

OPINION: Disasters, children and families: have we arrived at a comprehensive model of emotional health care?

Professor Brett McDermott explains that the emotional health of children is a key factor in resilience during and following disaster.



The emotional health care of young people and their families post disaster is still an area of response requiring attention and service delivery refinement. I conducted my first research into the impact of disasters on children's mental health following the Sydney bushfires in 1994 where I directed a project that screened 4 000 children. A smaller project was undertaken after the Canberra bushfires (2003), then major service initiatives (school based programs to identify and intervene with distressed children) followed Cyclone Larry (2006), a mini-tornado in Brisbane (2009), and the Queensland floods and Cyclone Yasi disasters (2010-2011).

The current model of emotional health care has developed out of these past events and over the last three projects, clinical psychologist Dr Vanessa Cobham, has been crucial to the development of the model. Currently, the team from the Mater Children's Hospital in Brisbane is co-ordinating the Tasmanian bushfires child and family response in a new and exciting collaboration with Beyondblue and the Australian Red Cross.

Prior to this recent model of care, child and adolescent emotional health service provision in the post-disaster setting was typified by either whole-of-community efforts (with an emphasis on a return to usual routines), promoting social connectedness, and limiting secondary impairment by encouraging social and financial recovery. Providing information was a strength of past initiatives but direct therapy for children was a secondary focus. When therapy was offered, the efforts often included the use of guided trauma workbooks.

Such initiatives were trialled for some children after Ash Wednesday and the 1994 Sydney bushfires. For occasions when expertise was sought (and this was not always the case) it was often from international experts who had few local connections and were often not mindful of local service delivery implications. However, all of these initiatives were helpful and the expertise offered was greatly appreciated.

The last decade has seen a burgeoning of local research that has informed service initiatives, including published rates of severe to very severe posttraumatic stress disorder (PTSD) after bushfires, cyclones and floods. In addition, 18-month follow-up data is available for children who experienced *Cyclone Larry*, as well as published research on resilience and family functioning in the aftermath of natural disaster. Looking forward, the next 12 months will see studies published on the effectiveness of therapy, how quality-of-life is associated with post-disaster child mental illness symptoms, and parent satisfaction with a post-disaster screening program.

A major advance in Queensland after the 2010-2011 disasters was implementing a public health intervention via a 'stepped-care' model. This approach acknowledges existing Child and Adolescent Mental Health (CAMHS) services are at capacity prior to a natural disaster and have little surge capacity to meet a sudden increase in need following a disastrous event. Further, not all individuals will require the intense interventions that are usually provided by CAMHS. A stepped-care approach is a solution which provides a range of integrated interventions across the spectrum of consumer need. In essence - wide reaching, low intensity interventions can be provided to all families, while greater intensity interventions can be reserved for those individuals with higher need.

The tiered approach

In the Queensland response (McDermott & Cobham 2012) the first tier of the model (wide reaching low intensity interventions) included a Youtube vodcast² series for school teachers, guidance offices, and

² A vodcast is a video podcast, a video broadcast over the Internet.

parents. This use of technology complimented traditional community forums and tip sheets and other paper resources detailed child and adolescent reactions, management advice for parents, and how to obtain further assistance.

The second tier was teacher training and parenting seminars. The ethos of teacher training was not to turn teachers into therapists; rather to promote the continuation of school routines. Training provided advice about communication and identification of symptoms (given the inevitability of classes with many distressed students) along with referral pathways. Another important module focused on teacher self-care. The teacher training manual and seminar was created by staff from the Centre of National Research on Disability and Rehabilitation Medicine (CONROD) led by Professor Justin Kenardy.

The response also included a parent intervention based on research that parenting can change in the aftermath of a natural disaster. If these changes persist they may provide a barrier to a child returning to their pre-disaster level of functioning. Changes in parenting include overprotection of the child, hyper-vigilance of their activities, and removal of a child's autonomy (Cobham & McDermott in press). In collaboration with Professor Matt Sanders, 'Disaster Recovery Triple P' was developed. This two-hour parenting seminar was designed to educate about these potential changes in parenting and offer practical advice about returning the family to their pre-disaster functioning.

The third tier of the model (narrow reach, highest intensity) was Trauma-Focus Cognitive Behaviour Therapy (T-F CBT). Past clinical experience, consistent with published research, has found few parents seek a mental health assessment for their child following a traumatic event. Reasons for this are multiple. For many families, there is no tradition for seeking help from a mental health professional following a disaster and some may be concerned about the stigma associated with mental illness. Many young people withhold their feelings from their parents believing their parents have enough to deal with following a natural disaster. And finally, parents themselves experiencing PTSD and/or grief may not be as adept as usual in identifying subtle differences in their child's emotions and behaviours.

In response, the Queensland approach offered school-based screening to identify children and adolescents with persistent symptoms three to four months after the natural disaster. The first stage of screening was a pencil and paper questionnaire administered in the classroom. Screening required parent consent and measures were standardised to the child's age. Our experience is that children eight years and older can complete this questionnaire without difficulty and without distress. Over the last ten years, more than 8 000 children have completed the school-based screening. If the child scores above a predetermined cut-off then a more rigorous face-to-face assessment is advised.

All cases identified by screening must ethically be offered an evidence-based intervention. The Australian Clinical Practice Guidelines³ for Posttraumatic Stress Disorder (2013) clearly establish T-F CBT as one such treatment. When providing this stepped-care model in places other than Queensland, for example parts of rural Tasmania, local practitioners have been trained in T-F CBT and remote supervision has been provided via telehealth or Skype.

To summarise, the reality is that the emotional health needs of children and adolescents after a natural disaster cannot be met by existing mental health services. Further, a public health model is the only meaningful response to a large scale event. Many years of research, service provision and collaboration with creative and resourceful colleagues has led to an integrated, increasingly evidenced-based and comprehensive post-disaster model of care for children, adolescents and families. Future directions include better awareness raising and uptake of these resources. Continuing to evaluate aspects of the model is imperative, so too is further work to establish the benefits of integrating new technologies into current interventions. A comprehensive model of emotional health care, which provides timely intervention to all children and families, should help local health providers not feel the need to 'reinvent the wheel' following a disaster.

References

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About the author

Professor Brett McDermott is the Executive Director of the Mater Child and Youth Mental Health Service in Brisbane, Professorial Fellow at the Mater Medical Research Institute and Professor at the University of Queensland, a By-Fellow at Churchill College, Cambridge University, and a Director of the Beyondblue. His clinical and research areas include children and adolescents with depression, post-traumatic mental health, and child and youth mental health service provision.

This article reflects the opinions of the author and are not necessarily those of this publication.

3 The Australian Clinical Practice Guidelines. At: www.clinicalguidelines.gov.au.