COMMUNITY DEVELOPMENT AND JUSTICE STANDING COMMITTEE

INQUIRY INTO THE RECOGNITION AND ADEQUACY OF THE RESPONSES BY STATE GOVERNMENT AGENCIES TO EXPERIENCE OF TRAUMA BY WORKERS AND VOLUNTEERS ARISING FROM DISASTERS

TRANSCRIPT OF BRIEFING
HELD IN NEW YORK, USA
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SESSION TWO

Members

Mr A.P. O'Gorman (Chairman)
Mr A.P. Jacob (Deputy Chairman)
Ms M.M. Quirk
Mr I.M. Britza
Mr T.G. Stephens

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Briefing commenced at 1.07 pm

KATZ, DR CRAIG L.
Psychiatrist, Mount Sinai School of Medicine:

The CHAIRMAN: I will quickly explain a little bit about who we are and what we are doing. Margaret and I are two members of a five-member parliamentary committee called the Community Development and Justice Standing Committee. We have responsibility for looking at 17 portfolios, of which emergency management is one. One of the questions that has been posed to us and that we pose to ourselves and that we are looking at now is the mental wellbeing and mental health of our volunteers and our regular full-time firefighters and police and first responders. We have just been to an international disaster conference in New Orleans, and we have come up here and talked to a lot of people about 9/11. Just for our benefit, could you give us some of your background in regards to emergency management and mental health?

Dr Katz: Sure. I am a psychiatrist and I co-founded a group called Disaster Psychiatry Outreach back in 1998, to use psychiatrists to help people after disasters. In that capacity, over time, I have responded to lots of disasters here, domestically and internationally. One thing that we did was help to start the World Trade Center rescue worker program at Mount Sinai, which I ran for a number of years and now have more of an advisory role to.

The CHAIRMAN: Thanks for that.

Ms M.M. QUIRK: What was the original catalyst for starting it up?

Dr Katz: The organisation?

Ms M.M. QUIRK: Yes.

Dr Katz: Well, we were training in psychiatry and we kind of randomly got involved in a response to an air crash—Swissair flight 111, which crashed off Nova Scotia. Four of us who were trainees in psychiatry wound up at JFK [airport] helping out the families that were coming in; it was an international flight. We did not quite know how we got there; it was through a bit of randomness. We also did not know what equipped us to be there, or whether people would actually want us there, besides the organisers, but we found it to be really compelling. Then we found it was actually quite random and we could have used better training. We met with local disaster organisations like the Red Cross, and they thought it would be great if they could be able to turn to psychiatrists, in particular, to help out after disasters and organise in a less serendipitous way.

The CHAIRMAN: Can you give us a bit of an idea of how, from your point of view, psychiatrists and psychologists respond to disasters, and what they can provide?

Dr Katz: There is actually quite a scarcity of science underlying what is the right thing to do, and that is a problem. So, in the end, I think you fall back on good old clinical common sense and what feels like the right thing to do. I think a lot of it is managing very intense reactions, intense so-called fight-or-flight responses that have outlived their utility, when there is no reason to be fighting or fleeing, and helping people just to decompress so that they can function as soon as possible and do the things that they need to do.

For those who are aggrieved, we potentially help them through that process. I think a lot of it is also psycho-educational. When things are calm, it sounds kind of silly— you need to tell people to sleep and eat and standard routine, but I actually think that in times of crisis, it actually helps to have someone telling you that, and it particularly helps to have a doctor telling you that, because people listen better.

I think probably the most fundamental function, and one that I think could be better organised, is screening— to screen people who are at high risk, even if they are asymptomatic, of having long-term mental health sequelae; identifying them and, potentially, following them, and/or referring those who are highly symptomatic to ongoing care.

Ms M.M. QUIRK: So if they are asymptomatic, what would you look for?

Dr Katz: There are pretty well-defined risk factors. Having a high exposure would probably be the most evident one, although how you measure exposure can be a little complicated; it is not like a radiation badge. [9/11] Ground Zero was very simple: "How many hours did you work?" Not that anyone observed that, but we knew intuitively, and science supports that the longer you were down there, the more likely you were to sustain some kind of lasting psychological damage. So, exposure to prior traumas; there is a whole debate about whether repeated traumas create callouses and make you tougher, or scrape up the wounds and make you more vulnerable.

But generally, I think, after a while you can only take so much, so repeated traumas in the past, having a prior psychiatric history of any kind, having problems in your life before—economically, personally, socially—and having a perceived or real loss of support after the disaster, particularly if you have lost loved ones. Those are probably the best-known risk factors. Being a woman is a risk factor, too; possibly being an ethnic minority may be a risk factor. There are ways to potentially identify people, not that I actually know of an instrument that looks at those particular risk factors, but it has been shown over and over that that is who you would follow.

The CHAIRMAN: You said you have responded to many disasters now, around the world.

Dr Katz: Yes.

The CHAIRMAN: Aside from 9/11, what other ones?

Dr Katz: We have done a couple of aviation disasters here in New York. Hurricane Katrina, although I did that from here in New York, my colleagues— I have been President of this organisation forever; cannot get anyone else to do it! So often I am sort of behind the scenes, doing things. We helped with the Katrina evacuees who came up to New York; my colleagues went down to Baton Rouge. I have been to post-earthquake El Salvador, post-tsunami Sri Lanka, and I was just in Japan for the long-term follow-up to the tsunami two weeks ago. We have done some remote work in China after the 2009 earthquake; we did it through Skype. We did some long-term work in India after the Gujarat earthquake which, I think was 2007— maybe older than that.

Ms M.M. QUIRK: Qualitatively, when would you be using a psychiatrist as opposed to a psychologist or a counsellor?

Dr Katz: It is a really good question. A psychiatrist—at least, here in the States—we can prescribe and the others cannot, so there is the opportunity there to have that in your bag of tricks. Not that we want to go and medicate everybody, but it is definitely a simple and easy option. How to know when that is going to be is another question, but I have generally found with psychiatrists, they are often in some settings the only physician, so you actually wind up doing basic medicine or giving counsel.

A crash victim's mother was about to board an aeroplane to go up to the crash site off Nova Scotia, and had chest pain. The airline was saying, "You're not going", and the Mayor's office was saying, "She is going." And so we stepped into that and said, "Let's just go get her an EKG"; JFK has a clinic. We did that, and she was fine, and we put her on the aeroplane. There was actually a physician at the clinic to read it, but I could probably read EKG if I had to, still. Sometimes you have to just act as a physician, and then as a psychiatrist, you have the medication piece. I also think it depends on the bent of the mental health professional, but I think when you are working in the acute setting, it does not matter what your discipline is in mental health; you just have to kind of know that you are operating in somewhat virgin territory from an evidence base and you have to kind of be like what Socrates says: the wise man is he or she who knows what they do not know. I

just think you need someone who tends to be grounded in scientific literature as much as they can be. Psychiatrists can be—certainly psychologists can be, too—that grounded. I think social workers come from less of a science background.

Ms M.M. QUIRK: You are being very kind, I think.

Dr Katz: They are very kind—

Ms M.M. QUIRK: No, you are being very kind!

Dr Katz: Oh, okay. I think you want to know the science and know whether you are out of your depth.

Ms M.M. QUIRK: What is your feeling about, in the case of first responders early debriefing? There seems to be a bit of a controversy developing about whether that should be done or not done?

Dr Katz: It seems to me that there are some people that want to talk right afterwards and some people that do not, and I think most recommendations are that if you want to talk, all right, and if you do not, do not make somebody talk, unless, in the rare instances we have seen, people become literally mute. Their family says, "My mother's not talking, she's not eating—help". Except for that, you do not really make people talk until they are ready, so I think that is the long and short on debriefing. I mean, after a disaster, lots of people say, "I want a debriefing" or "So-and-so needs a debriefing." It tends to be in the air; it is in the sort of pop culture. You just kind of have to know how to listen and when to expect somebody to talk.

The CHAIRMAN: You set up the program at Mount Sinai straight after 9/11. What prompted that and what did you actually set up? What was the process?

Dr Katz: At Mount Sinai we have a division of occupational medicine that has worked for many decades with the local labour unions in New York, so it has a long tradition of tending to occupational bumps and bruises. They, very quickly after 9/11— given that 40,000 to 80,000 people responded, depending on who you count, down to Ground Zero— got some government funding to address the occupational exposures that they suffered. In piloting it, they very quickly realised that a lot of these guys were coming in and that they wanted to talk; they were just balls of tears and emotion. So they approached my Department of Psychiatry and said, "You better help us or we're going to go to Columbia!"

I remember the conversation. In New York that works really well, actually; people snap to attention! But it turned out that there I was, the disaster mental health expert in the Department, and I previously had a conversation with the Robin Hood Foundation [www.robinhood.org/home.aspx] here in New York about trying to meet unmet needs after 9/11. They said, "If you find an underserved population, come back and see us." It was sort of a no-brainer to go back to them and say, "Here you go; here's a bunch of responders who are not going to get mental health services because the government is going to pay just for medical and they are going to throw in a P-test e-survey and that's going to be the end of it." These were men, largely working class, who tend not to see mental health professionals, so they probably were underserved anyway. And here was the opportunity.

The CHAIRMAN: The unions came to see you. Why would it be a union rather than the Fire Department or the City that employs the people? Why would it be their representatives rather than their employers?

Dr Katz: That is a good question. My colleagues in occupational medicine probably know the politics better than I do, but I think there is an institutional sense that "We can take care of our own", and then there is a sense from the unions that they are not there for their workers; they are there for their own institutional self-preservation. Certainly, we heard that from a lot of guys. Whether it is accurate or not, I do not know, but there is that perception. The sense was, "They got us into this trouble", or there was a large perception that the government was not honest about the

occupational exposure, so there was a big mistrust of authority. I think it helped a lot to be the outsider that had an inside track, at least from an occupational medicine perspective, and in mental health, we were able to sort of piggyback onto that sense of trust.

The CHAIRMAN: What did you actually set up?

[1.21 pm]

Dr Katz: Well, this was July 2002. At that point, the plan was for people who met certain exposure criteria— which are basically being there on the first day, or for a certain number of hours— were going to be coming in for occupational health exams that would span three to four hours. That would involve a range of physical examination and blood testing and radiological testing, pulmonary function tests. So what we did is we got funding to have basically a mental health booth as part of that day, so we basically added a mental health stop along their way, and we hired psychiatrists and social workers to work in teams to do the same day onsite screening. That was the magical ingredient— so-called co-locating us right there— because no way they were going to come in to see us, but they were going to come in because they were worried about their coughs or whatever. So we were a stop along the way.

Initially there was a lot of debate with our colleagues in occupational medicine about what to call us. If they called us psychiatrists, they did not think people would come; they would stop. So we called ourselves counsellors for a while; we sort of swallowed that. But I think over time we just sort of became part of the system. Our original program was going to be just for one year. When I wrote the first grant it was just going to be for one year. But each year, occupational medicine got renewed for their medical screenings, and then we would go back to our private funder and say we have to play catch-up. So we did that for five years; every year we went back.

The CHAIRMAN: So that was privately funded through the Robin Hood Foundation?

Dr Katz: Exactly. We got a little bit of money from SAMHSA, which is the Substance Abuse Mental Health Services Administration, and we got a little bit of money from Project Liberty, which was the big, government FEMA crisis-response program. But we got millions of dollars from the Robin Hood Foundation over quite a number of years. They really trusted us. We turned out to be their biggest recipient.

The CHAIRMAN: You mentioned earlier on about how it is important to say to people, "You need to eat; you need to sleep". So how important is that to get into emergency management plans, where you know if there is a disaster and you get so many responders, you are going to do eight hours, eight hours, eight hours, or 12 and 12, whatever it is? Do you have any input in getting them into management plans?

Dr Katz: I actually think— I actually sent a paper I wrote to David earlier today with this, because I thought it might be relevant— if you integrate that into the culture of your workforce before the disaster, it is going to work a lot better during the disaster. So if you have a work culture that emphasizes balance and self-care and even physical and mental health, it is going to carry over a lot better. In an ideal world, it is more like prevention. Other than that, if that is too idealistic, I think you sort of need a physician around the table. I do not know that it necessarily needs to be a mental health professional. It could be, but we are not talking about rocket science. If it is someone who feels strongly about it and can look over a plan and say, "Well, it is nice that you say in the last paragraph 'and we will address the stress-related needs', but how are you going to do that?" Everyone puts that in— it is sort of politically correct— but how are you going to operationalise it?

So having someone just act as a consultant and be at the table. I think the problem, at least for a psychiatrist, is that we tend not to be proactive. We tend to be reactive bunch, so people come to us in our offices eight months later instead of our being there at day one or eight months before.

The CHAIRMAN: The reason I ask is because when we went to Christchurch and we spoke to some of the first responders there, right up to the top levels, the police chief and the Police

Commissioner and the head of Red Cross, and they said very early on they kind of figured that they had to break the shifts up and have eight, eight, eight, which is eight hours on the job, eight hours at home looking after your family and yourself, and eight hours that was allocated for sleep. They recognised that they could not force everybody to do that, but it was part of the regime. But here we heard that for some people they just worked 18 hours or 20 hours, and the thought was, well, that is what they need to do, so we will just let them do it, until it becomes a risk factor and you have to take them out because they are just too tired and they are making mistakes.

Dr Katz: That is great that they did that.

The CHAIRMAN: They actually took it one step further in the recovery process where they allocated an extra six days leave to be taken over six months. That would come at the front or the back of a weekend, so it would give you—it did not force you—the opportunity to head out of town so you are actually not in the disaster zone any more. It just seemed to me to be good sense.

Dr Katz: Yes, in a sense it is just common sense. But around here, maybe New York tends to be a somewhat hard-charging place under the best of circumstances. But we generally need to slow people down.

Ms M.M. QUIRK: In terms of peer support for firefighters, police or what have you, is it your observation that that is enough, or there needs to be some injection from a mental health professional like yourself?

Dr Katz: I think it should be a tiered system, right. For the most part, peer-support or home-support or spiritual-support will suffice. But we need to have sort of a fall-back mechanism I think.

Ms M.M. QUIRK: And the nature of the jobs that police and firefighters do is kind of very macho, and you are not encouraged to express your feelings or pain or whatever. How do you deal with those sorts of special challenges?

Dr Katz: Well, it is not easy. I think the main way we dealt with it is again just by co-locating with medicine. That makes it so much easier. And then over time they have gotten to know us and they trust us, so now we have like about 1,000 people in treatment at any one time, far longer than I would have thought we would. I also think, though, it probably starts with the top. Who do leaders get to speak to, whether in government or in uniformed services or the military? Who do they debrief with? I think the more you can get them to pay attention to what they are doing. Again, maybe this is idealistic, but there should be a trickle-down effect.

I think most people say after 9/11 that what Mayor Giuliani did was a model of leadership, and part of what he did was actually endorse people feeling what they felt and acknowledge the emotions of it, and I think that that really set a tone. So I think getting leaders to address their stress. I mean it would be great if in Christchurch the mayor or whoever were doing eight, eight and eight themselves—maybe they were— but I think your role model for everybody else down the line of command.

The CHAIRMAN: Psychiatrists hear all the bad stories as well. How do they take care of their mental health?

Dr Katz: That is a very interesting question, because we had about 400 psychiatrists volunteer with us right after 9/11, working at the family assistance centre— at the gathering place— and we asked the same question: "What was it like for them to be exposed to all of this?" Most of them we did not know before; everyone wanted to work with us right after. So we actually did an online survey and we got 12 responses— from psychiatrists of all people, right— do as I say, not as I do!

The CHAIRMAN: They are used to asking questions and not answering them. That is the problem!

Dr Katz: Exactly. But what we encouraged people to do is we had shifts, and we would have a shift leader who was not really doing the clinical work, and then we would have some who were doing the clinical work, speaking with people, and we would suggest that they just gently debrief, just,

"How was it? Did you see any concerns?", and even, "What could we have done better?"— just something reflective— and then we had some meetings, we just invited people to dinners to just chat about how is it going, et cetera, so fairly informal stuff.

The CHAIRMAN: So how important is dinners and things like that, the informal things, because in Christchurch as well they did a lot of barbecues and different things like that where it all seemed to work really well.

Dr Katz: Yes. I think that is really important, particularly for at least physicians, who tend to be workaholics anyway and also tend to be tight-lipped. So I think acknowledging— if you think of it, social support is like the lowest budget and perhaps one of the most effective ways to help people recover from a mass trauma. Get-togethers and food and nourishment and socialising is fantastic.

The CHAIRMAN: In our remote stations, our remote fireys are volunteers; they are all volunteers in our remote areas. A lot of the time they tell us how they do it is they sit behind the shed and have a few beers, chat about it, and that is about as far as it goes. Whether that actually solves all the problems or not, I am not sure. But after 9/11, have you gathered any data on the patients you treated or the people you treated on suicide and things like that?

Dr Katz: On suicide, we did not encounter— I would have to double check— it just was not an issue at the family assistance centre in the immediate aftermath. We put out a paper about the symptoms that we saw, and suicidality was not even in there— it just did not come up— and we are usually pretty aggressive about asking about it; and I can assure the quality of all the psychiatrists who work with us.

Ms M.M. QUIRK: What were the most common symptoms?

Dr Katz: Anxiety, insomnia, and loss of interest, like: what is the point? Those are the three top ones, which are pretty typical.

Ms M.M. QUIRK: And they have lot of crossovers with clinical depression. So how do you use your professional judgement to work out what is pre-existing and what is a direct result of the crisis?

Dr Katz: Well, as careful history-taking as you can get, and the closer you are to the event, the easier that is. All these years out, it is really, really hard.

Ms M.M. QUIRK: From a professional point of view, is there anything that is unique about 9/11 or anything that is different, or was it just the volume or scale of the thing?

Dr Katz: Yes, I think it was the volume of it. We have a sense— we have never studied it— that there was a level of symptomatology that did not rise to the level of an official diagnosis like PTSD or major depression but that nonetheless was a problem that endured even though it did not meet the symptom count. We have not really adequately studied that to be sure, but most people think that there are so-called sub-syndromes, and I think we saw a fair amount of that.

But other than that, unique to 9/11, no. I think in some sense it struck in a place that really was not accustomed to large-scale disaster, so in that sense it sort of caught people by surprise. On the other hand, if you think that fewer prior traumas actually make you hardier or stronger, then maybe the city was better positioned to take that hit on the whole.

The CHAIRMAN: Psychological first aid— from your point of view, how important is that?

Dr Katz: It makes perfect sense. I think of it as— what would I call it— it has more of an educational role for other professionals to let them know that there are very basic things you can do that have a psychological impact. You might not think that when you are connecting someone with shelter for the night or dinner that you are doing anything psychological, but you are. So you just want to get people thinking psychologically. We did a training for emergency departments around the city in 2004, like an hour or two, for all the emergency department professionals, from orderlies

up to doctors, and teaching them about psychological first aid and how to weave it into the work they do.

So I think it is awareness building. As a psychiatrist, the things it says are not that advanced. But you do not need advanced for most people. I think it is really nice having a first-aid equivalent, and I think it does actually work quite well.

The CHAIRMAN: People who are in emergency rooms, they are not first responders as such, but they still see a lot of trauma.

Dr Katz: Yes.

The CHAIRMAN: Have you as a group or as a psychiatrist done anything in terms of their mental health, aside from the psychological first aid?

Dr Katz: As part of that particular training, we try to emphasise the culture of self-care, and we particularly encourage the idea of having buddies, in a sense, so that if you are going to be on-call in a crisis situation that you are paired off with somebody and you check in on each other— "Did you take a break; did you call home; did you go home?" So you kind of parent one another, and that is what we have encouraged. Whether people have listened, I do not know.

The CHAIRMAN: Do you have any idea about what proportion of people who have post-trauma stress— their full recovery rate? Is it possible for everybody to recover or is there always a percentage loss?

Dr Katz: I think the numbers suggest that maybe about a quarter go into chronic PTSD; and in psychiatry the longer you have something the longer you have it, particularly PTSD. So I think it is about a quarter. I still think, although we have not proved this, that if we had got in earlier, identified those who are at higher risk and got them treatment earlier, we would have cut down on the number immensely. It just makes sense. It is just a matter of finding a way to do it. It is very hard to do double-blind placebo controlled studies in a disaster setting.

[1.37 pm]

Ms M.M. QUIRK: We have heard some evidence that there are some personality types that tend to go into the police or fire services that might exacerbate the problems. Is that something you have come across?

Dr Katz: I think it sort of cuts two ways, but, on the whole people who tend to be avoidant, it helps them to function as a responder, but it may not help them to function in the long run. So, whether it is turning to drinking or acting out or whatever, some of the things that help for your job may not help in your personal life. We had about 40 psychiatrists down at Ground Zero—I was one of them— sort of roaming around talking with the responders and seeing how they were doing— really kind of going outside our comfort zone. Some people criticised us because they said, "That's not a time for them to reflect, they need to be searching and rescuing and not being emotional and operating heavy machinery; they do not need to be asked, 'How are you feeling?'" You have to have a certain level of denial, but you have to know when to leave it at the door.

The CHAIRMAN: I know it was July following the September [2001] that you got on board. If it is now in the plan and you are on board straightaway, do you think it is going to be much more effective, and how much more effective will it be?

Dr Katz: I am not so sure it will be much more effective. If I had my way I think we would still be available. We were available at the beginning of 12 September, and I would still be available but with a better system for linking that up with long-term care, and definitely a better system for screening so it was not so random. If something happened again here I actually do not know if we would do anything any better. I think now, these days, there are just more people who know about the stuff, and it may actually cause like a second disaster with people even more so converging on the scene because they all think they can do it, but I am not sure. I think the city is good at setting

up the family assistance care models— that is pretty good— but I actually think there will be a tumult from a mental health perspective. Everyone is an expert now.

The CHAIRMAN: So it does need some time; not to be there as a first responder, just a little bit after, once things start sinking in and people start having memories.

Dr Katz: Yes, but if I had finite resources, like we all I suppose do, I would not be there the first day, I would not necessarily be there day one or day two; I would be there in a month or two months, and maybe at the outer limit two months later. Assuming it is not an event with recurrent tremors or whatever— a recurrent event— I would probably be there parked and ready to go at two months with screening, and at that point looking for psychiatric disorders, which at that point things probably should have resolved and you are looking more at longer term issues.

Ms M.M. QUIRK: You would have first started this work with certain assumptions maybe. What is the one that has changed the most over time or that you have got rid of?

Dr Katz: I am more and more impressed with the long-term and less concerned with rushing in straightaway, although, again, if I could do it all, I would do it all, short and long-term, but if I had to face my priority, the people who are going to have the longer term problems tend to be the ones who had the problems before. There will be a minority of people who did have problems, but they were just so highly exposed that they suffer consequences. But I would really be focused on systems building in the long run, not rushing and staking out one's territory in the short term. I am still with our disaster organisation and I still have an interest in it, but over time I have shifted to doing more development work just building up systems under the best of circumstances.

Ms M.M. QUIRK: What exactly do you mean by that— just preparing in advance?

Dr Katz: Well, what we are trying to do in one of the Caribbean Islands, Saint Vincent and the Grenadines, we are actually trying to pilot a mental health check-up and integrate that into the practice of primary care clinics and into the culture of the island.

Ms M.M. QUIRK: So it is building up resilience?

Dr Katz: Yes.

The CHAIRMAN: So that comes to communities. I might be getting the wrong handle on this, but I am getting the impression that lots of the things that people seem to have psychological or psychiatric issues over— yes, you are saying trauma and all that— if your community is not around, it is more pronounced?

Dr Katz: Yes.

The CHAIRMAN: If you have a really solid community, less of these things seem to come to the surface?

Dr Katz: Yes, that is correct.

The CHAIRMAN: But communities around the world seem to be becoming more disaffected with each other. In the street I live in, I was the first house on the street and I used to know everybody. Over time the houses have changed, and now I know half of them, if that. Some of the new people who come in, we have never connected with at all. How important is that to actually making things less of an issue when you have these great big disasters?

Dr Katz: Well, on the one hand it was a bad start, but on the other hand there tends to be the sort of heroic phase and this sort of almost utopia-like period of time when there is a lot of bonding and people come together; it is sort of the silver lining in the clouds. So I think it very quickly can trump that. But, again, it is in the longer term when people go back to the way things were before, particularly if they suffer personally with lives lost or economic loss then you are going to be probably even more fractured than you were before, so the heroic phase tends to be transient. Yes, I think that, in a global sense, is a bad place to start from, and what to do about it, I am not sure.

The CHAIRMAN: Have we got more questions?

Dr Katz: I would add that the internet may help with that, even though we could say that people are huddled behind their computers et cetera, but there is a connectedness, and certainly if you need social support in the context of an infectious outbreak, that is going to be the safest way to do it.

The CHAIRMAN: So that is through Facebook and things like that. We have not been to Queensland yet, but we have heard that Facebook and Twitter, I think it was, played a major role in getting information out and getting things coordinated and things happening. I think we are going in July, so we can investigate further. For 9/11, Facebook and things like that were not as predominant or even around.

Dr Katz: No, I do not think they were around then. It is unbelievable. I, myself, am not that steeped in them— I never even use Twitter— but we have been trying to think about ways to use them in a clinical way. There have to be ways.

The CHAIRMAN: What about Skype?

Dr Katz: I think that would have the same potential, and obviously with the value of face time. We have been looking at doing that between countries, but certainly you could do it locally as well.

The CHAIRMAN: If there was one thing you thought we should add into disaster management in terms of the mental health of responders, what would be the ideal thing to prepare our responders?

Dr Katz: Excuse me if this sounds idealistic, but I would say that an agency has a responsibility where the individual has the requirement to have had a mental health check-up in an X time period prior to participating in a disaster response.

Ms M.M. QUIRK: That could be done within the context of a normal physical, and, obviously, some of these first responders have to be in physical shape so they are required to undergo that. It is appropriate to have it within that setting?

Dr Katz: For the first responders?

Ms M.M. QUIRK: Yes.

Dr Katz: Absolutely. If they could trust their employers, or maybe it gets subcontracted out, I do not know, but it would be. They would be concerned about fitness-for-duty issues, but that is part of the point. Yes; I think it would be appropriate.

The CHAIRMAN: I think we are exhausted. We are coming to the end of our trip and our brains are starting to slow down quite a bit.

Dr Katz: No problem.

Principal research officer: Does the World Trade Center mental health program give you data about marriage breakdowns, suicide attempts, alcoholism?

Dr Katz: Well, it should, but the problem we have had is that we have been so busy doing, and we are a service program, that we have had little pause to research what we are doing, to be honest. Our clinical impressions, I can say quite strongly, are that there is an enormous amount of family discord. Trauma really is a family problem and trauma kind of radiates out. So I would say definitely familial discord, breakdowns in relationships, workplace issues around that, interpersonal issues. Suicidality; certainly we have had attempts and we have had, I think, a few people complete, but it is not clear to me that over a 10-year period it would have been anything otherwise in such a large number of people.

Ms M.M. QUIRK: Survivor guilt as an issue, I am interested in that. Have you come across much of that?

Dr Katz: Sure. “Why them; why not me?” certainly comes up, and there is lots of guilt. I think a lot of it has to do with how well defined your role is as a responder— like what is your purpose. The

better defined it is, the better you can assess whether you have succeeded or not, and I think also the more the leadership tells you it is okay or not, or communicates you could have only done so much. But I think a certain amount of survivor guilt is normal. We want to remember the people we lost, so there is a measure of guilt and all sorts of bad feelings that come up; that is part of being human that we are not going to rub out, and I do not think we would want to.

The CHAIRMAN: Craig, can I thank you for making your time available. We know you are pretty busy.

Dr Katz: My pleasure.

The CHAIRMAN: It will help the Western Australians figure out what they need to do. Our disasters, our emergencies, are on roads and the normal things that civilisations have, and we get bushfires. So far we have been very lucky; we have had no loss of life, and in fact I do not think we have had any serious injuries out of that. We have had lots of lost property. Our other major ones are flooding and cyclones in the north west of our state. It has come to me, having talked to people here, that they keep saying you have to prepare for what you do not know is going to come, so the worst possible case scenario.

Nobody pre-empted the World Trade Centre. For us, I am thinking: what is our issue? One of the things that comes to me are our LNG plants up north. While they are not in populated areas, if they go, it is a huge economic loss to the state and to all those people, as well as loss of life and all those sorts of things. They are the sorts of things I am now starting to think about that I would not have had a clue about last week. Thanks for coming to see us.

Dr Katz: My pleasure. When are you heading back?

The CHAIRMAN: We are heading back on Saturday.

Ms M.M. QUIRK: We were at a conference in New Orleans so we got a bit of the flavour of Katrina, which was interesting.

The CHAIRMAN: We met with Red Cross yesterday and the Port Authority and that was interesting. When we walked into the room I thought: “Oh, I am in the wrong spot”, because there were seven of them and only three or four of us.

Dr Katz: They travel in packs!

The CHAIRMAN: Yes. All of those people—

Ms M.M. QUIRK: Bar one.

The CHAIRMAN: — had been involved in the 9/11 issues, and it was really good to get a firsthand perspective of what happened that day. I think we are meeting with the chief medical examiner, and we are trying to meet with the fire department, hopefully. The port authority has offered us a tour around its new building to have a look around and show us the improvements they have made. I think they reckon it is about half a billion dollars to build it, or something like that—huge. Thanks for that.

Dr Katz: Good luck with your work. Enjoy the rest of your time in New York. The weather could not be better for this time of the year.

Briefing concluded at 1.51 pm