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
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SESSION THREE

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 12.23 pm

FORBES, PROFESSOR DAVID
Director, Australian Centre for Posttraumatic Mental Health,
1/340 Albert Street,
East Melbourne 3002, examined:

The CHAIRMAN: On behalf of the Community Development and Justice Standing Committee I would like to thank you for agreeing to meet with us this afternoon. The Community Development and Justice Standing Committee is a committee of the Legislative Assembly of the Western Australian Parliament. The committee may look to use information it receives today as part of its deliberations for its final report. Before we proceed to the questions we have for you, have you completed the "Details of Witness" form?

Prof. Forbes: Yes.

The CHAIRMAN: Do you have any questions in relation to appearing at today's briefing?

Prof. Forbes: No, that is fine.

The CHAIRMAN: Can you describe to us the key points of the research you do into the trauma experienced by staff and volunteers during and after a natural disaster or any disaster?

Prof. Forbes: There is probably a range of things we could talk about. Our organisation works with a range of organisations, including state government and federal government and industry, to manage the aftermath of trauma—the mental health effects of trauma. There is a broad range of things in relation to that I can talk about. Were you interested in our response post the bushfires specifically?

The CHAIRMAN: Yes.

Prof. Forbes: In the aftermath of the Victorian bushfires, ourselves and other key trauma experts from around the country, representatives from DoHA, the state health department in Victoria, as well as the professional health bodies—so the Royal Australian College of General Practitioners, psychiatrists and APS—kind of gathered together as a group and developed a program effectively, or a blueprint, for what the mental health needs were likely to be in the aftermath of a bushfire. Although service delivery is obviously a state responsibility, our role was really around developing what might be an education and training program for service providers that might assist the potential for best practice treatment to be delivered to trauma survivors across the affected areas. We, together with our colleagues, developed what we call a three-level framework for mental health care in the aftermath of trauma and disaster specifically. Then with partners—through the Australian Psychological Society around two of those levels, which I am happy to talk about, and one of those levels with *beyondblue*—we developed this three-level framework and we will roll out education and training initiatives across the three levels over the course of the next probably 12 months.

The CHAIRMAN: David, is there any particular agency in Australia that does take really good care of their volunteers and their workers after disasters?

Prof. Forbes: When you are saying "agency", for example emergency services or —

The CHAIRMAN: Yes, that you deal with

Prof. Forbes: Look, we have a lot. Probably the key national agency that we would have a lot to do with would be the military; we think the military does serve as a good model. Although it is not after natural disasters specifically, although obviously the military is involved in the aftermath of disasters as well, they do have a good model for how to look after their members. It is increasingly

towards planning for prior to exposure, and then in surveillance—identifying what mental health problems—and putting in screening processes to identify any difficulties their members might be experiencing and then developing the service system to be able to provide that kind of support.

The CHAIRMAN: Do you know what was in place before—what training it gives people to build up that resilience?

Prof. Forbes: Within the military?

The CHAIRMAN: Yes.

Prof. Forbes: Recently they have been using a program called BattleSMART. This is something they use in the context of military deployments, and it orients them towards identifying what are the likely reactions they might have in relation to the experiences they are going to go through, to pre-prepare some strategies around coping and education and how to manage those responses, how to look after their peers, how to identify difficulties within their peers, and also where to seek care themselves should they need it. That program is reinforced upon return and it is embedded then in the system of care that occurs afterwards. So that would be, I guess, an example, and they have probably been one of the international leaders, I would be saying, in terms of what we might regard as resilience-building initiatives in a workforce where there is a higher likelihood of exposure to traumatic stress.

Ms M.M. QUIRK: Is that for everyone who is deployed serving overseas or is it for the supervisors, if you like?

Prof. Forbes: That is for the members being deployed, but there are also equivalents for the supervisors. I think you have raised an important point, if I can get it across, which is whether it is the military or organisations, one of the things we know is that one of the biggest predictors of how people are likely to recover post-exposure, whether it is a natural disaster, a motor vehicle accident, combat, assault, sexual assault, is the extent of support and social support they experience afterwards. It is critical to not only educate those who are likely to be exposed themselves or have been exposed about how to manage their reactions, how to seek care and help, and also beyond training the service providers about how to provide best practice help, but also it is how to assist in increasing the likelihood that this person is going to get the kinds of social supports they need. Particularly within organisations like emergency services and the military, the perception the member has of the support they receive from that organisation personally is a very significant factor in influencing their recovery.

Ms M.M. QUIRK: Obviously family support as well.

Prof. Forbes: Family support also.

Ms M.M. QUIRK: We were struck in Christchurch that a lot of the first responders were also victims and there was a lot of tension between the families that thought they should be staying there sorting out their mess, but they were going off and sorting out other people's mess.

[12.30 pm]

Prof. Forbes: That is right; they get caught between the two.

Ms M.M. QUIRK: What sort of funding does your centre get? You are, presumably, commissioned to do projects for various organisations?

Prof. Forbes: Yes. We receive some level of core funding from the Department of Veterans' Affairs for the provision of expert advice around managing mental health, and then we receive the remainder of our funding on a project basis; we do research, we do training, we do policy advice, and we receive funding from whoever the sponsoring organisation is on the basis of the work we do.

Ms M.M. QUIRK: So if it is not sensitive, what are some of the organisations you have been doing some work for?

Prof. Forbes: We have done work with a range: veterans' affairs; the military; health and ageing; and some emergency services—for example the Queensland Police Service. We are rolling out a psychological first aid program for the Queensland Police Service. They are examples of the some of the organisations we deal with; we also deal with motor vehicle accident authorities.

Mr I.M. BRITZA: With the military, I have two questions: first of all, because of the military's involvement with trauma and fatality and what have you, is the members' involvement in these programs considered too negative? The second question involved with that is: we have found that it is pretty difficult to get emergency workers to actually admit they are having a problem themselves.

Prof. Forbes: Yes.

Mr I.M. BRITZA: With the military, number one: is that right? They understand they need to have preparation for it? Okay. But the volunteers in the emergency services do not have the same mentality, would you agree? Is that a bit harsh?

Prof. Forbes: I would say that within the military there is a major cultural shift occurring towards the recognition of mental health, and they have gone through a significant amount of work in the last five to 10 years to de-stigmatise mental health, firstly in terms of recognition of one's own mental health as well as recognition of the acceptability of mental health within one's peers and then within the military generally. There has been a significant shift. Having said that, there is still a fair way to go. I think that although there is increased recognition, I think some of the issues you have observed in emergency services still would exist within the military as well, even though it has come a long way. But I think what you have described is probably the major challenge around initiatives to improve awareness of mental health and in the acceptability of recognising where one is, oneself, struggling, the impacts of that, and then where to seek help and the okay-ness about seeking help. I think that is still a major issue across emergency services.

Mr I.M. BRITZA: Trying to deal with the stigma with that —

Prof. Forbes: That is right.

Mr I.M. BRITZA: — for volunteers and professionals is pretty difficult.

Prof. Forbes: Yes, both. From the contacts we have had with a range of emergency services, many of them are going down the path of trying to address that now, although there is some room to go still.

Mr I.M. BRITZA: When you say "address it", is it unfair to use the word "mandatory", to try to possibly take the stigma away?

Prof. Forbes: As in making screening and assessment mandatory?

Mr I.M. BRITZA: Yes.

Prof. Forbes: To some degree. That is one strategy some of them have tried.

Mr I.M. BRITZA: Especially after.

Prof. Forbes: Yes. There may be routine screening afterwards, so that you are not the only person walking into the counsellor's office.

Mr I.M. BRITZA: Exactly right; yes.

Prof. Forbes: That is one of the strategies; routine screening is certainly something they do in the military. A number of emergency services have tried to work towards routine screening, but to the best of my knowledge it is still largely voluntary. A lot of work is being done with the area commanders around trying to lead by example in terms of making mental health acceptable and

themselves going through a screening and assessment process, and visibly being seen to do so, to increase the acceptability for their staff and for their broader constituency.

Ms M.M. QUIRK: There seems to be a bit of controversy around the post-incident debrief—what form that should take.

Prof. Forbes: Yes.

Ms M.M. QUIRK: Some people seem to suggest it should just be spill your guts and almost forced on people at that time; others suggest, no, it is better to wait. Do you have any views on that?

Prof. Forbes: Yes, I do. Psychological debriefing was really around the idea of being able to talk in detail about the event that the person has experienced and to share your experiences with your colleagues and your reactions. It was hoped that it would prevent the development of psychological disorders like post-traumatic stress disorder; the literature is pretty clear that it does not prevent the development of PTSD. So then the question is: if it does not do that, does it do any harm? For most, probably not, but for a subgroup of people we do wonder about whether it is unhelpful in that people cope in different kinds of ways. We do not know a lot about the varying ways in which people manage, and a one-size-fits-all kind of intervention for someone who is struggling to cope in the aftermath of an event to have to talk about it or sit and hear other people talk about it in a compulsory fashion, we think, is an unhelpful thing to do.

We have developed national guidelines around managing the aftermath of trauma, and one of the recommendations is that routine psychological debriefing is not recommended, and in its place should be a process that we might call psychological first aid. That is around just providing care and support, providing information to people about what has happened if that is necessary, being able to recognise when they might need some support, just managing their anxiety or arousal levels, providing them with general social support and connectedness where they are going to get help, helping them get in touch with family if that is what it is about, and doing the things that, practically, they need to be able to manage, rather than actually having to talk about it if they are not wanting to talk about it.

Ms M.M. QUIRK: So almost disguising it as a sort of operational debrief and giving people the tools they need to do other stuff?

Prof. Forbes: That is right. If it is a group, you might well gather people together so that they get the chance to talk with each other, if they want to—not if they do not—and tell them who they have to talk to and who they do not. They will choose; some of them might want to talk to their peers, some of them prefer to talk to their families, and some of them prefer not to talk at all and just park it for a week and until they are feeling more in control, and think about it when they are actually feeling like they have a sense of routine back. Those coping strategies are so varied amongst people, and the last thing we want to do is actually cut across them.

Ms M.M. QUIRK: One size does not fit all.

Prof. Forbes: That is right.

Ms M.M. QUIRK: So this controversy is really a non-controversy; everyone generally subscribes to your view now?

Prof. Forbes: Well, it is not my view; it is a view to which I ascribe.

Ms M.M. QUIRK: The view you ascribe to, yes.

Prof. Forbes: I would say that to some degree I think it is likely that versions of psychological debriefing are still practised by some of the emergency service organisations. I would have to say that it was developed for formed units like that; it was never formed for community survivors of a disaster who might not know each other—for example, a train derailment—who may actually have no relationship because the person sitting next to you on the train is not someone you know. So

getting people together as a group to talk about these things was never even an intended application of psychological debriefing; it was developed for emergency services units that worked as a team. They are still used to some degree by emergency service units, and if it is going to be appropriate anywhere, that is where it would be, but we still do think there are elements people need to be careful about and therefore we do not recommend it, because the first caveat is to do no harm.

The CHAIRMAN: You mentioned peers in the military context; is there particular training that has to go to peers to be able to recognise what is happening with your colleagues?

Prof. Forbes: There is a program they do. It is commonsense, and it has two aims: again, to de-stigmatise mental health, and to recognise that people are less likely to seek help for themselves. It was seen that looking after your colleagues is probably a more acceptable thing, particularly given within the military context that it is so—as it is with emergency services—critical to the culture and to the philosophy that you mind the back of the guys you are going in to fight, and it was really presented in that context about how to keep your mates safe. I think it is that you would not leave them alone on the battlefield, and you do not leave them alone here either; so really pushing that line. It is commonsense. It is training not because it is sophisticated, but because it is just key messages that need to be learned because it is not natural to the military environment otherwise.

[12.40 pm]

The CHAIRMAN: Are there particular ways to put that training up in the context of emergency services?

Prof. Forbes: I hope they do not mind that I mentioned them, but the Victorian ambulance service is a standout for me in terms of a program whereby they have made as public as possible the message of mental health, and they have a psychological first aid program in place where peers are trained in the process of how to look after their colleagues. I pick them, not because I am familiar with all of the emergency services around the country and that is the best, it is just the one I know the best.

Mr I.M. BRITZA: We heard today, and I will be careful how I present it, but Ambulance Victoria actually suffers with a fair bit of trauma response.

Prof. Forbes: It does; that is true.

Ms M.M. QUIRK: These things often come down to resources, so if you were chief commissioner of police or head of the fire service here or whatever, what would be the sort of programs you would put in to try to minimise the impact of critical incident stress?

Prof. Forbes: Firstly, it would be policies around ensuring that mental health was everybody's business, so that it was understood that the mental health and wellbeing of their staff was the responsibility of senior officers and sergeant-equivalents also. Then it would be around training programs for the members themselves and their peer supporters, as well as for the sergeants and officers, and different kinds of skills about how to recognise mental health and to provide support and assistance around mental health. Critical in the way that we think about it is that the NCOs or the sergeants know their members well, and the health providers within those organisations are there and it is important that they provide best practice.

But ultimately you know what you are asking your members to do. You know their circumstances and you know what they look like when they are functioning and you know when they are starting to act and behave differently. For a culture where recognition of and talking about mental health is low, they are unlikely to say they are really upset about what they have just been through and what they have seen. But they may well be quieter than usual; they may be a bit more agitated than usual; they may be more argumentative. You may know, for example, if they have come across a death. You may know that they have a child the same age as the child they have just resuscitated or not been able to resuscitate. I think that we can sometimes underestimate the importance of those roles in being able to detect behavioural differences in a culture whereby no-one talks about how they are

responding emotionally, and identifying what might be higher-risk actions than they might otherwise be, based on the idiosyncrasies of experience of that officer. Training the sergeants and officers in charge and NCOs in those kinds of behaviours is critical, and also where to get help.

Ms M.M. QUIRK: You have alluded to—we have heard this elsewhere—the older and more established members having a lot more difficulty embracing these concepts than the younger members. Is that your experience, and do you think that with time some of this stuff will sort itself out?

Prof. Forbes: I think that is largely true, although not always the case. Often it is the older members who have seen the cumulative effects and have become more recently convinced that these are issues that they needed to have thought about many years earlier. I think that both of those are true. I think that some of those views are encapsulated in the older members, but I have also seen great advocates amongst the older members based on some epiphanies they have had in relation to the way they have handled things. They have the potential to be very powerful champions of culture change within the organisation because they have often held the attitudes that they can see dispersed across the organisation, and having worked their way through it and having a lot of credibility, having seen almost every kind of incident under the rubric of that organisation, they are often very important and credible champions of culture change.

Ms M.M. QUIRK: Are you aware what the military does in terms of family members?

Prof. Forbes: I could probably comment less on that. Largely that is the responsibility of the Defence Community Organisation, and we have probably been involved less with DCO than we have with the Mental Health Directorate, so I probably would not be able to comment too confidently on that.

Ms M.M. QUIRK: Ideally, the minimum they should have access to is counselling.

Prof. Forbes: That is true.

Ms M.M. QUIRK: Are there any other things that you would consider helpful?

Prof. Forbes: I think providing a close contact with the family—there is one in counselling, but also in logistical support. For example, when they are missing a key parent, male or female, is the family functioning well; and assisting and supporting that at a logistical level as well as the health and mental health level is very important.

Ms M.M. QUIRK: So the added stress and worry of that is being placed on the person that is serving.

Prof. Forbes: Correct—for them to know that the home base is secure and supported is critical as well. That also plays into the sense of the organisational support: can I rely on my organisation? If I am going to put my life on the line can I rely on my organisation to look after what is important to me?

The CHAIRMAN: David, do you put out some educational material, some DVSs and that? How effective has that been and what are those educational videos geared towards?

Prof. Forbes: We have put out a few kinds of products. There is the face-to-face training programs we ran in the aftermath of the bushfires. Just prior to the bushfires we developed a DVD that described the national guidelines and the treatment of PTSD. It became available, coincidentally, in the aftermath of the bushfires, so that was dispersed as widely as we could disperse it, and also largely through the Rural Health Education Foundation as well as the College of GPs. How effective it has been is very hard for us to comment on unfortunately. We are able to comment on what the reach was, how many copies went out and we got some valuable feedback to say that those who received it found it useful and were able to describe that quite specifically. But the degree to which it has reached the people that it needed to reach—those providing care to those affected—we do not know.

Mr I.M. BRITZA: In the aftermath of the bushfires was there anything that you observed that was disturbing or surprised you?

Prof. Forbes: I think what was an issue was the degree to which there was an uptake of mental health; the limited uptake of mental health care partially surprised me. The reality is that in the aftermath of these events a vast amount of the effort is going into the logistics of reconstruction and recovery, and people are preoccupied with that—understandably. That is where a lot of the interventions we described fitted in, which was: stay out of the way, do not stop people from doing what they have to do to recover physically and logistically. But the uptake was low.

Mr I.M. BRITZA: We just heard a statistic—others may have known it, but I did not know about it—that in just the last couple of months, or in a period of two weeks, five people in the community took their life.

Prof. Forbes: In the last few weeks?

Mr I.M. BRITZA: Up in Kinglake.

Prof. Forbes: I did not know that.

Mr I.M. BRITZA: Just in the last couple of months—or over a two-week period—five members of the community is a fairly discouraging statistic, I would imagine; that would be one where you would feel pretty helpless because the community would not know what to do, let alone the professional departments.

Ms M.M. QUIRK: That would be consistent with what you are saying: you are dealing with the here-and-now logistics first, and it is only later that people have a bit of time for reflection. Presumably the next couple of years would be critical.

Prof. Forbes: We would certainly not be suggesting that we take our eye off the ball, because there is a level of strong community bonding in the aftermath, in the sense of the eyes of the nation are on you and you feel there is potentially a lot of support; but as time goes on and recovery—in terms of physical health, mental health, financial circumstances or your life circumstances, vocational circumstances—has not got on track, there is a risk period over the course of time. It is critical that services are on their toes still and that the community members are on their toes. One of the parts in the three-level framework, level one, is for community, so key members of community organisations, sporting organisations, knowing how to look out for those who are struggling, how to speak to them and how to refer them for care if needs be—whether that is the local hairdresser, barman, whoever that might be—rather than health professionals, being the eyes and ears around mental health within the community and being able to point people in the right direction. But it is a tragic figure that you describe and it is disheartening.

[12.50 pm]

Mr I.M. BRITZA: Yes, it is.

Ms M.M. QUIRK: We are hearing the term "psychological first aid" a lot. I have some reservations in the sense that I think people will be using those buzz words but there will be a multitude of things coming under that umbrella. For clarity can we get what you consider to be psychological first aid?

Prof. Forbes: You are right in that. Part of the concern we have is that it does not become another packaged intervention in some respects. When we are talking about psychological first aid we are talking about basic care, making contact with people, checking that they are okay, providing some strategies to help them calm down if they are particularly hyper-aroused, providing practical support, logistical support, communications with family; monitoring them and putting systems in place whereby you can check on how they are going.

Ms M.M. QUIRK: So you would be looking for the same sort of pointers you might look for in, say, clinical depression or something?

Prof. Forbes: Probably not that just yet. They are things, some of which might be consistent with clinical depression —

Ms M.M. QUIRK: Like sleeping?

Prof. Forbes: — like not sleeping, angry and irritable, spending more time alone than you want them to, not functioning, not being able to concentrate at work or panic attacks. It does not have to be a clinical disorder. One of the most important things is being able to pick up some of these signs early and provide —

Ms M.M. QUIRK: They are all things that can be picked up by a lay person who has had a bit of training?

Prof. Forbes: Yes, that is right. Then the next level is general counsellors and health professionals—before even getting to mental health professionals. The vast majority of people do not develop frank mental health disorders, but a significant number of people develop problems. The wider we can go in terms of training, whether it is community members or general health professionals, the local GP, in how to recognise general mental health adjustment problems and intervene at that level, rather than necessarily putting all our eggs in the basket of the counsellors and the psychiatrists and the clinic psychologists, that is very important. But the reality is the folks they will see are going to be a small minority of the people who actually need —

Ms M.M. QUIRK: Do you think those who present to GPs might be given some sort of chemical solution? Is that prevalent with GPs?

Prof. Forbes: I think it is. Working with GPs around what are some basic non-pharmaceutical interventions you can provide, particularly given what we were saying before about what are the biggest predictors—care, social support, practical support, problem solving and things that—if we can assist GPs in being able to provide these kinds of interventions, even within the time they have got, and then linking it in can go a long way. I think the risk is otherwise the easiest thing to do is prescription.

The CHAIRMAN: Building resilience within organisations seems to be the way to go at the moment. What are the best training activities that an organisation can do to build that resilience with staff and with the volunteers?

Prof. Forbes: When we think about resilience it is importance for us to think about strategies not only for the individual, but also organisational systems that build resilience as well. We would want to keep both of those issues in mind. For individuals, it is around recognition of what their unique signature is of coping or not coping based on their experiences and educated in or being sensitive to what those look like and what the early signs of those things look like, and then working with them around strategies to manage those—psychological, behavioural and interpersonal strategies. When we talk about resilience we talk about the individual, but I think on the systems level it is critical how the system looks after its members, which is a bit like what you described before about moving towards kind of routine screening and assessments to de-stigmatise mental health, where everyone is walking in and just like they get their physical health check once a year, they get their mental health check once a year and it just becomes part of it.

So there is a strategy around de-stigmatising mental health more broadly, particularly couched in "looking after your mates", and then providing the skills to the health professionals as well as to the sergeants and the managers about what to look out for, how to support their staff and making that public and known and an expectation of their positions that they do these things and that that is then credibly delivered. I think part of the gap can often be where these things might be introduced but not then delivered in a way that rings true or credible for the members themselves and it sounds and feels a bit like lip service. That must become organisationally valued and reinforced.

The CHAIRMAN: That is prior to a disaster, but what happens during a disaster? What is the best thing an organisation or an individual can do?

Prof. Forbes: During the disaster itself—it obviously depends on the duration of the event. Are you talking about the immediate aftermath?

The CHAIRMAN: Yes.

Prof. Forbes: There are some strategies around managing arousal that are very important. One of the big predictors is if you are very hyper-aroused in the aftermath and that is not settling for hours, and you are up there for the first 24 to 48 hours, which is one of the bigger predictors of negative response. The other is where the person feels numb and shut down or feels like they are out of their body, or time is slowing down or speeding up—things that we call dissociative responses. Those kinds of responses are perhaps the less helpful ones in the aftermath. So providing people with strategies in the immediate aftermath to manage their arousal levels, which have been taught in advance, and someone on the ground checking on them and reminding them to use some of those strategies, as well as being able, if they find the people are numbed, to identify that, recognise that and address that through strategies that help to ground them. There are a range of coping strategies that help people ground when they are feeling disconnected from what is going on around them. They are probably the two most extreme reactions for which it is important to have strategies in advance, and also having those around who are skilled in knowing how to either de-arouse somebody or connect someone with reality if they are shut down and disconnected.

The CHAIRMAN: After events, how long should that go on for? Obviously it depends on the level of trauma and the event. Anniversaries and things like that—major issues?

Prof. Forbes: I think certainly anniversaries are issues where it is important for there to be information and education in preparing people. It is not waiting for the anniversary to occur, but talking about it coming up, reminding people about strategies to manage and to cope and expecting that there is going to be a blip, to some degree, around anniversary time. Again it is not only personal strategies but reminding people to make sure that they spend time being around loved ones, being around people that they feel connected with and supported by in that time in preparation. Should they find themselves having reactions, it is planning in advance what their strategy might be for coping with that, both within themselves and who you are going to talk to, who you are going to go to—making sure that there is somebody available for you, particularly where they are predictable triggers such as anniversaries.

Having said that, these are the kinds of things that you are planning for people, generally speaking, given that a lot of the triggers are less predictable. When you work with someone in the aftermath and they have had a negative reaction, it is recognising that there are going to be a whole lot of triggers that might take them by surprise and working with them in advance around how they might manage within themselves, where they might get help and who they might want to be around.

I keep coming back to the issue of interpersonal support—again, friends, family, your work colleagues—and then the care system. Whilst it is really important to work with individuals in terms of managing their own responses, we just keep coming up against an increasing body of evidence that is telling us it is around embedding social supports. If you can educate those supports in how to help that person with those same strategies—"These are the strategies that Jack uses when he feels like this"; that the person Jack turns to at those times knows about that and knows how to help him.

[1.00 pm]

It is particularly in the context of irritability and anger. Because we are talking about high arousal states, anxiety and panic and we often we see things like anger. Anger can often be associated then with aggression. For people to have in advance strategies for when they are managing their arousal, understanding about whether there is any patterns of aggression attached to it and how to short circuit those and manage those before they do things that they are going to regret, particularly if

they are talking in the context of young families as well, with the level of agitation. The risk for violence is —

Mr I.M. BRITZA: It would not have surprised you, David, that when we found that in the middle of the Black Saturday disasters, the men who were being "heroes" and dealing with stuff excellently were going home and manifesting violently. That is not a surprise. It was to us who are uninitiated.

Prof. Forbes: Problematic anger is not uncommon in post-traumatic stress. We have got a heightened level of arousal, a sense of combating a threat, frustration. That can often be coupled with the system around you not necessarily assisting you as it might. When we are talking about that state, the potential for it to spill over into anger and aggression is not uncommon. It is very important that people are aware of that. If it has manifested into a problem, it is addressing it clinically, but very important is also some brief short-circuit strategies where people can recognise it and short-circuit those in a way that is clear and identifiable and pre-rehearsed and that the family members know as well.

An example of that would be: if I feel like I am getting angry and I am going to act on that, I might withdraw. My strategy might be: just walk out the door, because I know in two minutes I will feel better, but if I stay here, it is dangerous. If the person withdraws, but the family member is not educated about why they are doing that, and they follow them him out—"Why aren't you talking to me?"—it is potentially explosive. Really important is not only that the person has strategies but partners and families know what those strategies are also, so they act as a team and they can put a sign in between each other to say, "Okay, I'm having one of my moments; let me be," rather than things that might escalate it—educating the partner; educating the person.

Ms M.M. QUIRK: Quite often in these sorts of situations the first responder cannot rescue someone or there is some problem. How big a deal is guilt in resolving some of these issues?

Prof. Forbes: It is not uncommon. Guilt used to be a symptom of post-traumatic stress; it has come out as being associated. It is not at all an uncommon part. It is guilt in relation to what you have not been able to do, but often it is survivor guilt as well, when your mates around you are killed, and you think, "Why did I survive and they did not." It is very often you see both of those. One is guilt about what I did or did not do, and guilt for survival sometimes also.

Ms M.M. QUIRK: That is dealt with just with cognitive therapy.

Prof. Forbes: Cognitive therapy would be a way. If it is manifesting itself as persisting, there is nothing like talking to your family and your mates about it too in the early phases as well.

Ms M.M. QUIRK: And I suppose if you are all sharing, "Oh well, I feel relieved it was not me", and they are also saying, "So do I," then you do not feel quite so badly about it. Our figures suggest that something around about 20% of staff and volunteers suffer long-term effect of trauma following a disaster. Does that sound high to you, or is that about right? Something like the Queensland floods or the Victorian bushfires.

Prof. Forbes: The 20% of people?

Ms M.M. QUIRK: Yes.

Prof. Forbes: Some kind of problem, that would not surprise me. We would expect the rates of PTSD to be around maybe about eight per cent—other disorders, other anxiety disorders, depression. That someone experiences some kind of mental health problem being around 20%.

Ms M.M. QUIRK: Is that the same sort of figures that the military act on?

Prof. Forbes: The military just published their prevalence rates last year. It was 20%—exactly 20%.

Ms M.M. QUIRK: Gee, that is difficult when you are looking at people being returned for another stint.

Prof. Forbes: This is across the military, whether or not they have been deployed, because it includes a lot of non-military trauma as well or military trauma that does not relate to deployments, like training accidents. There is a series of studies occurring at the moment that are following up the current operations from Iraq and Afghanistan that they will be reporting on over the course of the next 12 to 18 months. But the current state of mental health problems at the moment across the military is 20%.

Ms M.M. QUIRK: That is terrible.

Prof. Forbes: Events vary on their likelihood of developing mental health problems. Things that are of an interpersonal nature tend to be higher—assaults, sexual assault. Things like motor vehicle accidents or natural disasters in their own right tend to be on the lower end, maybe about eight per cent for particular disorders, but generally up around 20%. These events are often complicated. It is not only just managing the immediate threat of the fire, for example; it is all the things that can occur afterwards and what people did and did not do. It is not just often managing the natural elements in its own right.

Ms M.M. QUIRK: Think of all those Vietnam veterans. It is just mind blowing really, is it not?

The CHAIRMAN: It is a high number, is it not? It is one in five. Mental health problems in the general community is expected to be one in five anyhow, is it not?

Prof. Forbes: That is right.

The CHAIRMAN: From the Black Saturday bushfires, are there any particular lessons that you picked up on?

Prof. Forbes: I think capacity planning is going to be important, which is that we were hurriedly trying to roll out this training program in the aftermath of these events. The reality being what it is with obviously services just completely focused on trying to do what needs to be done logistically, I think for everyone it was clear that, whilst you can never predict these things, we seem to be in an environment whereby natural disasters are becoming less unpredictable. It is hard to know where and when and what kind at any given point in time but that they occur. And developing capacity within the service system to be able to manage events in advance is something I think is the biggest learning.

The other issue is that these skills are generalisable. These are skills that are generalisable to all kinds of traumatic events the person might experience, even aside from natural disaster—survivors of motor vehicle accidents, assaults, for combat veterans—so that local services being able to be skilled up in providing best practice care for those who experience highly stressful or traumatically stressful events is something that I think the investment to develop the capacity planning in advance.

The CHAIRMAN: David, is there anything that you think we should know that we probably have not asked the question? Just read our minds.

Mr T.G. STEPHENS: Sorry, can I just ask—it is slightly off the point. But just on the issues of profession, the legal and the combative nature of adversarial law, for instance, is there stuff that suggests there are professions that produce trauma that you are aware of from any of your work? I am not a lawyer. Margaret is the lawyer.

Ms M.M. QUIRK: He is trying to be cautious, because I am a lawyer. He is saying: are there any people with a predisposition? Are there any occupations that —

Mr T.G. STEPHENS: Are there any occupations that come up in the sort of work that you have done or the work you are across?

Prof. Forbes: Professions that lend themselves.

Ms M.M. QUIRK: Or personality types.

Mr T.G. STEPHENS: I was thinking of the professional stuff—in that situation where the combative nature of law —

Prof. Forbes: To mental health more broadly?

Mr T.G. STEPHENS: Yes.

Prof. Forbes: Probably less to traumatic stress, because presumably there is no kind of traumatic stressor as such in the way we might define it.

Mr T.G. STEPHENS: I am thinking of both trauma and traumatic stress.

Prof. Forbes: I think professions that have high exposure to trauma, and in thinking about the legal profession, it is less about the combative nature but more about the kind of information that you would potentially have to come across in certain kinds of cases and the details of repeated exposure to pretty horrific information. Certainly the professions that have high exposure to trauma and higher levels of stress and higher levels of arousal is a pretty potent combination. To be honest with you, I cannot comment about the legal profession.

Mr T.G. STEPHENS: I just thought that it might have turned up in literature and stuff. People do say the dental profession.

Ms M.M. QUIRK: They have a high suicide rate, do they not?

Prof. Forbes: It always strikes me as a rather dull profession to be a cause of trauma, but anyway, there you go.

Ms M.M. QUIRK: When you get a meaningful conversation with anyone, because they all go "Aaaargh".

[1.10 pm]

Prof. Forbes: But in terms of predictive factors, it is important to know that individual factors are less predictive of longer-term recovery than is the number one predictor, which is what happened in the event. Number two is social support. They are our biggest predictors by far and away. That you might have been anxious beforehand or had certain kinds of experiences in your life beforehand is a predictor, but it is significantly less than what happened to you in this event and what happened to you, what kind of support did you get after the event. They are our number one and two predictors.

The CHAIRMAN: The critical thing for volunteers and professionals that show up to these traumas all the time is that the organisation has to back them and support them, but the organisation also has to extend that to making sure that their family and their immediate community are supporting them as well.

Prof. Forbes: Yes, exactly.

Mr T.G. STEPHENS: I cut you off as you were trying to summarise.

Prof. Forbes: If I was to reinforce one message, I think that when it comes to emergency services, that support, embedding that support, organisational morale, a strong sense of supportive culture and education around mental health is going to pay absolute dividends down the track, irrespective of whether it is responding to disaster or responding to the traumas that are an everyday event in those professions.

The CHAIRMAN: Quite often we get the media looking for a scapegoat, looking for the person to blame or the organisation to blame. It is obviously not helpful. How do you counteract that when they actually pick out and say, "Right, you're the person to blame," and then they start featuring you in articles left, right and centre?

Prof. Forbes: When the media pick out the person?

The CHAIRMAN: Big issue?

Prof. Forbes: It is an issue. The degree to which the organisation protects that person from that or not I think is going to be critical. A risky part is where the organisation picks that person. Without naming names, we have seen that occur. The implications of that are absolutely devastating for that individual and for the organisation more broadly, because no-one feels safe in the organisation because it could be you next.

Ms M.M. QUIRK: A corollary of that, I think, is the organisation that says, "Shut up and do not say anything." If that is at a time when someone is wanting to say, "I feel frustrated because the radios did not work" and he is not open to say that without fear or favour within the organisation, I would have thought that might be unhealthy too.

The CHAIRMAN: Thank you again, David. We will send you out a draft of what we have spoken about. If there are any major changes that we need to make with that, could you make them and send them back to us? Thanks very much, David.

Prof. Forbes: Thank you very much.

Hearing concluded at 1.12 pm