
Reflections from the end of the Earth: Social work planning, preparation and intervention with evacuees on haemodialysis treatment following the 2011 Christchurch earthquake

Anna C. Stewardson & Nicolette Crump

Nicolette Crump has been a Social Worker with the Whangarei Renal Service of the Northland District Health Board for the past nine years. Nicolette has an interest in Emergency Preparedness and the need for dialysis dependent patients to be prepared and have plans to remain safe in weather emergencies.

Anna Stewardson has worked for the Whangarei Renal Service of the Northland District Health Board for seven years. She has an interest in how patients cope with the special difficulties that arise for people with chronic health issues.

Abstract

The February 2011 earthquake in Christchurch caused damage to infrastructure which made it impossible for people with end stage renal failure to have haemodialysis treatment in Christchurch for an undetermined period. Guided by the National Civil Defence Emergency Management Plan (Ministry of Civil Defence and Emergency Management, 2009) and the National Health Emergency Plan (Ministry of Health, 2008), the National Emergency Response Team decided to transfer dialysis-dependent people out of Christchurch to the Northern District Health Board.

This article discusses the links between social work and emergency preparedness and emergency responsiveness and the role of social workers before and immediately after disasters. It will provide a practitioner's view of the planning, preparation and social work intervention to support identified acute psychosocial needs for the group of haemodialysis patients evacuated from Christchurch to Whangarei following this earthquake, with particular focus on emotional and psychological stress, isolation and financial resources.

The evacuated Christchurch patients expressed feeling as if they were being sent to 'the end of the earth'. This article will reflect on issues of resilience, group dynamics, the role of social workers with evacuees, managing media and community boundaries, and social worker's self care.

Introduction

The Christchurch earthquake in 2011 led to a human disaster which affected people throughout New Zealand. The challenge to provide disaster relief in Christchurch was immense

and a huge effort was demanded from emergency response teams, health professionals and community organisations as well as individuals. There was extensive damage to buildings and infrastructure and the hospital in Christchurch was inundated with disaster victims. There was widespread concern for people's safety and well being. McClellan (2001) describes how in a natural disaster people with a chronic health problem such as end stage renal failure have the added concern for their critical and immediate need for dialysis treatment. The New Zealand Government declared a National State of Emergency and the National Emergency Response Team decided to transfer people dependent on ongoing dialysis treatment out of Christchurch. The Northland District Health Board (DHB) offered to provide dialysis treatment for the people from Christchurch and a number of them were evacuated to Whangarei which, from their perspective, seemed like the end of the earth.

The aim of this article is to provide a practitioner's view of the planning, preparation and social work intervention with the Christchurch evacuees and contribute to the body of knowledge about the role of social workers in the field of disaster preparedness and responsiveness. As Northland DHB renal social workers, the authors responded to the challenge of supporting the Christchurch evacuees during their enforced stay in Whangarei. This article will describe the issues that arose and how our ability to provide social work intervention was underpinned by our social work knowledge and skills, social work theories and models, and our knowledge and experience with emergency preparedness and responsiveness.

Background and context

Health social work

Health social workers offer a social work service to clients of primary or secondary health providers by carrying out psychosocial assessments and using social work practice models based on social science theories. Health social workers largely practise within a multidisciplinary team (Beddoe and Deeney, 2012). Weld (2010) describes how social work is uniquely placed to bring the emotional, social, spiritual and psychological aspects of a person's world to the multidisciplinary team.

Kidney failure and chronic health

The medical term for kidney failure is renal failure. People with end stage renal failure are unable to remain alive without some form of medical technological intervention, usually some form of dialysis therapy where a machine takes over part of the functions of the kidneys. This may be haemodialysis or peritoneal dialysis. People who are on haemodialysis treatment must be attached to a dialysis machine for many hours each week, usually on alternate days for up to six hours at a time. A haemodialysis machine requires electricity, water and sewerage services. Without this treatment people will become very unwell due to a build-up of fluid and toxins in the body and death can occur within days or weeks. Renal failure is irreversible and is a chronic condition; treatment is ongoing and lifelong. With adequate treatment, people with renal failure can have a good quality of life which can include work, looking after family, being involved in their community or any other activity that is important to them depending on their situation and stage of life.

Renal social work

Together with doctors, nurses and dieticians, renal social workers are part of a team of hospital-based health professionals who assist patients to manage their renal failure. Renal teams

are guided by Ministry of Health guidelines on working in chronic care as outlined by the National Health Committee (2007). Renal social workers build relationships with patients, their families and whanau, and review the effectiveness of interventions over a long time.

Renal failure can affect people from all walks of life and of all ages. As renal social workers employed by the Northland DHB we work with a diverse group of clients aged from 17 years and upwards.

Emergency preparedness and social work

The Ministry of Health has emergency management plans for every imaginable type of national or local disaster or emergency and every district health board has plans developed to deliver services in various local disasters or emergencies, and to contribute to national emergency management.

Part of our renal social work role in Northland is patient education about emergency preparedness and responsiveness. Our intervention in this activity is guided by the National Public Education Strategy (Ministry of Civil Defence and Emergency Management, 2009) which identifies that it is necessary for all individuals and communities to be aware of risks and prepare to cope in an emergency.

Weather disasters which damage roads and infrastructure and interrupt access to dialysis services are an annual occurrence in Northland. As renal social workers, we work closely with the local Civil Defence Management Group to develop disaster response plans with our patient group. We undertake this task using strengths based models and encourage patients to be prepared to work with their families and communities to remain safe in emergencies. We are guided in this by work done by renal services in the USA following cyclone Katrina as outlined in the booklet *Preparing for emergencies: A guide for people on dialysis* (The Centers for Medicare & Medicaid Services, 2007).

Emergency responsiveness and social work

Yanay and Benjamin (2005, p. 271) argue that, '... social workers are the professionals best prepared to deal with complex situations resulting from an emergency'. Yueh's study (2003) of social workers' involvement in Taiwan's 1999 earthquake found that social workers have important roles and functions in both rescue and recovery stages, particularly in linking the victims' needs to available resources. Yueh (2003) concluded that social worker functions in disaster aid include supporting individuals and families, linking individuals' needs and resources and helping the clients to access resources, preventing severe physical and mental problems, and preventing individuals, families, groups and communities from breaking down.

Renal disease and natural disasters

McClellan (2001) says that all facets of modern society are interdependent. No one is equipped to survive entirely on their own. People with end stage renal disease are dependent on medical technology and a constantly demanding treatment requirement, along with the need to manage fluid, diet and medications. These patients depend on a complex array of services and utilities for their existence. Natural disasters that disrupt people's ability to have dialysis when needed engenders extreme stress and as toxins build up people can become unwell and can lose their capacity to advocate for themselves.

Earthquake

On February 22nd 2011 a severe earthquake occurred in Christchurch with devastating consequences. This was well reported in the media and by the end of that day a National State of Emergency had been declared by the Government. This is an indication that the resources required to deal with the situation were greater than regular emergency services could manage. Guided by the National Civil Defence Emergency Management Plan (Ministry of Civil Defence and Emergency Management, 2009) and the National Health Emergency Plan (Ministry of Health, 2008), the National Emergency Response Team decided to transfer dialysis-dependent people out of Christchurch. The Clinical Director of the Northland DHB Renal Service involved us in conference calls on 23rd February to discuss hosting several haemodialysis-dependent evacuees in Whangarei and we were given the task of providing social work intervention to this group of evacuees.

Planning and preparation

We understood that working with a group of evacuated renal patients from Christchurch would be very different to our usual practice. These patients and their support people did not choose to come to Northland. They were used to dialysing at home and the evacuation was not because of a change in their medical condition but because the treatment they needed was no longer available in Christchurch. A substantial need for non-medical support could be expected. It was not a situation anyone had any personal experience with and as social workers we trusted that our social work knowledge, experience and our 'kete' (basket) of skills would guide us to provide the appropriate social work support that these people needed.

It was our social work role to decide what immediate non-clinical issues might need to be addressed on their arrival. We had little knowledge of what state the evacuees would be in when they arrived or what they were able to bring with them and in the information vacuum decided that we could only develop a plan by 'catastrophising' – imagining the worst case scenario. This led to an assessment, which was based on the images coming out of Christchurch as shown on national TV, that people might arrive without any of the normally accepted accoutrements to modern life. To immediately meet their needs would require significant goodwill and support from the community and generous support from the Northland DHB.

There was initial reluctance from the local Renal Service Managers and Northland DHB to us approaching the community. Using knowledge from Jim Ife (2002) who talks about professionals thinking they are experts, but communities themselves having specialist knowledge and ways of doing things that work, we were able to explain that communities need to be needed. Having been saturated with images of the disaster, New Zealanders would be feeling empathy and helpless and would want to do something useful. We explained that the wider Northland community would want to engage in disaster relief and we were given the go-ahead to contact local businesses and voluntary organisations. By the end of the day, the Whangarei community had provided sufficient resources for each evacuee's immediate needs on arrival and not one of the suppliers was offered or sought payment. Modest but suitable accommodation had been arranged for each evacuee, which was funded under national emergency provisions.

While we were preparing for their arrival, the evacuees had been flown by the Air Force to Auckland where our Counties Manukau renal team colleagues met them, provided a rapid medical assessment, a dialysis session and rest. They were then loaded onto a bus to travel to Whangarei.

Arrival of the evacuees

On Friday 24th February 2011, late in the afternoon, the bus pulled up at the front door of Whangarei Hospital. The door opened and one of us boarded the bus to greet the weary travellers. After welcoming them to Whangarei, a tired wee voice replied 'We thought we were being sent to the end of the earth'. A promise was made that the ground did not shake at this end of the earth. General laughter followed as colleagues arrived to assist with unloading tired, weary travellers and their bits and pieces to the relative safety and privacy of the renal unit.

Social work interventions

Social work interventions on that first day were focused on the provision of food and shelter and meeting the most immediate needs, such as ensuring that people with mobility issues had the equipment they needed. Most of the evacuees were not quite as badly off for resources as we had imagined but they were in a state of shock. We visited everyone personally at their motels to help them settle in, assist them to make contact with loved ones, and supply information about what to expect during the following days. Once these most immediate needs were met, people were able to take back a little control over their lives.

The next day, we set to work to strengthen our relationships with the evacuees and we carried out an initial psychosocial assessment. This assessment was partly a data gathering exercise which included questions about family, finances or work status, cultural and spiritual needs, and partly it was an assessment of their coping abilities and psychological state. The following paragraphs will deal with the main issues that directed our social work response during the five-week period that followed.

Emotional and psychological stress

Living through an earthquake, being evacuated and having to leave loved ones, homes and belongings caused a huge amount of stress. Milligan and McGuinness (2009) explain how a disaster may bring on symptoms of mental distress such as insomnia, anger and anxiety, and how these symptoms are normal consequences in the aftermath of a disaster. Working with the Christchurch evacuees, we observed all of these reactions. Some evacuees initially showed great resilience but found it more difficult to cope the longer they remained in Whangarei. In others, we could see their coping abilities grow as time went on. Some of the evacuees had been through horrific experiences in Christchurch or felt huge anxiety about the people they had left behind. No one knew how long the evacuees would have to stay in Whangarei before they could go home and for some the moment when they were allowed to go home could not come soon enough, while others were dreading their return to a broken Christchurch.

A study of evacuees following Hurricane Katrina in the USA describes how compared to the general population, evacuees are more likely to report feeling nervous, restless, worthless or hopeless (Mortensen, Wilson and Ho, 2009). McClellan (2001) describes how, as well as all

the concerns that people have during a natural disaster, renal patients have the additional worry about their critical need for treatment. A tour through the Whangarei dialysis unit immediately after their arrival had helped to alleviate some of those added worries. To support the evacuees who appeared to be in need of in-depth therapeutic intervention, sessions with one of the hospital psychologists were available and access to counselling support in the community was arranged through the primary health organisation.

As renal social workers we listened to the evacuees' stories and concerns and gave them an opportunity to vent their feelings. Brammer (1993, cited in Javadian, 2007) explains how retelling stories and descriptions of disasters can help alleviate or prevent stress and post traumatic stress disorder. In addition, we identified what contributed to their stress and what could relieve it. For example, some of the evacuees felt a strong need to see the almost continuous stream of news and pictures coming out of Christchurch, while others wanted to escape from these vivid images and sounds. On the dialysis unit, we worked with the nurses to ensure that everyone was positioned so that TV access met their individual needs.

McClellan (2001) describes how dialysis patients can fare very well as long as an established routine is maintained. West (2006) explains how one of the most helpful steps in the healing process is to re-establish a normal routine after a traumatic experience because it can bring about a sense of control during times of chaos. Having to come to hospital three times a week for dialysis treatment helped establish some routine. We observed how stress levels of the dialysis patients appeared high at the beginning of their stay and seemed to ease once they had developed trust in our dialysis service, while stress levels of the partners who had come with them seemed to increase the longer they were separated from their families in Christchurch. An explanation for this could be that attending their dialysis treatment helped the dialysis-dependent evacuees to regain a routine.

Some of the evacuees described feelings akin to survivor's guilt. This manifested itself by expressions of feeling guilty for being looked after and having an 'easy' time as if they were on holiday while they knew their families and loved ones in Christchurch were struggling for basic necessities such as water and sanitation.

Isolation

Following their sudden departure from Christchurch, the evacuees found themselves isolated from their own natural support systems. Steinglass and Gerrity (1990, cited in Mills, Edmondson and Park, 2007) suggest that negative effects of forced relocations are largely due to loss of social ties and support systems.

Many of the evacuees had left partners, children and family in Christchurch. Others had family elsewhere in New Zealand or on the other side of the world and it quickly became clear how important it was for the evacuees to stay in close contact with their nearest and dearest. The Northland DHB Information Technology department had provided the evacuees with a cell phone each with unlimited free calling within New Zealand. This was later identified by the evacuees as one of the most useful things done for them. The hospital had also provided a laptop with internet access which proved invaluable as a communication method for those with young adult children.

Some of the evacuees were accompanied by their partner, who found themselves in a situation where they had to abandon their homes, work, families and commitments because of the needs of their loved one evacuated to Whangarei. Their role was limited to being a support person. At home they may have been used to assisting with the dialysis treatment, whereas here in Whangarei it had been decided for reasons of clinical safety that the dialysis nurses would perform those tasks. As social workers, we were clear that the support people were as important as the renal patients and we visited them at their motel units, provided a listening ear and offered practical support.

During our initial assessment many evacuees expressed a desire to meet with people with whom they shared a similar religious, spiritual or ethnic background and we used our existing community networks to link evacuees to relevant churches and ethnic groups. Where this was not possible, the laptop with internet access enabled people to stay in touch with their own culture by listening to programmes and music of their own origin.

Financial resources

Forced evacuation has the potential to affect people's income and finances. Income and social status are key determinants to health (Weld, 2010). Mills, Edmondson and Park (2007, p.121) state that 'individuals with limited financial resources or existing health problems are some of society's most vulnerable in a disaster situation, both in terms of initial exposure and ability to recoup'. Mortensen, Wilson and Ho (2009) describe how employment and income are socio-economic characteristics closely tied to wellbeing and how they were affected by Hurricane Katrina.

Providing patients with information regarding their eligibility to financial assistance is an important part of our job as renal social workers in Northland and we regularly witness the negative effects of financial difficulties on health and well being. As a token of support and to prevent financial hardship during their first weekend in Whangarei, our hospital board had made a grant available for each evacuee of \$100. In our brokerage role, we had negotiated for WINZ case managers to visit the evacuees on Saturday, the day after their arrival, and they saw to it that Civil Defence applications were dealt with promptly. In addition, we facilitated applications to the Red Cross for hardship grants.

With these measures in place, it seemed we had relieved most of the immediate financial stress. The focus of the evacuees appeared to be short term. The long-term financial implications of the earthquake were unknown and so incomprehensible that the evacuees did not identify them as a source of stress in those first five weeks following the earthquake.

Reflections

Resilience

Saleebey (2002) identifies resilience as the ability to bend in adversity and once bent, to be able to spring back. This is similar to a model being developed by the New Zealand Resilience Trust (Ministry of Civil Defence and Emergency Management, 2008). As renal social workers, we work with our Northland dialysis community to ensure that they will be able to survive in weather-related disasters and our work with the evacuees was enhanced by our confidence that they too could bend and spring back. We understood that we would need to meet some critical immediate needs but we observed how with appropriate resources

and support, their resilience developed individually, and as a group as their natural leaders emerged. Many of the evacuees were able to make the most of the situation they found themselves in and accepted some of the many generous offers of recreational activities without letting go of their focus on a return to Christchurch.

Group dynamics

The group of Christchurch evacuees was very diverse and included different ethnicities, people in different stages of life, of different socio-economic and educational backgrounds, some with their partner but many on their own, with different coping abilities, different levels of mobility and also at different stages in their dialysis journey. We soon discovered that it was not a united group but more a gathering of people who had never met before and the only things they had in common were the earthquake and the fact that they or their partner depended on dialysis treatment to stay alive.

West (2006) describes how peer support is an effective approach to addressing trauma and one that can provide safety, understanding and connection. We observed how the evacuees bonded with each other through their common experience and how they changed from a group of individuals to a cohesive group that was able to support each other through this difficult time. The Christchurch evacuees identified dialysing with each other and seeing how other people managed with the demands and difficulties of forced evacuation and dialysis, and the realisation that they were not the only ones going through this, as supportive and inspiring. After their return to Christchurch, the evacuees made the decision to continue contact with each other.

Role of the renal social worker with the evacuees

Working with the Christchurch evacuees was very different to the way we usually work with our Northland renal clients. McClellan (2001) describes how active self-management of renal disease and an established routine are vital to dialysis patients for living long and well. This is reflected in the way we usually work with renal patients, using empowerment and strengths based models while focusing on development of self-management and long-term goals.

During the early part of their forced relocation, the Christchurch evacuees were in need of practical support and an opportunity to talk. Once the initial shock had passed and the time came closer for the evacuees to return to Christchurch, their focus changed to plans or concerns about the future and their return to Christchurch. While we did not have time to think about social work theories and models at the time, on reflection we used crisis intervention and task-centred models at first and changed to a strengths based approach as time passed and the needs of the evacuees changed.

Our social work interventions with the Christchurch evacuees consisted of all of the functions and roles that social workers have after disasters as described by Yueh (2003). We supported the evacuees by our presence and helped them to identify solutions to problems, we linked people with resources, we listened to people's stories and provided them with an opportunity to vent their feelings, and we helped people stay in touch with their families and communities.

Managing media and community boundaries

While it was our role to link the evacuees with available resources and organisations, we also had a role to protect their privacy as described in the Northland DHB Privacy/Confi-

dentiality Statutes and Regulations (2009). Most New Zealanders, including the people of Whangarei, wanted to help the people of Christchurch. It was important that the eagerness to help did not result in the evacuees feeling as if they were in a fishbowl with people looking in. Together with the motel operators we managed to keep the addresses where the evacuees were staying out of the local press. However this resulted in many requests to the renal service from the general population, dignitaries as well as health professionals who wanted to meet with and offer their support to the Christchurch evacuees. Where we could, we filtered these requests and acted as an intermediary to facilitate visits to the dialysis unit in those cases where the evacuees had agreed.

Self care

As well as supporting the Christchurch evacuees, we also had a responsibility for ourselves (Aotearoa New Zealand Association of Social Workers, 2008). Professionals are more effective in providing care, encouragement and services when they have cared for themselves (McClellan, 2001). It proved vital that as social workers we developed self-care plans as soon as we realised dialysis patients from Christchurch would be sent to Northland and our workload would increase. Self-care plans that included increased clinical and peer supervision, contingencies for the care of our own families, and time for relaxation proved effective to ensuring energy levels could be maintained and minds remained clear and focused.

In addition, we liaised with our service manager and colleagues about how to deal with our usual busy workload. The renal service is an outpatient chronic care service which has the advantage that all staff are familiar with the patients and their families and that there is not usually the time pressure that acute inpatient services experience. This made it easier for nurses to assess, prioritise or deal with issues that usually would have been referred to the renal social worker. During the five week period that the Christchurch evacuees were in Northland, our own renal patients received a minimalist social work service. It is a reflection of everyone's desire to support the people of Christchurch that this was accepted by our clinical team colleagues and patients without any objections.

Conclusion

In this article we have looked at planning, preparation and social work intervention with a group of dialysis-dependent renal patients temporarily evacuated from Christchurch following the February 2011 earthquake which severely damaged that city's infrastructure. Upon reflection, we note that the work we undertook was consistent with the social work roles and functions following disasters as described in the literature.

We have identified that because of their training and skills, while not specific to disaster work, social workers are well prepared to assist vulnerable populations in disaster situations. We note that social workers are skilled at co-working, networking, brokerage, listening and individual and group advocacy.

We have identified that preparing for and planning to deal with natural disasters are appropriate social work activities. New Zealand Civil Defence also identifies these as core tasks for their organisation, with the goal of enhancing individual and community resilience. As Northland DHB renal social workers we work closely with the local Civil Defence

Management Group and have incorporated emergency planning in our regular work with our client group.

Summary of learning

Our journey with the Christchurch dialysis patients who had been evacuated to Whangarei was intense, stressful and exhausting but at the same time rewarding, interesting, exhilarating and full of learning, for example:

- We discovered that the title social worker matters in disaster situations and can have influence when dealing with organisations and businesses.
- We learned that social workers have a unique and valuable body of knowledge and skills about disasters and communities that our clinical health professional colleagues may not have.
- We learned that we too are resilient.
- We confirmed our understanding that applying a particular model of practice does lead to certain predictable outcomes and that different models lead to different outcomes.
- We discovered that much can be achieved very quickly with goodwill and we learned to trust that people will do what they said they will do.
- We learned that as well as meeting the Northland DHB record keeping requirements, lists were very important.
- We confirmed that good supervision, family support and a sense of humour help a lot.

Recommendations

Social workers worldwide are involved in the field of disaster preparedness and disaster responsiveness and recovery. As supported by Yanay and Benjamin (2005) and Javadian (2007), we encourage social workers to enhance their unique body of knowledge and skills in this specific field of practice and to incorporate emergency preparedness and planning in their day-to-day work with all vulnerable clients to improve clients' survival chances in disasters.

Social workers can enhance survival for their clients by being individually prepared and having an up-to-date survival plan with their own family or household members, which means that in a disaster situation social workers can put that plan into action and have the time and energy to support their vulnerable clients.

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