strategies for the families of the responders, organizations, politicians to deal with the stress;</td>
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<tr>
<td>• develop an effective system of ‘disaster bureaucracy’;</td>
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<tr>
<td><strong>Recommendations you would like to add:</strong></td>
<td></td>
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</tbody>
</table>
B) Recommendations and dilemma's on insecurity and anxiety

<table>
<thead>
<tr>
<th>Comments suggestions/ modification/amendment/agreement</th>
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</thead>
<tbody>
<tr>
<td>• psychosocial care should be an integral part of emergency preparedness and response;</td>
</tr>
<tr>
<td>• combine psychosocial care with medical health checks</td>
</tr>
<tr>
<td>• use a process-oriented approach with a long term perspective, although the long term is difficult to plan because of the unknown long term consequences;</td>
</tr>
<tr>
<td>• create awareness of psychological principles f.ex. uncertainty has a strong psychological and emotional impact on people;</td>
</tr>
<tr>
<td>• credibility and trust are key issues: 'nuclear guys' and government are not easily trusted;</td>
</tr>
<tr>
<td>• make use of a group of good communicators working with the people on acceptability of radiation levels and lifestyle choices;</td>
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Recommendations you would like to add:
<table>
<thead>
<tr>
<th>C) Recommendations and dilemma's on mission conditions</th>
<th>Comments suggestions/ modification/ amendment/ agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>• provide for robust training, continuity of training and ongoing development of new skills;</td>
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<tr>
<td>• organizations should work similarly in terms of command structures, communications and operating structures; interoperability is an important condition to respond effectively;</td>
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<td>• take into consideration the dilemma of the safety of the responders in relation to risk of CBRN intoxication and the speed of the response;</td>
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<td>• provide for enough resources, people and equipment to facilitate resilience;</td>
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<td>• prepare for stakeholder involvement;</td>
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<td>• provide information on insurance issues;</td>
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Recommendations you would like to add:
## Topic II: Project Follow up

<table>
<thead>
<tr>
<th>D) Recommendations for follow up</th>
<th>Comments suggestions/modification/amendment/agreement</th>
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<tbody>
<tr>
<td>• After finishing the guidelines provide for implementation of the conclusions and recommendations</td>
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<tr>
<td>• It is recommended to start with services in areas and/or countries with a high incidence score on CBRN incidents</td>
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<tr>
<td>• This makes it possible to formulate indicators to measure the progress into practice of psychosocial support of psychosocial care in case of CBRN incidents</td>
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**Recommendations you would like to add:**
Working group on recommendations regarding the Training Course for Hospital Staff

‘Psychosocial Crisis Management in CBRN Incidents’
Abstract

Objectives:
The psychosocial effects at the emotional, psychological and behavioral levels that result from CBRN incidents have been shown to be more widespread and long-lasting than the direct physical effects, in terms of their impact on society and the general health of the population. However, it is clear that even small-scale CBRN incidents can cause psychological stress that has lasting effects on the health of the affected individuals. Especially nurses and physicians in emergency units are likely to deal with patients being affected by a CBRN incident either seeking medical help on their own (self-referring) or being brought by ambulance. Being well prepared—knowing what to do and how to handle infected / contaminated patients—means that hospital staff:

a) is well informed about the hospital’s disaster management plans
b) has knowledge about emotional, psychological and behavioral distinctions of individuals facing a CBRN threat
c) have psychosocial competences that respond to these distinctions
d) involve (hospital-internal) other occupational groups to enhance the psychosocial support in CBRN incidents

Method:
To begin with, we analyzed the current state of hospitals preparedness concerning CBRN incidents. The analysis was conducted by focusing on three different sources. First, we used literature databases to search for relevant literature describing existing strategies how hospitals should cope with the psychosocial needs of infected / contaminated patients. Second, standardized interviews with hospital managing directors were conducted to examine the current state of hospitals’ preparedness with regard to CBRN incidents. Third, we conducted a survey with our own hospital staff by mailing questionnaires ascertaining the state of knowledge hospital personnel has about CBRN situations.

Using the results of this analysis, we developed a 1-day training course combining theoretical instructions and practical exercise. The training was addressed to nurses and physicians working in hospitals. The overall goal was to achieve increased psychosocial competences on one hand to handle one’s own feelings, and on the other hand, to promote compliance in those seeking medical treatment.
Results:
Our survey showed that the current state of preparedness regarding CBRN incidents is quite low. Hospital disaster plans often do not focus on this type of incident. Furthermore, hospital personnel seems to be mostly unfamiliar with rescue processes, risk and crisis communication – especially under personal protective suits - when dealing with CBRN incidents. Specialized training courses as the one we developed during the project “Psychosocial Crisis Management in CBRN Incidents” have been evaluated by the participants as highly valuable for dealing with the psychosocial challenges of a CBRN event and managing the unique nature of the implicated stressors.

Conclusions:
Emergency service and health workers should have ongoing training in the management of patients suffering from the effects of a CBRN threat. Hospitals should develop disaster management plans with specialized response frameworks to ease the handling of CBRN situations for their medical staff. It is important to note that the effectiveness of psychosocial support can be disturbed by the use of personal protective suits because the protective suits interfere with the so-called bodily characteristics that contribute to the activation of the attachment behavior. Integrating other occupational groups (e.g. psychiatry) to anticipate and manage the needs of affected individuals seeking medical help is likely to contribute to better medical treatment compliance.
## Recommendations A: ‘Psychosocial crisis management in CBRN incidents’ for hospital personnel – Recommendations for Hospitals

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### 1. Know the facts about CBRN situations in hospitals:

Hospital personnel need to know how to deal with contaminated patients. Detailed alarm plans create guidelines for action which should include for example:

- explanations of specific terms used in CBRN incidents
- overview maps of traffic routes
- labels of non-contaminated and contaminated areas
- precise descriptions of the decontamination process
- planning for collecting points for relatives of victims
- the creation of documents.

-> Hospital alarm plans that explicitly define the processes in CBRN incidents create a clear framework for effectively dealing with the situation.

### 2. Establish structural requirements:

Next to material requirements (e.g., procurement of personal protective equipment, creation of decontamination areas, etc.), hospital staff must be intimately familiar with the rescue processes for CBRN incidents. Therefore it is recommended to define clear agreements between the fire brigade on-site, other rescue services and the hospital emergency room.

-> Clearly defined procedures are essential in order for the first response team at the scene and the emergency care staff in the hospital to work together effectively.
### Recommendations A: ‘Psychosocial crisis management in CBRN incidents’ for hospital personnel – Recommendations for Hospitals

<table>
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<tr>
<th>3. Create a specially trained CBRN team:</th>
<th>Comments suggestions/ modification/amendment/agreement</th>
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<tr>
<td>The CBRN team consists mainly of medical doctors and nursing staff of the hospital, which is directly involved in the rescue mission, before the incident reaches a larger scope. These employees should be very familiar with personal protective equipment, decontamination processes, and the psychosocial aspects of CBRN incidents.</td>
<td>-&gt; Specially trained personnel has the relevant knowledge to improve on CBRN crisis management and has the respective competence.</td>
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<tr>
<th>4. Involve other hospital-internal occupational groups to enhance the psychosocial support in CBRN incidents:</th>
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<tr>
<td>Involvement of other occupational groups within the hospital is recommended to offer the best support in large-scale disasters. This includes, for example, medical and nursing personnel from psychiatric clinics, physical therapists, pastoral services, cafeteria employees (e.g. in order to support victims’ family members).</td>
<td>-&gt; Other occupational groups can provide a valuable contribution caring for concerned, agitated patients as well as family members, and should be included in the psychosocial care.</td>
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<th>5. Establish psychosocial aftercare for hospital staff:</th>
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<tr>
<td>A clear understanding about components of post-disaster psychosocial care for hospital staff underlines the importance of psychosocial support for all hospital staff after involvement in CBRN incidents. However, it is important to be aware of the long-term effects of CBRN incidents on people’s physical and mental health.</td>
<td>-&gt; It is imperative that the hospital staff is very familiar with the hospital’s</td>
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### Recommendations A: ‘Psychosocial crisis management in CBRN incidents’ for hospital personnel – Recommendations for Hospitals

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<th>PPE policies and arrangement.</th>
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<th><strong>6. Implement trainings specifically about CBRN incidents:</strong></th>
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<td>Implementation of frequent CBRN hospital trainings will create more awareness about CBRN incidents. The hospital personnel will strengthen their competence and increase their confidence in handling such incidents.</td>
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<td>-&gt;CBRN training courses should therefore become a part of the regular training program for medical personnel.</td>
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**Recommendations you would like to add:**

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**Technisches Hilfswerk**
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<tr>
<th>Recommendations B: Learning objectives of the training course ‘Psychosocial crisis management in CBRN incidents’ for hospital staff</th>
<th>Comments suggestions/ modification/amendment/agreement</th>
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<tbody>
<tr>
<td><strong>1. Develop competence in providing psychological first aid while using personal protective equipment (PPE):</strong>&lt;br&gt;Test and apply best practices from crisis communication using PPE (Personal Protective Equipment). First responders will gain experience for real-life situations and will enable them to act as effectively and efficiently as possible in CBRN incidents.</td>
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<td><strong>2. Define deployment and operations processes involved in CBRN incidents:</strong>&lt;br&gt;Increase hospital personnel’s understanding of the potential effects of hazardous materials and CBRN-related toxic agents, as well as their potentially long-term effect the health of those exposed. Having a thorough understanding of the impacts will reduce the hospital staff’s reluctance and thereby increase their motivation to work under CBRN conditions. This will also help with concerns about one’s family (ensuring family’s safety).</td>
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<td><strong>3. Understand the reactions of affected people in CBRN incidents:</strong>&lt;br&gt;Knowledge about the possible reactions of CBRN victims will help staff be better prepared for CBRN incidents. It is crucial for emergency care personnel to be familiar with the typical human reactions that arise from those affected by CBRN incidents.</td>
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<td><strong>4. Develop Effective Risk and Crisis Communication:</strong>&lt;br&gt;Risk and crisis communication is closely related to staff guidelines that outline the process of dealing with those affected by CBRN incidents (this includes best practice examples for crisis communication, examples of</td>
<td></td>
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</table>
### Recommendations B: Learning objectives of the training course 'Psychosocial crisis management in CBRN incidents' for hospital staff

| Communication using body language, etc.). When first responders are well-prepared for communicating and dealing with those affected by CBRN incidents, they will be more motivated and confident performing well under CBRN conditions. | Comments suggestions/modification/amendment/agreement |

### Recommendations you would like to add:
**Topic II: Project Follow up**

**Recommendations C: Project Follow-up and implementing on-going psychosocial crisis management for hospital personnel in CBRN incidents**

**Key components for effectively integrating this CBRN curriculum into regular hospital staff trainings:**

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<tr>
<td>1.) A training course should be offered (e.g. by brochures) with the goal of making medical directors of hospitals aware of the extreme levels of stress that personnel involved in CBRN situations are under compared with “regular” large-scale disasters, i.e., those without CBRN conditions. Since the use of PPE in CBRN incidents often creates a barrier to psychosocial support of those affected, the CBRN curriculum should not just cover how to use PPE, but also discuss the effects of PPE on psychosocial support in CBRN incidents.</td>
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<td>2.) Present this training course aimed at hospital staff to public health authorities to gain their support.</td>
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<td>3.) Incorporate this training program into the regular training curriculum of e.g. nursing schools and continued education programs for medical personnel.</td>
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<td>4.) Create hospital emergency plans that have been modified to account for CBRN incidents in close collaboration with the local fire brigade as well as other rescue services, such as the Red Cross etc.</td>
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**Recommendations you would like to add:**
Project: Psychosocial support for civil protection forces coping with CBRN
**Project rationale:**

The risk regarding CBRN situations has increased in almost all EU Member States. Civil protection forces deployed in emergency and disaster response operations under CBRN conditions are exposed to additional risks and pressures that are likely to cause heavy psychological strain. However, psychosocial crisis management is in most EU Member States not yet part of the training programme of specialists in CBRN.

The project addresses this deficit by developing and testing a pilot training course for first responders (including volunteers) and hospital staff who have to cope with CBRN incidents.

**Project objective:**

Enhancing the efficiency of crisis management and reducing the long-term effects of psychosocial stress by improving the preparedness of first responders and their ability to cope with CBRN incidents.

**Starting point:**

The adequate use of psychosocial support (PSS) helps to facilitate crisis management and first response by:

- Enhancing the capability of responders to cope
- Avoiding long term effects of stress
- Improving the coordination during the mission
- Fostering the cooperation of the affected
- Facilitating risk and crisis communication

**Project tasks & deliverables:**

- Study of the current situation in the EU Member States regarding CBRN and Psychosocial Support (PSS)
- Study of the interface between responders and hospital staff
- Curriculum and teaching material for a training course including exercises (for responders and hospital staff respectively)
- Documentation of ‘Lessons learnt’
- Adaption and development of (new) guidelines for psychosocial support targeted at uniformed services, volunteers and hospital staff
- Recommendations
- Two European conferences: the 1st at the beginning, the 2nd at the end of the project to share insights and lessons learnt, to create awareness and to promote increased training in the field of psychosocial support in the context of CBRN

**Expected results from the EU-Project ‘CBRN Incidents and PSS’:**

At the end of this project, two training courses will have been developed enabling first responders and hospital staff to cope with CBRN incidents. The training curricula are developed on the basis of EU-wide research. During the two-year term of the project, the training courses will be tested twice by pilot groups of first responders and hospital staff.

By the end of the project, the training courses and recommendations developed during its implementation, will be translated into English and disseminated for EU-wide application. The guidelines for psychosocial support, developed within this project for uniformed services, volunteers and hospital staff, will be published in English.

Generally, it is expected to raise awareness – EU-wide – for the importance of and the need for providing psychosocial support for civil protection forces coping with CBRN.
The Project Group:

Partners in the Project are:

- German Federal Agency for Technical Relief (DE)
- Centre of Psychotraumatology, Alexianer Krefeld GmbH (DE)
- Impact – Dutch Knowledge & Advice Centre for post-disaster psychosocial care (NL)
- Dirección General de Protección Civil y Emergencias, Ministerio del Interior (ES)
- German Federal Office for Civil Protection and Disaster Assistance (DE)

Members of the Steering Committee are:

- German Fire Services Association (DE)
- British Red Cross and Red Cross EU-Office (UK/BE)
- NOFER Institute of Occupational Medicine (PL)
- German Federal Agency for Technical Relief (THW) Regional Office for Bremen, Lower Saxony (DE)

About the project:

- Coordinating Beneficiary: Bundesanstalt Technisches Hilfswerk (DE)
- The project is co-funded by European Commission, Directorate-General for Humanitarian Aid and Civil Protection (DG ECHO); Grant Agreement No 070401/2010/579071/SUB/C4
- Project duration: 2 February 2011 – 31 January 2013
EU-Project ‘Psychosocial Support for Civil Protection Forces Coping with CBRN’

CBRN Incidents and Psychosocial Support for First Responders

Improving Resilience through Training

European Conference
Berlin, 12 – 14 July 2011
Psychological Support for Civil Protection Forces

Coping with CBRN

- Final Conference

National School of Civil Protection

Rivas-Vaciamadrid, 25-27 September 2012