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 EVIDENCE
TAKEN AT MELBOURNE
TUESDAY, 3 JULY 2012

SESSION SIX

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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Hearing commenced at 4.14 pm

GORDON, DR ROB
Consultant Psychologist,
921 Station Street,
Box Hill 3129, examined:

The CHAIRMAN: Can I ask you to give us your full name and the capacity in which you are here today?

Dr Gordon: My name is Rob Gordon. I am a private psychologist but I have had a longstanding consultancy relationship to Department of Human Services here for the recovery plan and also for the emergency work with Red Cross. I am also on the committee of the APS for disaster.

The CHAIRMAN: You have quite a few roles.

Dr Gordon: Yes.

The CHAIRMAN: Rob, can you just tell us a bit about APS and what its involvement was in studying stress and trauma and especially in the TAPIG group?

Dr Gordon: I would need to say that most of my involvement has been through my consultancy role with the department, but the APS established a reference group for disaster research and involvement, and I have been a member of that for several years. That group did bring together people from around Australia as a kind of reference group to look at how the APS might support what is predominantly of course a state-based response to disasters. We have discussed various things about deployment of volunteers, appropriate models of psychologists assisting and things of that sort.

The CHAIRMAN: Rob, is it possible to give us some key points about the research that you have undertaken into trauma experienced by staff and volunteers during and after disasters?

Dr Gordon: Perhaps if I just give you a little bit more of my background, I was first involved in Ash Wednesday as a member of a children's hospital team working in the Macedon area. I worked there four years, visiting. Arising out of that, there was this request when it was recognised really that not much in 1983 was known about what was really needed. I was invited to take this role as a consultant with the department. That has given me an ongoing role long for about 25 years in disasters in Victoria. The APS role is like a recent add-on to that ongoing work which probably on at least a weekly basis involves me in the planning meetings, training and then, when an event happens, actual work in the field. For 18 years I was on contract as the clinical director for critical incident stress program for the Department of Human Services, which looked after all the impacts on the staff. That included youth justice, child protection, disability and so on. While that was an ongoing role throughout the year, of course whenever there was an emergency they played a fairly major role in recovery. Again, I was looking at supporting them. I conduct training every year throughout the regions in early intervention and psychological first aid for departmental or other health and welfare staff. I have been providing ongoing support and supervision to grief counsellors and bereavement support group counsellors since Black Saturday. During that time, I have really pursued a number of research interests, not in the form of formal academic research projects but really in terms of trying to conceptualise the issues and really develop models that can be implemented and then evaluated for recognising how to prepare staff. I understand your focus is really on the traumatic impact on various state government —

Ms M.M. QUIRK: First responders, really .

Dr Gordon: Yes. Really the 18 years I spent working with staff showed me a lot about what actually makes people vulnerable. When things go wrong, what is it really that causes the problem? I suppose my research has led me to three main issues. One is that I think the key concept to follow here is what in psychology we call "arousal"—that is, the adrenaline; the adrenal activity.

[4.20 pm]

I think we should understand and treat that in the same sort of way that we should understand and treat infection control if we were dealing with an epidemic. I think we have very good understanding of the importance of sterile care and decontamination and so on, but I would like to say I think we are at the pre-Pasteur stage of understanding arousal and stress. We know there is a problem, but we are still really working out what is required.

I think that, if I can just speak about that for a moment, when the adrenaline kicks in, it boosts those functions that are designed to deal with an immediate physical threat. That is what was selected out by evolution. The problem is many of our threats are predominantly social. There is no clear pathway of vigorous physical activity other than for, say, emergency service personnel. Even then, they do not go into a clear-cut fight or flight, they have to constrain it and maintain their role, their training and all the rest of it. What we find is that if you look at the way that people experience things in an adrenaline state, we know that adrenaline predominately activates the right frontal lobe of the brain where we think in pictures and actions at the expense of the left frontal lobe where we think in words and concepts. This is why people must be trained to routinise and go through and develop procedural memories for how to do things, because otherwise when we go into high arousal we will not be able to get access to our verbal memories. We will only retain those things that have been totally routinised by having done them many times.

When people go into the event, if they get into too high arousal before they go in, then they are likely to (a) lose a lot of their training, and (b) they are likely to totally ignore themselves because the adrenaline system—you will be familiar with how adrenaline shuts down pain, say, in a football field or something. You do not feel it until you come out of the adrenaline state in the shower and you feel these bruises.

So in fact one of the principles that I have come to is that you cannot use the normal way of people regulating their involvement, their fatigue, their need for even water or whatever, because all that is shut down and they will work until they drop. What we have to do is build that into procedures based on knowledge that is in the training. If they get into too high arousal, what is likely is they will overexpose themselves. They will work outside the formal roles. I remember the story went round about the September 11 firefighters in Ground Zero who worked a shift and then clocked off and then got in their truck and drove around and clocked on for another shift at another gate. I think this is absolutely a recipe for burnout and serious, irreversible damage. I would guarantee that any firefighters who did that a few times are not firefighters now. I think that this issue of managing arousal by ensuring that systems retain their well-planned procedures and roles is the most important protective factor. What I see is that in many organisations, as the arousal increases, it pushes people out of their role. I see the role that we have as like a spacesuit or a life-support system. It has got a series of behaviours and knowledge and skills that interface with other people's roles as part of a large system that defines things like your responsibility, what you are there to do, what you do not do, who you relate to, what you do if you get out of your depth and how you pass things up.

If the role is appropriate, then the person is embedded in the whole social structure, which is really what delivers support and it limits their exposure. If the arousal is too high—it is like actually going in without putting their spacesuit on—that is when I think we have serious problems.

Ms M.M. QUIRK: This idea of following the book, although that is always viewed a bit pejoratively, it is in fact a protective mechanism because —

Dr Gordon: Yes.

Ms M.M. QUIRK: — that lack of flexibility it is a positive thing —

Dr Gordon: Yes.

Ms M.M. QUIRK: — because they are not going out of the comfort zone, if you like.

Dr Gordon: Unless it is so rigid that it does not adapt to the actual situation. Then it places the person into a very severe conflict. What I have learnt about planning is that the best plans are the most generalised. Just have some very basic principles, but they are absolutely well ingrained.

The problem is, in my area of the health and welfare field, we very rarely get to practice. The emergency services with their lights and sirens and setting buildings on fire and so on are practising all the time, but it is actually too expensive to do full-scale practices of recovery programs and deploy the health, welfare, child protection, disability and so on and disrupt hospitals and so on. For instance, how we set up evacuation sectors and staff them and have the rotations and so on, are not exercised often and end up being improvised.

What I learnt in Black Saturday, because I have trained a lot of the DHS staff that were going out there, is even very experienced people, if they are deployed by a manager who is in adrenaline may be inadequately briefed. Because I see adrenaline as like an infection, it goes right through the system, through the department and, on occasions up to the minister and through the state government into the Prime Minister. I thought, for instance, when Kevin Rudd offered case managers, he made the statement that everyone will have a case manager within 24 hours this was an example of the right strategy being offered in a highly aroused manner. This created such a convulsion in the system. The way adrenaline contaminates us into acting—acting now. What happened was of course we had several generations of case managers that were in a developing system and not very clear about what they could offer. I think it would have been much better for him to have said, "We understand you need case managers. We are going to give you case managers. It is going to take us a few weeks to get that going, because we do not want to give you people who do not understand what they can do. Here is what you do in the meantime." Then, when the case managers did arrive, they would really give value for service. That happened but only after a couple of generations of case managers who were rapidly deployed and could not stay there for long because of being pulled out of all sorts of other systems. That is my perspective.

I have a very experienced colleague who was sent up to one of the evacuation centres. She was despatched at great speed by, I would say, a high-adrenaline manager who said, "Get up there". "What am I going to do?". "Just get up there. You'll know what to do." She drove through a still burning environment to get there. She became quite concerned about her own safety by the time she got there. When she got there, nobody really knew she was coming. She did not actually have a clearly defined role and she ended up making cups of tea and talking to people. She could then use her skills, but as a result, she actually felt (a) very threatened, (b) devalued because she did not have a clear role and (c) that she had a very unsuccessful experience. She contacted me for an informal debrief.

That is just a single anecdote, but when we train people, I think we need to train them in how to clearly understand their roles and the limitations to what they can do, because you will have a lot of health and welfare staff who will be used to actually doing a lot more for people than they are going to be able to do in an evacuation centre or a disaster environment, so I think there is a lot of concern about that.

[4.30 pm]

Having defined a role that is different from their standard role, so if you have a mental health clinician who is used to seeing people in an office to talk about maybe horrific traumas that have occurred from days to weeks to decades ago, and then you put them straight out and they are actually getting people walking out of the disaster and unloading it in a much more intense and

direct way, then they are liable to be quite severely impacted by this, because they find pretty rapidly, "I'm no longer in my role. I'm in an unfamiliar role, and I'm not sure how to use my skills." This would be the basis for the training we give in psychological first aid, so they have got another role and another set of assumptions to switch into.

It is different for emergency services. I think the principles are the same but they will have to be deployed very rapidly. But I think when it comes to all of the staff that are going to be picked up, the difference between a briefing which might only take 15 minutes and no briefing is the difference between having put on your spacesuit and not, because the briefing should just activate already familiar skills and knowledge and organisational structures. But when the system goes into high arousal, everyone goes into tunnel vision and action mode instead of actually stopping and thinking the whole system. Normally when that happens, the staff will become the medium for dealing with the problem that is out there in the community so there is no attention on the staff.

One of the things we did in the Department of Human Services when we had some very large-scale ongoing incidents; for instance, there have been a number of occasions where they have set up large telephone call centres—Bali and so on, we activated some of our trained debriefers to just rotate around the room. There would always be someone in the room who could just move over and chat quietly to someone who is on an intense call, wait till they finish and just come over and say, "How was that?" and so on, and provide this low-key support.

I think it is terribly important to organise to have somebody in the system who is not in high arousal. The way you will get that is they do not have an operational responsibility. Their responsibility is back onto the staff. My observation is that that gets lost when the senior managers go into high arousal.

The CHAIRMAN: What you are really talking about, and explain to me if I am wrong, is peer supporters for —

Dr Gordon: Yes, in that case.

The CHAIRMAN: In that case.

Dr Gordon: Peer support would be someone like me. In this case, they are operating at a peer support level but they would be much more trained debriefers, maybe mental health professionals, but yes they are operating in a peer support model, yes.

The CHAIRMAN: A fair share of our inquiry has been around peer support, because it has been promoted to us as a very efficient or a very successful way of dealing with first responders particularly. Have you got any insight on peer support and what you think works or does not work?

Dr Gordon: I think, first of all, it is very important that peers are well trained and supported. One of the problems is that, if they have not got a very well-defined role, they get over enthusiastic. They are often people who really want to help, and there is a bit of a risk that they will try to get more involved than is appropriate. I think, provided they are very well trained and that they have an ongoing sort of professional development component there, I think they are enormously valuable. I think most people are not going to need anything major in the nature of a formal kind of structured mental health intervention. What they really need is to convert their experience into words early, and the earlier the better. I think peer support close to the front line is essential, but I would like to embed that in a clearly defined briefing process that briefs them into their role and prepares them.

I think any kind of verbal anticipation or rehearsal of what you are going to experience is immensely valuable—for instance, if people are going to see gruesome things I think the verbal account of it before being exposed to it is helpful. If they are not going to see them but hear people who have come out of very gruesome situations, I think I would want to be telling the support people what happened in graphic detail, so that they can come to grips with the images before they hear them from the people they are there to support. I do not think that takes a long time; as I say, I

think you could do it in 15 minutes, but it is a very important component to be structured. Ideally, the peers are part of that, but they do not have the operational role; they have the support role.

The CHAIRMAN: From what we have heard in the last two days from CFA and people like that, that is the kind of methodology they apply.

Dr Gordon: Yes.

The CHAIRMAN: If you are a fiery who is attending, you are not a peer supporter for their group that is there; it is someone else from outside.

Dr Gordon: Yes. They need to be, shall we say, organisationally independent, so their accountability line is not the operational accountability line because if the commander goes into high arousal, they want to deploy them instead of having them fluffing around at the edges, so it is a different accountability line. I think it is extremely important that everyone is clear about that, otherwise there gets to be confusion. I think the people vary in how receptive they are still to this notion of psychological support.

Mr T.G. STEPHENS: You are suggesting some sort of mandatory nature of verbalising in order to digest. Is that pushing organisations into the debriefing techniques of necessity or does it leave open —

Dr Gordon: The debriefing is a structured process in the form of a session. There has been a lot of confusion about debriefing. The critical studies of debriefing have in every case but one, applied it in situations where I do not believe it is ever intended; it was applied for people who are not in a work role, not doing things they are trained to do, using skills they have got in an organisational context. It has been trialled on burns victims, rape victims, victims of crime, car accident victims and so on doing the randomised control trials. The reason it does not really work for them is that they are having a full-on personal trauma and that is not what it was designed for. But I think there are some principles underpinning the debriefing process: what I like to call the psychology of high arousal, that apply whether you do it in the form of psychological first aid, peer support debriefing or clinical work. It is to do with adrenalin in the brain.

The memories will be activated by adrenalin and what will be selectively retained as a result of the effect of adrenalin is the sensory emotional and action memories at the expense of the verbal. They will not be linked together in meaning systems. The most basic meaning system, for instance, is temporal sequence—time—so they will not be embedded in a time sequence very well. This is evident when you listen to someone tell the story; they inevitably pause at a moment of high drama and you get this gap, which I think shows that there is a lack of connection with what comes next. Very often the gap will be where someone thinks something terrible is going to happen but it does not. In actual fact the level of arousal is as if the terrible thing happened because they do not actually connect it to the fact that they thought it was going to happen, but it did not. I think that is really where the verbalisation comes in; it forces the person to make logical sequences. Even putting something into a grammatical form, forces us to organise it in our minds. The fact that you give it a verbal form means the words begin to make lots of meaning links. I think the problem is that when people come out of the environment with this immense charge of visual, emotional and action memories, people vary on their ability to process that in their own minds. Some people can do it well; other people do not do it well. The degree of arousal will also impair that, so we need a procedure. I think that procedure needs to be designed with the basic psychology for each situation.

[4.40 pm]

I think we have learnt a lot about when you do a debriefing and when you do not; who you do it for and who you do not; how you adapt the structure of the session and the nature of the session for different types of people and different personnel—debriefing for fire is different from welfare people and so on. I think we actually want a broader concept, and that is the notion of a briefing to be able to hold your system together so that you do not lose your ability to think verbally about

what is going on and then, as you come out of it, to have a procedure whereby you systematically put it into words. Operationally, people will generally have to write reports of some sort or attend operational debriefs. The problem is they are being structurally asked to only put impersonal objective things into words. We want another situation where they can put into words the personal dimension—what it brought up in me; what I thought was going to happen as opposed to what really did happen, et cetera. I believe the only way that really works—I do not care whether you call it a debriefing, peer support or anything else—is that it has to be structured in as part of operational arrangements so that it becomes routine. Ideally, people step out of their shift into a process where they review what has happened—do a handover, for instance—and then have an opportunity to stop and reflect how the shift was; what they experienced et cetera, and then be prepared to move out, and later on we follow that up because they will think about things later.

Mr T.G. STEPHENS: With reference to natural disasters, is there an organisation you want to pinpoint that handles this sort of issue if you lose best practice in this field?

Dr Gordon: I think there are a variety of models, and they all have enormous value. I think the best model for the victims is the psychological first-aid model because it makes no assumptions.

Mr T.G. STEPHENS: Is there an organisation?

Dr Gordon: Sorry. In terms of supporting the staff, the organisation that specialises in this—there would be a couple, the Australian Centre for Posttraumatic Mental Health is very focused on the psychological first-aid methodology.

Mr T.G. STEPHENS: I beg your pardon; I think I am confusing you with my question. I was thinking of an organisation that looks after personnel dealing with emergency response. Is there a department or a firefighting service?

Dr Gordon: I really think it has to be an integral part of the organisation itself. The only peer support, for instance, firefighters or police are going to really talk to are their own. I think each department has to develop its own processes. In the Department of Human Services, where I was involved for many years, you have people with mental health qualifications working in child protection and disability and so on. We trained them up with additional skills so that we would then tend to deploy across regions. If there was a disaster in one region you would be using the debriefers from another region, for instance. Where you get an organisation that does not have those qualified people on the staff, I think they will have to make arrangements to get them in. In Victoria our arrangements would include the use of local mental health staff who have had appropriate training to support the staff in various agencies; probably not police and fire because they would have their own independent systems, but whether we get other organisations such as Parks Victoria or the Department of Sustainability and Environment—people whose normal involvement is not as intense and much more specific. When they get tangled up in large disaster, they will often call on people. We really need a group of staff. In the training I do around the regions, it would be government agencies of mainly the health and welfare people plus locally funded agencies in welfare, health agencies and mental health. Community health is very effective, so that there is a group of those people and, ideally, there is some organisational infrastructure to deploy them and use them. Otherwise I think you are going to need some fairly specialised training for people who may not have a great deal of background.

Ms M.M. QUIRK: A lot of organisations use employee-assistance programs. A lot of them are just used in the day-to-day employment things; they are not used for post-traumatic stress or anything. Would it be your proposition that they are better than nothing?

Dr Gordon: Yes.

Ms M.M. QUIRK: There is not the potential that they could do more harm than good?

Dr Gordon: Look, I have a certain amount to do with some of them. Some of them put considerable effort into training their staff around traumatic exposure in the organisations they are

working with. Others, from the stories I hear, do not. I hear stories of staff who have come to me and told me how EAP counsellors have reacted. I think if supporting staff after traumatic events and disasters is included in the contract, then that particular department could actually investigate how the EAP provider was going to train their staff to do this and then they would be very valuable, but I think it would need to be stipulated in a contract. I do not think you could assume you would get good value by just using, you know, the services that are basically there for marital problems and smoking and things like that.

Ms M.M. QUIRK: Is there any world's best practice where you think they have got it about right?

Dr Gordon: I would have to ask: for what? Because that is where the controversy comes in.

Ms M.M. QUIRK: Looking after their workers and in terms of post-traumatic stress?

Dr Gordon: I can only say anecdotally I think the Department of Human Services in the regions where it is working well has got a good system here. But in my experience, some regions were operating well; others were not. It varied basically with who the regional director was and who the coordinator was, but the model was there. I probably do not have an intimate enough —

Ms M.M. QUIRK: That is all right; that is fine.

The CHAIRMAN: Rob, thank you very much for coming in and giving us the benefit of your experience. We will send you a copy of the transcript for any corrections in case we got it tragically wrong!

Hearing concluded at 4.48pm