Supporting the entire person

A comprehensive approach to supporting people affected by emergencies and disasters

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Introduction

We want to briefly indicate some of the issues confronting us as recovery management co-ordinators, particularly in the area of psychosocial responses to disasters. Our conclusions are derived from the experience of ourselves and other professionals as managers and service providers who have worked in a diverse range of events.

However, we acknowledge that our conclusions need to be tested before significant weight can be put on them. We also believe that similarly rigorous testing needs to be applied to many of the other views, opinions, conclusions, treatment regimes, diagnostic practices and strategies applied in the field of supporting people affected by disasters and emergencies. Much planning and practice, it seems to us, is based upon unsupported subjective experience and anecdote. While subjective assessment is often a valid tool it needs to be sustained by a body of observation and be publicly defensible.

Our interest lies in opening up the debate, in challenging some strongly held views, in seeking more direct evidence that trauma is widespread after disasters and in asking directly whether we spend too little time dealing with the majority of people whose responses to disaster are less than traumatic.

We are also interested in developing the theory of personal support and therapeutic intervention so that it can be couched in operational and management terms and so provide practical assistance in emergency management.

As a colleague suggested, the analogy for much personal support after emergencies and disasters is that of a bus crash involving many people. Too often we provide intensive surgical support to the few people with multiple major injuries but ignore the other survivors.

Background: the nature of disasters

The classification of disasters by the nature of the hazard agent (fire, flood, etc.) continues to dominate the thinking of most emergency managers. This includes those concerned with providing personal support to affected individuals and groups. This leads to an emphasis on activities to contain the hazard, supports a philosophy that favours short-term activities (those necessary until the threat was removed) and encourages a focus on the dramatic and threatening aspects of disasters to the exclusion of other less spectacular effects.

This can perhaps be seen most clearly with the Sydney bushfires of January 1994. By their nature bushfires are spectacular events. These bushfires were close to Sydney, the country's largest city and easily accessible to the media. They therefore captured the attention of the country in a way in which, for example, the much more extensive and more damaging Victorian floods of October 1993 did not. It can be argued that decision-makers and the public were influenced to assess the significance of the events by the media portrayal of the drama and not by the type, level or severity of the impacts.

Largely as a result of the efforts of human service agencies, this standard is being challenged. Increasingly we see disasters and emergencies in terms of their effects on people and communities rather than the atmospheric or geophysical agent causing the damage.

This makes sound management sense. After all emergencies are about people, their social lives and their communities.

This new approach also assists us with the classification of disasters and, by extension, with criteria for deciding on appropriate assistance measures. Fitting events such as shootings, bushfires and toxic chemical spills into the one category of 'disasters' was almost impossible given the disparate nature of these events, and required us to either engage in mental contortions or to ignore the problem. We usually did the latter. The causes, modes of transmission, frequency, spatial distribution, warning time and all the other attributes typically assigned to hazard agents differed too much between hazards to allow us to comfortably or convincingly group them.

Now, however, we have a method of classification that is useful and can be applied, that is, the *consequences* of a disaster. We now understand that there are common outcomes that are useful in analysing the event and which help us in developing management and service delivery strategies. All disasters affect people, all cause disruption and stress, all generate uncertainty. Without these outcomes an event is not a disaster.

Of course, there will be some different impacts. Criminal events may not destroy residences as bushfires do. But both will cause personal stress and community disruption.

Disaster effects

We have made considerable progress in recent years in anticipating and identifying outcomes for individuals, groups and communities of the impact of emergencies and disasters. This in especially so in the area of psychosocial consequences.

But despite this progress, and while we now acknowledge impacts on people as the proper focus of emergency management, we do not fully understand all those impacts. This is particularly the case in their secondary and tertiary effects and how different impacts interact. So, for example, we understand how the loss of income earning assets affects lifestyle, but we do not understand full range of psychosocial impacts of income loss, or how trauma resulting from a life threatening situation, income loss and the stress generated by income loss may interact.

We do not completely understand the incidence and distribution of psycho-social impacts. What causes trauma, what causes stress and what is simply annoying, disruptive and inconvenient?

Rob Gordon, in a paper on Port Arthur, speaks of some major irritants to the survivors that included being asked to pay for their bandages. He states the symbolic effect of this was

highly significant for the emotional state of the victims—an apparently trivial issue had a very considerable and unintended outcome.

Nor do we understand what people (or classes of people) are vulnerable to particular impacts. Of course we have general views about how the young, the aged and the socially marginalised may react, but these are vague, often untested generalisations. These impressions may be useful in developing strategies—or better still in developing research hypotheses—but of less use in developing specific services.

Also we focus on those who have suffered loss, trauma and bereavement and who apparently cannot cope with day-to-day life and work towards their own recovery. We do not focus on those people who display resilience (strength, fortitude, courage, stoicism, hope, faith and so on). As a consequence we do not learn from these people—we put people back together again but we do not try to develop preventative programs. We assume that people will fail, not that they will succeed. We are interested in collapse, not in growth. We favour the study of vulnerability over the study of resilience.

In other areas of recovery management, particularly infrastructure repair, we are increasingly turning our attention to the developmental opportunities provided by a disaster, looking for ways to improve the situation of the affected community. And we increasingly acknowledge that recovery is concerned with moving forward and is not about returning to the past.

But when it comes to dealing with what goes on inside people's heads we are concerned to patch up the damage, to restore the loss, to minimise harm rather than to foster growth, independence, confidence and resilience.

We have indicated here some significant problems. The positive side of this is that 10 years ago—even 5 years ago—we were not even aware of these issues, let alone concerned to tackle them.

Victorian involvement in disaster management

The recognition that disasters are defined by their consequences rather than their causes has lead Victorian recovery arrangements to embrace a range of events beyond the traditional body of natural disasters (bushfires, floods and windstorms).

Over the past decade we have provided recovery services to people and communities affected by bushfires, floods, storms, toxic chemical contamination, transport accidents, criminal shootings, hostage situations, failed financial institutions and sudden-impact community economic dislocation.

Our involvement has been over a wide scale of events, ranging from incidents that have involved only a few number of people to the floods of 1993 that rank as perhaps the fourth-largest natural disaster in this country (in terms of principal residences affected). Some of these events have been stressful and potentially traumatising for the people involved. Some have been violently destructive of homes and other property.

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Some have affected only a few people and localised communities, while others have had an impact across a wide area.

In all of them, we have encountered people who have suffered greatly and whose capacity to manage their own affairs and to manage their own recovery is greatly impaired. We have encountered some people who have required intensive assistance to overcome the impact. However, these people are a very small proportion of the affected population.

Equally, we have met relatively few people who have been so traumatised that they have been psychologically disabled or deeply affected that they have not been able to contribute to their own recovery.

While formal research investigations have not been undertaken (and this is an issue in itself) there is no indication from our program staff, our community development officers, the staff of local government or the staff of non-government organisations that trauma after any of these events is frequent and widespread. Its incidence in any given affected appears to be low.

Personal support strategies

Given an initial assessment of an event based on our experience of previous events and the professional skills of our managers and service providers, we are generally confident that the majority of people affected will be able to manage their own personal response to the event.

Our first action after an event is to assess likely impacts: numbers of people affected, the nature of the impacts, types of people have been affected, what local or other support networks and services are available.

At the same time we will make available in the affected area information on the range of possible psycho-social effects of the event and coping strategies. We will also provide skilled consultants to advise our managers and service providers on the event and its likely repercussions for the community.

As far as possible we will refer people to established networks and, unless there is evidence of greater need, retire to a consultancy role provided only on demand.

For large-scale events, we will parallel the provision of information with an outreach program, typically conducted by churches and other non-government organisations supported by local government and the Department of Human Services. This activity arranges for a skilled volunteer or para-professional to visit each affected household. The purpose of this visit is to confirm the damage to the site, provide information to household members and to make an informed initial assessment of how well people are coping.

Where more intensive support is required, group debriefing processes, in conjunction with local support networks, may be set up in the first weeks after the event. The purpose of these sessions is to put the event into context and to provide the affected population with a greater range of self-applying support skills and to further link people into formal support networks.

A next step may be to provide

counselling services to people. Our own staff, social workers, counsellors from the National Association for Loss and Grief and other agencies may all provide individual or group services for the affected population.

Where affected people show a clear incapacity to maintain a reasonably normal life and to manage their own recovery then referral to a clinical psychologist or psychiatrist may occur. The support these professionals provide may continue for an extended period.

The important elements of this approach are:

- we do assume that most people, with access to information and advice about possible coping strategies, will be able to manage their own affairs
- no assumptions are made about the extent or intensity of the impact on any individual
- information on possible affects and appropriate coping strategies are made available
- initial assessment of impacts is accompanied by constant monitoring of personal and community responses
- trauma is not assumed to be an inevitable outcome of the event
- support is provided in a graduated and co-ordinated manner
- debriefing and counselling services are always available if necessary but are provided only after assessment.

Organisation of personal support

An important element in service provision has been identified and deserves description as a significant approach.

Throughout this process support from a para-professional or caring administrator is always available. For affected people these staff are conduits for information, providers of logistical support and access points for a wide range of services.

This service continues throughout the recovery process and underpins and supplements all other services, especially clinical support.

It has been observed that clinicians (apart from charging for their services which may restrict availability for affected people) see their clients generally for short periods at defined times, and they are not readily available outside these pre-determined appointments. This applies even where an immediate and unexpected need may occur.

Now, while the more profound or traumatic aspects of the impact may need to be addressed by clinician services, the logistical and day-to-day support, essential to maintaining a normal lifestyle and to achieving recovery, is equally important.

The para-professionals or administrators providing these services are often the people to whom the affected people turn first for support, sympathy, advice and resources. They are the people who provide the context and resources in which recovery proceeds.

Now, this program of providing personal support may be compared to the process of surgery. We can identify the critical role of the surgeon in the medical process, but their position makes no sense unless we place it in the context of the operating theatre with a nurse, assistant surgeon and anaesthetist.

For many the only help needed was information ... most contacts required only one visit, but they were supplied information of where to go should they need further assistance ... We found that the type of assistance needed by many of the survivors had little to do with clinical services. They asked for many things, such as assistance with accounts, questions about appeal funds, conversions of bathroom fittings, transport to appointments etc.'

Further, the surgery cannot be understood—nor would it be successful without the involvement of the general practitioner who first identified a problem, the nurse who provides day-to-day care, the physiotherapist who ensures rehabilitation and the love and comfort of relatives and friends.

In our experience the clinician and the treatment of trauma stands in the same relation to other recovery workers as the surgeon does to the other medical staff.

This analogy may be taken a little further. Medical and paramedical staff, particularly physiotherapists, are concerned not just to repair the damage or to restore a physical function but to improve the body's capacity to withstand injury. The aim is recovery but also improvement.

Psychosocial workers can learn from this and should aim not to just minimise the damage and restore equilibrium but to encourage growth and resilience.

A compilation of case studies from Victoria's recent experiences

Port Arthur shootings

In the days and weeks following this tragedy, the Department of Human Services advertised a central contact number for any survivors requiring assistance. From this central point, calls were diverted to each regional office. Calls were taken by each Regional Debriefing Coordinator, who then arranged visits by clinicians, debriefers and trained counsellors from agencies, for example the Victorian Council of Churches. For many the only help needed was information. Callers were given verbal advice or sent packaged information. Most contacts required only one visit, but they were supplied information of where to go should they need further assistance.

We found that the type of assistance needed by many of the survivors had little to do with clinical services. They asked for many things, such as assistance with accounts, questions about appeal funds, conversions of bathroom fittings, transport to appointments, or someone to be with them when interviewed by the Homicide Squad.

Dandenong Ranges bushfire

A similar strategy was used in our response. The recovery of the fire-affected community was enhanced by the early supply of personal support responses. Information was sent out through informal and formal channels, including an outreach walkabout, but also through other systems across the Ranges. For example council tree loppers were supplied with information in case community members asked them for information.

Mitcham siege

This was another example where the early supply of personal support was successful. Eight employees were held by a gunman for over 5 hours. Personal support was offered to families of the victims as they waited at the police barricades. Police information was given as often as possible. Some relatives found the loan of a mobile phone the most helpful personal support assis-

tance. (This event happened in the middle of the day and one Melbourne radio station broadcast continuously from the site.)

After each witness had given their police interview, personal support staff were in attendance at the police station.

Although there have been affected people from these events who have sought clinical services, there are many who have required other support.

When some survivors are having a 'down day', they will phone asking perhaps for information about accounts etc., but where time permits and a visit can be arranged, it is clear that while the contact was initially about information, they are actually seeking something else. This 'something else' is not about therapy or counselling, it has its own quality. Perhaps it is the survivor knowing that there is *someone* who can respond in a multitude of ways and that while others are expecting them to 'get on with life', he or she knows that there is still someone looking out for their whole-of-life recovery.

In Victoria, those who are involved in personal support services following emergencies have 24-hour access to the Clinical Director Rob Gordon. Rob is contracted to the Department of Human Services to provide consultancy and advice to debriefers involved in this work.

The Victorian response to the tragedy of Port Arthur has been to make available to affected people a continuous range of support services, ranging from practical transport services to logistical support to clinical treatment.

This is a typical array of services after emergencies, but in this case we have found a greater-than-usual reliance on the support provided by non-clinical providers. In some cases this is because injuries and wounds have required greater physical assistance. Overall it seems that people are generally able—or at least willing—to try to manage their own recovery, but require information and day-to-day support in practical matters to achieve this.

This support includes transport services, information, advisory services, service co-ordination, liaison and advocacy, referral and general discussion sessions with recovery workers (often an affirmation process for the affected person).

This situation also applied after the Dandenong Ranges bushfires. Three people were killed, 44 houses were destroyed and many thousands of people lived within the affected area.

As well as municipal and state personal support co-ordinators, the Department of Human Services funded a Community Development Officer at the Shire of Yarra Ranges for 12 months after the fires. Other agencies, such as the Victorian Council of Churches, have been instrumental in providing support through outreach services and visitation programs. Local community committees have been set up as self-help groups.

More so than in most previous events, local people have taken responsibility for their own recovery and have rallied to provide an extensive range of support services to each other.

These have included temporary accommodation, food supply services, clean-up and debris removal, information services, tree removal, commemorative services, fund-raising services, and ceremonial and symbolic services.

The incidence of trauma following this event appears to be relatively low. In fact, referral and access to local health services declined very significantly after the first few months. This incidence of disabling stress and trauma is, on the face of it, lower than in previous bushfires.

Prima facie we attribute this to the comprehensive and well-organised range of personal support services offered by State and municipal government and by the affected community itself.

People were able to easily obtain information about possible personal responses and about useful strategies for dealing with these, and for working towards recovery.

This is not to say that some people were not significantly affected or traumatised, and there is an indication from the slow progress of rebuilding that the bushfires had a profound effect on some people.

But it suggests to us that the role of personal support and local community programs may be instrumental in alleviating some traumatic responses.

Conclusions

1. The Victorian experience is that trauma is not an inevitable outcome of disasters and that where it does occur it is unlikely to be widespread.

2. Assumptions of psychopathology may be inappropriate in the context of disasters that typically impact on otherwise mentally healthy people.

3. We acknowledge that some groups of people may be more susceptible to trauma and severe stress and that some events—particularly those that have threat to life and a horror as central elements—may be more likely to generate trauma.

4. A range of psycho-social responses require an equal array of services to meet those needs and those services need to be structured and ordered in the way in which they are provided.

5. Developing successful coping strategies will require a better understanding of resilience and will necessitate putting proportionately less emphasis on negative responses.

6. The support of affected people and communities requires an approach that integrates clinical services with all other services and which places the individual, rather than the professional practice, at the centre of the management strategy. This may be termed 'addressing all life issues that are relevant to the affected persona and not just the manifestations of extreme psychological reactions'.

The area we are exploring at the moment concerns setting conceptual boundaries to events. It seems from some recent events, such as the Port Arthur shootings and the outbreak of anthrax at Tatura, that negative personal and community reactions are more likely where the cause of the event is not explainable (even as an 'act of God') and where there is a moral dimension to the event.

People need to understand the cause of an event and to understand and accept why it happened. For events such as floods and bushfires this is easily done.

Floods by and large occur on flood plains and after heavy rain. Bushfires happen in areas prone to fire and a source of ignition is usually evident.

However, other events particularly criminal events directed by malice or some other mental state, are less easily explained and rationalised. It seems that in these cases people have difficulty accepting their losses and often have difficulty working with their community to overcome the impact. Where they are isolated they in turn lack many of the usual support networks.

The novelty of our approach is that we acknowledge the partnership of services and professional service providers. We do not accord greater standing or status to any particular group of workers (community development officers, psychiatrists, therapists and so on), and we understand that only integrated and collaborative service provision will provide an effective range of services to support people in achieving their own recovery.