

Mental Health Disaster Subplan

Western Australia

Authorisation

The Western Australia Mental Health Disaster Subplan (the Subplan) has been developed as a subplan to Westplan-Health and to support the Disaster Response Guide for Mental Health Services. This Subplan details procedures for managing people who require mental health intervention as a result of a disaster.

This document has been endorsed formally as the Standard Operating Procedure to be followed in the event of such a disaster.

Approved



Dr Peter Wynn Owen

A/Director

Office of Mental Health



Dr Andrew Robertson

Divisional Director Health Protection Group

Department of Health

Dated 12 April 2006

Foreword

The Subplan outlines the state and area response required to ensure that the mental health response to an emergency is coordinated and local resources can be supplemented where necessary. The Subplan highlights the responsibility of area health services to provide for an initial mental health response to a disaster occurring within their area.

Activation of this Subplan will occur at the State level by the State Mental Health Coordinator in response to any disaster that threatens the mental health of people and requires resources beyond area (including regional and metropolitan) capabilities.

It is important for all health institutions to have plans in place, which recognise the emergency management principles of prevention, preparedness, response and recovery.



Dr Peter Wynn Owen

A/Director

Office of Mental Health

February 2006

Table of Contents

Authorisation	2
Foreword	3
Amendment Certificate	4
Table of Contents	5
Distribution List	6
1.0 Introduction	7
1.1 Background	7
1.2 Aim	7
1.3 Scope	7
1.4 Objectives	8
1.5 Basic Assumptions	8
1.6 Title	8
1.7 Related Plans	8
1.8 Authority and Planning Responsibility	8
2.0 Operational Management	9
2.1 Introduction	9
2.2 Roles, Responsibilities and Authorities	9
2.3 Management Structure	13
2.4 State Activation Procedures	14
2.5 Coordination	15
Appendices	16

Distribution List

Organisation	Number of Copies
Department of Health	
Director General	1
Divisional Director, Health Protection Group	1
State Health Emergency Operations Centre	1
Areawide Medical Coordinator	1
Metropolitan Business Continuity Coordinator	1
Metropolitan Emergency Coordination Centre	1
Teaching Hospitals, Emergency Departments	1
All Private Hospitals	1
All Public Hospital Emergency Coordination Centres	1
All Mental Health Services	1

1.0 Introduction

1.1 Background

There is a very large body of literature on the relationship between disasters and other traumatic events, and mental health outcomes. Whilst it is acknowledged that research in the disaster area can be difficult to conduct, many of the existing findings are limited by a shortage of psychometrically sound studies. Methodological limitations include small sample sizes, biased convenience samples, treatment seekers or compensation seekers, and great variability in the use of measures and assessment time points. Furthermore, the vast majority of studies has focused chiefly on assessing Post Traumatic Stress Disorder (PTSD) and has ignored other more prevalent outcomes, such as depression and other anxiety disorders.

More than 90% of adults will not experience a major mental health disorder after exposure to a disaster. The majority of those that do, will experience full recovery in 12 to 24 months.

Of those people who go on to develop a disorder, acute stress disorder, PTSD, major depression, generalised anxiety disorder, substance abuse, somatisation disorders, adjustment disorder and complications of bereavement may occur. Other problems can include family violence and child or spouse abuse.

The Office of Mental Health has developed the Disaster Response Guide for Mental Health Services in order to provide information and detailed guidelines and procedures to assist mental health professionals in their response to disaster situations (*See Appendix 1*).

The mental health organisational response to disaster comes from a number of different systems and primarily comprises two broad roles. These are:

- Emergency response role - immediate response and of relatively short duration.
- Recovery response role - longer term integrative process.

The Subplan details the command and control hierarchy and the steps that should be taken when a disaster occurs.

1.2 Aim

The aim of this Subplan is to provide a basis for managing and coordinating the delivery of mental health services as necessary in the event of a disaster.

1.3 Scope

The Subplan identifies the roles and responsibilities of the Office of Mental Health, the State Mental Health Coordinator, the Deputy State Mental Health Coordinator, the Area Mental Health Directors, the Clinical Director, Psychiatric Emergency Team, the Workforce Coordinator Disaster Response and the Executive Officer Disaster Response in coordinating the delivery of mental health services in the event of a disaster.

1.4 Objectives

The objectives of this Subplan are to:

- Describe the Office of Mental Health's management structure when coordinating a mental health disaster response.
- Provide the basis for the provision and coordination of a health emergency management response during a major mental health emergency.
- Provide guidelines for the operation of the Subplan following its activation.

1.5 Basic Assumptions

The following basic assumptions have been made in the development of this Subplan:

- All mental health services have copies of the Disaster Response Guide for Mental Health Services.
- In the event of a major disaster, the basic tenets of the Westplan-Health will apply, to ensure the greatest good for the greatest number and management graduated from local or district to state level as required.

1.6 Title

The plan shall be titled the Western Australian Mental Health Disaster Subplan and abbreviated to "the Subplan".

1.7 Related Plans

Related plans that may be activated to support this Subplan are:

- Westplan-Health.
- Metropolitan Perth Business Continuity and Disaster Plan.
- Regional/District Health Disaster Plans (however titled).
- Individual Hospital Disaster Plans.
- Overseas Mass Casualty Plan.
- Medical Team Subplan.
- WA Burn Disaster Subplan.
- State Health Trauma Disaster Subplan
- Area Mental Health Disaster Plans.

1.8 Authority and Planning Responsibility

The development, implementation and revision of this Subplan is the responsibility of the Office of Mental Health, Department of Health in consultation with the Disaster Preparedness and Management Unit, Department of Health and the State Health Disaster Management Committee.

2.0 Operational Management

2.1 Introduction

Mental health can be identified as a support organisation in the event of an emergency, whether this emergency is as a result of natural causes or of human activity. Major emergencies occur with resultant risks to an individual's mental health. These may be of such magnitude that local mental health services are overwhelmed.

In the event of an emergency, the role of mental health is to provide emergency mental health assistance to those affected as a result of the emergency. The functions that mental health staff carry out are to:

- Identify persons who are at high risk of mental illness and provide appropriate emergency intervention.
- Provide assessment and organise appropriate, safe and timely interventions as required for those affected by an emergency.
- Identify and suggest coping mechanisms for persons displaying symptoms of acute stress.
- Provide assistance as needed to minimise the long-term affects of maladaptive coping responses.
- Manage and closely monitor existing clients in the affected area to ensure that they have access to adequate support from mental health services during the recovery phase.
- Be available to continually debrief and advise other agencies if and as requested.

Emergency management requires a structure to coordinate all actions needed to deal with incidents or disasters. This section outlines the roles and responsibilities of those persons implementing the Subplan.

All mental health incidents or disasters will, in the first instance, be managed within the individual area according to the area mental health disaster plans.

Escalation to the Subplan will occur:

- If the number or severity of mental health victims is deemed to be beyond the normal capabilities and responsibilities of the area mental health staff.
- In the development of a worsening situation.
- When it is necessary to coordinate resources across areas.
- When it is required that the Westplan-Health be activated.

2.2 Roles, Responsibilities and Authorities

2.2.1 Office of Mental Health

The Office of Mental Health is administered by the Director and is a statewide body. The primary objective of the Office is to ensure the development and coordination of the Subplan and the activation of the Subplan in response to an emergency.

2.2.2 State Mental Health Coordinator

The State Mental Health Coordinator is the Director, Office of Mental Health. He/she has the authority to command the coordinated use of all mental health resources within WA for response to, and recovery from, the impacts and effect of a major emergency. He/she is the first point of contact when mental health services are required to be mobilised in response to an emergency. He/she will manage mental health issues on behalf of the State Health Coordinator.

The roles/responsibilities of the State Mental Health Coordinator are to:

- Take advice and instruction from the State Health Coordinator.
- Activate/deactivate the Subplan and coordinate all activities relating to the activation of the Subplan.
- Monitor the mental health response to the major disaster.
- Chair and facilitate the activities of the Mental Health Disaster Response Sub Committee.
- Liaise with the State Health Coordinator.
- Advise on mental health related issues in the disaster.
- Liaise with the media on mental health disaster related issues as appropriate.
- Ensure the Office of Mental Health works closely with other relevant agencies and organisations in the provision of a coordinated disaster response.
- Establish the need for research in conjunction with appropriate research institutions into the services provided to victims of the disaster.
- Provide regular reports to the State Health Disaster Management Committee during and following the disaster response phase.
- Represent the public mental health sector on state and national disaster response committees or delegate responsibility for this task.
- Ensure the preparation, testing and maintenance of the Subplan.

2.2.3 Deputy State Mental Health Coordinator

The Deputy State Mental Health Coordinator is responsible to the State Mental Health Coordinator for planning and coordinating the operational control of all resources required to activate the Subplan.

The roles/responsibilities of the Deputy State Mental Health Coordinator are to:

- Identify the resources required to provide an initial mental health response to the disaster.
- Coordinate the provision of the resources to the affected area in liaison with the Area Director, Mental Health Services of the affected area.
- Liaise with the State Mental Health Coordinator and the Manager Disaster Preparedness and Management in monitoring the mental health response to the disaster.
- Ensure a process is in place for mental health services to work closely with other relevant agencies and organisations in meeting the mental health needs of those affected by the emergency.
- Ensure a process is in place for the referral of people to specialist mental health services.
- Ensure that general practitioners are provided with information about post-disaster mental health issues and that consultative processes are available including access to specialist mental health services where appropriate.
- Provide a report to the State Mental Health Coordinator on the outcomes of the response.
- In the absence of the State Mental Health Coordinator liaise with the media on disaster related issues as appropriate.
- Represent the public mental health sector on state and national disaster response committees as directed by the State Mental Health Coordinator
- Oversee the establishment of a communication strategy to keep all key stakeholders informed of the mental health response to the disaster.

2.2.4 Clinical Director Psychiatric Emergency Team

The Clinical Director Psychiatric Emergency Team is responsible to the Deputy State Mental Health Coordinator for the coordination and mobilisation of psychiatric emergency services in responding to a disaster.

The roles/responsibilities of the Clinical Director Psychiatric Emergency Team are to:

- Ensure the provision of a dedicated 24 hour triage telephone line for people experiencing distress/trauma in relation to the disaster.
- Liaise with the Deputy State Mental Health Coordinator and the Area Director Mental Health Services in ensuring that the mental health of current clients is affected as little as possible as a result of the disaster.
- Ensure the provision of a consultative service to general practitioners and welfare organisations on the need for mental health interventions and the provision of a referral process to specialist mental health services if appropriate.
- Provide regular reports to the Deputy State Mental Health Coordinator on the number of contacts and presenting problems when a disaster occurs.
- Liaise with the Workforce Coordinator Disaster Response to ensure the maintenance of a database of mental health clinicians, including private practitioners, who are trained in providing psychosocial interventions in the event of a disaster.

2.2.5 Area Director Mental Health Services

The Area Director Mental Health Services is responsible to the Deputy State Mental Health Coordinator for the coordination of local area mental health services (in the metropolitan or rural and remote areas) in responding to a disaster.

The roles/responsibilities of the Area Director Mental Health Services are to:

- Activate area mental health disaster plans.
- Ensure that local area mental health services are able to provide the necessary resources to respond to the disaster.
- Establish a communication strategy for ensuring that area mental health services are regularly briefed on the current status during a disaster.
- Establish an Information Centre, this may be in conjunction with other agencies, for community members with mental health needs.
- Ensure that area mental health services work closely with local health and welfare services in responding to the disaster.
- Ensure that there are area mental health staff who have received training in disaster response counselling.
- Liaise with the Deputy State Mental Health Coordinator in coordinating the provision of mental health resources to the affected area.
- Advise the Deputy State Mental Health Coordinator of the need for extra resources to meet the demand of those affected by the disaster.

2.2.6 Workforce Coordinator Disaster Response

The Workforce Coordinator Disaster Response is responsible to the Deputy State Mental Health Coordinator for the coordination of the mental health workforce in responding to a disaster.

The roles/responsibilities of the Workforce Coordinator Disaster Response are to:

- Liaise with the Clinical Director Psychiatric Emergency Team to ensure the maintenance of a database of mental health clinicians, including private practitioners, who are trained in providing psychosocial interventions in the event of a disaster.
- Coordinate training on the provision of psychosocial interventions for mental health practitioners utilising recognised experts in the field.
- Develop a process for an ongoing, sustainable program of training and accreditation in level 2 competency as identified in the WA Interdepartmental Personal Support Disaster Counselling Model (*See Appendix 2*).
- Represent the public mental health sector on state and national disaster response committees focussing on workforce development.
- Provide expert advice to Deputy State Mental Health Coordinator on the mental health workforce needs for effective disaster response.

2.2.7 Executive Officer Disaster Response

The Executive Officer Disaster Response has the Disaster Management portfolio in the Office of Mental Health and maintains an awareness of disaster management initiatives occurring statewide and nationally. He/she is responsible to the Deputy State Mental Health Coordinator for providing executive support to the committees involved in the coordination of mental health activities in responding to a disaster.

The roles/responsibilities of the Executive Officer Disaster Response are to:

- Maintain an up to date awareness of disaster management initiatives statewide and nationally.
- Work closely with key government agencies and welfare organisations to facilitate a coordinated approach to disaster management.
- Assist the Workforce Coordinator Disaster Response to coordinate training on the provision of psychosocial interventions for mental health practitioners.
- Provide secretariat support to the Mental Health Disaster Response Subcommittee including the preparation and distribution of agendas and records of each meeting, undertaking research and following up on matters arising from the meetings and communication with members on relevant matters relating to the business and conduct of the meetings.
- Represent the public mental health sector on state government committees as directed by the Deputy State Mental Health Coordinator.

2.3 Management Structure

2.3.1 Control, Coordination and Communication

This Subplan will be activated by the State Mental Health Coordinator who has overall responsibility for the control and coordination of the mental health emergency response and is the first point of contact for queries in relation to mental health emergencies and requests to activate this Plan. The organisational structure is outlined at *Appendix 3*.

The State Mental Health Coordinator is supported within the Department of Health by the Deputy State Mental Health Coordinator. The Deputy State Mental Health Coordinator is responsible for planning and coordinating the operational control of all resources required to activate the Subplan.

The Deputy State Mental Health Coordinator is supported by the Area Director, Mental Health Services, the Workforce Coordinator Disaster Response, the Clinical Director Psychiatric Emergency Team, and the Executive Officer Disaster Response. He/she will liaise closely with the Manager, Disaster Preparedness and Management in the disaster response phase.

The Area Director Mental Health Services is supported by the managers of the mental health services. The services are responsible for maintaining their individual disaster plans and ensuring they are congruent with the Area Mental Health Disaster Plan.

2.3.2 Mental Health Disaster Response Subcommittee (the Subcommittee)

Purpose - The purpose of the Subcommittee is to ensure that mental health staff have the ability to coordinate and monitor the mental health disaster response on a Statewide basis. This will include but is not limited to:

- Appropriate staff training.
- Appropriate response plans in place.
- Close liaison with other State Disaster response groups such as the Department for Community Development.

Accountability - The Subcommittee reports to the State Health Disaster Management Committee.

Responsibilities - The Subcommittee shall:

- Coordinate and monitor mental health disaster planning on a Statewide basis.
- Develop and update the WA Mental Health Disaster Response Subplan that will outline the process for the State Mental Health Service response to a disaster.
- Facilitate specialist training in disaster management/emergency counselling for mental health staff Statewide.
- Develop and maintain a Statewide database of mental health staff with expertise in disaster management/emergency counselling.
- Work closely with the Department of Health and other State Disaster Response Groups in the development of Disaster Response Plans
- Work closely with all States and Territories in the development of a National Mental Health Disaster Response Plan.
- Evaluate the mental health service response to future disasters.
- Report to the State Health Disaster Management Committee.

Membership - The Subcommittee, as outlined in *Appendix 4*, will consist of members appointed by the State Mental Health Coordinator.

2.4 State Activation Procedures

The activation procedures detailed hereunder relate to state level mental health arrangements. Similar procedures should be developed and followed at the metropolitan and regional level.

The Subplan may need to be activated:

- If the number or severity of mental health victims is deemed to be beyond the normal capabilities and responsibilities of the area mental health staff.
- In the development of a worsening situation.
- When it is necessary to coordinate resources across areas.
- When it is required that Westplan Health be activated.

Once the decision is made to activate the Subplan, the State Mental Health Coordinator shall activate and manage the Subplan accordingly.

2.4.1 Stages of Activation

The Subplan will normally be activated in stages. In an impact event, these stages may be condensed with stages being activated concurrently.

Stage 1 Alert (Code White) - Stage 1 is activated when advice of an impending emergency is received or when, following the occurrence of an event, it is unclear as to whether a Mental Health response is needed. During this stage, the situation is monitored to determine the likelihood and nature of the Mental Health response. The following actions are undertaken:

- The State Mental Health Coordinator to liaise with the Deputy State Mental Health Coordinator to determine the extent of the response required.
- The State Mental Health Coordinator to advise members of the Mental Health Disaster Response Subcommittee of the impending emergency.
- The Deputy State Mental Health Coordinator to liaise with the Area Director Mental Health Services and the Clinical Director, Psychiatric Emergency Team to determine what response is required.

Stage 2 Standby (Code Yellow) - Stage 2 is activated when information received is sufficient to warrant preparatory activities in readiness for a response. The following actions are undertaken:

- The Mental Health Disaster Response Subcommittee to meet to consider the situation and determine a strategy.
- The Clinical Director Psychiatric Emergency Team to ensure the process for a dedicated 24 hour telephone line triage is in place.
- The Workforce Coordinator Disaster Response to activate the database of mental health practitioners and ensure that it is current.
- The Deputy State Mental Health Coordinator to meet with the Clinical Director, Psychiatric Emergency Team and the Area Director Mental Health Services to identify the resources required to provide an initial mental health response to the disaster.
- The Deputy State Mental Health Coordinator to contact other relevant agencies and organisations to develop a process for close collaboration in meeting the mental health needs of those affected by the emergency.

Stage 3 Response (Code Red) - Stage 3 is activated when a mental health emergency response is required and resources are deployed accordingly. The primary action would be to implement the strategy developed at Stage 2 by the Mental Health Disaster Response Subcommittee. This would include:

- Advising those practitioners on the database of the possible need for their services.
- Establishing a communication strategy to keep all key stakeholders informed of the mental health response to the disaster.
- The Deputy State Mental Health Coordinator coordinating the provision of the resources to the affected area in liaison with the Area Director, Mental Health Services of the affected area.
- Providing general practitioners with information about mental health issues post-disaster and the availability of a consultative process including access to specialist mental health services where appropriate.
- Advising the State Health Disaster Management Committee of the strategy that is being put in place.
- Contacting other relevant agencies and organisations to ensure a coordinated approach to meeting the mental health needs of those affected by the disaster.

Stage 4 Recovery (Code Green) - Stage 4 is activated when the immediate mental health response is no longer required and may include the following actions:

- Mental health staff are informed of “stand down” by the State Mental Health Coordinator.
- Arrangements for debriefings are advised.

2.4.2 Debriefing

The State Mental Health Coordinator will ensure the operational debriefing of all mental health service staff within a reasonable time following stand down and will participate in any general debriefing conducted by the Department of Health.

2.4.3 Reports

The State Mental Health Coordinator will arrange for the provision of a report relating to the mental health response to the State Health Disaster Management Committee. The report is to identify any problems or shortfalls relating to the provision of health emergency management support and any amendment that may be required to the Subplan.

2.5 Coordination

2.5.1 Public Relations and Media Coordination

Overall responsibility for the preparation of Department of Health media statements and coordination of media inquiries during an emergency event lies with the Manager, Public Affairs or nominated delegate. No mental health personnel are to make media statements without the approval of the State Health Coordinator, the State Mental Health Coordinator and the Manager, Public Affairs.

The State Public Information Emergency Management Support Plan can provide additional media relations support for the health emergency management functions if required. The State Mental Health Coordinator, with advice from the Manager Public Affairs, is responsible for determining if such assistance is needed.

2.5.2 Disaster Response Guide for Mental Health Services

The Disaster Response Guide for Mental Health Services developed by the Office of Mental Health provides guidelines and procedures to assist mental health professionals in their response to disaster situations and to minimise the impact of any disaster that threatens life or health. The Guide is attached at *Appendix 1*.

Appendix 1

Department of Health Western Australia - Disaster Response Guide for Mental Health Services

Prepared by the WA Mental Health Disaster Response Group 11th November 2004

Foreword

Mental Health Services play a vital role in the response to a natural disaster (eg. cyclone), a large scale incident (eg. a war) or an act of terrorism.

There is a significant body of scientific research that is available to guide mental health professionals as to the appropriate response at the time of the incident and post crisis. Providing the right assistance at the time of the event and identifying those individuals who may require ongoing support is critical.

This guide provides detailed information on the possible reactions of people who have been exposed to a disaster. It describes factors that help people recover and risk factors that may contribute to future mental health problems.

The aim of this guide is to provide detailed guidelines and procedures to assist mental health professionals in their response to disaster situations and to minimise the impact of any disaster that threatens life or health.

It is important for all health organisations to have plans in place to meet these challenges in recognition of the emergency management principles of prevention, preparedness, response and recovery.

The assistance and support provided by Professor Beverley Raphael, Director, New South Wales Centre for Mental Health, in the development of this guide is very much appreciated. This guide was informed by The New South Wales Disaster Mental Health Response Handbook (2000), produced by the New South Wales Centre for Mental Health and the New South Wales Institute of Psychiatry.

I also wish to extend my thanks to Dr Jon Rampono, Margaret Jones, Dr Johann Combrink and Peter O'Hara who have worked together as the WA Mental Health Disaster Working Group, to complete this guide for clinicians working in mental health services.

Dr Aaron Groves

Director, Office of Mental Health
11th November 2004

Table of Contents

Part 1 Introduction	18
1.1 Aim	18
1.2 Definition Of A Disaster	18
Part 2 Reactions To Disasters	18
2.1 Individual Reactions	18
2.2 Mental Health Outcomes	18
2.3 Preparation & Training	18
2.4 Risk Factors	20
2.5 Protective Factors	20
2.6 Special Populations	21
2.7 Prevention	21
Part 3 Operational Management	22
3.1 Immediate Response	22
3.2 Triage	22
3.3 Initial Screening And Assessment For Risk Of Post Disaster Problems	22
3.4 Response Process	23
3.5 Referral To Specialist Services	26
3.6 Dealing With The Media	28
References	29
Appendix 1	30
Disaster Mental Health Intake Form 159	30
Appendix 2	32
Peritraumatic Dissociative Experience Outcome (Pdeq)	32
Impact Of Event Scale (Ies)	32
Impact Of Event Scale-revised	32
Appendix 3	34
Timeline Of Mental Health Interventions Post Disaster	34

Part 1 Introduction

1.1 Aim

The aim of this guide is to provide information and detailed guidelines and procedures to assist mental health professionals in their response to disaster situations.

1.2 Definition of a Disaster

An unforeseen and often sudden event that causes great damage, destruction and human suffering. Though often caused by nature, disasters can have human origins. Wars and civil disturbances that destroy homelands and displace people are included among the causes of disasters. Other causes can be; building collapse, blizzard, drought, epidemic, earthquake, terrorism, explosion, fire, flood, hazardous material or transportation incident (such as a chemical spill), hurricane, nuclear incident, tornado or volcano.

Part 2 Reactions to Disasters

2.1 Individual Reactions

For the great majority of survivors of a disaster, reactions will be transient, meaning a normal response to an abnormal event. In some people, resilience and positive outcomes have emerged. According to Ursano et al (1996), a benefited response has been reported in the combat trauma literature.

Table 1 summarises common stress reactions seen in individuals after disasters.

2.2 Mental Health Outcomes

There is a very large body of literature on the relationship between disasters and other traumatic events, and mental health outcomes. Whilst it is acknowledged that research in the disaster area can be difficult to conduct, many of the existing findings are limited by a shortage of psychometrically sound studies. Methodological limitations include, small sample sizes, biased convenience samples, treatment seekers or compensation seekers and great variability in the use of measures and assessment time points. Furthermore, the vast majority of studies has focused chiefly on assessing Post Traumatic Stress Disorder (PTSD) and has ignored other more prevalent outcomes such as depression and other anxiety disorders. Thus, it is important to bear in mind that the findings described in these sections of the guide may be limited by methodological concerns.

It is necessary to state here that more than 90% of adults will not experience a major mental health disorder after exposure to a disaster. The majority of those that do, experience full recovery in 12 to 24 months (Freedy & Kilpatrick, 1994).

Of those people who go on to develop a disorder, these may include, acute stress disorder, PTSD, major depression, generalised anxiety disorder, substance abuse, somatisation disorders, adjustment disorder and complications of bereavement. Other problems could include family violence and child or spouse abuse.

2.3 Preparation & Training

All mental health personnel involved in disaster mental health response must be familiar with their local, state and national policies and procedural plans, have an understanding of the range of psychosocial responses and appropriate interventions and have knowledge of the roles of other agencies.

McFarlane (1995) has shown that training is a predictor of post disaster adjustments. Including the mental health response in disaster training is relevant for all workers (Emergency Management Australia, 1999). It is vital that staff are well trained to function in difficult situations and are clear about both their roles and the likelihood of being exposed to disturbing sights and experiences.

Table 1: Common Stress Reactions

Emotional Effects	Cognitive Effects
Shock	Impaired concentration
Anger	Impaired decision-making ability
Anxiety, fear	Memory impairment
Despair	Disbelief
Emotional numbing	Confusion
Terror	Distortion of sense of time
Guilt (about living when others have died)	Decreased self-esteem
Grief or sadness	Decreased self-efficacy
Irritability	Self-blame
Helplessness and loss of control	Intrusive thoughts and memories
Feelings of insignificance	Worry
Loss of derived pleasure from regular activities	Dissociation (eg. person feels they are in 'dreamlike' state, 'spacey' or on 'automatic pilot')
Physical Effects	Interpersonal Effects
Fatigue	Alienation
Insomnia	Social withdrawal
Sleep disturbance	Increased conflict within relationships
Hyper arousal	Impairment in capacity to work
Somatic complaints	School impairment
Headaches	Increased affiliate behaviours
Gastrointestinal 'problems'	Adapted from Young et al (1998)
Decreased appetite	
Decreased or increased libido	
Startle response	

Most Australian communities have little pre-disaster training and preparation for what to do, should a disaster occur. Mental health support services should be available in readily accessible places in the community, or through outreach programs. Training can be used to limit exposure, alter the type of exposure, decrease surprise and the unexpected, and maximise the sense of mastery and hope.

Training is more likely to be available for disaster workers than general community members. Nevertheless, the more knowledge available to people beforehand about what to expect and what to do, the less likely it is they will be severely traumatised by their experience.

2.4 Risk Factors

The risk factor most frequently shown to be associated with negative outcomes following disaster events is the *severity of the exposure* to the event (extent of life threat, loss, and injury). The greater the sensory exposure ie. the more one sees distressing sights, smells distressing odours, hears distressing sounds, or is psychically injured, the more likely PTSD will manifest (Holloway and Fullerton, 1994).

Certain types of exposure place survivors at high risk for a range of post disaster problems:

- Exposure to mass destruction or death
- Toxic contamination
- Sudden or violent death of a loved one
- Loss of home or community.

Other risk factors described in the literature include:

Gender - Studies on the relationship between gender and the outcome following disaster have been mixed, although when differences are found more symptoms are usually reported in women and girls. This bias, however towards a female gender, may be a function of the symptoms and disorders studied by researchers.

Age - A study in the United States of America (USA) showed that younger adults exhibited the most distress in the absence of disaster but middle age people did so in its presence. Children are particularly high risk during time of disaster (Ursano et al, 1995).

Relationship Status - Married women or single parents may be more vulnerable to disaster effects, possibly because they are relied on to support others, creating additional burdens. Single parents are at higher risk for losing access to emotional support following a disaster, and access to such support at a moderate level seems to mediate the stress.

Post disaster stress - Exposure to post disaster and major life stress such as community and personal disruptions, marital stress or divorce, job loss and financial losses has also been associated with adjustment problems.

Pre existing psychopathology - Pre-existing psychological problems have been shown to predict disaster-related distress in a number of studies. Several factors present in the acute-phase recovery environment have been found to aggravate stress reactions and therefore increase survivors' risk of developing negative outcomes (Emergency Management Australia, 1999). These include:

- lack of emotional and social support;
- presence of other stressors such as fatigue, cold, hunger, fear, uncertainty, loss, dislocation, and other psychologically stressful experiences;
- difficulties at the scene;
- lack of information about the nature and reasons for the event;
- lack of, or interference with, self-determination and self-management;
- treatment in an authoritarian or impersonal manner; and
- lack of follow-up support in the weeks following the exposure.

2.5 Protective Factors

Protective factors that may mitigate negative effects include:

- social support;
- higher income and education;

- successful mastery of past disasters and traumatic events;
- limitation or reduction of exposure to any of the aggravating factors listed above;
- provision of information about expectations and availability of recovery services;
- care, concern and understanding on the part of the recovery services personnel; and
- provision of regular and appropriate information concerning the emergency and reasons for action

(Emergency Management Australia, 1999).

2.6 Special Populations

Children & adolescents

The responses of infants, children and adolescents to disaster is a relatively neglected area and many of the studies that have been conducted are limited by their focus on prevalence of posttraumatic stress syndromes. More general findings indicate that the effects of disaster will vary according to the developmental stage of the infant or child. This is in addition to the particular characteristics of the event, the stressors to which the child is exposed, the responses of parents or other carer, and the capacity of the social environment to support the child.

Older adults

Older adults are often seen by our society as people who have lived their lives, managed 'all-right' and therefore able to 'handle' disasters better than the rest of society. In fact, clinical experience and some limited research have shown that older adults are among the top three high-risk populations for disaster interventions.

The impact of disaster-related losses has shown that a higher incidence of personal loss, injury and death are experienced by older adults. In addition, existing problems with sight, hearing and mobility all place older adults at higher risk for physical injury. Research has also shown that older adults are less likely to evacuate, less likely to heed warnings, less likely to acknowledge hazards and dangerous situations, and are much slower to respond to the full impact of losses.

Indigenous peoples

Indigenous peoples may be adversely affected by disasters because their communities are often suffering with marginal status, poor physical health and housing, problems of cultural loss and ongoing trauma and grief.

Refugee and migrant populations

The few studies conducted in this area seem to suggest that a catastrophic event such as a natural disaster may have a more pronounced effect on the mental health of refugees and asylum seekers who have experienced previous traumatic events.

Some of the factors which may exacerbate this effect include limited social support, limited English language skills, inadequate information about disaster response, anxiety about loss of treasured mementos from the old country, and anxiety about loss of documentation about their status in Australia.

People of diverse cultural backgrounds

Cultural factors may also be powerful in determining the reaction of the affected person and the response of others. There may be cultural rituals that deal with the aftermath of disaster and are healing. Specific rituals and social traditions associated with grief need to be understood and supported.

2.7 Prevention

The aim of all management should be the humane, competent and compassionate care of those affected, with the goal of preventing adverse outcomes for health and enhancing the well-being of individuals and communities. Factors that may help facilitate positive outcomes include recognising and reinforcing people's strengths; provision of clear, accurate information and education; reinforcing supportive networks; and supporting and developing community strengths and processes.

Part 3 Operational Management

3.1 Immediate Response

- In all settings of intervention the overriding requirement is *FIRST DO NO HARM*.
- In times of disaster, mental health professionals providing acute assessment and intervention may need to do so alongside emergency support and assistance in the recovery process. (See *APPENDIX 1*)
- The provision of practical help may be seen as more helpful and positive than the specific psychological care offered. The initial interventions following disaster must focus on the establishment of safety, the provision of food and water, and protection from the environment.

3.2 Triage

As noted in previous sections, serious problems may arise for some people after a disaster, especially if there have been particularly horrific experiences. Human-made disasters may be more likely to lead to such difficulties, particularly if human malevolence has contributed (Raphael, 1993).

Triage is a critical event in disaster management. Triage is for those who are distressed, or otherwise acutely affected, or demonstrate a disturbed mental state. As with other first aid, ongoing heightened *arousal* which does not settle, ongoing disturbed or abnormal *behaviour* and ongoing *cognitive* impairments, such as continuing dissociation, or impact on concentration or memory, would all call for triage. This process can link those affected into either support or protection if still on site, or if appropriate, to emergency medical/mental health care. It can also ensure that those likely to be at higher risk are provided with necessary intervention or care and linked to *follow-up* (Emergency Management Australia, 1999).

Triage needs to take into account psychological, psychiatric and neuropsychiatric effects, including anxiety, depression, organic brain effects, panic, delirium, cognitive impairments, and their potential sources. While this differentiation can be difficult, confusion about time or place, presence of hallucinations, extreme levels of fear and arousal all suggest potential acute organic effects (Di Giovanni, 1999).

The initial contact and assessment must encompass a compassionate and human response, the ensuring of safety and survival and the assessment and management of any physical injury or threat to life. Experience suggests that following most traumatic events, very few individuals require immediate treatment because of the severity of their behavioural decompensation.

An individual may or may not be in a state in which he or she wishes, or is prepared, to discuss what has happened. Nevertheless, some gentle querying may, if appropriate, be utilised for a 'therapeutic assessment' to identify whether a traumatised person who is showing arousal, cognitive or behavioural disturbance needs emergency mental health care.

3.3 Initial Screening and Assessment for Risk of Post Disaster Problems

For the majority of disaster affected persons early assessment and intervention will be unnecessary as even those showing psychological symptoms may spontaneously recover. Most of this recovery takes place during the first 3 months.

Mental health professionals involved in disaster management must be aware of issues such as the importance of timing of an assessment, and the impact that the assessment process may have on individuals. Documentation and registration are also important activities of disaster response.

A large range of instruments have been developed to assist in the initial screening process. A standardised intake form should be used. The Impact of Events Scale (Horowitz et al, 1979) and the Peritraumatic Dissociative Experiences Questionnaire (Marmar et al, 1994) would be recommended for the initial assessment of survivors of disasters. (See *APPENDIX 2*)

Identification of strengths

Many people show resilience and adaptation following disaster. The majority of disaster-affected individuals cope and get back to their lives quickly and usually make full psychosocial recovery.

Identification of risk factors

It will be important to identify those who are at greater risk of developing post-disaster problems. Some of the risk factors include life threat, loss of loved ones, severity of exposure to disaster eg. witnessing of grotesque forms of death, reactions of children, high intensity of initial response and dissociation.

Screening for psychopathology

Various screening measures and assessment tools are described and reviewed in this section of the guide. The mental health outcomes most commonly reported in the existing literature are also reviewed.

These include acute stress disorder, posttraumatic stress disorder, bereavement complications, depression and general health issues. Brief screening processes are recommended.

3.4 Response Process

Psychological First Aid

The primary helping response at this time for all workers should be psychological first aid. This aims, like other first aid, to sustain life, promote safety and survival, comfort and reassure and provide protection. It does not involve probing those affected for their reaction but rather provides a calm, caring and supportive environment to set the scene for psychological recovery (Raphael, 1993).

Table 1: The ABC of psychological first aid

Arousal
This involves reducing very high arousal, comforting and consoling distressed survivors, facilitating reunion with loved ones, protecting from further threat, and ensuring physical necessities.
Behaviour
The person showing behavioural disturbances should be protected from harm resulting from these, and linked to systems of support. Facilitating some sense of mastery will be important.
Cognition
Cognitive disturbances such as dissociation should be dealt with through general support, information provision and good orientation to specific reality-based tasks and sharing the reality of the experience if the person wishes to talk. Mental state assessment should include potential organic factors such as head injury or toxic effects and linking the person to ongoing systems of social support.

Components of psychological first aid

The components of psychological first aid include:

- **The basic human responses of comforting and consoling a distressed person.**

Offering human comfort and support is the most important component of psychological first aid. Being with those affected, protecting them from further harm, ensuring basic needs are met, conveying compassion and recognition for what they have been through are all very important tasks (Raphael, 1993). Shock and terror in children can be best assisted by personal contact, warmth and truthful reassuring words, particularly if parents or caregivers are extremely distressed.

- **Provision of information.**

Provision of information is critical to recovery, both in practical terms and because it can diminish levels of stress. Information giving is another critical aspect of psychological first aid. Information needs to be simple, accurate, brief, and to the point, readily understandable and available in major community languages. It should assist with the registration of those affected and provide information on the whereabouts of others as soon as this is available.

It will also provide a structure within a period that often seems confusing and chaotic. It is particularly important for advising what to do, and for those separated from family members (Raphael, 1993). There should be one main source of information and those involved in gathering and providing it should be sensitive to its psychological as well as practical significance. Information should be repeated at regular intervals and updated (Lundin, 1994). Communication of information should be clear at individual, group and community levels. It can significantly decrease anxiety, hyper-arousal and panic and focus activity appropriately.

Information about when and where to get help, both practical assistance and general support such as access to welfare or social aid is also necessary. Newsletters and regular news updates can provide focussed information to assist survivors progressively through the recovery process.

- **Protecting the person from further threat or distress as far as is possible.**

Providing a safe environment is critical. Many survivors may have experienced an overwhelming loss of safety and this needs to be restored. Reuniting individuals with family and friends is important to regaining feelings of safety. When reunion is not possible, information about family and friends should be made available, particularly if the family and friends were also in danger or affected by the trauma (Holloway & Fullerton, 1994; Osterman & Chemtob, 1999).

- **Furnishing immediate care for physical necessities, including shelter.**

Meeting the physical needs of the individual is extremely important and should be done immediately. This includes providing water and food, warmth and respite. Providing survivors with blankets and food helps reassure them that someone is concerned about them. Medical treatment should be given as needed. Other interventions may be experienced as an intrusion if the individual is exhausted, hungry, and cold. Care must be taken to assure physical needs have the first priority (Holloway & Fullerton, 1994; Osterman & Chemtob, 1999).

- **Providing goal orientation and support for specific reality-based tasks.**

Activity during the acute trauma stage can be productive or non-productive. Productive activity is oriented to the reality of the situation and involves the survivor taking an increasing and active role in his or her own return to functioning. As soon as possible disaster survivors should be encouraged to participate in simple but useful tasks (Di Giovanni, 1999).

- **Facilitating reunion with loved ones from whom the individual has been separated.**

Injured and frightened survivors should not be left alone, and parents should be reunited with their children (Di Giovanni, 1999). Ensuring the reunion of primary attachment figures may be essential to acute recovery and longer-term adaptation.

It has been shown that separations of children from parents at this time may have unwanted long-term effects, even when such separations are ostensibly provided in the best interests of the children (McFarlane, 1987a).

Children may also become distressed about the loss of pets or toys.

If separation from parents or caregivers is unavoidable this information should be prepared and explained. Separation anxieties can be mitigated by contact with trusted adults other than the parents and by retaining pets, toys, photos and transitional objects such as teddy bears and security blankets. Adults should be encouraged to explain to children that the coming events and separations are not their fault or responsibility.

- **Sharing the experience.**

Once survival and the safety of loved ones is assured, people may wish to share their experience with others, particularly those who have 'been through it' with them and also those responding. Such natural talking through of what has happened is often the beginning of a process of making meaning of the experience, a giving of testimony and ventilation of feelings. If it occurs in such natural groups or settings, eg. a shelter, it should be supported. However, it should not be expected or forced. People vary enormously in the ways they adapt to disaster, both in the immediate aftermath and subsequently. Natural talking through may be part of an adaptive process for those who have the need to do so, but having to talk in groups may be quite inappropriate for others: the timing may be wrong, or different coping styles may have greater validity.

It is important to *expect recovery* following disaster and to acknowledge a range of reactions that are a normal response to an abnormal life situation. Validation of feelings may be very important in the acute recovery phase following trauma (Holloway & Fullerton, 1994).

This is the first stage of telling the story and if dealt with in a caring and supportive manner, may help set the person on the path of psychological recovery.

While many feelings may appear at this stage - there is now much to suggest that they will settle in the following days or weeks. Intervention should only be provided when there is evidence that these feelings are not subsiding and the person appears to be at risk as a consequence. Feelings of fear, guilt, hostility and so forth may or may not be ventilated at this time, but a more specific exploration of such issues should only occur if these reflect ongoing problems.

- **Linking the person to systems of support and sources of help that will be ongoing.**

It will be important to link survivors to support systems and services that will take over after the acute phase has passed and provide follow-up and assistance to those in need.

One of the most important issues throughout all work conducted is *human dignity*. The loss of personal possessions, clothes and essential items such as glasses for example, the overwhelming dehumanisation of the disaster experience, the subsequent dependence on others for even the simple basics of everyday life may all be threats to the individual's personal dignity. Wherever possible those caring for survivors should be sensitive to these issues. Handouts of old clothes for which the survivors are expected to be grateful may be the sort of thing that highlights such vulnerability, making them feel ashamed, humiliated or even angry (Raphael, 1993).

- **Facilitating the beginning of some sense of mastery.**

Trauma survivors frequently experience a sense of helplessness and powerlessness. Survivors of human-made trauma may feel particularly valueless and debased. It is critical to provide an opportunity for the survivor to regain a sense of self-esteem and control over their life. Assumptions about personal invulnerability, the existence of a meaningful world and positive self-perception may have been shattered (Holloway & Fullerton, 1994).

The recovery environment should provide support, protection, containment, and structure and must avoid the further stigmatisation of converting disaster survivors into 'patients' or 'permanent' victims. Stigmatisation isolates survivors at the time when they most need social support (Holloway & Fullerton, 1994).

The recovery of children can best be facilitated by establishing an environment of security, routine, educational activities, contact with peers and opportunities for play and self-expression.

Children may have beliefs that they through their own actions (or the actions of monsters) caused the disaster and efforts should be made, primarily through caregivers and education services, to help them understand what happened and how, and that the disaster was not their fault or responsibility.

- **Identifying needs for further counselling or intervention.**

Identifying those who are particularly stressed or at risk and ensuring that they are followed up by counsellors or mental health outreach workers is another important part of psychological first aid.

Changed Work Circumstances

All disaster workers should be familiar with the principles of psychological or emotional first aid and these should be taught alongside other first aid, so that they can be applied by all those responding to traumatised individuals in an acute emergency period (Raphael et al, 1996).

In a major disaster, mental health services may be delivered on site, at hospital emergency services, and in disaster relief and application centres including shelters, community centres, schools, religious centres, work sites or essentially wherever survivors and workers are. Mental health response requires the delivery of services in ways that differ from those typically delivered by mental health professionals.

Post-disaster Worker Skills (See APPENDIX 3)

Counselling following disasters involves a different pattern of relationship and work from traditional counselling settings where those affected present themselves as people with problems needing help from professionals.

Teams should have members that have skills in helping children, the elderly, those in crisis or acutely stressed, those injured and those with ongoing physical illness and disability. Case review and supervision are important backup for staff in these settings, especially as they may themselves become stressed.

Debriefing

Debriefing means different things to different people. Operational debriefing is a routine and formal part of review of the organisational response to the disaster and the lessons learnt. It is perceived as an appropriate practice and may also be accompanied by some overall sense of meaning and a degree of closure.

Psychological or stress debriefing covers a variety of meanings and practices for which there is *little empirical evidence*, and it is strongly suggested that psychological debriefing is not an appropriate mental health intervention.

Critical incident stress debriefing (CISD) is a formalised structured method of group review of the stressful experience of a disaster. It has been developed only for emergency and formal rescue workers and may be perceived as helpful and may have some contribution if integrated with previous training, briefing, and stress management programs in an occupational health and safety framework. There is *no evidence* it prevents PTSD or other psychological morbidity and it may make some people worse.

There is no evidence that CISD is either appropriate or beneficial for broader disaster affected populations. Available evidence shows that it may in some instances add to the traumatic experiences, or possibly complicate recovery, so it should not be used. It is quite inappropriate for acutely bereaved persons.

3.5 Referral to Specialist Services

Specialist referral may be necessary in some instances and should be carried out supportively.

The problems outlined below need particular attention and subsequent referral to professional services specialising in their management. (Raphael, 1993).

- **Extreme agitation**, particularly if it leads to actions that are life threatening to the self or others.
- **Overt psychiatric disturbance** requiring care in its own right, for example, 'psychotic' decompensation where the affected person appears out of touch with reality and perhaps even responding to hallucinations or delusions. This is rare but may occur.
- **Prolonged denial of reality**. Some shutting out of what has happened is natural initially but the person who continues, for example, to talk about somebody killed in a disaster as if he or she was still alive is likely to need specialist care.
- Persons distressed by **overwhelming bouts of anxiety**, dread, or panic when the danger has long since passed. Some panic is natural in the beginning but when this does not gradually fade and lessen in intensity as the weeks and months progress, then specialised assistance is probably necessary.

- Although some **depression** is very likely in the aftermath of disaster a picture of severe depression, accompanied by hopelessness, unremitting despair and a loss of belief in any worthwhile future, indicates a severe response.
- In addition, if self-esteem is low, sleep severely impaired, there is marked weight loss and loss of interest in the world, and a general slowing-down in all activities, then a depressive illness should be suspected and specialist assistance sought urgently.
- Although **suicide** is not that common after disaster, one should be alert to the possibility that feelings of hopelessness may be associated with this level of despair. Similarly a bereaved person preoccupied with thoughts of reunion with someone who has died in the disaster should be of concern.
- **Body complaints** particularly mild, ill-defined and chronic complaints such as listlessness and headaches, often accompanied by irritability and sleep disturbance, may reflect chronic, hidden and unresolved psychological distress that requires assessment, possible psychiatric illness or a risk of developing physical ill-health.
- **Disturbed interpersonal relationships** appear as a severe and prolonged disturbance of the capacity for interpersonal relationships (for instance in family or marital breakdown, rejection or the formation of only transient relationships).
- **Post traumatic stress disorder**. This is a serious and disabling condition and often becomes chronic unless treated early in its course and with the most effective forms of treatment. People with such indicators should be referred to specialist professionals and services for assessment and care. People with PTSD are also at increased risk of other psychiatric problems such as severe depression or alcohol and other drug problems, and thus may develop a series of chronic conditions needing care.
- **Alcohol or medication abuse** may be another symptom of the person's attempts to deal with unresolved psychological distress related to the disaster experience. Many attempt to shut out or numb painful experiences in this way, but such coping devices usually only lead to further difficulties. If this cycle cannot be broken by the support being provided, specialist referral is suggested (Raphael, 1993).

General practitioners

Many people present to their local primary care health provider in the post-disaster period (Ursano et al, 1996). This may be with acute distress related to their experience, or seeking support or counselling, or perhaps something to help them sleep or 'settle down'. It is important that these 'gatekeepers' be alert to the normal responses to disaster, in order not to 'pathologise' normal recovery. More generally and in the ensuing weeks however, there are commonly presentations with general somatic complaints such as headaches, tension, tiredness and stomach upsets. Unfortunately there are few systematic studies of general health effects or help-seeking behaviour, but those that have explored these issues have found higher self-reported rates of a number of conditions (Clayer et al, 1990).

General practitioners should be aware of the potential for people experiencing the psychosocial effects of disaster to present in primary care. A careful querying may reveal the onset of symptoms and their relationship to distressing disaster exposures. It should also be noted that there may be potential for effects on physical health through impact of immune function, health related behaviours and perhaps other mechanisms.

Mental health services should provide information to general practitioners about mental health issues post-disaster, as well as ensuring consultative processes are available and where appropriate, access to specialist mental health care.

Community-based interventions

Community based interventions range from consultation with disaster and community leadership to encouragement of supportive post-disaster environments, networks of support, information and ceremonies to facilitate recovery. They may also be focussed in particular settings, eg. workplace, schools, local government areas, shelter and accommodation sites.

Liaison with other agencies

There are a number of agencies designated as welfare organisations, which will have complimentary roles in the post-disaster period. These include both government agencies (eg. Health Department), and non-government organisations (eg. Red Cross).

Establishing cross-linkages between fellow professionals who have disaster responsibilities helps ensure that appropriate physical and psychosocial resources are available when required.

Longer-term follow-up

Disaster-specific pathology can be managed with specific programs linked to community mental health services in the early months. Ongoing problems should be integrated into the regular systems of mental health care provision.

3.6 Dealing with the Media

- Communication with the public by print media and by television and radio is crucial in a disaster. There should be a policy for handling media requests for interviews with mental health professionals, whose messages must be consistent with ongoing events.
- Mental health professionals interviewed by the media have a powerful opportunity to facilitate public understanding of mental health issues and the roles of mental health workers.
- Only those staff who are authorised by the State Mental Health Coordinator are able to speak to the media.

References

- Clayer, J.R., Divakaran-Brown, C., Turner, N. & McKie, I. (1990) Suicidal thought and behaviour in an urban Australian Aboriginal population. Draft only.
- Di Giovanni, C. (1999). Domestic Terrorism with Chemical or Biological Agents: Psychiatric Aspects. *American Journal of Psychiatry*, 156, 1500-1505.
- Emergency Management Australia (1999). *Disaster Medicine-Australian Emergency Manual*. Melbourne: Author.
- Freedly, J.R. & Kilpatrick, D.G. (1994). Everything you ever wanted to know about natural disasters and mental health. *National Center for PTSD Clinical Quarterly*, 4, 6-8.
- Holloway, H.C. & Fullerton, C.S. (1994). The psychology of terror and its aftermath. In, R.J. Ursano, B.G. McCaughey and C.S. Fullerton (Eds). *Individual and Community Responses to Trauma and Disaster: The Structure of Human Chaos*. Cambridge University Press: London.
- Horowitz, M.J., Wilner, N., & Alvarez, W. (1979). The impact of event scale: A measure of subjective stress. *Psychosomatic Medicine*, 41, 209-218.
- Lundin, T. (1994). The treatment of acute trauma: posttraumatic stress disorder prevention. *Psychiatric Clinics of North America*, 17, 385-391.
- Marmar, C.R., Weiss, D.S., Schlenger, W.E., Fairbank, J.A., Jordan, K., Kulka, R.A., & Hough, R.L. (1994). Peritraumatic dissociation and posttraumatic stress in male Vietnam theatre veterans. *American Journal of Psychiatry*, 151, 902-907.
- Marmar, C.R. (1997) Trauma and dissociation. *PTSD Research Quarterly*, 8, 1-8.
- McFarlane, A.C. (1987a) Posttraumatic phenomena in a longitudinal study of children following natural disaster. *Journal of Academic Child Adolescent Psychiatry*, 26, 764-769.
- McFarlane, A.C. (1995). Stress and disaster. In, S. E. Hobfoll, & M.W de Vries (Eds). *Extreme Stress and Communities: Impact and Intervention*. London: Kluwer Academic Publishers.
- NSW Health (2000). *Disaster Mental Health Response Handbook: An educational resource for mental health professionals involved in disaster management*. NSW Health.
- Osterman, J.E. & Chemtob, C.M. (1999). Emergency intervention for acute traumatic stress. *Psychiatric Services*, 50, 739-740.
- Raphael, B. (1993) *Disaster Management*. National Health and Medical Research Council publication. Canberra: Australian Government Publishing Service.
- Raphael, B., Wilson, J., Meldrum, L., & McFarlane, A.C. (1996) Acute preventive interventions. In B.A. van der Kolk, A.C. McFarlane, & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body and society* (pp.463-479). New York: Guilford.
- Shalev, A.Y., Peri, T., Canetti, L., & Schreiber, S. (1996) Predictors of PTSD in injured trauma survivors: A prospective study. *American Journal of Psychiatry*, 153, 219-225.
- Ursano, R.J., Fullerton, C.S & Norwood, A.E. (1995). Psychiatric Dimensions of Disaster: Patient Care, Community Consultation and Preventive Medicine. *Harvard Review of Psychiatry*, 3, 196-209.
- Ursano, R.J., Grieger, T.A., & McCarroll, J. E. (1996). Prevention of Posttraumatic Stress Disorder and Identification in Disaster Workers. *American Journal of Psychiatry*, 156, 353-359.
- Weiss, D.S., & Marmar, C.R. (1997) The impact of event scale-revised. In J.P. Wilson & T.M. Keane (Eds.). *Assessing psychological trauma and PTSD* (pp.399-411). New York: Guilford.
- Young, B.H., Ford, J.D., Ruzek, J.I., Friedman, M.J & Gusman, F.D. (1998). *Disaster Mental Health Services: A Guidebook for Clinicians and Administrators*. National Centre for PTSD, Department of Veteran Affairs Employee Education System: St Louis, Mo.

Appendix 1

Disaster Mental Health Intake Form 159

INTAKE CENTRE		RECORD NO.		TIME & DATE:	
FAMILY NAME		GIVEN NAME		D.O.B.	AGE
SEX		USUAL ADDRESS		POSTCODE	PHONE
				HOME:	
				WORK:	
				MOBILE:	
CURRENT ADDRESS (if different from above)					
GP DETAILS				PHONE	
CHILDREN/DEPENDANTS OF CLIENT (names and whereabouts)					
IF CLIENT A CHILD : accompanied by <input type="checkbox"/> parent / primary carer <input type="checkbox"/> other appropriate carer (specify: _____) <input type="checkbox"/> care needs to be arranged					
NEXT OF KIN / PERSONS FOR NOTIFICATION		CONTACT DETAILS (Include Phone No)		NATURE OF RELATIONSHIP	
1.					
2.					
ETHNICITY		INTERPRETER REQUIRED		IF YES INDICATE LANGUAGE REQUIRED	
		<input type="checkbox"/> YES			
		<input type="checkbox"/> NO			
REFERRED BY		POSITION		AGENCY	
NAME					
PHONE					
INVOLVEMENT IN DISASTER: <i>Include details of any significant trauma or loss and also length of time since disaster occurred.</i>					
<input type="checkbox"/> Head injury		<input type="checkbox"/> Witness to horrific scenes			
<input type="checkbox"/> Physical injury: <i>type</i>		<input type="checkbox"/> Life threat to significant other			
<input type="checkbox"/> Exposure to environmental hazards (eg noxious fumes) <i>specify:</i>		<input type="checkbox"/> Death of significant other			
<input type="checkbox"/> Personal life threat		<input type="checkbox"/> Other significant loss (eg house, financial) <i>specify:</i>			
RELEVANT MEDICAL AND PSYCHIATRIC HISTORY: <i>Include routine medications and previous history of trauma.</i>					
Client's perception of external supports <input type="checkbox"/> good <input type="checkbox"/> poor					
PRESENTING CONDITION:			INTERVENTION		MENTAL HEALTH FOLLOW UP PLAN
AROUSAL : (high)	BEHAVIOUR : (highly disturbed)	COGNITION : (impaired)	<input type="checkbox"/> none		<input type="checkbox"/> none
<input type="checkbox"/> fearful	<input type="checkbox"/> disruptive	<input type="checkbox"/> derealization	<input type="checkbox"/> general support		<input type="checkbox"/> temporary disaster MH program
<input type="checkbox"/> irritable	<input type="checkbox"/> withdrawn	<input type="checkbox"/> confused	<input type="checkbox"/> psychological first aid		<input type="checkbox"/> general MH services
<input type="checkbox"/> restless	<input type="checkbox"/> aggressive	<input type="checkbox"/> disorientated	<input type="checkbox"/> specialised mental health treatment		<input type="checkbox"/> psychiatric admission
<input type="checkbox"/> anxious	<input type="checkbox"/> dangerous to self	<input type="checkbox"/> numbing of feelings	DISPOSITION		<input type="checkbox"/> medical review organic disorder
OTHER (<i>specify</i>)			<input type="checkbox"/> home		<input type="checkbox"/> GP
			<input type="checkbox"/> welfare / recovery centre		<input type="checkbox"/> other (<i>specify</i>):
			<input type="checkbox"/> other temporary accommodation		<input type="checkbox"/> URGENT <input type="checkbox"/> NON-URGENT
			<input type="checkbox"/> other (<i>specify</i>)		
INFORMATION TAKEN BY - NAME: _____ SIGNATURE: _____					
POSITION TITLE: _____			PHONE NO. _____		
Please use reverse of document for any further details					

Appendix 2

Peritraumatic Dissociative Experience Outcome (PDEQ)

The PDEQ (Marmar et al, 1994) was developed to index dissociated responses during the period immediately following a trauma. It consists of ten items that index depersonalisation, derealisation, and amnesia. In reviewing the studies that have used the PDEQ, Marmar (1997) concluded that the scale has acceptable internal consistency, reliability and validity. Most impressively, in a prospective study Shalev et al (1996) found that PDEQ scores 1 week after the trauma predicted symptomatology 5 months later.

Peritraumatic Dissociative Experiences Questionnaire

1. Do you ever lose track of what is going on around you. That is do you ever 'blank out', or feel 'spaced out' and don't feel part of what is going on?
2. Do you ever 'lose time'?
3. Do you ever end up doing things that you haven't actively decided to do?
4. Does your sense of time ever change, when things seem to be happening in slow motion?
5. Do you ever feel as though you are a spectator, watching what is happening to you as if you were an outsider?
6. Do you ever feel as though you are disoriented, as though you are uncertain about where you are or what time it is?

If your client endorsed the above statements it is likely that he/she experiences dissociation.

Source - Adapted from Marmar CR, Weiss DS, Metzler TJ (1997). 'The peritraumatic dissociative experiences questionnaire'. In Wilson JP et al (eds). *Assessing psychological trauma and PTSD*. NY: Guilford Press

Impact of Event Scale (IES)

The IES (Horowitz et al, 1979) has been used to index intrusive and avoidance symptoms in the acute posttraumatic phase. The IES is a 15-item inventory that comprises intrusion and avoidance scales, has been shown to correlate with PTSD and possesses sound psychometric properties. The IES is probably the most popular index of the intrusive and avoidance symptoms of PTSD. To address the omission of arousal symptoms, Weiss & Marmar (1997) developed the IES-Revised (IES-R) which added seven items pertaining to hyperarousal. Studies to date indicate that the IES-R possesses good internal consistency and test-retest reliability.

Scoring Method

Avoidance Subscale:	Mean of items 5,7,8,11,12,13,17,22
Intrusions Subscale:	Mean of items 1,2,3,6,9,14,16,20
Hyperarousal Subscale:	Mean of items 4,10,15,18,19,21
IES-R Score:	Sum of the above 3 clinical scales

For valid comparisons with scores from the IES, use just the sum of the Avoidance and Intrusion subscales.

Impact Of Event Scale-revised

Instructions: The following is a list of difficulties people sometimes have after stressful life events. Please read each item, and then indicate how distressing each difficulty has been for you during the past 7 days with respect to the disaster. How much were you distressed or bothered by these difficulties?

	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Any reminder brought back feelings about it.	0	1	2	3	4
2. I had trouble staying asleep.	0	1	2	3	4
3. Other things kept making me think about it.	0	1	2	3	4
4. I felt irritable and angry.	0	1	2	3	4
5. I avoided letting myself get upset when I thought about it or was reminded of it.	0	1	2	3	4
6. I thought about it when I didn't mean to.	0	1	2	3	4
7. I felt as if it hadn't happened or wasn't real.	0	1	2	3	4
8. I stayed away from reminders about it.	0	1	2	3	4
9. Pictures about it popped into my mind.	0	1	2	3	4
10. I was jumpy and easily startled.	0	1	2	3	4
11. I tried not to think about it.	0	1	2	3	4
12. I was aware that I still had a lot of feelings about it, but I didn't deal with them.	0	1	2	3	4
13. My feelings about it were kind of numb.	0	1	2	3	4
14. I found myself acting or feeling like I was back at that time.	0	1	2	3	4
15. I had trouble falling asleep.	0	1	2	3	4
16. I had waves of strong feelings about it.	0	1	2	3	4
17. I tried to remove it from my memory.	0	1	2	3	4
18. I had trouble concentrating.	0	1	2	3	4
19. Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart.	0	1	2	3	4
20. I had dreams about it.	0	1	2	3	4
21. I felt watchful and on guard.	0	1	2	3	4
22. I tried not to talk about it.	0	1	2	3	4

Appendix 3

Timeline of Mental Health Interventions Post Disaster

This is a timeline of the types of responses and interventions that mental health professionals will typically be engaged in following a disaster. In all settings the overriding principle guiding mental health intervention is *FIRST DO NO HARM*.

- Decisions regarding **attendance** at a disaster site should be made between the State HSFAC and the State Mental Health Controller.
- **Consultation/liaison** is a major part of mental health disaster response.
- Acute mental health interventions:
- Implement **Psychological First Aid** techniques.
 - comfort, ensure safety, provide information and practical support
 - observe ABC (arousal, behaviour, cognition) and respond to normalise these or triage
- Provide **support** (eg. bereaved people viewing dead bodies).
- **Triage** (eg. acutely aroused or distressed, disturbed mental state, cognitive impairment, disturbed behaviour etc.)
- Offer contact, **outreach** and follow-up if indicated.
- Allow for **initial adaptation** and adjustment to disaster stresses (about 2 weeks).
- Identify people at **increased risk** of developing post-disaster psychopathology.
- **Screening** (through use of generic forms and self-report measures)
- Clinical **review** if indicated (eg. very high arousal, behavioural disturbance, cognitive impairment)
- Comprehensive mental health **assessment** for symptomatology and specific syndromes.
- Refer for **follow-up** and specialised treatment if indicated.
- Fold disaster mental health response back into usual mental health services.
- **DO NOT** conduct psychological or critical incident stress debriefing.

Supportive debriefing may be provided, but only if natural group processes indicate that this is appropriate.

Appendix 2

Extract from the WA Interdepartmental Personal Support Disaster Counselling Model

Competency Criteria, Dimensions and Process

Level One

Certification at Level One, Personal Support Disaster Counselling, credentials the holder to provide practical and emotional support to those affected by disasters or major critical incidents, as a member of the Early Support team.

1. Essential Criteria

- Nomination by agency or employer.
- Police check.
- Compliance with competency dimensions of knowledge, skills and aptitude.
- Submission of completed application form.

2. Dimensions

2.1 Knowledge and understanding of:

- Terminology and language of disasters and emergency management.
- Overview of Western Australian state emergency arrangements.
- Stress reactions and natural recovery.
- Needs assessment
- Duty of care
- Confidentiality
- Awareness of individual, cultural and religious differences
- Code of ethics
- Self care.

Further complementary training courses are also recommended.

2.2 Skills:

- Ability to communicate effectively with people from a range of backgrounds.
- Ability to relate sensitively.
- Respect for wishes and rights of others.
- Awareness of personal and role related limits and boundaries.
- Fundamentals of problem solving and conflict resolution.

2.3 Aptitude: (nominator provides this information.)

- Suitability for deployment in Early Support because of the candidate's coping style and capacity.
- Sensitivity to needs and wishes of others.
- Responsiveness to direction and ability to work within a team.

Assessment and Accreditation:

A Western Australian State Welfare Emergency Committee (SWEC) certificate of competency in personal support disaster counselling, level one, will be issued to a candidate who has met the following requirements:

- Fulfilment of the essential criteria.
- Acquisition of the recommended knowledge and understanding.
- Demonstration of skills and aptitude.
- Submission of the completed application form.

Level Two

Certification at Level Two, Personal Support Disaster Counselling, credentials the holder to provide practical, emotional and psychological support to those affected by disasters or major critical incidents, and to be deployed as a member of the Psychological Support team.

1. Essential criteria:

- Nomination by agency or employer
- Police check.
- Compliance with competency dimensions of knowledge, skills and aptitude as described for Level One.
- Compliance with further competency dimensions in knowledge, skills, and aptitude, as described in 2.2, 2.3, and 2.4.
- Mental Health qualification.
- Submission of completed application form.

2. Dimensions:

2.1 Knowledge and understanding of:

- A range of appropriate individual and group interventions and strategies.
- Signs and symptoms of typical stress, Acute Stress, Post-Traumatic Stress and other trauma related disorders.
- Needs in short, medium and long term.
- Process and timelines for recovery.
- Documentation practices.
- Confidentiality and disclosure practices and protocols in the disaster setting.
- Contemporary knowledge and good practice.

2.2 Skills

- Ability to apply an individual or group needs assessment.
- identification of severe stress and trauma reactions.
- Provision of education as to typical reactions, coping, resiliency development, and when expert assistance is indicated.
- When and where to refer for specialist support.
- Problem solving with both those being supported, and at the system level.
- Provision of emotional defusing.
- Ability to provide consultancy to Early Supporters, and Team Leaders, as required.
- Conflict resolution.
- Record keeping.
- Information briefings.
- Operational Debriefing.
- Ability to recognise and apply time for completion and closure, or to refer on.

2.3 Aptitude:

- Recognises, understands and adheres to limits of professional knowledge and skills.
- Flexible, with an ability to provide for clients' needs in diverse settings.
- Ability to self-monitor for functioning, bias, stress, fatigue, effectiveness, and capacity.

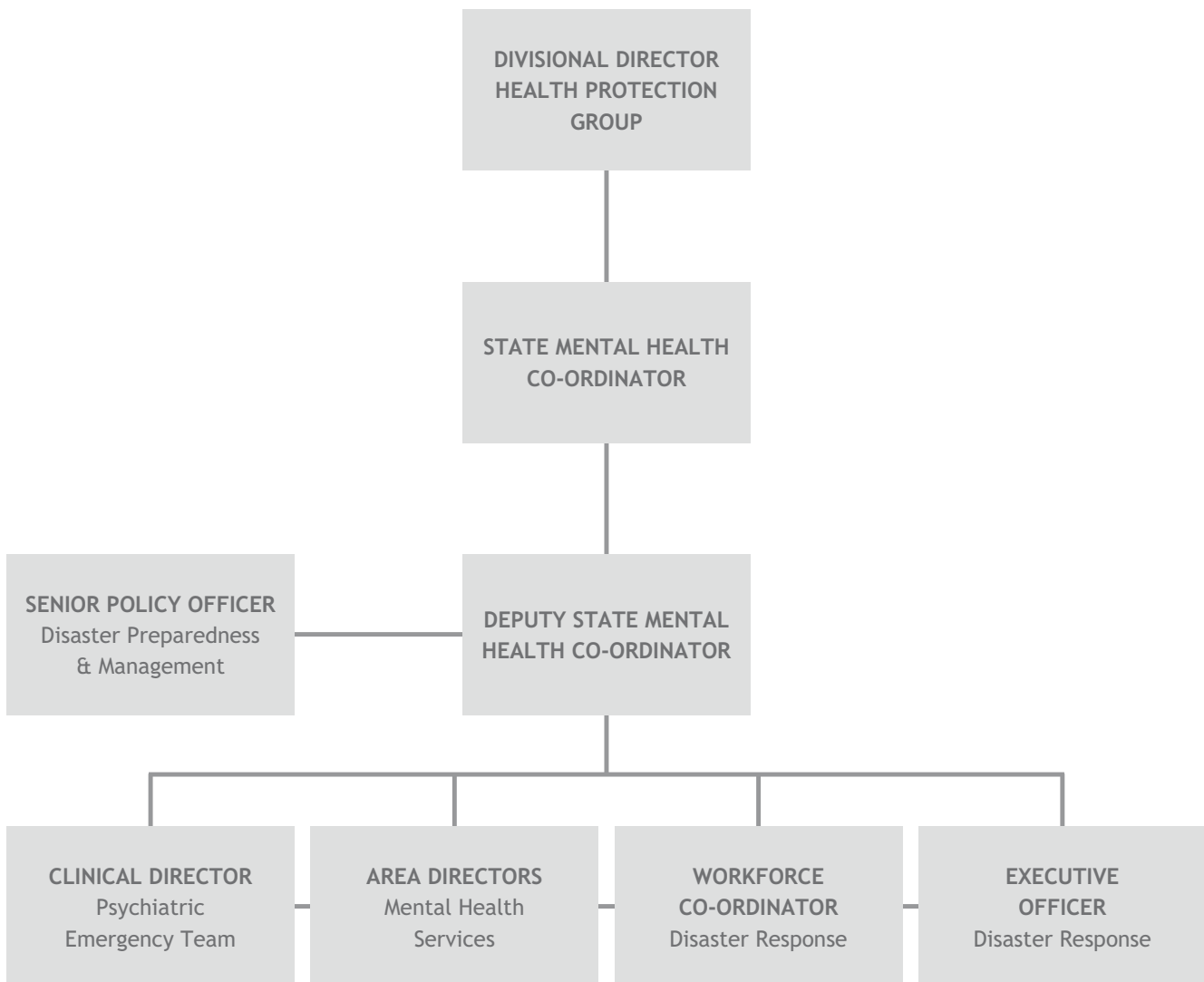
Assessment and Accreditation:

A SWEC certificate of competency in personal support disaster counselling, level two, will be issued to a mental health professional who has met the following requirements:

- Fulfilment of the essential criteria.
- Acquisition of the recommended knowledge which may be through training and experience, or evidence based.
- Demonstration of skills and aptitude.
- Self-appraisal indicating confidence in meeting the required standards of knowledge, skills and aptitude.
- Completion of a one-day group credentialing session, which allows for reflection, sharing of experience and new information, and alignment with current good practice.
- Confirmation and undersigning by the nominating employer or supervisor, and the accreditation facilitator.

Appendix 3

Mental Health Disaster Response Organisational Structure



Appendix 4

Mental Health Disaster Response Subcommittee

Membership of the Subcommittee is as follows:

- Dr Peter Wynn Owen, State Mental Health Coordinator, A/Director, Office of Mental Health
- Dr Johann Combrinck, Deputy State Mental Health Coordinator, Director, Psychiatric Emergency Team.
- Margaret Jones, Senior Clinical Psychologist, Workforce Coordinator, Disaster Response
- Hazel Harley, A/Manager, Disaster Preparedness and Management Unit, Department of Health.
- Peter O'Hara, Senior Consultant, Executive Officer, Disaster Response

Delivering a Healthy WA

