NSW Health
Disaster Mental Health

Handbook 3 - General and Broadly Based Interventions for Mental Health Consequences of Disasters

A collaboration between NSW Health and University of Western Sydney

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As noted in the previous chapters, and earlier, there is the acute phase of the emergency, then transition to the "recovery" phase and potentially longer-term management of the disaster impacts. These may be very significant, disrupting individual and community functioning. Or there may be evidence of resilience, rapid "recovery" with the disaster consequences being incorporated into, for example, "just another flood". As noted previously the mental health impacts may be significantly greater if there is a high number of deaths; threat to life; multiple other losses; major destruction of the community infrastructure; and lack of needed resources. Difede and Cukor (2009) report on the lack of good longer-term studies to assess post-disaster morbidity. There is also the difficulty of reaching, with mental health services, those who may be most vulnerable to such ongoing effects; or lack of resources to provide care. In addition much of the service provided is evidence-informed, rather than evidence-based, because of the difficulty carrying out randomised controlled trials in the post disaster context.

There are large numbers of informal and formal responders, who attempt to contribute to the management of "recovery" for those affected, including a wide range of non-government organisations, individual "counselors" who converge on the scene to offer their help, faith-based services, and many others. In addition there are multiple levels of practical need, as well as other ongoing consequences of the incident, perhaps even ongoing threat.

General or specialised mental health interventions need to be delivered as a recognised component of response for those affected. Mental health systems of response need to be provided by people who have been educated and trained to deliver such care in the post disaster context. There is a requirement for accountability, documentation, and service prioritisation in response to level of need. Assessment of individuals should take into account the nature of their problem and distress, their view of the sources of their difficulties; the impact on functioning; other general health issues; and whether or not their situation is improving with a potential recovery trajectory, or worsening with implications of extent of need.

Mental health consensus processes have, for the most part, agreed on a tiered system of care, with focus on the following themes: Level 1 – Psychological First Aid and Personal Support; Level 2 – Skills for Psychological Recovery and other general mental health assistance including through primary care; Level 3 – Specialised Mental Health Interventions for those who have been identified or diagnosed with significant psychiatric pathology or as at very high psychiatric risk. Intervention ideally should be provided on the basis of systematic needs assessment, and targeted appropriately. This chapter will address mental health Level 2, programs for the recovery phase and how such interventions are relevant in the broader context of health and other impacts. It will also consider the need to provide a spectrum of interventions including: consultancy and advice; information and education for those potentially or actually affected; supervision, support and consultancy for others involved in providing care; self-help strategies; web based strategies; group and community intervention, for instance in collaboration with community organisations; linkages and potentially collaborations with primary care and other such providers; referral pathways for those most severely affected, to skilled expert specialist mental health clinical service provision through public or private sectors with psychiatrists, psychologists, and so forth. It must be emphasised however that, while the concept of different "levels" of care is useful, the problems people have as a consequence of disaster may not be so clear-cut. Services provided should be related to assessed need, as much as is possible, and the tiered concept applied as is appropriate and realistic.

The aims identified below describe strategies that can be utilised to assist with psychosocial and mental health needs for those affected by disaster, and some of the research that informs them. They should always be considered in terms of the specific circumstances of those affected and priority need.

Aims

To support disaster affected communities and individuals through a range of community and individual programs that aim to build on strengths, enhance resilience, mitigate mental health impacts, and contribute to recovery. All such programs should ideally be linked into the "Recovery Plan", and its broad strategies and governance. These include the following components.

1. **Transition:** recognition of, and support for, the transition from the acute emergency to the longer-term aftermath and recovery.

2. **Communication and information strategies** including media releases, web sites, internet and interactive programs such as Facebook, information centres and programs, meeting key principles and interactive two-way options.
3. **Outreach programs** for affected groups and individuals, for instance with call centres, or through local communities or individuals and families.
4. **Support initiatives for individuals**, families including "case managers", "family bereavement liaison officers" generic "counsellors" and linkage processes to resources and practical actions.
5. **Community engagement** and assistance programs with the aim of supporting local actions for recovery and, community resilience, taking into account diverse and multiple nature of "communities".
6. "**Psycho-education**" to assist broadly and community education and self help.
7. "**Skills for Psychological Recovery**" Programs to assist individuals and groups in general strategies for psychological recovery.
8. **Health, Mental Health, Primary care and recovery programs** for people to access for post disaster concerns, health assessment, management of these and information or referral if this is required.
9. Strategies for "looking out for, looking after" and engaging with those affected and their communities, agencies; and specifically, **more vulnerable groups/populations** e.g. culturally and linguistically diverse, indigenous, or disabled persons. Children and older people also need to be "looked out for", "looked after".
10. Recognition of, and support for **social ritual and meaning making**, and community initiated and driven recovery programs.

Rationale

While considerable literature now exists demonstrating the resilience of many across diverse disasters, it is also clear that significant morbidity may arise for those most severely affected (Norris et al, 2002a, 2002b, 2005). As emphasised in a recent review, Norris and Wind (2009) make clear that the numbers of deaths correlate with increased risk of pathology. For individuals there is a heightened risk of mental disorders such as Post Traumatic Stress Disorder if they have been exposed to personal life threat, such that they

thought they could die, or to multiple deaths of others. Comorbidity of PTSD and major depression is common, with some studies suggesting that bereavement and loss may more commonly be associated with depression outcomes, but also Prolonged or Complicated Grief Disorder. Anxiety disorders, substance use problems, changed health behaviours and impacts on functioning are commonly described in multiple studies. Terrorism has been shown to be associated with more negative outcomes (Ursano et al 2007). For a great many of these disasters there is little in the way of longer-term outcome studies (i.e. more than a few years) (Difede and Cukor, 2009). However a longer follow-up of the Buffalo Creek disaster demonstrated ongoing effects (Green et al, 1990), and other long term consequences have been identified, as in studies of 9/11 with the 10 year Anniversary (Di Grande et al, 2011).

A number of recent publications has drawn together many of the studies of disaster affected populations and implications for intervention. These include Neria et al's (2006) report on response to 9/11 terrorist attacks; Ritchie et al's (2006) drawing together of intervention studies for Intervention After Mass Violence and Disaster; Blumenfield and Ursano's (2008) Intervention and Resilience after Mass Trauma; Ursano et al's (2007) Textbook of Disaster Psychiatry; and Mental Health and Disasters (Neria et al 2009). Research developments have been drawn together by Norris et al (2006) in Methods for Disaster Mental Health Research. A rapidly growing scientific literature is also reflected in extensive publications, with a good many focusing on PTSD studies after major events, but also looking beyond this to the range of mental health, and social and general health outcomes.

All these studies, many dealing principally with adult populations, have provided evidence of the factors influencing risk and vulnerability as well as more recently, resilience and protective factors. The more limited scientific literature on children demonstrates similar patterns, but also the critical importance of developmental themes, family effects, and schools (McDermott et al 2010).

Stressor exposure is central to disaster mental health effects in terms of life threat; loss / bereavement; severity, closeness or proximity to threat; extent of damage to home, infrastructure; loss of "resources" more broadly as described in Hobfoll's Conservation of Resources model (Hobfoll, 1989); lack of support; social support that is perceived as unhelpful; lack of resources; dislocation from home, community or other significant network or place; preexisting vulnerabilities such as past trauma and loss, preexisting psychiatric disorder; and population group vulnerabilities (e.g. culturally and linguistically diverse, children, etc); ongoing stressor exposures such as threat, reminders, concurrent,

consequential, or coincidental major stressor exposures. Disintegration of social networks through community disruption, damage, loss of workplaces or social institutions and damage to social capital may all contribute.

Mental Health Implications

It is repeatedly shown that most people do not develop mental health problems, i.e. do not have identified disorders resulting from the disaster. They are "resilient". Nevertheless many people will have generic distress and difficulties, as a consequence of the disaster. They may need broad support programs, assessment and access to practical support, information and advice and generic assistance and/or referral.

While there are studies addressing specific disorders that might be identified in the post disaster setting, either through the overt severity of this person's condition, presentation or pre-existing diagnosis, the usual picture in the aftermath is a spectrum of distress, sadness, difficulties, and often fluctuating hope and effective actions. This "generic" distress includes a range of symptoms affecting sleep, concentration emotional lability including sadness, anger, fearfulness, and uncertainty. These reactions to what has happened may reach the level of diagnosis for disorders or syndromes and become "clinically significant" requiring more focused interventions. However the intent of programs directed to this level of care is directed to the more generic distress, subsyndromal symptoms; to mitigating the risk of disorders; and the treatment or referral of those so affected should such need arise.
The program components identified below are for the most part evidence-informed, or based on sound principles such as first not to harm, practical need, and observed utility.

Centrally throughout is the importance of recognizing and supporting priority resource needs, practical assistance required, people's own actions for dealing with what has happened, and the critical role support for these.

Resilience (for details see Chapter 9)

Community resilience (Norris et al 2008) has been suggested to be a process over time, with four key pillars; information and communication; social capital and connectedness; resources and access to them; and community competence.

Individual resilience reflects the capacity to cope effectively with adverse experiences, i.e. personal efficacy, perhaps seeing these as a challenge. It is also related to the capacity to "bounce back" after adversity; to be hopeful; optimistic; and as suggested by Walsh, "to bounce forward" (Walsh, 2002) with future orientation. Connectedness to others, social support, and capacity to act (self-efficacy and competence) are important protective factors. As noted elsewhere, past stressors or adversities may "immunise" or "sensitise", the former being more likely to be associated with positive outcomes. Information, communication, resources, may also make a difference, as may some level of preparedness. Individual resilience is also a process and may fluctuate over time, may occur in some but not all domains of behaviour, and may also coexist with other difficulties.

The time and process aspects of both pathology and resilience constitute further challenges with respect to intervention. Interventions need first not to harm; and secondly to build on strengths, to support and enhance these; this is highlighted by individual and community activities that those affected may engage in to address their own recovery processes. Interventions need to be attuned to, and support these strengths and adaptive processes, while offering a range of options for assistance, when and if this in needed, and in ways that are feasible, effective and readily accessible. Broadly based interventions have incorporated a number of approaches.

Level 2 General Intervention Programs and Strategies

It is clear the levels and nature of such intervention will:

i. Depend on assessed need as identified by communities and individuals
ii. Be integrated components of recovery plans and governance
iii. Be well integrated with community lead initiatives
iv. Take into account health, welfare, social and other needs and programs; and be integrated with and complimentary to these.
v. Have core aims of
   - enhancing resilience
   - promoting positive health and mental health
   - identifying and facilitating more specialised assessment and care when required.

It needs to be recognised that there are diverse general intervention programs/specific interventions at this level; that there may not clear-cut "levels" for care; that needs vary over time; that the various strategy components identified need to be relevant to the specific experiences and needs of affected populations and persons and to the time lines post emergency. These components are identified below.

1. Transitional programs: Emergency to Early Recovery

There is an important process for transition from emergency strategies such as Psychological First Aid through to Personal Support as provided by non-government agencies such as Red Cross and Red Crescent Societies, to the specific programs relevant for the recovery phase. Transition to recovery may be facilitated further with establishment of Family Liaison, or Case Management workers to coordinate access to resources and to provide general support, along the pathways of "recovery"; through to what may be needed as early intervention or treatment in the post-acute setting; through to more specific services. The boundaries between generic and specialised intervention are often unclear. The principles of transition that may inform any intervention are useful throughout in terms of the psychological framework they provide: promoting safety; calming; self-efficacy;

connectedness and mutual support; hope (Hobfoll et al, 2007). Nevertheless early interventions are usually set in the post emergency context where there may be extensive practical and human needs: for safety, shelter, reunion with family; financial and other resources; a place to be; the capacity to work. People who have been very independent may find it very difficult to seek help, or accept assistance, and may feel distressed by their inability to provide for themselves and family. These issues, such as the need to find a place to live if one's home has been destroyed; work if one's source of income has gone; bring additional challenges in the aftermath.

The Sphere Project and the IASC Guidelines of the World Health Organisation (Sphere Project, 2011 & WHO, 2007) address some of these issues as they are relevant particularly in developing / low-income countries, but many of these themes may apply in other mass disaster aftermaths. They summarise these processes in a "Matrix of Minimum Responses in the Midst of Emergencies". They encompass common factors such as: coordination; assessing mental health and psychosocial issues; some mental health and psychosocial functions including human resources needed, community mobilisation and support; general health services; education; dissemination of information; and addressing social needs such as food, security and nutrition; water and sanitation; shelter and site planning. They provide detailed advice on these issues (The Sphere Project Handbook, 2011, www.sphereproject.org/ and IASC Guidelines, http://www.humanitarianinfo.org/iasc/).
The use of "psychosocial" refers to the broad aspects, and "mental health" to the more specific. A Handbook of Psychosocial Intervention has also been developed with support of the International Federation of Red Cross and Red Crescent Societies (2009). This outlines the nature and context of Psychosocial Support; Assessments; Planning and Implementation; Training; Monitoring and Evaluation. It is a useful, broadly based resource (http://www.ifrc.org/en/what-we-do/health/psychosocial-support/).

A further, new resource has been developed in association with this, with IASC's Guidelines, (humanitarianinfo.org/iasc) for assessment of need for populations so affected. This HESPER scale provides for population assessment if needed, including physical and psychosocial need in Humanitarian Emergency Settings. It is a new resource developed by the World Health Organisation. It is noted in previous chapter, and relevant in that identifies basic

human needs and psychosocial distress but does not directly link to the need for specialised mental health care.

It is referenced under the name HESPER "The Humanitarian Emergency Settings Perceived Needs Scale" and links to other WHO strategies for such populations in diverse circumstances including post disaster. It links to IASC's Guidelines on Mental Health and Psychosocial Support in Emergency Settings. It provides a tool for conducting broad population-based practical, and to a degree, psychosocial needs assessment. **Details are attached in Appendix E.**

2. Communications Strategies

There are uncertainties, disruption and diverse media presentations in the aftermath. These continue to variable degrees over the weeks and months following the disaster, often with a focus on problems, but also on achievements.

Governments and leaders can develop and implement a communication strategy relevant to the recovery period, the impact, and one which focuses on accurate, consistent information; updating as relevant; and positive leadership "faces" telling what is being done, where people can find out more, what they can do themselves, how to access resources, and what ongoing information and communication will be available.

Such a strategy needs to be regularly updated, responsive to current developments, emerging issues, and involve two way processes so people can ask questions and have responses to their concerns as far as possible (See Communication Strategy Template, Appendix F).

Communication messages need to be consistent, but not inflexible; have common agreed processes and themes for such consistent messages from government and leadership; and to work in partnership with mass media outlets as appropriate.

Multiple media and channels are important, including social networking such as Facebook, Twitter, as well as traditional visual, print and other media. All must be up-to-date, accurate

as far as is possible to the time, and open to discussion. Queensland Police Service's use of Facebook during the 2011 floods is one such example.

There should also be support for local and community communication – for instance information meetings, community radio, newsletters and other relevant strategies.

Effective communication processes can provide a basis to lessen the anxiety generated by uncertainty, and can support the power of information to assist people make their own choices for the future.

3. Outreach Programs

These can be provided in diverse ways, usually in the earlier phase of recovery, but can be continued over time.

Outreach programs involve notifying people of resources, common reactions, and where and how to get assistance. They may be advertised through the media, provided through call centres, implemented with community engagement, facilitated through organisations and institutions such as schools, workplaces and the like. In some instances they involve "door knocks" to affected people and communities. Their aim is usually to identify need, provide support and assist people to access resources, including mental health if needed.

They are frequently provided by NGOs such as the Red Cross. They usually provide information and other general support. They are reassuring in that people know that there is still concern for their wellbeing, and a channel they can go to for advice and help.

"Call centres" are important components of outreach and vary in what they offer. They are often in the form of widely advertised phone contact and offer information, linkages to relevant services and even "warm" transfers to necessary services, or counselling etc. They may also build on existing telephone counselling services such as Lifeline.

4. Individual Support and Generic "Counselling"

The term "counselling" is applied generically and ranges from generalised support, to specific programs such as financial or insurance advice, information about available resources and services, to general discussion.

Individuals may need urgent individual assistance with both practical and general goals. This is exemplified in the "Family Liaison Officer" program for bereaved families, recommended after the London bombing to facilitate support for people through DVI (Disaster Victim Identification) and other such processes; the "Case Manager" concept after the Victorian bushfires, to assist people to access practical resources; and similarly, with outreach to affected people by Government agencies through Centrelink counsellers, and other such Guidance/support. Such "counselling" or guidance does not have specific mental health goals, but may assist people to lessen distress through the practical actions as a platform to address their concerns.

"Counselling" in its many forms is provided by a range of agencies in the aftermath. The majority of counselling programs offered are not highly specialised in the clinical sense. They may be provided through organisations offering bereavement support and generic "grief counseling" in individual or group settings; relationship counselling; well-being programs; programs from faith-based organisations which may focus on spiritual or religious needs or provide support more broadly. It should be noted that many people turn to their spiritual beliefs in difficult and distressing times and this should be respected. "Therapists" of diverse kinds may offer resources including massage, alternative therapies, exercise, or practical group-focused support. Most of these are provided in a supportive framework, including some from non-government groups, and with positive intentions. There are also counselling strategies from government agencies involved in practical assistance, for instance Centrelink as discussed above.

Mental Health Implications

These organisations and people providing general "counseling" services also need to be clear about the ethical responsibilities that they have to those who have been through a disaster; who may be vulnerable; who may or may not be ready to make a decision about "counselling". The convergence of many differing counsellors, "debriefers", and other helpers to disaster-affected communities may at times overwhelm them. Those offering services of this kind need to also be aware of the importance of respecting people's wishes, needs and preferences; their right to work things out in their own way and in their own time; and the importance of not engaging in any strategies that may make things worse.

Counsellors should not offer clinically focused services or interventions unless specifically trained to do so, and should make this clear to those with whom they are working. Ideally all such persons working in the post-disaster context should have information handouts of what they can offer, their organisation affiliation, and their expertise (potential contribution) for such post-disaster care. Furthermore they should be aware of when people may need mental health referral and assessment. Ideally all such groups should link to the recovery governance processes for the affected community.

5. Community Engagement and Community Support Programs

Community engagement is a central component of the Australian Government's National Disaster Resilience Strategy, and applied across the All Hazard approach of Prevention, preparedness, Response and Recovery.

> An important component of recovery is the engagement between leaders, governments and communities, including community leaders with the goals of assessing need broadly and providing support for local action and the spontaneous resilience of most communities. This involves local government and the communities for which they are responsible, and frequently support such as resource access and recognition. It can provide additional momentum for the pillars of community resilience ie: information and communication; resources and access to them; social capital, connectedness and support; community competence. Mental health consultation and engagement with affected communities can assist with advice; identification of potential needs; and pathways to mental health assessment and care.

This engagement and support at national, jurisdictional and other levels is symbolically and actually important, particularly if it assists when major difficulties arise. It is most important however as an acknowledgement of, and support for, the strengths of "ordinary people"; "ordinary communities" and their "extraordinary responses, actions and achievements" in dealing with the disaster.

This type of "community engagement" also needs to include strategies for positive engagement with the multiple "communities" and organisations of contemporary society. These include, but are not limited to:

- School communities
- Culturally & Linguistically Diverse Communities
- Indigenous Communities
- Business communities
- Essential services communities such as Energy, Water, Food, Safety, IT, Financial services, Shelter, Reconstruction
- Transport Communities
- Media communities, and communication

- Aged care communities
- Others or relevant to the disaster and its impacts

The purpose of these engagements is to enhance the resilience of these groups, contributing information, knowledge, potential courses of action; building for instance on their business continuity and preparedness strategies; and to facilitate their return to effective functioning; and to also support their contributions to overall community recovery, and renewal.

Specifically mental health community engagement can also assist people to recognise mental health needs and the value of getting help for these, should this be needed. It can also help by making clear that people can be both strong and "resilient", but also potentially in need of, and benefit from mental health assistance.

6. Psycho-Education

Psycho-education refers to education about psychological issues with the intent of enhancing knowledge, and thus improved mental health outcomes.

"Psycho-education" is the phrase that has been used to cover a wide variety of interventions that provide education on psychosocial issues with the intent of assisting adaptation. Wessely et al (2008) have provided a very useful critical appraisal of psycho-education with respect to trauma, and the disaster context in particular, finding that it has not been demonstrated to be effective in preventing the development of psychopathology. It may in some forms heighten the risk, for instance if there is a strong emphasis on the risk of pathology. By listing symptoms, it may increase a focus on negative outcomes. Wessely et al's review examines the limited evidence, identifying only one randomised controlled trial which reported no evidence of benefit and that the most distressed might be the most likely to be harmed. Other studies looked at the psycho-education component of stress debriefing, again showing little evidence of benefit and some of potential harm for the most vulnerable. They note however that preoperational briefing may be positive, perhaps because of the stress management / inoculation and resilience focus, as for instance with "Battlemind" preparation for the military, for troops going into combat. Other secondary studies do not provide evidence of benefit.

"Psychoeducation" is also used to describe education about problems, what you can do yourself to deal with these, and when, where and how to get help.

These authors go on to discuss what people do naturally, and that these processes should be recognised as valid in determining the nature, delivery and focus of any psycho-education. Such themes should be encompassed in more systematic research.

Psycho-Education

People, as reported in a number of studies, prefer to turn to their own social networks, family and friends, colleagues or general practitioners, faith based support systems, rather than mental health professionals, and usually do so effectively. Thus psycho-education "can comprise constructive information that proactively encourages expectations of resilience, and if necessary, help-seeking" (Wessely et al 2008, p.296). Psycho-education, they suggest, needs to be reformulated so that it enhances "those mechanisms associated with adaptation and resilience and minimises those that may contribute to pathologising and dysfunction" (p.297). Training in procedural aspects, as with the requirements for tasks or actions, and group support during the process (e.g. group cohesion in military, or emergency service units) is likely to be helpful in those professional settings where anticipation is possible. However whether disaster preparedness for broader civilian / community populations, and its psycho-educational aspects is helpful, remains to be established. This could potentially be effective through increased self and community efficacy, social connectedness and mutual support networks, and the building of protective social capital.

The focus of educational material provided and how it is communicated, needs to utilise communication principles regarding consistent core messages, hopefully positive expectations, and advice about where and how to get assessment and treatment if problems arise. The general practitioner is one of the first ports of entry to the health care system with others such as community health, emergency departments and other contexts. Any psychosocial or other health education also needs to be provided in multiple languages, and to be culturally sensitive, and provide clear advice re: access to appropriate assessment, plus intervention if this is required.

7. "Skills for Psychological Recovery"

Skills for Psychological Recovery is a program developed in the USA and based on available evidence of what is likely to be effective in helping people with the challenges of recovery in the post-disaster context (National Center for PTSD, http://www.ncptsd.va.gov/, National Child Traumatic Stress Network, http://www.nctsnet.org/. It has been adapted for the Australian context in a training model available through the Australian Centre for Post Traumatic Mental Health following the Victorian bushfires (Australian Centre for Posttraumatic Mental Health, http://www.acpmh.unimelb.edu.au/.)

A brief form is available on the Australian Psychological Society (APS) website www.psychology.org.au/.

This program is composed of a number of elements, and is seen as 'educational' for the most part in terms of knowledge and skill development to promote adaptation. Many of its elements have a positive focus. It is also seen as useful in group settings. Like the majority of interventions described, they are 'built' on evidence, are "evidence-informed", but not tested in randomised controlled trials, or to the author's knowledge, in more formal evaluation.

Mental Health Implications

The "Skills for Psychological Recovery" program aims to "reduce psychological distress caused by traumatic events and to facilitate recovery" (p.9). It can be provided as a one-off, stand-alone intervention (45 minutes minimum), or ideally 3-5 contacts. The authors see it as an "intermediate", "secondary prevention" model. It has the goal of teaching basic skills that may enhance self-efficacy. Basic goals, stated as follows (p.6), are to:

1) Protect the mental health of disaster survivors
2) Promote and/or accelerate recovery
3) Prevent maladaptive behaviours

It can be used with children, adolescents and families; people such as disaster workers; and can be provided to individuals or groups. It is a relatively broadly based program. It is seen as being provided by mental health workers or others trained in its delivery, for instance health, community, school, non-government and faith-based organisations and others. It is proposed as a strategy, after the emergency, and as appropriate for broad use.

The guidelines emphasise: the importance of a developmental perspective; sensitivity and responsiveness to cultural issues; and the importance of the relationship between the counselor and the affected person/s. It aims to "respond to the survivors in a compassionate and helpful manner" (p.8), while establishing a "practical, skills-oriented" and "focused", "efficient" manner; to help people to tolerate uncertainty and changes; to provide "active listening, validation of concerns and empathy"; and "foster perseverance, motivation, strengthening of existing positive traits; and to build on existing skills with new coping" (p.8).

The strategy goes on to discuss processes of engagement and then the core actions which comprise the skills to be developed, and concludes with information on relapse prevention. The six key actions are described briefly below, but can be accessed further on the sites mentioned previously.

Skills for Psychological Recovery: Key Actions

- Action 1: Gathering Information and Prioritising Assistance

  This involves: explaining the rationale for information gathering, identifying current needs and concerns; prioritising areas to address; making an action plan; plan and implements for the priority problem, with relevant SPR intervention (a screening form is provided for this).
- Action 2: Problem solving skills

  This involves: introduction to problem solving; defining the problem; setting the goal; brainstorming; evaluating and choosing the best solution; implementation and review.
- Action 3: Positive Activities

  This involves: explaining the rationale for engaging in positive action; identifying and planning one or more activities; scheduling activities in the calendar, and follow-up review is expected.

- Action 4: Managing Anxiety, Grief and Loss

  This includes: explaining rationale for learning how to manage distressing reactions; identifying distressing reactions and their triggers; teaching skills to address priority reactions; creating a plan to manage a reaction. The priority reactions are identified in terms of: trauma reactions; grief reactions; worry about the future; anger; depression; sleep difficulties; alcohol and substance use; chronic stress.

  The skills to be developed and implemented are core to this management / self-care and include:

  1. Calming skills such as slow breathing, self talk, support
  2. Skills to put thoughts and feelings into words, e.g. writing them down
  3. Recognising and managing triggers and associated reactions
  4. Skills to develop a personalised strategy

  This action is the one closest to counselling and has 'alerts' identified for those who may be at heightened risk of decompensation, or harm to self.
- Action 5: Promoting Helpful Thinking

  This includes: explaining the rationale for helpful thinking; identifying unhelpful thoughts; identifying helpful thoughts; rehearsing helpful thoughts; practicing helpful thoughts. It is noted this may be more difficult in group settings with diverse views.
- Action 6: Rebuilding Healthy Connections

  This includes: explaining the rationale for rebuilding healthy social connections; developing a social connection map; reviewing this map; making a social support

From Skills for Psychological Recovery: Field Operations Guide, NCTSN & NCPTSD

There are helpful details, handouts, developmental perspectives and cautions, as appropriate in this useful resource. It concludes with guidance for 'preventing setbacks' which aims to summarise the counselling received, and achievements, and to prevent relapse by: understanding recovery; identifying possible triggers and times of heightened risk; identifying 'early warning signs'; and devising a personal action plan to address these.

It is most likely to be of value as a template of strategies which can be used flexibly, attuned to specific need/s.

The child version (and developmental issues) is integrated with the resource throughout. The appendix includes both adult and child versions and the handouts for each, and is extensive, practical and detailed.

Implementation should take into account the balance between educational and skills development, and counselling elements. There is a need to clarify these, ensure those providing such guidance, are aware of the counselling aspects and have access to skilled consultation and/or supervision. Referral guidelines are also needed, although some such issues are touched upon in the appendix and in advice about matters for concern. It is generally helpful and future evaluation of its real world as well as scientifically assessed effectiveness is needed, e.g. with Randomised Controlled Trials.

8. General Mental Health / Health Integrated Interventions

These range through a number of components that can also be used appropriately or with selective focus depending on resources and circumstances.

a) Promoting health

Health is broadly affected by the stressful experience of disaster exposure and to varying degrees. Active health promotion as well as risk reduction strategies, and identifying and caring for those where health has been affected, are important elements. There is evidence that disasters can be associated with increased smoking, alcohol and drug use; sleep difficulties; changed nutrition; less exercise; and changed health behaviours more broadly. In addition existing health problems may be exacerbated or treatment disrupted. Many people present to their GP with general symptoms requiring assessment and management.

Promoting health should include public messaging i.e. looking after your general health in the disaster aftermath with adequate rest, sleep, exercise, good nutrition, watching drug and alcohol intake, and positive activities. Mental health components are also relevant such as social connectedness and support. Advice on positive health and mental health promotion should be widely available as part of recovery and health programs, and through communities and organisations. This general health advice should also indicate the value of a health check if there are ongoing or worsening difficulties, for instance a check by the family doctor or similar person. Changed behaviours, especially in children, withdrawals, irritability, acting out problems, all warrant a health and mental health review if they continue or disrupt function.

b) Community screening, support and referral

This is a broad concept, which could include some of the skills identified below in "Skills for Psychological Recovery". It also potentially includes programs such as those of Brewin et al, (2002, 2008), which is focused on a "screen, filter and treat" approach and was used after the London bombing. This was effective with the screen identifying potential persons at risk, seventy four percent of whom were referred, after detailed assessment, and for further treatment if indicated. The screening measure (see Appendix B) was useful and the authors found large effect sizes for treatment, "comparable to those previously obtained in randomized controlled trials" (p.3). They concluded also that this program, run with clear referral processes and access to a dedicated trauma service and team, "succeeded in its aims of generating many more referrals of affected individuals than came through normal referral channels" (p.3). While this program was reported to have positive outcomes, screening is ethically complex if there are not adequate resources for treatment.

There is also the specific question of whether screening itself, if no problems are found, is beneficial or harmful. The need for such screening to include positive or resilience measures has not yet been adequately addressed.

Mental Health Implications

Screening programs may be helpful for affected populations or persons in terms of identifying risk / potential problems, but should be used carefully. They need to have brief reliable and valid measures that could indicate need for further assessment. Such assessment and intervention resources should be available if screening is to take place, so that follow-up and intervention can be provided. Screening should be such that it does not harm, and is a potentially helpful process, identifying positive / resilient processes as well as problems, and linked to necessary support resources. It also needs to be attuned to the realities of the disaster context and to people's human circumstances and priorities.

c) Assessment of mental health and health needs for those presenting to primary care

Screening measures such as the 4-item PTSD primary care scale, the Impact of Event Scale and measures of distress such as the K6 or K10 could be useful in primary care settings. (See Appendix C & D). Nevertheless the Brewin measure described above has identified capacity in the post-disaster context and could be applied to help establish support and referral processes. In another study, Polusny et al (2008) studied 105 patients screened for disaster exposure, PTSD symptoms and self-reported physical health complaints. Disaster exposure, and generalised psychological distress correlated with physical health complaints, and the cluster of avoidance and arousal symptoms, correlated with higher levels of post disaster health care utilisation, after controlling for age, gender and pre-disaster health care utilisation. This pattern of physical health presentations / symptoms / concerns has been identified in other studies, indicating the need to assess general health issues, and the importance of primary care in managing both physical health symptoms and consequences, as well as potential mental health issues.

General health "check ups", including brief screening and assessment tools are an important element of addressing broad health and related mental health distress/difficulties in the recovery phase. These can involve brief checklists, scales for health, psychological distress, trauma and grief (see Appendix A-E). Such indicators can provide a basis for generic interventions addressing identified needs. They may also provide pathways to specialist mental health assessment and intervention if required.

d) Stepped care and screening for the injured

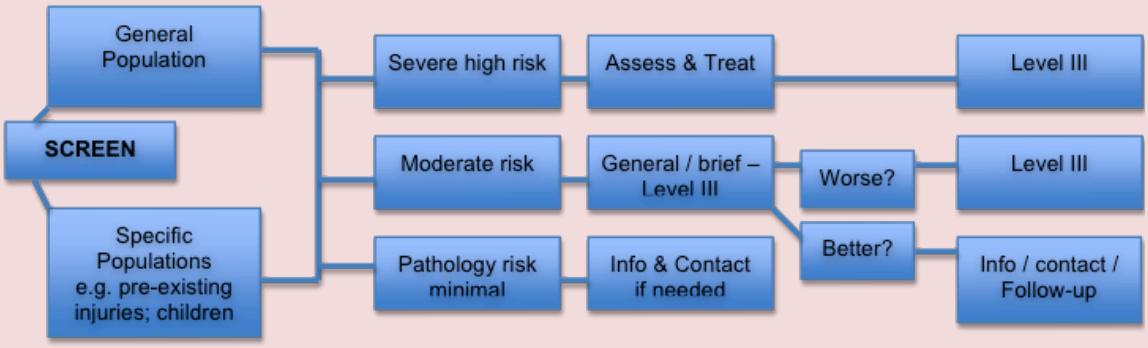
Screening for mental health and other impacts such as injury can be integrated, with management of the physical and psychological trauma. Zatzick et al (2008) described a "Stepped Collaborative Care" model for injured patients with three components: 1) Continuous post-injury case management; 2) motivational interventions for substance use problems; 3) evidence-based pharmacotherapy and/or CBT for those with persistent PTSD. This model showed, in the RCT vs usual care, that rates of PTSD and substance use problems increased in treatment as usual compared to the same level or decreased with the collaborative care intervention. This integrated approach could be utilised for post-disaster injury or collaborative care to deal with health and mental health consequences post disaster (Zatzick, 2007).

This model is valuable in that it demonstrated a declining trajectory for PTSD symptoms for those receiving the intervention program. In addition Zatzick's model is integrated with service systems, both in acute inpatient / trauma centre processes of care and across into the community.

This is exemplified in the model below. This is a potential template for other broad as well as specific specialised interventions.

Mental Health Implications

Stepped Care models are particularly relevant for circumstances such as those of hospitalised, injured or ill patients post disaster, as these mental health components can be integrated with other care.



Adapted from Figure 9.1, p.197 'Textbook of Disaster Psychiatry'. (Ursano et al 2007)

A intergrated general mental health support for medical/surgical disaster casualties.

Similar considerations arise for collaborative / integrated mental health care, with broad and specific interventions provided for other medical-surgical disaster casualties. Rundell (2007) describes such an integrated management into "disaster victim medical-surgical triage and treatment" (p.164). These could address generic fear-triggered responses that may arise in the face of a threat returning, or which may become elevated when the nature of an attack is known, e.g. CBRN. How information is communicated may lessen the risk of elevation of fear to pathology. This highlights the variable nature of threat, and impacts, and the importance of recognising the range of strategies that may contribute to lessening pathological outcomes.

This, as with other general interventions can lead to processes to identify psychiatric casualties for referral to specialised mental health programs for treatment.

With respect to those with significant physical injuries, Rundell emphasises the "primary survey" of trauma victims, which deals with airways, breathing, circulation, and effects of possible head injury. This is followed by a broader secondary survey of "whole body", "head to toe" of the trauma patient, and their histories. This can inform a "tertiary" psychiatric "survey" to identify psychiatric casualties (p.169). Mental state examination is a critical part of this. Rundell goes on to emphasise the possibility of "effective community prevention and response" (p.183), which could mitigate potential psychiatric casualties. This would require well-organised and practiced health system response and effective communication and health information strategies, to help to limit "psychological contagion" (Lating et al, 2004).

Clinical approaches / treatments that aim to prevent the psychiatric casualties, particularly in association with injuries such as burns, loss of body parts and functions, disfigurement, death, dying and grief, and other sources of distress and agitation are important. Managing these issues early on, in an integrated fashion, aims to mitigate potential adverse mental health effects.

e) Self-help, the Internet and other resources

There is much information and self-help guidance available from multiple sources and sites – both well known resources such as the National Center for PTSD & national Child Traumatic Stress Network in the USA (http://www.ptsd.va.gov/), (http://www.nctsnet.org/); and in Australia organisations such as the Australian Centre for Posttraumatic Mental Health, (http://www.acpmh.unimelb.edu.au/). As with most work in the field they are chiefly focused on trauma and PTSD. A review of studies of Internet based interventions to the time of their writing (Benight et al 2008) showed that these therapies could be taken up and were effective for many in terms of their goals. Issues ranged from the number of sessions provided, the context and capacity of those using the sites to carry out their therapy tasks; the drop-out rates and variable uptake; and the specific value of therapist assessment components (Litz et al 2004). A further development tested the web-assisted cognitive behaviour therapy (CBT) program compared to an internet based supportive counselling group in a population of survivors of the Pentagon attacks or combat veterans from the Iraq / Afghanistan war. Although there was 30% drop-out for this group (chiefly men, average age 38), both groups had significant declines in mean PTSD symptoms (avoidance and hyper-arousal, but not re-experiencing). Depression also declined. The CBT had significantly assisted decline. At 6 months the CBT group showed greater benefit, with a greater proportion no longer meeting criteria for PTSD.

As reviewed by these authors, and fits more specifically with the broad and supportive theme of Level 2 interventions, a study of survivors of 9/11 by Ruggiero et al (2006) demonstrated the potential utility of such programs to meet the needs of disaster-affected populations. This web-based stand-alone program provided information in brief modules; translation of cognitive behavioural approaches; clinical symptom self-assessment to link people to appropriate modules; and user motivation components (state of change approach); individual feedback. Individuals participating in an epidemiological study were approached and over one third of these logged on to this self-help resource. While some data was collected, this study 2 years after 9/11 did not evaluate outcomes, but established the feasibility of such an initiative. Knowledge improved about the problems and actions to take and 83% said they would recommend the site to others. Similar approaches included Benight's evolving internet based program using a social cognitive therapy model for enhancing self-efficacy which is seen as central to trauma recovery, in terms of significant research findings supporting this (Benight et al 2008). The site, "Journey to Trauma

Recovery", (http://ww.davidniblack.com/trauma/current.htm) has a range of assessment and intervention components including self-talk, social support, relaxation, managing triggers, negative coping, and seeking professional assistance. It is yet to be tested for effectiveness.

In a recent paper Barak (2010) reviewed the psychological role of the Internet in mass disasters, looking at past evidence and future opportunities. As a psychologist in Israel with extensive research on the use of the Internet, this chapter is particularly valuable. He suggests that in the past decade, with the range of mass disasters that have occurred, the Internet, through its various online processes provided many of those affected with effective psychological support, helping them to survive mentally following mass adversities, horrendous experiences. This is further supported by Taylor et al's (2011) studies following the floods in Queensland of 2011, indicate that the use of social networks such as Facebook further contributes to a form of Psychological First Aid, and to building resilience.

Barak's studies with trauma and this review of other's work lead him to suggest mass-disaster specific web portals. These could be utilised in terms of specific disasters and needs to provide effective future resources, a potential model for development of service systems for recovery.

Mental Health Implications

As indicated above, there are many web-based self-help and other intervention programs. Their contributions range from progressive provision of information and education; cognitive and other strategies; mental health and self-monitoring; problem solving and goal setting; through to specific programs for conditions or disorders. Reviews more broadly include those of Amstadler et al (2009). These authors reported that these Internet Based Interventions (IBIs) for traumatic stress, anxiety and related conditions such as panic disorder, complicated grief, depression, comorbidity, i.e. general common components of CBT frameworks, psycho-education, cognitive restructuring, goal setting, exposure), were effective to the level of "generally comparable to traditional psychosocial treatment" (p.410).

Other internet-based intervention programs have tested the effectiveness of interventions for depression (Christensen et al 2006), and for Complicated Grief (Wagner et al 2005, 2006) and found these to be effective for such syndromes, suggesting they could also contribute to the management of these conditions post-disaster.

These reviews emphasise the potential benefits in terms of access to interventions suited to the person's own time and pace. However little information is available about any negative components, and for this and multiple reasons, considerable research addressing these issues is needed. Nevertheless it is one further set of resources that may be available to those needing mental health assistance in the aftermath of disaster. How these could also be available or effective for the most needy and disadvantaged also remains to be established.

As is apparent from the above the merge from Level II to intensive, Level III interventions is not necessarily clear.

9. "Looking Out For", / "Looking After" More Vulnerable Population Groups

This theme addresses the need to be tuned into specific populations such as those identified previously and ensuring they have equity and access in terms of communication, resources, recognition of and response to need, and that they do not face further difficulties such as discrimination, in the post disaster aftermath. It also requires recognising and supporting their strengths. It may include groups who are isolated geographically; are culturally isolated; those with internal support but lesser access to external support; or who have faced greater damage, or lesser access to resources.

"Looking out for, looking after" and protecting children who may be vulnerable following disaster impacts, and mobilising family, school and other support processes is likely to be critical for their future mental health. Supporting their resilience, recognising their needs and possible psychological "injuries", can create more supportive and protective environments for their recovery. As with adults, they too benefit from opportunities to be actively involved in actions for recovery.

This component of the recovery program should also take into account those whose needs may not be realised because of the external profile such individuals or groups may also show, of strength in the emergency – for instance emergency services, health service providers and people who have been intensely involved in supporting others, but whose own disaster related impacts may not be acknowledged. Communication with, and information specifically addressing both needs and potential sources of assistance, may be helpful.

People with pre-existing vulnerabilities are also relevant, for instance past trauma and loss; as with refugee groups, people with disability, pre-existing illness; or mental illnesses; are all likely to require evaluation and review of care needs.

"Looking out for, looking after" mental health and wellbeing of those potentially vulnerable:

Importantly all such potentially vulnerable groups should have their strengths, resilience and courage recognised; their sources of valued support acknowledged, and their chosen adaptive strategies, so that they are supported by outreach and engagement rather than seeing this as lessening their independence, not recognising their capacities, and their rights and future hopes.

10. Recognition and Support for Social Ritual

Many social rituals take place to acknowledge loss, progress, achievement, meaning making and future goals. Communities need recognition of such locally generated activities, their value in "healing" and "celebrating", even when there are still many ongoing difficulties/challenges.

Leaders play an important role in making clear the value of such events as reflecting community processes, and their attendance and acknowledgment can be very helpful. Some such events may also be lead by Government, recovery or other authorities, for instance in recognition of deaths and losses, memorialisation; or in celebrating achievement – new buildings, goals met and so forth.

Social ritual symbolises and facilitates many processes, but is particularly relevant in terms of two processes: of grieving; paying tribute to the lost, the past and honouring it and its realities; humanity; and looking to the future, the hopes and challenges ahead (Stroebe & et al, 1999, Dual Processing model for grieving). Funerals, testimonies, and tributes recognise the former, the past. Plans, achievements, strategies and celebrations recognise the future.

Supporting these overt, symbolic representations of the disaster, the losses, the impacts, and the human spirit of survival and endeavour for the future, carries important messages of respect, recognition and shared experience.

Mental health implications

The review of these resources and approaches leads to a consideration of the level of mental health expertise necessary for their implementation, either directly in the delivery of the programs or indirectly through consultation, education, oversighting or supervision. Specific challenges also lie in how the need for more in-depth assessment and service provision is linked into this level of intervention or available to support it and to facilitate referral. It is frequently difficult to distinguish the need for more skilled, experienced and sophisticated clinical programs, and in particular the pathways to referral and access. There are several key pathways that need to be addressed to oversight, support and ensure that programs "do no harm":

1. Mapping broadly the range of "mental health" focused resources that are "on offer"; the issues they address and if possible, their quality and safety; and which organisations are providing them. Ideally any such programs should be linked into the governance of the recovery process and should be meeting certain standards for the care they offer. People, of course have the right to choose what they wish but often find it helpful to have guidance, or template against which they can "check off", which could include, but not be limited to:

    - Names of groups and their aims, processes, who they hope to assist and how, and people's options (e.g. drop out, cost etc). Those who provide them should be educated and trained to do so, ideally accredited, and be aware of limitations, risk, etc.
    - Information should be readily available about what programs are offered, their basis, what they can provide and how they have been evaluated; how to access them, documentation and so forth.
    - While it is not the role of mental health services or leaders to "police" what is on offer it is important to have some understanding of it, as people may need advice. Many programs would avoid delineating their role as "mental health", but nevertheless provide strategies with very significant mental health components and implications, including risk of adverse outcomes.
    - General advice to the public about levels of counselling, and how people can determine what they need. At a local community level there is often a convergence of a variety of resources offering counselling, healing and so forth. People may need to be clear about the range of 'counselling' that may

be available, so they can choose what they see as appropriate. They may also need to know what professional and specialised assistance is available, how this can be helpful and how to access it.

- Mental health service development for the recovery program can provide consultation and advice to such organisations if appropriate, assist decision-making, or alternatively provide such generic mental health assistance through community programs.

2. Real-world disaster experiences.

While community health, mental health and other services may operate with broad counselling and support programs and be engaged in a range of the initiatives described above, there are several issues that may need to be encompassed by broad support programs, or specific interventions, which are not necessarily high level clinical interventions. These include for instance:

- Dealing with the mass destruction and major disruptions of social networks, infrastructure, resources and the like, that have resulted from the disaster impact. These include, but are not limited to;
    - Loss of a home and dislocation to temporary accommodation or with ongoing stressors concerning rebuilding, moving, insurance. General counselling may be needed to assist decision-making, access to resources as well as re-engaging social support.
    - Relationship difficulties that arise in the aftermath, for instance lack of work, role change, frustration, and crowded temporary accommodation, family conflict, and even domestic violence.
    - These possibilities should be taken into account, as well as access to appropriate services.
- Multiple stressor exposures through consequential, concurrent or coincidental difficulties arising in the aftermath, which may be "tipping points" to problematic adaptation. Not only may there be "triggers" reminding of the initial experience, but also 'immersion' in the disaster consequences. This was reflected in the Victorian bushfire-affected communities where empty house blocks, burnt and blackened forests challenged people every day and for more than a year afterward.

- "Off the front pages", the sense of abandonment that many communities may feel over the prolonged period of recovery, when it is difficult to deal with ongoing challenges of resources, rebuilding, bureaucracies and promises. These may not seem to be recognised and responded to, and frustration, anger and blame may become intense and disruptive to functioning
- Priorities. People may not be able or ready to use the range of resources for many reasons. Firstly they may choose to do what most people do as reported previously, i.e. seek support from family, friends or workmates. Secondly, they may have overwhelming practical needs, commitments or activities that do not allow time for repeated counselling sessions. Or they may seek help from non-formal groups, for instance the minister of their church.

There are other aspects of real-world disaster experiences and aftermath that need to be understood, and respected. Resources need to be broadly available to assist with these issues as far as is possible, with realistic time or resource demands and with positive expectations.

3. Resilience and self and community efficacy are the norms. These should be recognised and supported, ideally through community engagement and back-up for community leaders, and with assistance should conflicts arise. Another aspect of this is respecting strengths, and not providing interventions that may appear to patronise those affected, or pathologise what are normal reactive processes, from which most will recover. Labeling people in terms of disorders may be premature. "Looking after" resilience and supporting communities with their own developments is an important aspect.
4. Consultancy, partnerships and related strategies. While mental health services and professionals may have many direct roles in these broader strategies they can also make a significant contribution through establishing consultancy programs. These can provide expert advice and guidance to recovery organisations, and to the diverse groups that may offer assistance and would value access to expert advice when this is needed. There are several elements that can be important components of a broad strategy, for instance:

    - Establishing a consultancy and advice process that could be utilised by organisations, for instance with concerns about access to mental health

services, client risk, and so forth; or for education to enhance knowledge, skills; or for supervisory sessions.

- Partnerships with a consultancy and advisory role are important in terms of health systems, such as primary care / general practice, community health, etc; as in the possible "screen and treat" layered model, or to deal with comorbid physical and mental health, or in pathways to more specialised mental health assessment and treatment.

Hospital and rehabilitation systems and community health engagements are important to support management of mental health aspects of injury, burns, rehabilitation, and so mental health providers can access medical / health information for those affected, should these be needed.

- Partnerships with a range of other groups as required, depending on the disaster but potentially local government, emergency services, impacted work places, affected institutions, non-government organisations and so forth.

5. Information and communication strategies can provide information on a range of issues, such as where and when to seek mental health advice; web-based strategies for self-help as described previously; involvement in information evenings more broadly to bring the supportive processes of mental health and provide a forum for questions and contact; contributions to local news sources such as radio, TV, newsletters, newspapers and so forth; pamphlets. The critical issues to be communicated will depend on the disaster but should be informed by regular contact with affected groups, so as to be responsive to identified and emerging issues. Promoting core advice, positive strategies and information about access should this be required; and becoming a trusted source to help people through the "tough times", while recognising and supporting achievements to date are important aspects. Such consultancy processes may include advice and support for leaders. Mental health leaders should also have a specific role in the recovery governance and process, and where possible, in facilitating practical solutions.
6. Specific Partnerships. A number of formal partnerships need to be established by mental health leaders starting at senior levels, but also linked appropriately to organisations at relevant levels. These aim, with the goal of facilitating recovery, to:

- Support leaders and provide consultation and advice if required.

- Collaborate with schools which are a focal point for most communities affected by disaster and where support, education and information for the "school family" may be very important for children, young people and their families, teachers and for the community more broadly.
- Engage with and support organisations, including business, government and non-government, to facilitate their activities through consultation, information and mental health support and referral pathways as needed.
- Facilitate the management of mental health issues for Emergency response agencies and their members, and work with their support groups if required.
- Support and facilitate the capacity of health systems to look after their workforce, including both general health and mental health.

Such initiatives can enhance outcomes, support resilience, and help to demonstrate the 'face' of mental health as a trusted community resource. It should also be noted that these processes may align with broadly based interventions, but can also contribute if more specialised assistance is needed.

7. Looking out for the potentially vulnerable groups and ensuring access to the range of broad supportive strategies identified, i.e. psycho-education; Skills for Psychological Recovery; web-based information and internet, other self-help or group programs; primary care, other integrated assessment and support programs; and broadly based "counselling" services, as appropriate to their needs. This includes but is not limited to those whose experiences include:

    - More adverse socio-economic circumstances: those who have fewer socio-economic and related resources prior to the disaster are likely to be more adversely affected and vulnerable in the aftermath. They may not have: resources to travel to services of care; computer access for information and self-help; or money for needed 'extras' for the family. They may have many additional stressors to deal with, related to disadvantage, and greater risk of adverse mental health outcomes. Specific outreach and access strategies are important but should be sensitive to the strengths, independence and capacities of people vulnerable in this way, and the reality of resource needs. This resource access including financial resources should be supported through partnerships and links to agencies such as Centrelink. Mental health can be supported with this practical assistance.

- Culturally and linguistically diverse population groups may need resources that are shaped to language and culture, for instance in partnership with multicultural organisations, SBS and like resources. These would address broad mental health and resilience programs in ways attuned to the specific disaster experience, cultural requirements and longer-term needs.
- Indigenous populations may have specific needs, particularly in terms of adverse basic health status; histories of high levels of trauma and loss; socio-economic disadvantage; and cultural issues. These need to be recognised and culturally appropriate resources developed in partnership with those affected and their communities.
- Children and young people may be developmentally vulnerable. Mental health resources should be shaped to their needs, especially through family, schools and community.
- Older people may be more frail, isolated and vulnerable, and may require outreach through neighbourhood, volunteers, nongovernment agencies and aged care services.
- Particular groups may be more vulnerable in particular disasters, with poorer access – for instance rural and remote communities; people of ethnic groups who may be associated in people's minds with potential terrorism.
- People with preexisting mental illnesses or physical problems such as chronic disease or disability. Further research is necessary to clarify the degree of heightened risk they may experience, and possibly also risk for their carers.

8. When more specialised services are needed: significant challenge lies in understanding when someone engaged in any of the identified strategies may in fact need more intensive and specialised care. There is often a merging of seeking help, and using some of these broadly based initiatives, with a "testing of the water" about quite significant mental health issues. This may be driven by uncertainty; concerns that one will be seen as weak or not coping; that one should be grateful for surviving and not need help because "other's" needs are "greater"; or one fears opening a 'Pandora's box' of troubles; or prioritising family needs; or fears of stigma; or for many other reasons.

Mental health services and management may be concerned that they will not have needed resources, although access to specialised counselling through primary care /

general practice referrals, Better Outcomes programes, and related funded initiatives, can provide many of these additional programs. Key requirements for mental health include:

- Identifying when referral for more specialised assessment may be needed: for instance:
  - Worsening symptoms and functional impairment: more severe, more symptoms, more impairment.
  - New symptoms indicating further pathology.
  - Suicidal or self-harm thoughts, for instance with loss of a loved one and ideas of reunion; or with depression, despair and helplessness about dealing with the aftermath, for self and family, with possibilities of self and other harm.
  - Physical health problems or deterioration.
  - Substance use problems / increase.
  - Behavioural changes of concern such as withdrawal, relationship difficulties, domestic violence.
  - General concern about the person's wellbeing.
  - Other indications that the person is very psychiatrically unwell.
- Identifying pathways of access to assessment and specialised referral and treatment. This is a critical challenge, particularly if there are ongoing service disruptions, workforce shortages, and very high demand and utilisation levels. Mapping and providing clear guidance about referral processes is vitally important, for while most people are resilient, some will specifically need and benefit from more expert interventions for the range of disorders that may arise
- Identifying and ensuring follow-up for those with pre-existing major psychiatric disorders whose continuing care is critical, and who may become 'lost' in the post-disaster milieu. Also relevant in this context are the specific needs of those with chronic depression, PTSD and other disorders, and with past adverse traumatic experiences which may contribute to post disaster pathology.
- Strengthening two-way health partnerships to ensure needed referral access is in place for general practitioners and specialist services, for those

affected, but also linkages for health and other staff who may themselves have been affected

9. Documentation and Evaluation of Level II programs and their effectiveness, as far as this is possible, is an important component. This may be difficult to achieve, but a Community Advisory Group can be helpful in facilitating such processes, as it is in the community's as well as provider's interests to know what worked and what else may be needed in the future. It is also important component of care in the broad sense, and accountability.

Conclusion

Broadly based and supportive interventions are the most likely to be needed and provided at this level. Such programs need to be informed by key mental health principles and to have access to expertise and advice. They are likely to reach many members of affected communities, so it is critical that they are integrated with community processes, supportive of positive adaptations, do not disrupt normal resilience, but respond respectfully, sensitively and compassionately to "need" as the community members identify this.

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Appendices

Appendix A

Primary Care PTSD

Primary Care PTSD Screen (PC-PTSD)

Description

The PC-PTSD is a 4-item screen that was designed for use in primary care and other medical settings and is currently used to screen for PTSD in veterans at the VA. The screen includes an introductory sentence to cue respondents to traumatic events. The authors suggest that in most circumstances the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any 3 items. Those screening positive should then be assessed with a structured interview for PTSD. The screen does not include a list of potentially traumatic events.

Scale

Instructions:

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

1. Have had nightmares about it or thought about it when you did not want to?

   YES / NO

2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?

   YES / NO

3. Were constantly on guard, watchful, or easily startled?

   YES / NO

4. Felt numb or detached from others, activities, or your surroundings?

   YES / NO

Current research suggests that the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any three items.

Prins, Ouimette, & Kimerling, 2003

Appendix B

Trauma Screening Questionnaire (TSQ)

APPENDIX N: TRAUMA SCREENING QUESTIONNAIRE (TSQ)

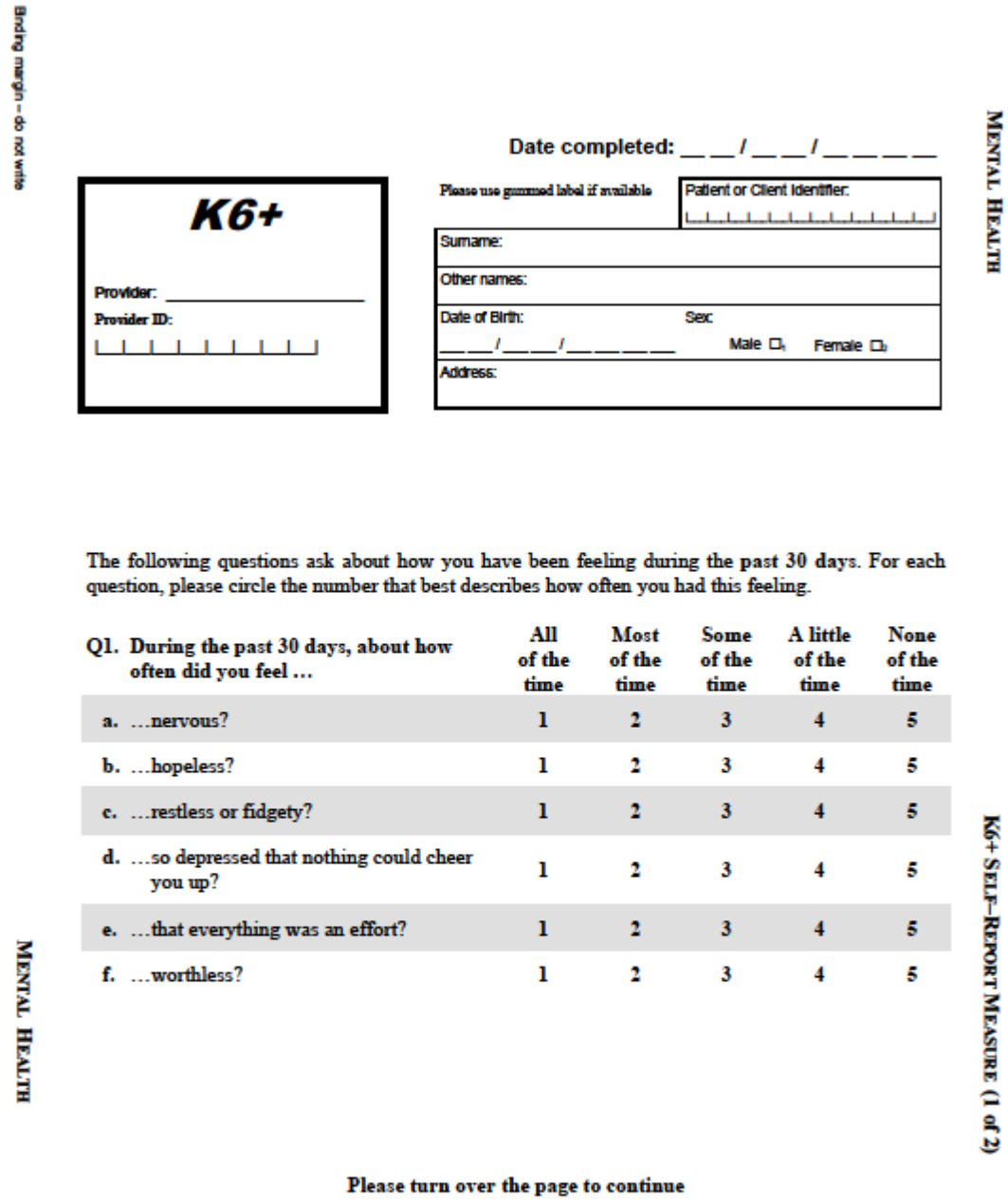
Please consider the following reactions which sometimes occur after a traumatic event. This questionnaire is concerned with your personal reactions to the traumatic event which happened to you. Please indicate (Yes/No) whether or not you have experienced any of the following at least twice in the past week.

1. Upsetting thoughts or memories about the event that have come into your mind against your will	□ No	□ Yes
2. Upsetting dreams about the event	□ No	□ Yes
3. Acting or feeling as though the event were happening again	□ No	□ Yes
4. Feeling upset by reminders of the event	□ No	□ Yes
5. Bodily reactions (such as fast heartbeat, stomach churning, sweatiness, dizziness) when reminded of the event	□ No	□ Yes
6. Difficulty falling or staying asleep	□ No	□ Yes
7. Irritability or outbursts of anger	□ No	□ Yes
8. Difficulty concentrating	□ No	□ Yes
9. Heightened awareness of potential dangers to yourself and others	□ No	□ Yes
10. Being jumpy or being startled at something unexpected	□ No	□ Yes

Source: **Brewin, C. R., Rose, S., Andrews, B., Green, J., Tata, P., McEvedy, C., Turner, S. & Foa, E. B. (2002) Brief screening instrument for post-traumatic stress disorder.** ***British Journal of Psychiatry, 181,*** **158-162.**

Appendix C

K6 - The Impact of Event and measures of distress Scale



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MENTAL HEALTH

K6+

Provider: _____

Provider ID:

Date completed: __ __ / __ __ / __ __ __ __

Please use gummed label if available

Patient or Client Identifier:

Surname:

Other names:

Date of Birth: __ __ / __ __ / __ __ __ __

Sex: Male ☐ Female ☐

Address:

The following questions ask about how you have been feeling during the past 30 days. For each question, please circle the number that best describes how often you had this feeling.

Q1. During the past 30 days, about how often did you feel …	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. …nervous?	1	2	3	4	5
b. …hopeless?	1	2	3	4	5
c. …restless or fidgety?	1	2	3	4	5
d. …so depressed that nothing could cheer you up?	1	2	3	4	5
e. …that everything was an effort?	1	2	3	4	5
f. …worthless?	1	2	3	4	5

MENTAL HEALTH

K6+ SELF–REPORT MEASURE (1 of 2)

Please turn over the page to continue

Appendix D

K10 - The Impact of Event and measures of distress Scale

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MENTAL HEALTH

Date completed: __ __ / __ __ / __ __ __ __

K10+

Provider: _____

Provider ID:

Please used gummed label if available

Patient or Client Identifier:

Surname:

Other names:

Date of Birth: Sex:

__ __ / __ __ / __ __ __ __ Male ☐1 Female ☐2

Address:

The following questions ask about how you have been feeling during the **past 30 days**. For each question, please circle the number that best describes how often you had this feeling.

Q1. During that month, how often did you feel …	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. … tired out for no good reason?	1	2	3	4	5
b. …nervous?	1	2	3	4	5
c. …so nervous that nothing could calm you down?	1	2	3	4	5
d. …hopeless?	1	2	3	4	5
e. …restless or fidgety?	1	2	3	4	5
f. …so restless that you could not sit still?	1	2	3	4	5
g. …depressed?	1	2	3	4	5
h. …so depressed that nothing could cheer you up?	1	2	3	4	5
i. …that everything was an effort?	1	2	3	4	5
j. …worthless?	1	2	3	4	5

K10+ SELF-REPORT MEASURE (1 of 2)

Please turn over the page to continue

Appendix E

HESPER (The Humanitarian Emergency Settings Perceived Needs Scale)

Appendix 1 - Humanitarian Emergency Settings Perceived Needs Scale (HESPER)

Date:	Interviewer name:	Participant number:
Location (name of city, village or camp):	Gender:	Age:

Rating: 0 = no serious problem 1 = serious problem 9 = does not know / not applicable / declines to answer	Ratings

I am going to ask you about the **serious problems** that you may **currently** be experiencing. We are interested in finding out what you think – a serious problem is a problem that **you** consider serious. There are no right or wrong answers. I am going to ask you about your own serious problems first.

1. Drinking water Do you have a serious problem because you do not have enough water that is safe for drinking or cooking?	
2. Food Do you have a serious problem with food? For example, because you do not have enough food, or good enough food, or because you are not able to cook food.	
3. Place to live in Do you have a serious problem because you do not have a suitable place to live in?	
4. Toilets Do you have a serious problem because you do not have easy and safe access to a clean toilet?	
5. Keeping clean *For men:* Do you have a serious problem because in your situation it is difficult to keep clean? For example, because you do not have enough soap, water or a suitable place to wash. *For women:* Do you have a serious problem because in your situation it is difficult to keep clean? For example, because you do not have enough soap, sanitary materials, water or a suitable place to wash.	
6. Clothes, shoes, bedding or blankets Do you have a serious problem because you do not have enough, or good enough, clothes, shoes, bedding or blankets?	
7. Income or livelihood Do you have a serious problem because you do not have enough income, money or resources to live?	
8. Physical health Do you have a serious problem with your physical health? For example, because you have a physical illness, injury or disability.	
9. Health care *For men:* Do you have a serious problem because you are not able to get adequate health care for yourself? For example, treatment or medicines. *For women:* Do you have a serious problem because you are not able to get adequate health care for yourself? For example, treatment or medicines, or health care during pregnancy or childbirth.	
10. Distress Do you have a serious problem because you feel very distressed? For example, very upset, sad, worried, scared, or angry.	
11. Safety Do you have a serious problem because you or your family are not safe or protected where you live now? For example, because of conflict, violence or crime in your community, city or village.	
12. Education for your children Do you have a serious problem because your children are not in school, or are not getting a good enough education?	
13. Care for family members Do you have a serious problem because in your situation it is difficult to care for family members who live with you? For example, young children in your family, or family members who are elderly, physically or mentally ill, or disabled.	
14. Support from others Do you have a serious problem because you are not getting enough support from people in your community? For example, emotional support or practical help.	
15. Separation from family members Do you have a serious problem because you are separated from family members?	
16. Being displaced from home Do you have a serious problem because you have been displaced from your home country, city or village?	

Interviewers should be trained in the HESPER before use (see Appendix 2 of the HESPER manual).

17. Information *For displaced people:* Do you have a serious problem because you do not have enough information? For example, because you do not have enough information about the aid that is available; or because you do not have enough information about what is happening in your home country or home town. *For non-displaced people:* Do you have a serious problem because you do not have enough information? For example, because you do not have enough information about the aid that is available.	
18. The way aid is provided Do you have a serious problem because of inadequate aid? For example, because you do not have fair access to the aid that is available, or because aid agencies are working on their own without involvement from people in your community.	
19. Respect Do you have a serious problem because you do not feel respected or you feel humiliated? For example, because of the situation you are living in, or because of the way people treat you.	
20. Moving between places Do you have a serious problem because you are not able to move between places? For example, going to another village or town.	
21. Too much free time Do you have a serious problem because you have too much free time in the day?	

The last few questions refer to people in your community*, so please think about members of your community when answering these questions.

22. Law and justice in your community Is there a serious problem in your community because of an inadequate system for law and justice, or because people do not know enough about their legal rights?	
23. Safety or protection from violence for women in your community Is there a serious problem for women in your community because of physical or sexual violence towards them, either in the community or in their homes?	
24. Alcohol or drug use in your community Is there a serious problem in your community because people drink a lot of alcohol, or use harmful drugs?	
25. Mental illness in your community Is there a serious problem in your community because people have a mental illness?	
26. Care for people in your community who are on their own Is there a serious problem in your community because there is not enough care for people who are on their own? For example, care for unaccompanied children, widows or elderly people, or unaccompanied people who have a physical or mental illness, or disability.	

Other serious problems:

Do you have any other serious problems that I have not yet asked you about? Write down the person's answers. 27.
28.
29.

Priority ratings for serious problems:

Read out the titles of all questions you have rated as '1', as well as any other serious problems listed above. Write down the person's answers (write down the number and title of the questions). 1. Out of these problems, which one is the most serious problem?
2. Which one is the second most serious problem?
3. Which one is the third most serious problem?

* Throughout the HESPER form, the term 'community' should be replaced with the term that is most suitable to the local geographical area (for example village, town, neighbourhood, camp and so on).

Appendix F

Communication Principles - Guidelines

There are 5 key principles for effective communication in an emergency. They aim to provide information and knowledge progressively, to assist affected individuals and communities.

i) Provide information about what is known using trusted sources, for instance about the deaths that may have occurred, and where and when information will be available. Information should be provided honestly, in clear and simple language, and with use of community languages. It is important to be honest about the real situation and the limitations of current information and where, when and how further information will be available.

ii) Acknowledge concerns of those who are affected, with sensitivity and compassion. Be attuned to their emotional and mental states.

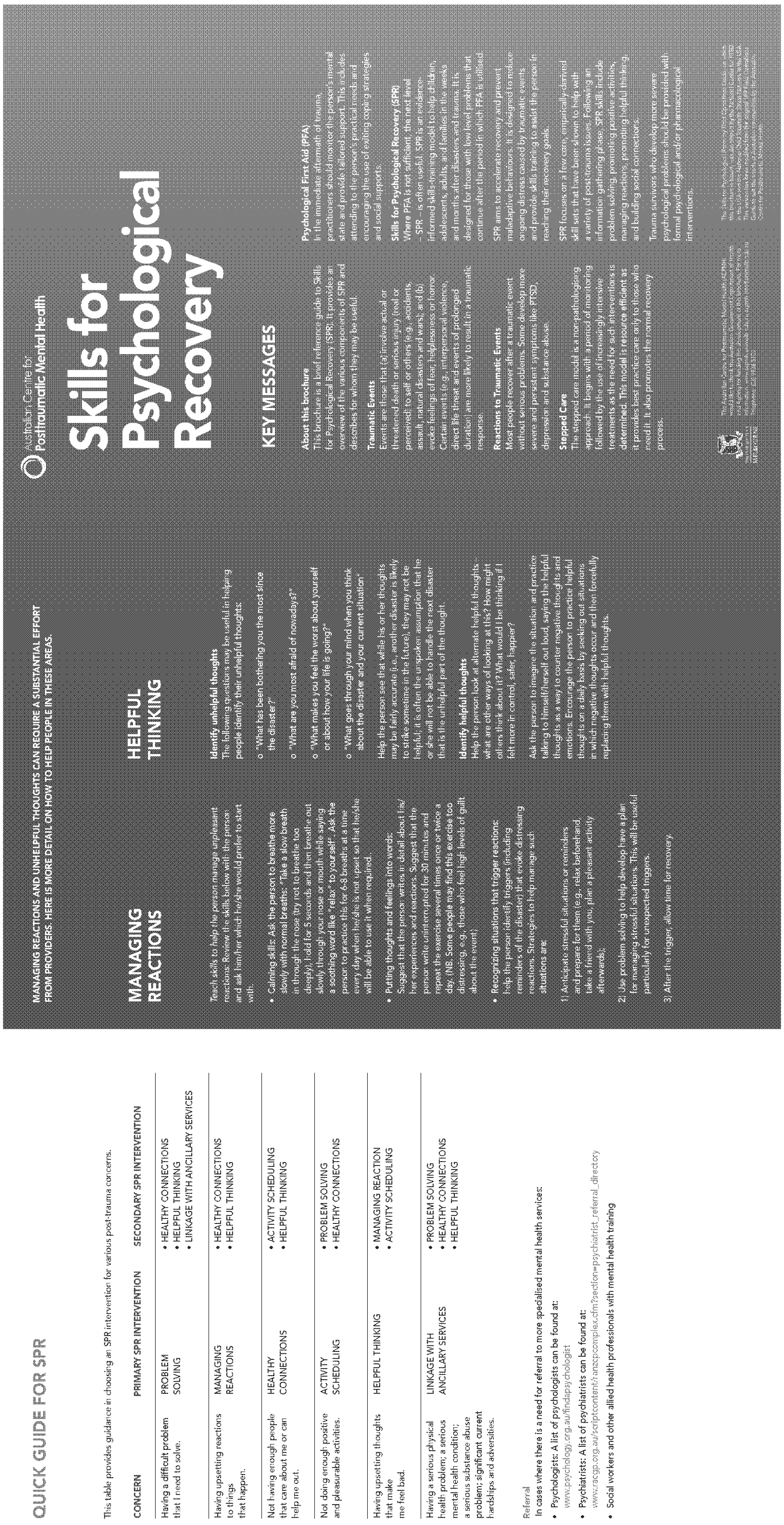
iii) Listen and respond to queries and seek further information as required. Discuss what is known, what is being done to find out more, and what is not known, and where people can take their queries for more information.

iv) Provide information about what people can do themselves, and what others are doing to address their concerns.

v) Identify the information process i.e. how further information will be progressively made available; when, where, and through what media; what people can do to access these sources; and what sort of contributions they can make to the information.

Appendix G

Skills for Psychological Recovery – Quick Guide



Australian Centre for Posttraumatic Mental Health

Skills for Psychological Recovery

KEY MESSAGES

About this brochure
This brochure is a brief reference guide to Skills for Psychological Recovery (SPR). It provides an overview of the various components of SPR and describes for whom they may be useful.

Traumatic Events
Events are those that (a) involve actual or threatened death or serious injury (real or perceived) to self or others (e.g., accidents, assault, natural disasters and wars); and (b) evoke feelings of fear, helplessness or horror. Certain events (e.g., interpersonal violence, direct life threat and events of prolonged duration) are more likely to result in a traumatic response.

Reactions to Traumatic Events
Most people recover after a traumatic event without serious problems. Some develop more severe and persistent symptoms like PTSD, depression and substance abuse.

Stepped Care
The stepped care model is a non-pathologising approach. It begins with a period of monitoring followed by the use of increasingly intensive treatments as the need for such interventions is determined. This model is resource efficient as it provides best practice care only to those who need it. It also promotes the normal recovery process.

Psychological First Aid (PFA)
In the immediate aftermath of trauma, practitioners should monitor the person's mental state and provide tailored support. This includes attending to the person's practical needs and encouraging the use of exiting coping strategies and social supports.

Skills for Psychological Recovery (SPR)
Where PFA is not sufficient, the next level – SPR – is often useful. SPR is an evidence-informed skills-training model to help children, adolescents, adults, and families in the weeks and months after disasters and trauma. It is designed for those with low level problems that continue after the period in which PFA is utilised.

SPR aims to accelerate recovery and prevent maladaptive behaviours. It is designed to reduce ongoing distress caused by traumatic events and provide skills training to assist the person in reaching their recovery goals.

SPR focuses on a few core, empirically-derived skill sets that have been shown to help with a variety of post-trauma issues. Following an information gathering phase, SPR skills include problem solving, promoting positive activities, managing reactions, promoting helpful thinking, and building social connections.

Trauma survivors who develop more severe psychological problems should be provided with formal psychological and/or pharmacological interventions.

THE UNIVERSITY OF MELBOURNE

The Australian Centre for Posttraumatic Mental Health (ACPMH) would like to thank the Australian Government Department of Health and Ageing for funding the development of this brochure. For more information:

The Skills for Psychological Recovery Field Operations Guide, on which this brochure is based, was developed by the National Center for PTSD in the USA and the National Child Traumatic Stress Network in the USA. This version has been modified from the original SPR Field Operations Guide to suit the needs of Australian communities by the Australian Centre for Posttraumatic Mental Health.

MANAGING REACTIONS AND UNHELPFUL THOUGHTS CAN REQUIRE A SUBSTANTIAL EFFORT FROM PROVIDERS. HERE IS MORE DETAIL ON HOW TO HELP PEOPLE IN THESE AREAS.

MANAGING REACTIONS

Teach skills to help the person manage unpleasant reactions: Review the skills below with the person and ask him/her which he/she would prefer to start with.

- Calming skills: Ask the person to breathe more slowly with normal breaths: "Take a slow breath in through the nose (try not to breathe too deeply), hold for 5 seconds and then breathe out slowly through your nose or mouth while saying a soothing word like "relax" to yourself". Ask the person to practice this for 6-8 breaths at a time every day when he/she is not upset so that he/she will be able to use it when required.
- Putting thoughts and feelings into words: Suggest that the person writes in detail about his/her experiences and reactions. Suggest that the person write uninterrupted for 30 minutes and repeat the exercise several times once or twice a day. (NB. Some people may find this exercise too distressing, e.g., those who feel high levels of guilt about the event)
- Recognizing situations that trigger reactions: help the person identify triggers (including reminders of the disaster) that evoke distressing reactions. Strategies to help manage such situations are:

1) Anticipate stressful situations or reminders and prepare for them (e.g., relax beforehand, take a friend with you, plan a pleasant activity afterwards);

2) Use problem solving to help develop have a plan for managing stressful situations. This will be useful particularly for unexpected triggers.

3) After the trigger, allow time for recovery.

HELPFUL THINKING

Identify unhelpful thoughts
The following questions may be useful in helping people identify their unhelpful thoughts:

- o "What has been bothering you the most since the disaster?"
- o "What are you most afraid of nowadays?"
- o "What makes you feel the worst about yourself or about how your life is going?"
- o "What goes through your mind when you think about the disaster and your current situation"

Help the person see that while his or her thoughts may be fairly accurate (i.e., another disaster is likely to strike sometime in the future), they may not be helpful; it is often the unspoken assumption that he or she will not be able to handle the next disaster that is the unhelpful part of the thought.

Identify helpful thoughts
Help the person look at alternate helpful thoughts – what are other ways of looking at this? How might others think about it? What would I be thinking if I felt more in control, safer, happier?

Ask the person to imagine the situation and practice talking to himself/herself out loud, saying the helpful thoughts as a way to counter negative thoughts and emotions. Encourage the person to practice helpful thoughts on a daily basis by seeking out situations in which negative thoughts occur and then forcefully replacing them with helpful thoughts.

QUICK GUIDE FOR SPR

This table provides guidance in choosing an SPR intervention for various post-trauma concerns.

CONCERN	PRIMARY SPR INTERVENTION	SECONDARY SPR INTERVENTION
Having a difficult problem that I need to solve.	PROBLEM SOLVING	• HEALTHY CONNECTIONS • HELPFUL THINKING • LINKAGE WITH ANCILLARY SERVICES
Having upsetting reactions to things that happen.	MANAGING REACTIONS	• HEALTHY CONNECTIONS • HELPFUL THINKING
Not having enough people that care about me or can help me out.	HEALTHY CONNECTIONS	• ACTIVITY SCHEDULING • HELPFUL THINKING
Not doing enough positive and pleasurable activities.	ACTIVITY SCHEDULING	• PROBLEM SOLVING • HEALTHY CONNECTIONS
Having upsetting thoughts that make me feel bad.	HELPFUL THINKING	• MANAGING REACTION • ACTIVITY SCHEDULING
Having a serious physical health problem; a serious mental health condition; a serious substance abuse problem; significant current hardships and adversities.	LINKAGE WITH ANCILLARY SERVICES	• PROBLEM SOLVING • HEALTHY CONNECTIONS • HELPFUL THINKING

Referral
In cases where there is a need for referral to more specialised mental health services:

- Psychologists: A list of psychologists can be found at: www.psychology.org.au/findapsychologist
- Psychiatrists: A list of psychiatrists can be found at: www.racgp.org.au/scriptcontent/ranzcpcomplex.cfm?section=psychiatrist_referral_directory
- Social workers and other allied health professionals with mental health training

GATHERING INFORMATION AND PRIORITISING ASSISTANCE

GOAL
To gather information to determine need for immediate referral or referral for other services, to understand the survivor's most pressing needs and concerns, and to prioritise and plan SPR intervention strategies.

RATIONALE
In the post-disaster period, survivors may need assistance with urgent medical or mental health conditions, be faced with a range of post-disaster hardships and adversities, have concerns about safety, and experience difficulties in interpersonal and role functioning. Gathering information is an important first step in assisting survivors to identify and prioritize their current concerns in order to help them efficiently address these.

Use for:
All survivors who are making a first contact or who are returning after a break in services.

STEPS

1. Explain rationale for information gathering
2. Identifying current needs and concerns. It may be helpful to use the SPR Screening Form (see Quick Guide) to identify patients' needs and help them prioritise them.
3. Prioritise areas to address
4. Make an action plan: Determine whether the problem areas can be addressed by you with SPR or other intervention, or if referral to another service is needed.

BUILDING PROBLEM SOLVING SKILLS

GOAL
Help survivors to solve difficulties or problems that they are currently facing.

RATIONALE
Disasters create many difficulties and survivors often feel helpless in the face of an overwhelming number of problems. Ongoing stress and pressures to "do something" can make it hard to step back and think carefully about the best way to handle a situation. Having a systematic way to solve problems can help survivors regain feelings of control and increase their self-efficacy.

Use for:
Survivors who identify concerns about:
(1) feeling overwhelmed by multiple problems
(2) feeling helpless that they can't solve their problems
(3) demoralization or lack of control over their situation
(4) family members who are having difficulty solving problems

STEPS

1. Explain the rationale for problem solving
2. Encourage the person to define the problem he/she is most interested in solving. Make sure it is a single, clearly defined problem, break larger ones into manageable steps.
3. Decide ownership: Many people, particularly children, take on problems that are not theirs to fix. Help the person identify whether the problem is hers/his to fix. If not, help her/him choose another to work on.
4. Set the goal: How would the person like this issue to be? Setting a goal will help identify practical steps towards a solution.
5. Brainstorm possible solutions: It may be helpful to identify several solutions to the same problem, at this stage, don't try to censor ideas.
6. Evaluate and choose the best solutions: Rate each according to pros and cons. Assist the person in choosing options that are practical and achievable. Follow up at the next meeting to see how it has gone.

PROMOTING POSITIVE ACTIVITIES

GOAL
To help survivors plan and engage in pleasurable activities that will help them improve their mood and regain a sense of normalcy and control in their lives.

RATIONALE
Disasters often disrupt normal routines and activities that provide a sense of purpose, control, and pleasure. Helping survivors identify, schedule, and engage in constructive and pleasurable activities can help them to re-establish routines. Engaging enjoyable activities and hobbies can improve mood and restore a sense of control.

Use for:
Survivors who identify concerns about:
(1) Feeling down or apathetic
(2) Ongoing disruption of normal life routines and activities
(3) Low involvement in pleasurable or positive activities

STEPS

1. *Explain rationale for engaging in positive activities*
2. *Identify and plan one or more enjoyable activity:* Be sure to choose things that are easily achievable.
3. *Schedule activity in calendar:* Help the person identify when they will do the activity, how, and with whom.
4. *Review at next meeting and problem solve if required.*

MANAGING ANXIETY, GRIEF AND LOSS

GOAL
Enhance skills to manage upsetting physical, behavioural and emotional reactions to loss and trauma, as well as to on-going stress.

RATIONALE
Disaster survivors may experience a range of upsetting physical and emotional reactions, both in response to the disaster experience itself and in response to ongoing stress or life changes. As well as being distressing for the person and their loved ones, these reactions can adversely affect decision-making, relationships, daily functioning, and physical health. Learning skills to manage these reactions can help to improve health and well being, enhance interpersonal and role functioning, and reduce use of unhelpful strategies such as social withdrawal and substance abuse.

Use for:
Survivors who identify distressing physical and/or emotional reactions.

STEPS

1. *Explain rationale for learning how to manage distressing reactions*
2. *Identify distressing reactions and their triggers:* People may be angry, sad, scared or worried. They may exhibit physical reactions like feeling tense and on edge. Try to establish what triggers these reactions, when are they at their worst or best?
3. *Teach skills to address priority reactions:* These may include calming skills, putting thoughts and feelings into words, and recognizing situations that trigger reactions. When a person can recognize these situations, he/she can anticipate them and plan how to manage them.
4. *Create a plan to manage a reaction:* A plan can include things they can do to prepare for trigger situations, what to do during the situation, and how to look after themselves afterwards.

More information on managing reactions is provided on the back page.

PROMOTING HELPFUL THINKING

GOAL
To help survivors take stock of what they're saying to themselves about the disaster experience and to help them identify and practice less distressing ways of thinking.

RATIONALE
Many survivors engage in negative thoughts that serve to maintain negative emotions such as fear, hopelessness, anger, anxiety, sadness, and guilt. Identifying and practicing more helpful ways of thinking can improve mood and reduce the intensity of distressing emotional and physical reactions.

Use for:
Survivors who identify concerns about:
(1) distressing emotional and/or physical reactions
(2) being overly self-critical or negative
(3) difficulty addressing fears and anxiety

STEPS

1. *Explain rationale for promoting helpful thinking*
2. *Identify unhelpful thoughts:* Help the person to identify the negative thoughts that are associated with negative feelings. It may be easiest to talk about the feelings the person is experiencing and then ask about the thoughts he/she has when these feelings occur.
3. *Identify helpful thoughts:* Helpful thoughts are not the same as positive thoughts – positive thinking may be just as unrealistic as negative thinking. Do not diminish the impact of the trauma or engage in discussion about whether negative thoughts are justified. Rather help the person see which thoughts are helpful and unhelpful, and to replace the negative ones with more rational alternatives.
4. *Rehearse helpful thoughts:* This gives the survivor a chance to get used to the experience of deliberately replacing unhelpful thinking with helpful thoughts. It also provides the counselor with an opportunity to see how well the survivor has understood the concept of helpful thinking.

More information on helpful thoughts is provided on back page.

REBUILDING HEALTHY SOCIAL CONNECTIONS

GOAL
To increase connections to positive relationships and community supports.

RATIONALE
Social connection is one of the most consistently identified protective factors in studies of disaster survivors. Social support from family, friends, and community resources enhances recovery after a disaster by helping survivors meet their emotional and practical needs.

Use for:
Survivors who identify concerns about:
- feeling isolated or disconnected from friends or family
- disruptions with social or community networks
- lacking access to community supports or resources
- lacking people to talk to about what they are going through
- wanting to provide support to others in need

STEPS

1. Explain rationale for rebuilding healthy social connections
2. Draw a social connections map: Help the person identify who is in her/his social network and who is easily accessible. This will help them see the 'big picture' of who they are connected to and what those connections mean to them.
3. Review social connections map: Discuss how those on the map will provide what kind of support (e.g., household help, giving advice, social activities). Then identify what sort of support/people are missing.
4. Make a social support plan: Choose one area of support to change and plan how to do this in the next couple of weeks.

SEVERE STRESS

If a person presents with severe distress at any stage, particularly if they express thoughts about self-harm or suicide, appropriate steps to ensure safety include psychiatric care or hospitalisation.

Other indicators of severe distress include severe insomnia, agitation, dissociation and social withdrawl.

Quick Guide for SPR **Continued**

PROBLEM AREA		HOW MUCH OF A PROBLEM?		
Physical Health	Do you have any concerns about your own or a family member's physical health?	None/low	Moderate	**High**
Emotional Difficulties	Do you have any concerns about how you or a family member is coping emotionally? [e.g. depressed; anxious; scared; grieving; worry; insomnia]	None/low	Moderate	**High**
Safety	Do you have any concerns right now or in the future about your own or your family's safety?	None/low	Moderate	**High**
Basic Necessities	Do you have concerns about meeting the basic necessities of daily life?	None/low	Moderate	**High**
Substance Use /Abuse	Do you have any concerns about your own or a family members' use of alcohol or drugs, or the overuse of prescription medications?	None/low	Moderate	**High**
Role Functioning	How well are you functioning in your daily life, like at home, work, or school?	None/low	Moderate	**High**
Interpersonal Life	How are you getting along with people, like your spouse/partner, family members, neighbors, friends, or people at work or school? [anger; withdrawal]	None/low	Moderate	**High**
Other Concerns	Is there anything else that you are concerned about or want to share with me? (Describe)	None/low	Moderate	High