His summer, floods have devastated many regions of Australia, especially in Queensland and Victoria. As of the end of January, 35 people have died, with nine people still missing. In Queensland, at least 70 towns and over 200,000 people were affected, and three-quarters of the State was declared a disaster zone, still only at the start of the wet season. In Victoria, flooding affected 83 towns. For some, this is the second or even third time they’ve been flooded in recent months. As we write, many people are still waiting for the waters to arrive or recede, and a huge cyclone is threatening the Queensland coast.

At the Flood Disaster Recovery Briefing organised by the APS in Brisbane in late January, Professor Justin Kenardy FAPS from the University of Queensland made the distinction between two types of flood experiences: rapid flooding with high threat and high loss/disruption, and slow inundation with less threat and moderate to high loss/disruption. Both kinds can cause devastating and widespread losses of livelihood, property and possessions – and in some cases, people die.

The APS is most fortunate to have a host of experts in disasters among its members, and the APS Disaster Preparedness and Response Reference Group has been an integral part of mobilising the psychological response to the Eastern States flood emergency. With the assistance of members of this Group, this special InPsych report has been quickly pulled together to help members understand the impact of the devastating floods on people’s psychosocial wellbeing and mental health, and the varied trajectory of recovery. The report highlights the types of help people are likely to need at different stages in the recovery process – and how psychologists can best respond.

Key to the APS response to the floods have been lessons learnt from previous disasters: ensure assistance is coordinated and integrated with the authorities in charge of the disaster response; build the capacity of local people and resources rather than bringing in outsiders; and promote the importance of relationships at all levels, from accessing social support for survivors through to building connections with the various stakeholders involved in long-term community recovery.

Worldwide, floods not only incur the majority of disaster deaths, but they account for 40 per cent of all disasters, and are seen as the most costly. The hardships for those affected can be profound; whole communities can go through a process of chaos, then banding together, and sometimes splitting apart as the strain starts to tell and the blame game begins after the immediate crisis has receded. Community recovery therefore involves social, economic and practical elements as well as psychological.

Natural disasters like floods, fires and cyclones are increasingly going to be part of our lives. The APS is working to support Australian communities to become better prepared, psychologically, for extreme weather emergencies, in order to enhance recovery. Together with the Red Cross, the APS is continuing to develop resources and training for preparing communities into the future. Our thoughts are with all members affected by the floods, and with their communities.

Compiled by Dr Susie Burke MAPS, Senior psychologist, Public Interest, Environment and Disaster Response, APS National Office, and other members of the Public Interest team.
What are some of the unique challenges that floods bring to communities, compared to other disasters like bushfires or cyclones?

In contrast to other recent disasters, the majority of people affected by the floods in Queensland and Victoria did not have their safety directly affected. Yet thousands were directly affected by loss and damage to property and valuables, which can often lead to delayed impacts. People needing to rebuild, or rely on insurance claims to assist their recovery, may have adjustment difficulties for years after the event.

The majority of disaster research tells us that mental health problems typically reduce over time. In stark contrast, however, one finding from Hurricane Katrina was that mental health problems actually increased as the years went by. This has been primarily attributed to the wearing down of people's resources for managing the ongoing stress caused by delayed rebuilding, community recovery and ongoing financial strain. Time will tell if similar patterns occur here.

What are some of the key lessons learnt in New Orleans that are very important in helping people to recover well?

In the wake of Hurricane Katrina, an innovative mental health response program was established, called Skills for Psychological Recovery (SPR). SPR was prepared to assist counsellors across the USA in delivering appropriate interventions that addressed the main needs of people after a disaster. This protocol was not intended to be a first response, but rather to assist many people with ongoing problems who were seeking assistance in the weeks and months after Hurricane Katrina. It was not an intervention for people with diagnosable disorders, but rather an intermediate step to address the range of significant psychological issues that typically arise. This program intentionally was based on evidence-supported strategies and included the skills of information gathering, problem solving, emotion management, healthy thinking, positive activities and social connections.

This approach was subsequently adapted following the Black Saturday fires, and resulted in many health professionals being trained across Victoria to assist mid- and longer-term needs of those affected. A key ingredient was that, although instigated by the APS, it was only implemented in close collaboration with the State and Federal Governments, as well as all the other mental health providers. This collaborative approach is essential. By coordinating the many disciplines involved in psychosocial response we reduce previous problems encountered post-disaster where agencies acted autonomously and independently, creating a chaotic recovery environment and thereby minimising the opportunity for any to work optimally.

What are some of the worst times for people after a flood?

There is enormous variability in how and when people respond to emergencies. What we've learnt is important is having a system in place to enable people to access the right sort of assistance when they need it.

Are there some people who might be more at risk of developing significant mental health problems after the floods?

From previous research, we know some people are more vulnerable – those with prior psychological vulnerabilities, or who lost loved ones or significant property, those who were relocated, or those having ongoing financial difficulties. What is key will be managing people who, for legal, financial or bureaucratic reasons, are not able to reconstruct their lives as quickly as others.

What encourages resilience from people in the aftermath?

Again one of the important things is that supporting people to reconstruct their lives as soon as possible helps alleviate the stress that can lead to psychological problems. The other major factor is social support. This is not just having people available, but rather accessing good social support at times when you need it.

Which skills are most useful for psychologists working with people affected by the floods?

From our experience in New Orleans, one of the most frequently used skills people required was simply good problem solving. With so many obstacles that people face every day, being able to appraise problems in a realistic manner, and then proceed with problem solving strategies in a practical way, was seen by many as one of the most useful skills people could learn – or offer.
Psychological support and treatment for victims of the floods

By Associate Professor David Forbes MAPS, Deputy Director and Professor Mark Creamer FAPS, Director, Australian Centre for Posttraumatic Mental Health

The floods across the Eastern States, particularly in areas such as Toowoomba and the Lockyer Valley in Queensland – with their heavy toll on life and property – will leave thousands deeply affected. The extent of devastation has been such that, for many, it will be a long time before lives return to normal. Lessons from the Black Saturday Victorian bushfires and the 1974 floods indicate that re-establishing a sense of normality and rebuilding after such events can continue for years afterward. For those who lost loved ones, the experience of traumatic grief will have an additional major impact on their lives. The loss of homes and communities, and the security that they provide, will make the recovery process longer and more difficult. How organisations and health services support those affected by the floods may have a lasting impact on individuals’ ability to cope. While much attention in the early stages will focus on broad community interventions designed to enhance cohesion and support, there is also an important place for individual assistance.

Initial support

Although most people affected by the floods are likely to experience distress, the majority will recover using their existing coping strategies and social supports. As such, more formal interventions are not generally recommended in the first couple of weeks after the event (Australian Centre for Posttraumatic Mental Health; ACPMH; 2007). Instead, psychological first aid (PFA), an evidence-informed approach to assisting people in the immediate aftermath of disaster (Brymer et al., 2006), is now internationally recognised as the recommended intervention. PFA is based on five empirically supported principles to guide post-disaster interventions: (a) promoting sense of safety; (b) promoting calming; (c) promoting sense of self and community efficacy; (d) promoting connectedness; and (e) instilling hope.

Interventions included in PFA are provided in a stepwise manner tailored to individual needs. PFA comprises eight components (see boxed information) and is designed to reduce initial distress and foster short- and long-term adaptive functioning. It is typically delivered by generalist health and disaster response workers, with support from mental health professionals (Allen et al., 2010). PFA is also recommended for use by emergency service organisations to support their own members. A detailed manual to guide PFA is available from the US National Center for PTSD website (www.ncptsd.org).

Importantly, there is international expert consensus that the routine use of structured interventions that focus on recounting the traumatic event and ventilation of feelings following disaster, such as psychological debriefing, are not recommended (Forbes et al., 2010). Obviously many survivors will wish to discuss their experiences and they should be supported in doing so. Psychologists, however, should be mindful of the survivor’s capacity to tolerate distress and the potential adverse effects of excessive ventilation in those who are very distressed or have dissociative symptoms.

Clinical and research data following disasters, however, indicate that a significant number will continue to experience distress despite their best attempts to cope and receipt of PFA-type support. These people may experience mild to moderate distress and report worry, sadness, insomnia, anger, social withdrawal, decreased ability to function at work, school or home, or other psychological issues. These problems are often exacerbated by practical issues arising from bereavement, destruction of property and other possessions, relocation and rebuilding. For these intermediate difficulties, a formal intervention called Skills for Psychological Recovery (SPR; Berkowitz et al., 2010) is gaining considerable international attention.

SPR has a strong focus on skills development and is provided by health practitioners or general counsellors. It was developed by the US National Center for PTSD and National Child Traumatic Stress Network in the aftermath of Hurricane Katrina, and first trialled in Australia in the aftermath of the Black Saturday bushfires. SPR utilises an evidence-based set of interventions, including assessment, problem solving, activity scheduling, helpful thinking, social support facilitation and distress management. Practitioners at this point are also well placed to assist survivors to begin addressing issues of loss. These interventions are provided over a period of one to five sessions in a flexible manner tailored to need. Data from the implementation of SPR following the Victorian bushfires indicated that health providers from various disciplines and paradigms perceived it as a useful intervention for disaster survivors with moderate levels of mental health difficulties (Forbes et al., 2010).

Psychological interventions for mid- and long-term problems

Although most people will experience reduced distress and a return to normal functioning over the initial days and weeks, a significant minority will continue to experience more serious problems requiring formal assessment and intervention. Common mental health problems following disaster include depression, anxiety disorders such as posttraumatic stress disorder (PTSD), generalised anxiety disorder (GAD), panic disorder (PD) and simple phobias, and complicated grief and substance misuse. These disorders may be newly developed in the aftermath of this disaster or may represent exacerbations of existing or remitted mental health disorders. Guilt, anger, somatisation, sleep and related problems may exist alongside, or independently of, these diagnosed conditions.
There is no ‘one size fits all’ approach for these conditions and careful assessment of specific presenting problems is important in order to tailor interventions. In terms of PTSD treatment, the Australian guidelines (ACPMH, 2007) recommend the use of trauma-focused psychological treatment such as trauma-focused cognitive behaviour therapy (TFCBT) or eye movement desensitisation and reprocessing (EMDR) in addition to in vivo exposure. The three key elements of these interventions comprise:

- Confronting the traumatic memory in a controlled and safe manner (imaginal exposure)
- Identifying and addressing maladaptive thoughts and beliefs about the event that may be interfering with recovery (e.g., cognitive therapy to address issues such as safety, control, trust and self-esteem)
- Confronting avoided situations, people, places or activities in a graded and systematic manner (in vivo exposure).

Importantly, these same elements are often appropriate for other posttraumatic mental health problems. These include, for example, cognitive therapy for trauma-related depression and GAD, in vivo exposure for simple phobias, and all three combined with grief counselling for complicated grief. In routine clinical practice, trauma-focused psychological treatments are embedded in a treatment plan that includes initial stabilisation and engagement, psychoeducation, arousal reduction and other symptom management strategies, and encouraging the resumption of key relationships and roles as soon as possible.

Pharmacological treatments for traumatic stress disorders are not normally recommended as a first-line treatment in preference to trauma-focused therapy unless psychological treatment is unavailable or the distress cannot be managed by psychological means alone. Where medication is considered for PTSD, depression and other anxiety disorders, SSRI antidepressants are usually the first choice. Other new generation antidepressants and older tricyclic antidepressants are considered as a second line pharmacological option.

**Dealing with comorbidity**

Posttraumatic mental health problems rarely exist in isolation, especially as conditions become more chronic. The co-occurrence of PTSD, depression and substance abuse present treatment sequencing dilemmas for practitioners. Generally, where PTSD is comorbid with mild or moderate depression, the PTSD should be treated first as depression often improves as PTSD symptoms reduce. Severe depression, however, should be treated first to minimise suicide risk and improve the person’s ability to tolerate trauma-focused therapy. When PTSD and substance abuse co-occur, they should be treated simultaneously due to the likelihood of mutual maintenance. The trauma-focused component of PTSD treatment, however, should not commence until the person is able to manage distress without turning to alcohol or drugs, and to attend treatment sessions without being under the influence. Re-assessing the severity of the depression following remittance of substance abuse, however, is important as the drug may have affected the nature and severity of the depressive features.

**Conclusion**

Psychologists have a great deal to offer in assisting individuals, groups and communities to recover from disaster and trauma. Our first responsibility should not be to intervene but, rather, to support the normal recovery process and naturally occurring networks. For those who do not show a normal recovery, however, it is incumbent upon us to provide the best available evidence-based treatment at an appropriate ‘stepped care’ level.

The principal author can be contacted at dforbes@unimelb.edu.au.

**References**


We as psychologists shouldn’t rush into the fray without first doing our homework

Professor Kevin Ronan MAPS, Chair of the APS Disaster Preparedness and Response Reference Group, brings a ‘voice from the ground’ as he lives and works in Rockhampton, which was the first town in Queensland to be majorly inundated in January 2011. For days, Rockhampton was cut off by land and air, hundreds of homes were flooded, and up to 3,000 properties were affected.

What was it like living through the flood?
We weren’t directly affected in this event but in November 2009, we did have to evacuate during some large scale bushfires in this area. However, we know many people who were affected, and as one of them told me while the water was still high in his area, stress was not a major issue then but he knew from experience that “the stress really starts once the water recedes”. One thing that I am noting anecdotally, that speaks to some theories and research done in psychology, sociology and other areas, is that the number of people who have put their hand up to try to help in various ways is truly gratifying, even weeks afterwards. For example, when the local Council put out the word for people to show up to help with cleaning parks and replanting along the riverside, hundreds took Saturday off to help. My family and I have pitched in both through community volunteer efforts as well as helping out those we know who were affected.

Another thing I am noting more recently is that the stories in the media have started emphasising some of the shortcomings of the response effort. This shift does mirror experience after other disasters, and also reflects some theoretical models about stages in community recovery. It is not helpful to buy in too much to such negativity at this stage, although proper evaluation is always important.

How would you advise APS members who might be considering making themselves available in a voluntary capacity to emergency relief/recovery efforts, or perhaps working in a professional role in situations such as this?
The first recommendation would be, following our training as psychologists, to make sure they have their ‘scientist-practitioner’ hats on and first know the research about what helps. Secondly, immediately after a disaster the best kind of help we can provide as psychologists is to be educating the public about the basics of the science – stress and distress is normal, and 80-90 per cent of people recover with a combination of time and support.

Support comes in different forms, including tangible, informational/problem solving, social and emotional, and, finally, through various means of self support. Thus, we can help people plug into various forms of support while staying ‘on message’ about the normal trajectory of initial distress but eventual recovery. Forcing or strongly encouraging people to talk about their experiences in the immediate aftermath is not recommended; we now know that such an approach may not only not help, it might for some make matters worse. Now that doesn’t mean we shouldn’t be available to speak with people who want to talk, but rather it supports the idea of ‘least intrusive intervention’ as well as voluntary forms of assistance. The major approach recommended now that fits with both these principles is psychological first aid. For the 10-20 per cent of people who might require more formal types of assistance, there are evidence-informed interventions available.

Given that we can expect more frequent extreme weather episodes, how would you like to see your profession and colleagues respond to such events in the future?
I would like to see an increasingly evidence-supported approach where we are able to fit into an overall coordinated response and recovery approach within affected areas. This can be done through getting up-skilled, becoming familiar with the research on psychosocial recovery, and developing relationships with government and non-government organisations in our own community concerned with disaster preparedness, response and recovery.

I’d also like to see psychologists get more involved in work prior to an actual disaster, in the ‘preparedness and prevention’ phase of the disaster cycle.

Is there a take-home message for psychologists?
First, we as psychologists shouldn’t rush into the fray without first doing our homework. Step one is to be aware of the range of normal reactions to an abnormal event. Those affected tend not to present for our services for some weeks or months after an event and, for that minority, one might consider getting trained in evidence-supported services. This way we can become involved more confidently and productively in a coordinated approach within our local communities.
The community itself is expected to lead and facilitate its own recovery

Kerrie Kelly MAPS is a member of the APS Disaster Preparedness and Response Reference Group who has a particular focus on community response to disasters. Kerrie lived in the tropics for a number of years and became accustomed to living with cyclones, and now resides in Kyogle in NSW, where floods are common.

Aside from your personal experience, how did you become involved with disaster preparedness and recovery?
In 2006, I was contracted to evaluate the psychosocial components of the community recovery response to Cyclone Larry. This cyclone was the first disaster of sufficient scale to test the new recovery arrangements introduced by the Council of Australian Governments (COAG) in 2004, across all three tiers of government (local, State and national). It was the first natural disaster in Queensland where the Department of Communities, rather than mental health services, became the lead agency responsible for restoring community wellbeing, and it contributed along with several lead agencies to a very fluid and dynamic process of community recovery.

What were the main lessons from Cyclone Larry that apply to other disasters?
It is clear that the new Community Recovery framework has revolutionised disaster mental health in Australia. The community rather than the individual is now seen as the primary focus for prevention, preparedness, response and recovery activities. This is a much more holistic and dynamic process which also involves economic and physical elements, and the provision of information, grants, accommodation and investment to strengthen community preparedness for the next natural disaster. The increased scope and complexity demands a high level of planning, communication and coordination, and all agencies are required to structure their services on the same set of principles.

What should we as psychologists be alerted to here?
The ‘old’ way of responding to disasters by gathering mental health practitioners (often from outside the area) to provide short-term crisis intervention has become redundant. Debriefing, in particular, is out. Individual interventions have been replaced with community-based recovery interventions delivered primarily by non-mental health specialists. The community itself is expected to lead and facilitate its own recovery, assisted by a range of service providers, including psychologists.

This community-wide approach is supported by a raft of research which shows that while a degree of psychological distress is common in the early aftermath of natural disasters, this will not necessarily progress to disorder. In most cases, reactions settle spontaneously as people use their natural coping strategies and social support networks and start to rebuild their lives and recover from their experiences. Resources need to be invested in rebuilding or replacing lost social and other resources, while individual-focused interventions should be reserved for those who are most distressed, have depleted social resources to begin with, or who suffer devastating resource loss. Given the long window of service uptake, post-disaster mental health services need to be integrated into the primary care system and psychologists are expected to contribute to the sustained recovery of their own communities through existing health services and programs such as Better Access, ATAPS and community health.

While mental health interventions following natural disasters have tended to focus on preventing posttraumatic stress disorders, there is a lack of clarity about the timing, nature and target groups, and whether they constitute preventative or treatment interventions. We need guidelines for community-level interventions to promote recovery, in keeping with the World Health Organization’s view that PTSD is not necessarily the main disorder resulting from disasters. We should cease to be preoccupied with PTSD and focus instead on a range of possible mental health problems and disorders and on ‘social’ rather than ‘mental health’ interventions following disasters (World Health Organization, 2003).

Is there a take-home message for psychology/psychologists?
As well as changing its focus away from PTSD, the psychological community needs to adapt its practices and terminology to reflect the disaster management concepts now in use throughout Australia: the ‘all hazards’ and all agencies approach, and the prepared community. All agencies involved in disaster response have had to reorientate their services away from a traditional crisis response role, toward a more holistic, integrated and longer-term approach. This opens the door for community psychologists to contribute to disaster mental health by identifying risk and protective factors that influence community resilience and recovery following disasters, and by becoming involved across the cycle of disaster management: prevention, preparedness, response and recovery.

Reference
Special report
Response and recovery after the floods

APS contribution to the flood disaster recovery

With the support of the APS Disaster Preparedness and Response Reference Group, the APS National Office has been significantly involved in the flood recovery efforts, particularly those in Queensland.

Liaison with other organisations and the State emergency recovery plan
The APS contribution has been part of an integrated and planned response that fits within the State emergency recovery plan. Liaison has been undertaken with the Queensland Department of Health and Department of Communities, the Federal Department of Health and Ageing, the Red Cross and World Vision to offer assistance in the delivery of psychosocial support to affected people, particularly in the mid- to longer-term recovery phases.

The APS has a Memorandum of Understanding with Australian Red Cross to support the organisation in responding to disasters, and discussions have been held regarding assistance with the flood recovery. The Red Cross is interested in the APS contributing to its Personal Support program in longer-term outreach in the coming months. We will keep members informed of any opportunities to contribute. The APS and Red Cross have just published a document on psychological first aid, which is available through the APS website.

Disaster recovery resources
The APS has developed a number of downloadable resources for the general public and for people providing support to those affected by the floods. The resources include Guidelines for looking after children who have been affected by the floods, and a brochure on Support for those working in communities affected by floods, and their clients. These resources and links to other organisations and resources can be found on the APS website at www.psychology.org.au/community/topics/flood.

The APS has also developed guidelines for psychologists working with communities affected by the floods (www.psychology.org.au/community/topics/flood/practitioner/#s1), as well as guidelines on offering pro bono work in the flood recovery (www.psychology.org.au/Assets/Files/EG-Disaster.pdf).

Much useful information on disaster recovery can also be found on the Psychosocial Support in Disasters website (www.psid.org.au), which the APS and other peak mental health organisations developed and launched last year.

Media releases
The APS has facilitated significant media coverage on preparing for disasters and psychological aspects of recovery, including caring for children, psychological first aid, and longer-term adjustment.

Disaster training
The APS is consulting with other agencies and authorities to plan the development and dissemination of appropriate training workshops for APS members, and to others as needed within an integrated plan. Training is likely to follow the model used successfully following the Victorian Black Saturday bushfires of 2009, where health professionals were trained to provide psychosocial support and mental health care to people affected by natural disasters. As well as psychological first aid as a first response, we trained many mental health professionals in Skills for Psychological Recovery (SPR), which is a brief, secondary prevention model designed to teach people basic skills like problem solving, managing reactions and rebuilding healthy relationships. Training was also offered in clinical interventions for people at risk of developing significant mental health problems.

In the short term, the APS is running brief webinars to provide people with an orientation to working with people affected by disasters, and how to apply skills in disaster recovery. These two-hour webinars also cover disaster preparedness.

Disaster Response Network
The APS disaster response network (DRN) is the place where psychologists with an interest in working with people affected by disasters can register their interest and expertise. The DRN is used to communicate with members and notify them of training opportunities, resources and research related to disaster response. The DRN is used when the APS receives a request from organisations or agencies seeking additional support from psychologists. Because of the current recovery environment, though, we mostly have more psychologists offering to help than organisations asking for psychologists to help! This is because roles and timelines in disaster recovery have changed in recent years. Formerly, when some form of critical incident stress debriefing (CISD) was routinely offered, there were greater opportunities for psychologists to go out into the field in large numbers immediately following a disaster. The emphasis now is on the provision of psychological first aid in the first hours and weeks after a disaster to restore safety, security, calm, connectedness, help and hope. These tasks are best achieved with minimal intervention from mental health specialists, to give people time and the opportunity to activate their own natural coping mechanisms. There is an emphasis, too, on the importance of building the capacity of local people and resources rather than bringing in outsiders.
Queensland Flood Disaster Recovery Briefing

The APS, supported by the Brisbane Branch, held a two-hour briefing for over 300 members and other interested professionals on 28 January in Brisbane on how to provide the best psychological support following a disaster of this scale. The briefing was presented by members of the APS Disaster Preparedness and Response Reference Group, Queensland Health, and other experts in disaster response and psychological recovery. The briefing panel was chaired by Dr Nicola Burton from the APS Brisbane Branch Committee and included:

- Professor Kevin Ronan MAPS, Chair, APS Disaster Preparedness and Response Reference Group and Central Queensland University
- Professor Richard Bryant FAPS, Scientia Professor in the School of Psychology at the University of New South Wales
- Professor Bob Montgomery FAPS, University of the Sunshine Coast
- Professor Justin Kenardy FAPS, University of Queensland
- Dr Susie Burke MAPS, Senior Psychologist, Public Interest, Environment and Disaster Response, APS National Office
- Associate Professor Brett McDermott, Director, Mater Child and Youth Mental Health Service
- Dr Aaron Groves, Executive Director, Mental Health, Alcohol and Other Drugs Directorate, Queensland Health
- Mr Andrew Coghlan, National Manager Emergency Services, Australian Red Cross
- Ms Julie Aganoff, Lifeline Queensland.

The briefing provided an orientation and overview of the field of disaster response, and information on current best practice for psychosocial response and recovery. This ranged from the provision of universal assistance to focused psychological and related services, including psychological first aid, skills for psychosocial recovery and more targeted interventions. An overview of the government and some community-based groups’ approach to disaster preparedness and response was also provided. The briefing concluded with information about the role of psychologists and the APS within a coordinated approach to response and recovery, as well as advice on clinician self care.

The Flood Disaster Recovery Briefing was recorded and is available on the APS website at www.psychology.org.au/community/topics/flood/briefing.