

General Practitioner Guide for Management of Mental Health and Related Consequences in the Victorian Bushfires

These guidelines are designed to assist general practitioners in caring for their patients and communities after the disaster of the Victorian bushfires.

They are informed by high quality evidence, the general consensus of experts in the field and clinical experience. They address issues related to general health and mental health, bereavement and loss, trauma syndromes, complex problems, and child and adolescent concerns.

The **General Practitioner Guide for Management** forms a living or dynamic document, which may be continually edited and updated.

We welcome input about concerns general practitioners might face in this work over the coming months and additional information they would find useful. Please contact us to provide any feedback or suggestions: <http://www.earlytraumagrief.anu.edu.au/contactus/>

Links to this document are

http://www.earlytraumagrief.anu.edu.au/health_general_practitioner/

http://www.earlytraumagrief.anu.edu.au/disasters_children/general_practitioner_disasters/

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Table of Contents

General Principles	4
Systems of disaster management and response	5
Important Principles for Patient Assessment and Care	5
1. Mental and physical health issues	5
2. Psychological Principles for Care	6
4. Children, Adolescents and Family	7
5. Longer Term Skills: Skills for Psychosocial Recovery	7
6. Setting in place follow-up care	7
7. Self-care	7
References	8
Section 1	9
Guidelines for GPs	9
Check List:	9
Chronic illness	9
Fire fighters and other volunteers performing physical activities	10
Medications and substance use	11
Medically unexplained symptoms	11
General issues	11
Relationship issues	11
Importance of maintenance of good general health practice in all patients.	11
General Observations	11
References	13
Section II	14
Mental Health: General Themes	14
Reference	15
Section III	17
Bereavement, Loss and Mental Health Problems	17
i) Information and support immediately after the disaster	17
ii) Skilled professional support	17
iii) Early intervention after losses of this kind is recommended	17
iv) Risks associated with outcomes of bereavement	17
v) Bereavement related problems	17
Management	18
The general practitioner may provide supportive care	18

Referral to specialised clinical care	18
References and Resources.....	19
Section IV	20
Trauma Syndromes	20
Acute Stress Disorder (ASD) and Post-traumatic Stress Disorder (PTSD)	20
Advice to the general practitioner following disaster	20
Screening	21
When to refer and to whom	22
Treatment for adults with PTSD & ASD.....	22
Primary Care PTSD Screen	23
Other available resources.....	23
Reference	23
Section V	25
Complexity of Problems.....	25
Chaos and destruction	25
Anger, disillusionment.....	25
Multiple stresses	25
People and communities have great strengths and resilience.....	25
Disaster effects are prolonged	25
Health problems may be complex and multiple	26
General Practitioners play a central role	26
Section VI	27
Children and Adolescents	27
Children's reactions will be influenced by:	27
Children's reaction can show in different ways, depending on their age, experience and ongoing circumstances.	27
General Practitioners can monitor children and adolescents' health	29
What the GP can do	29
Evidence of what works	30
Reference & Resources	30

General Practitioner Guide for Management of Mental Health and Related Consequences in the Victorian Bushfires

This guide is for general practitioners to assist them with the management of patients in the aftermath of the Victorian Bushfires. It is produced by the National Mental Health Disaster Response Group, the GP Fellow of Disaster Medicine at UWS and the Australian Child and Adolescent Trauma, Loss and Greif Network. Its suggested strategies are informed by the best available research evidence of potential physical and mental health consequences and assessment, management and referral options.

General Principles

People who have been exposed to these fires are likely to have experienced a diverse range of possible stressors depending on their situation, roles and the intensity and severity of what they have gone through. They will also have a great many personal strengths that they will draw on, as well as the support of others.

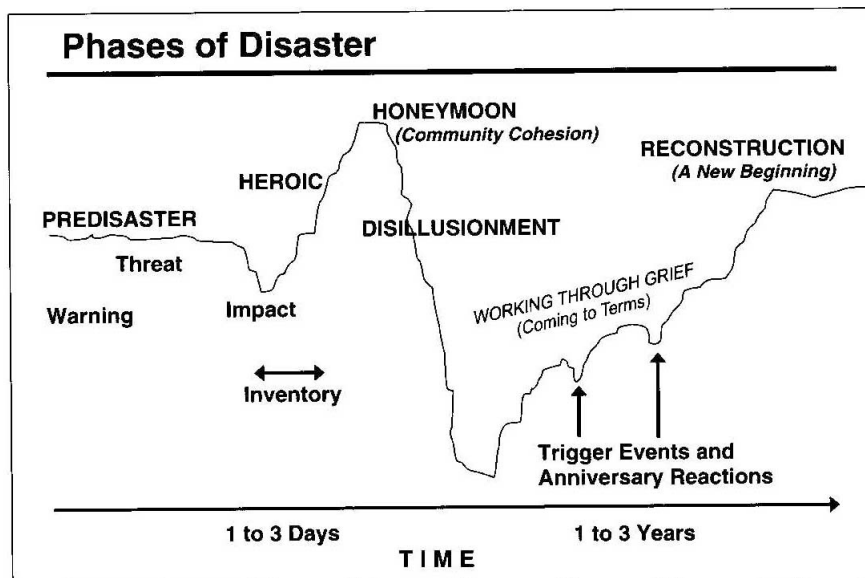
Some of the many stressors are listed:

- They thought they would die
- One or more family members or close persons died
- Home and property were destroyed, and possibly loved pets and livestock
- Community was destroyed
- Risked life helping others

The more severe and terrible the experiences of this kind, the greater the person's vulnerability to mental health and possibly physical health consequences, even though people are courageous and resilient.

"Phases of response" are variable but it is usually accepted that there is intense arousal and affiliative behaviours with the human response to assist others . This gives way after the early days to "let down", disillusionment and often anger and possibly guilt.

This diagram by Ursano et al (2007) demonstrates this pattern. It is relevant for individuals and populations.



It is also important to remember that the “hype” of early response affects us all. We may feel we cannot stop, we may feel we have to do more or guilty about what cannot be done. The sensory overload may also lead us to become anxious, fearful or over identify with those affected.

Nevertheless most people will mobilise resilience and personal strengths for recovery.

Systems of disaster management and response

There are many complex systems through general practice network, state public sector health, and mental health, recovery and welfare systems and non-government and multiple other organisations. It is helpful if you can get an idea of what these groups are, what they are offering, and have information to hand for your patients to assist them with what they can access. It is helpful for you to get a picture if you can of these organisational complexities. It is also true that there is a huge “convergence” of people wishing to help with good will. However this may be overwhelming for people who are stressed. The central role of the GP is to help patients to negotiate and understand the systems to obtain maximal benefit in ways that meet their own particular needs.

Important Principles for Patient Assessment and Care

1. Mental and physical health issues often coexist after such disasters. Patients often present with bodily symptoms as well as distress.

A brief health check to establish baseline condition and needs is important. This should include physical health and mental health. See Section 1 for Physical Health Check Guidelines.

Self care advice should also be provided at the first assessment.

People with pre-existing chronic conditions may need to be followed up if they have experienced a disaster, especially:

- the elderly
- patients with chronic disease - cardiovascular, respiratory disease, diabetes, arthritis etc
- people experiencing severe persisting mental illnesses

2. Psychological Principles for Care

• Early Phase: Psychological First Aid (NCPTSD)

- Comfort, listen if the person wants to talk, check and support practical needs
- Link them to family, friends and social support: connectedness helps recovery
- Triage: if someone continues to be
 - A) aroused to an extreme level
 - B) behaving in ways which place themselves or others at risk
 - C) cognitively impaired, confused

They may need to be referred for urgent mental health crisis assessment.

• Continuing principles for care. An international consensus process has identified the following 5 overarching principles as important for ongoing care (Hobfall et al 2007).

- Promoting a sense of safety, security
- Promoting calming
- Promoting a sense of effectiveness (people being able to take actions themselves will help with their recovery)
- Promoting connectedness – links to family, local groups, network of support can protect mental health
- Promoting hopefulness

These positive strategies can take place alongside assessment and care dealing with distress and suffering.

• Being ready to listen to stories of people's experiences and to identify their needs.

Empathy and kindness, genuineness and warmth are still core elements of helping, healing and recovery.

3. Stories of Loss and Trauma will come from patients if the circumstances are welcoming and the GP is able, at least when these stories first arise, to spend time to listen. Telling your story can be helpful especially if responded to empathically. It also helps to identify potential risk for mental health problems.

- Loss stories: those who have been bereaved in this horrific way may have special needs (see Section II)
- Trauma stories: the horror and fear generated for those directly affected or involved, for instance emergency responders, may lead to mental health needs (see Section III)
- Complex stories: other losses, previous problems, anger stories, past tragedies may also indicate vulnerability (see Section IV)
- Core actions to support psychological recovery. The National Centre for PTSD in the US has reviewed the literature and developed a field operations guide of skills that will assist psychological recovery. These involve the six core actions identified below:
 1. Information Gathering and Prioritizing Assistance
 2. Problem-Solving Skills

3. Positive Activities
4. Managing Activities
5. Helpful Thinking
6. Identifying and Maintaining Healthy Connections

4. Children, Adolescents and Family

Children and adolescents may be particularly vulnerable – if they have lost family members, home, school environments or friends. They may regress, act out, become quiet and withdrawn. Resources are available at <http://www.earlytraumagrief.anu.edu.au> (see Section V).

5. Longer Term Skills: Skills for Psychosocial Recovery

There is an increasing focus and consensus through the National Centre for PTSD and National Child Traumatic Stress Network.

6. Setting in place follow-up care

Many health and mental health problems may only appear over time and may require monitoring. Ideally brief physical and mental health checks could be carried out regularly – ideally monthly during the first 6 months, where possible and appropriate, and then 3-monthly for the following 12 months. This is particularly recommended for those who have been most directly affected.

7. Self-care

Putting in place strategies for self care is essential for doctors working in the aftermath of the disaster. The points listed below are useful for all involved in response.

- i) Look after your health: exercise (eg 20 mins); sleep, healthy food, keep any alcohol consumption within recommended guidelines, avoid recreational and other non-therapeutic drug taking, take 'time out' regularly, humour is also helpful.
- ii) Link up to your support network – connectedness helps, family, friends and supporters. Your family will feel with you, so remember the importance of two way affection and response.
- iii) Stress management strategies:
 - limit your load of stressful experiences / work
 - relaxation strategies eg. Slow breathing x 10; pleasant, positive thoughts
 - build your resilience eg. focus on achievements
 - build opportunities for recognizing hope and positive strength
 - allow yourself sadness and grief
 - allow yourself to be comforted by your loved ones and friends
 - maintain other aspects in your life and recreations
- iv) Seek expert mental health contact for back-up, consultation, and regular opportunities to 'debrief' on concerns related to your patients' problems.
- v) Develop a resource / diary of the key issues, what you have done, what has been helpful, what you have learnt, and what you think GPs need for such incidents in the future. This will help planners build better resources for GPs and writing this down will also help you see what has been achieved. There is scientific evidence that writing about one's experience helps.

Remember General Practitioners are greatly valued for their central contribution to community life and to the wellbeing of their patients. The courage and experience of doctors like yourselves who have often faced their own tragic losses and trauma, is a huge and positive resource in all our lives and for the future.

References

Hobfall, S.E., Watson, P.J., Ruzek, J.I., Bryant, R.A., Brymer, M.J., Steinberg, A.M., et al. (2007). Five essential elements of immediate and mid-term mass trauma intervention: empirical evidence. *Psychiatry*, 7, 4, 283-315.

Ursano,R.J., Fullerton,C.S., Weisaeth,L. & Raphael,B. (Eds) 2007. *Textbook of Disaster Psychiatry*. Cambridge:Cambridge University Press.

Section 1

Guidelines for GPs

Physical health consequences can arise from varied effects of the disaster – injury, or other health factors, or from the stresses of the experience.

General Practice Checklist in the weeks after the fires:

Check List: (from observations below)

Measurements:	Weight and height, especially in children
Cardiovascular:	Heart rate Blood pressure
Respiratory:	Respiratory rate Spirometry FEV1/FVC (if available)
Musculoskeletal:	Injuries Back or joint pain
Joints:	Arthritis - consider OT review if changed environment
Medications:	Current medication and any changes since the fire Non prescription medication, ie herbal or over the counter Alcohol and other illicit drugs Smoking
Health habits:	Exercise Sleep habits
Diabetes:	Glucometry
Mental Health:	General distress Specific problems eg. grief, trauma (see Section II and III)
Social:	Accommodation Financial/employment Relationship issues Children's behavioural issues (see Section VI)
Immunisations:	Tetanus to date Consider influenza vaccine

Many studies have shown the majority of health problems among disaster survivors are mental health problems (van den Berg, 2004) but physical review is also important.

Chronic illness

Patients with chronic illness are higher risk for other physical and mental problems. It has been suggested that education of patients about self-care before deterioration of condition would assist in improving the health status of those with chronic disease (Mori, 2007).

Fatigue can be enough to affect the health of those with chronic disease. There may be more physical or emotional work in the post disaster phase and this can increase fatigue (Mori, 2007).

A priority for some patients after disaster, especially those with chronic diseases, is procurement of medications, even obtaining extra in case of another emergency. Both the medications themselves and the prescribing doctors supplied emotional support for the patients (Mori, 2007).

Diabetics may have issues with maintenance of an appropriate diet and developing ways to cope with stress in the changed living environment which may include shelters. Control of diabetes, especially insulin-dependent diabetes, can be affected by stress and change in diet or appetite.

Chronic respiratory disease patients may request guidance in alleviation of any respiratory symptoms, as well as education on how to reduce stress and fatigue, to prevent aggravation of their disease. Some have reported thickened secretions after disaster from decreased fluid intake (Mori, 2007). Grouping in evacuation centres may increase some communicable diseases such as colds that may aggravate those with chronic respiratory disease. Air conditioners and ventilation systems may need to be cleaned before use (CDC, 2009). The National Asthma Council of Australia expects increased presentations for asthma in areas affected by smoke haze.

Arthritis patients may also request education on how to reduce stress and fatigue to prevent disease exacerbation. They may have issues with increased physical limitations in a changed environment. After the Great Hanshin Earthquake in Japan, "Some patients given a rice ball at the evacuation center could not eat it because their hands could not reach their mouths or because they could not eat it while standing when no chairs were available" (Mori, 2007). They may benefit from occupational therapy assistance.

Availability of medication, stress management, support for activities of daily living, appropriate food, and availability of support devices necessary to minimize symptom exacerbations are needs expressed by those with chronic illness after a disaster (Mori, 2007).

Fire fighters and other volunteers performing physical activities

Musculoskeletal strains and sprains to hips, knees and ankles accounted for from 11% to 41% injuries to fire fighters in recent fire fighting studies in Victoria (Robinson 2003). This is contributed to by stepping down from fire trucks, increased obstacles in areas burnt areas, and unaccustomed physical activity in some.

Usually sedentary volunteers with cardiovascular risk factors need to be aware of early symptoms of myocardial ischaemic disease such as increased fatigue, chest pain, heartburn, and excessive breathlessness, although the risk appears to be low.

In studies in fire fighters (Robinson 2003), endurance, several studies have shown strength, flexibility and core stability programs have reduced injury rates.

Medications and substance use

Increased substance use, with or without abuse, is seen after disasters with concomitant increased risk taking behaviour (Ursano, 2007, p.315). It is worst in those with prior drug abuse. In studies after September 11 it was raised at six months with alcohol increased in 24.6%, tobacco in 9.7% and marijuana in 3.2% (Vlahov et al., 2002).

Medically unexplained symptoms

Studies have shown medically unexplained symptoms (MUS) increase after disasters. These physical symptoms may include fatigue or pain in the stomach, head, chest, joints or muscles (van den Berg, 2004).

General issues

Concern for injury, acute illness and chronic disease is exacerbated in the recovery period (Bayleyegn, 2005).

Loss of their GP can also affect the sense of security those with chronic illness feel as had a trusting relationship with their local GP (Mori, 2007).

Patients who have had to relocate may benefit from a phone call to the new GP to ensure continuity of care.

In the first weeks following a disaster there is a higher risk of an infectious disease outbreak, although more likely in poor and developing regions, so it is important to be vigilant to the possibility (Waring, 2005).

Damaged households or public utility problems may have affected the ability to keep some medications cold, or possibly result in improper food storage or water supply problems.

Injuries in the cleanup may occur from various hazards including live electrical wires or spilt chemicals. Tetanus is important for any wounds or a prophylactic check of status before cleaning up burnt areas.

Concern about telephone communication in case of emergency or illness can also be an issue.

Relationship issues

Inter-family or marital relationship issues may arise due to extra stress following the fire. General questions on children's behaviour after the disaster may be useful.

Importance of maintenance of good general health practice in all patients.

Questions about nutrition, regular exercise and regular sleep habits are important.

General Observations

Increased heart rate or blood pressure in the aftermath may reflect increased psychological vulnerability, especially if it persists.

Measurement of weight and height in children may be useful as a baseline in case of future problems.

Self-rated health is an excellent measure of likely future health.

Self-rated health status

Q1. Overall, how would you rate your health during the past 4 weeks? [READ OUT]

- 1. Excellent
- 2. Very good
- 3. Good
- 4. Fair
- 5. Poor
- 6. Very poor
- X Don't know
- R Refused

Resources

Australian Centre for Grief and Bereavement Practitioner Consultancy Service provides information and support for practitioners working with bereaved patients experiencing complex and prolonged bereavement 1 300 858 113 <http://www.grief.org.au>

The GP Psych Support service provides GPs with patient management advice from psychiatrists within 24 hours:

Phone: 1 800 200 588

Fax: 1 800 012 422

Email: www.psychsupport.com.au

1 800 200 588 to setup a login.

Griefline (noon to 3am)	03 9596 7799
Lifeline	13 11 14
Suicide Helpline	1300 651 251
Mensline	1300 789978
Kids Help Line	1800 551 800

The Doctor's Health Advisory Service offers a confidential crisis & referral service

Phone: (02) 9437 6552 24hrs/7 days www.doctorshealth.org.au

or via The NSW Doctor's Mental Health Program website www.dmh.org.au

AMA Victoria Peer Support Service 1 300 853 338 8am-11pm 7 days

GP Support Program for RACGP members 1 300 366 789 business hours

For traumatic incidents and crisis counselling 1 800 451 138 24hrs/7 days

www.racgp.org.au/gpsupport

Locum Assistance

Tony McKinnon: tonym@rwav.com.au

Rural Workforce Agency, Victoria

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Section II

Mental Health: General Themes

Psychological distress is a natural reaction in the immediate aftermath of a disaster, although for some people there may be prolonged shock and a sense of unreality. Most distress settles during the early weeks and should not be treated as pathology or illness. Studies of those affected over time have demonstrated trajectories of change with many being resilient (Bonnano 2004). Communities are also often resilient. Some people even show post traumatic growth after catastrophes. Nevertheless a significant proportion will develop new mental health problems and disorders precipitated by their experience, or exacerbations of pre-existing illnesses (Ursano et al 2007). Assessment of such problems and their appropriate management by the GP or referral for expert mental health care are valuable strategies. It's important to remember that people may feel that they do not need care, or will cope with what has happened but they may. It is useful to identify a number of options for them - for instance referral to a psychologist, psychiatrist or allied health worker; web-based information of other self care strategies: online treatment resources.

Referral should be determined by the severity of the person's experience, current condition and mental state; and any risks of self-harm or violence.

Illnesses that have been demonstrated to be possible consequences of mass disaster include the following:

- Anxiety disorders: PTSD, generalized anxiety disorder, panic disorder, social phobias
- Depressive disorders: major depression and a spectrum of depressive symptom patterns
- Somatisation symptom patterns: often linked to concerns about physical health effects of the disaster
- Adjustment disorders related to stressful experiences or injury
- Substance use problems including alcohol, smoking, marijuana and other drugs
- Non-specific symptom patterns associated with disability
- Changes in health and social behaviours, functioning and relationships.
- Psychotic conditions may be exacerbated or more rarely precipitated.

Monitoring the range of possible mental health outcomes is important. A measure of psychological distress which can link to "caseness" in Australian National Mental Health and Wellbeing Surveys is the K10 or K6, which has been extensively used post disaster. It is also useful to assess the particular experiences / exposures, resilience and other matters of relevance.

Bereavement syndromes – Section III

Trauma syndromes – Section IV

Complex Problems – Section V

Children & Adolescence – Section VI

Reference

Bonnano, G. (2004). Loss, trauma, and human resilience. *American Psychologist*, 59, 20-28.

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K10 Questionnaire for measurement of psychological distress

K10

For all questions, please fill in the appropriate response circle. Fill in the circles like this: ●
Please do not tick or cross the circles.

In the past 4 weeks:

None of
the time

A little of
the time

Some of
the time

Most of
the time

All of
the time

1. About how often did you feel tired out for no good reason?

☐ — ☐ — ☐ — ☐ — ☐

2. About how often did you feel nervous?

☐ — ☐ — ☐ — ☐ — ☐

3. About how often did you feel so nervous that nothing could calm you down?

☐ — ☐ — ☐ — ☐ — ☐

4. About how often did you feel hopeless?

☐ — ☐ — ☐ — ☐ — ☐

5. About how often did you feel restless or fidgety?

☐ — ☐ — ☐ — ☐ — ☐

6. About how often did you feel so restless you could not sit still?

☐ — ☐ — ☐ — ☐ — ☐

7. About how often did you feel depressed?

☐ — ☐ — ☐ — ☐ — ☐

8. About how often did you feel that everything is an effort?

☐ — ☐ — ☐ — ☐ — ☐

9. About how often did you feel so sad that nothing could cheer you up?

☐ — ☐ — ☐ — ☐ — ☐

10. About how often did you feel worthless?

☐ — ☐ — ☐ — ☐ — ☐

Today's date / /
Day Month Year

A Guide to the K10 Symptom Scale

The K10 is widely recommended as a simple measure of psychological distress and as a measure of outcomes following treatment for common mental health disorders. The K10 is in the public domain and is promoted on the Clinical Research Unit for Anxiety and Depression website (www.crufad.org) as a self report measure to identify need for treatment. It is reproduced below.

The 10 item scale has five response categories and the score is the sum of those responses:

<i>None of the time</i>	scores 1
<i>A little of the time</i>	scores 2
<i>Some of the time</i>	scores 3
<i>Most of the time</i>	scores 4
<i>All of the time</i>	scores 5

Questions 3 and 6 are not asked if the preceding question was 'none of the time' in which case questions 3 and 6 would automatically receive a score of one.

Total scores range from 10 (no distress) to 50 (severe distress).

People who score **0-15** have one quarter the population risk of meeting criteria for an anxiety or depressive disorder as identified by the CIDI, and a remote chance of reporting a suicidal attempt in their lifetime.

People who score **16-30** have a one in four chance (three times the population risk) of having a current anxiety or depressive disorder and 1% chance (three times the population risk) of ever having made a suicide attempt.

People who score **30-50** have a three out of four chance (ten times the population risk) of meeting criteria for an anxiety or depressive disorder and 6% chance (20 times the population risk) of ever having made a suicide attempt.

- The first group comprise 78% of the population and are told their score is low and that they probably do not need the self help information.
- The second group, 20% of the population, are encouraged to use the information and self help techniques.
- The third group, 2% of the population, are strongly encouraged to seek medical help.

For further information on the K10 please refer to www.crufad.org or Andrews, G Slade, T. Interpreting scores on the Kessler Psychological Distress Scale (K10). *Australian and New Zealand Journal of Public Health*: 2001; 25:6: 494-497.

From CRUFAD (Clinical Research Unit for Anxiety and Depression) website.
www.gpcare.org Clinician Support / K10

Section III

Bereavement, Loss and Mental Health Problems

The Victorian Bushfire disaster is one of overwhelming grief. Understanding issues about bereavement, which differs from but may occur alongside trauma, is essential.

Bereavement is a normal part of life, but deaths in a disaster are most often sudden, unexpected and untimely, occurring in very traumatic circumstances. All these factors add to the vulnerability that is associated with such deaths (Raphael et al 2006). There are several areas of need.

- i) **Information and support immediately after the disaster** when loved ones may be missing and possibly dead and family members face fear and uncertainty
- ii) **Skilled professional support** to assist with identification of the deceased, especially if there are few remains, gross mutilation, prolonged uncertainty or even no remains. The extensive and terrible destruction of the bushfires means that these issues and their consequences may be major sources of stress and distress for the bereaved both in the early period, and over time (Mowl 2007).
- iii) **Early intervention after losses of this kind is recommended** because of the presence of both intense grief and intense trauma reactions, with the risk of pathological outcomes, including depression and PTSD (Litz 2004) (Raphael et al 2006).
- iv) **Risks associated with outcomes of bereavement** are indicated by:
 - Intense, continuing high levels of distress, beyond the first month
 - Horrific, violent traumatic circumstances of death leading to both psychological trauma and grief reactions
 - Pre-existing relationship difficulties, particularly with complex and dependent attachments
 - Lack of support
 - Vulnerabilities related to previous losses or trauma
 - Death of a child
 - Multiple other concurrent stressors
- v) **Bereavement related problems** and adverse health and mental health outcomes may arise:
 - Traumatic bereavement (trauma & grief)
 - Complicated or prolonged grief (Prigerson et al 2008)
 - Depressive syndromes
 - Other psychiatric morbidity
 - Adverse physical health outcomes in terms of immune functioning, cardiovascular disease and possibly other conditions (Stroebe et al 2008)

Management

The general practitioner may provide supportive care, assisting the bereaved persons' expressions of grief when this is appropriate, encouraging them when they are ready, to talk of the lost person; exploring the bereaved's understanding of and reaction to the way the person died; and encouraging links to supportive networks. This may be a sensitive and difficult area for the doctor because of his or her own complex feelings and personal losses. As noted above, ongoing intense grief, which disrupts functioning, may require expert care.

Referral to specialised clinical care can provide a more detailed assessment and planning for intervention.

Traumatic grief – dealing with traumatic grief involves addressing the traumatic circumstances of the death, potentially utilising cognitive behaviour strategies (CBT) alongside grief counselling which may involve reviewing the relationship and memories of the dead person and their associated emotions (Raphael et al 2006, Rynearson 2006, Litz, 2004).

Complicated and prolonged grief is diagnosed after 6 months (Prigerson et al 2008) and has been treated with CBT manualised interventions (Shear et al 2005).

Other complications such as depression should be managed in terms of the relevant clinical findings, while at the same time dealing assisting grief. Sensitivity to potential suicidal thoughts is important in these circumstances, as they may be related to fantasies of reunion with the dead person, or significant guilt.

Bereavement in horrific circumstances such as the fire may take a prolonged course and all those involved with care should be sensitive to the 'rollercoaster' of mood swings; the prolonged yearning and anger; and the reality that concepts of 'closure' may be inappropriate. Rather, those bereaved, such as those who have lost a child in these circumstances, may seek help at later times when they feel they are able to talk of their loved ones.

Family grief – family members may deal with their grief in different ways and at different times. Support for the family as a group, and information regarding different needs and patterns of grief; for instance for men and women, children of different ages, may be helpful. Family Focused Grief Therapy (Kissane & Lichtenthal 2008) addresses the complexities of family dynamics and relationships but has not yet been adapted to the acute disaster settings.

Community grief is profound in circumstances such as the fires, and there is great mutual support, which may help people to continue. Ritual, ceremony, acknowledgement and memorials can support this.

Children's grief requires special attention and is influenced also by the grief of their parents and other adults. See Section VI

Grief over other losses - loss of home, friends, community, way of life, pets, livestock, property and other valued possessions of emotional significance also

brings distress and mourning. These multiple losses may make grief more overwhelming & difficult.

References and Resources

Bereavement Centre Melbourne:

www.grief.org.au

www.earlytraumagrief.anu.edu.au (Children's grief)

The National Association for Loss and Grief (NALAG) <http://www.nalag.org.au/>

Bonanno, G.A., Boerner, K., Wortman, C.B. (2008). Trajectories of Grieving. In: Stroebe, M.S., Hansson, R.O., Schut H., & Stroebe, W. (Eds). *Handbook of Bereavement Research and Practice*. Washington DC. 14, pp.287- 307.

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Section IV

Trauma Syndromes

Acute Stress Disorder (ASD) and Post-traumatic Stress Disorder (PTSD)

Advice to the general practitioner following disaster

Following a major disaster, the general practitioner is likely to see an increase in number of patients with trauma-related symptoms. Patients may present with physical rather than mental health or emotional symptoms and it is important to be aware of the effects of trauma and potential screening and referral options available.

Acute stress disorder presents in the first 4 weeks, with re-experiencing, avoidance, and arousal symptom patterns, with dissociative symptoms being a key element. Post-traumatic Stress Disorder, PTSD, is diagnosed if symptoms of listed below have been present for more than a month:

- re-experiencing the trauma
- avoidance and emotional numbing
- hyperarousal
- impacts on personal, social or occupational functioning

It has often been assumed that traumatic pathology, such as ASD and/or PTSD, are the likely outcome for survivors of traumatic events such mass disaster. However the majority of survivors will not develop these disorders and will eventually return to a pre-event level of functioning.

Nevertheless a significant population may be affected as shown in studies after the 2003 Canberra bushfires (Parslow et al 2005) and other mass disasters. The Canberra findings are important because extensive high quality recovery programs in the broad sense were put in place yet morbidity was still significant even though there were strong efforts at appropriate outreach and access program. Risk may be heightened amongst those who have the following experiences (North 2007), (Benedek, 2007):

- thought they would die, and reacted with intense fear/horror
- were exposed to gruesome horrific deaths of others
- experienced continuing high distress
- experienced multiple other stress exposures
- may have had pre-existing vulnerability, including previous trauma

The following information is designed to provide GPs with an overview of the best available evidence regarding:

- 1) screening for ASD and PTSD
- 2) the most appropriate referral options
- 3) treatment recommendations for ASD and PTSD following mass disaster or terrorist attack

It also provides a number of resources in the form of websites for both national and international organisations which provide the most current evidence-based recommendations and information resources. The Australian Centre for Post Traumatic Mental Health provides many excellent resources dealing with these issues. See www.acpmh.unimelb.edu.au.

Screening

The US National Centre for PTSD recommends a 4-item screening tool (the *Primary Care PTSD Screen*, see attached). The PC-PTSD screen is designed to identify patients who *may* have PTSD. This traumatic stress self-report screening instrument may be completed prior to an appointment or screening items can be added to the standard medical history forms that patients complete when first attending. Some patients who screen "positive" will not be diagnosed with PTSD after a detailed clinical evaluation by a mental-health professional. However, this instrument may increase a GPs ability to detect PTSD and to initiate appropriate referral.

If distress such as high levels of arousal (jumpy, heart racing; numbing and unreality; re-experience what has happened, flashbacks) are continuing two weeks following the disaster, general practitioners may want to assess clinically for Acute Stress Disorder (ASD).

Some research indicates that early treatment for Acute Stress Disorder symptoms may lessen the risk of developing Post Traumatic Stress Disorder (Bryant et al 2003). Screening for PTSD using the attached primary health care scale can inform management.

It is also appropriate that the general practitioner undertake an assessment of general mental health as indicated in Section II.

It is vitally important that assessments are sensitive to the level of distress of the patient, the potential complexity of his or her problems that principles of psychological first aid and support are used to help the person and that any interventions offered more formally are linked to the affected person's readiness, to his or her trajectories of recovery.

When to refer and to whom

As discussed, a positive response to the PC-PTSD screen does not confirm a diagnosis of PTSD but does indicate that a patient *may* have PTSD or trauma-related problems and that further investigation of trauma symptoms is warranted. Patients who screen positive for PTSD should also be explicitly screened for suicidal ideation (US Centre for PTSD; <http://www.ncptsd.va.gov/ncmain/information>).

Those who screen positive should be referred to an appropriate mental health professional such as a psychiatrist or clinical psychologist familiar with trauma-focused cognitive behaviour therapy (TF-CBT). The following treatment recommendations are taken from the *Australian Guidelines for the Treatment of Adults with Acute Stress Disorder and Posttraumatic Stress Disorder* (www.acpmh.unimelb.edu.au) and represent the best evidence-based research findings available.

Treatment for adults with PTSD & ASD

For PTSD and ASD, *psychological trauma-focused interventions* (trauma-focused CBT) in addition to in-vivo exposure are the recommended treatments of choice. These may range up to 15 sessions. As noted by Litz et al (2007) and Benedek (2007) interventions need to be better tested and evaluated, for instance in real world disaster settings.

Drug treatments for PTSD should not be used as a routine first-line treatment in preference to a trauma-focused psychological therapy. Where medication is considered for the treatment of PTSD, SSRI antidepressants should be first choice for both general practitioners and mental health specialists. Drug treatments should generally *not be used to treat ASD* unless the person's distress/hyperarousal can not be managed by psychological means alone.

Extensive internet based models of intervention are available, have been tested for "proof of concept" (Litz et al 2007) (Benight et al 2008) and comprehensively reviewed recently.

It should be noted, as emphasized by Benedek (2007), there are considerable limitations to ASD and PTSD practice guidelines as these are generally not informed by clinical experience in real world settings. These guidelines rarely assess population-based approaches and the populations researched rarely include those with complex clinical presentations. Nor are they integrated with health care systems more broadly. Generalising the research findings to disaster affected populations, requires critical appraisal, as in other area of post disaster mental health intervention.

Primary Care PTSD Screen

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, **in the past month**, you

1. Have had nightmares about it or thought about it when you did not want to?

YES NO

2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?

YES NO

3. Were constantly on guard, watchful, or easily startled?

YES NO

4. Felt numb or detached from others, activities, or your surroundings?

YES NO

Current research suggests that the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any three items.

Other available resources

The patient and their family may also benefit from educational materials about trauma and PTSD, such as those on the Australian Centre for Post Traumatic Stress website (www.acpmh.unimelb.edu.au), the National Center for PTSD Fact Sheets (<http://www.ncptsd.va.gov/ncmain/information>), and the National Child Traumatic Stress Network (http://www.nctsnet.org/nccts/nav.do?pid=hom_main).

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Section V

Complexity of Problems

This disaster has been terrifying, intense and extensive, affecting large numbers of people directly and a great many more, indirectly. As with most areas of health, mental health complexity of problems and conditions is not unusual. In this circumstance the challenges of the multiple stressors in the disaster and its aftermath as well as the multiple systems involved in response and recovery add further complexity, which needs to be recognized and managed.

Key themes are outlined below.

Chaos and destruction are inherent in disasters. They affect those directly exposed, but also service providers, including emergency responders and recovery workers. They bring extra stresses until appropriate systems are in place, functioning and understood and accessed by all those who need them.

Anger, disillusionment. There will be different stressors and needs in the emergency through the transition to recovery and the longer term. The initial period is full of goodwill but anger and disillusionment start to appear for both communities and individuals.

Anger is:

personal – to do with losses and disruptions of life

community, broader – how did it happen, why, who might be to blame?

Query of fate – why me, why mine?

People may need support and the opportunity to channel some of the energy of anger into actions for recovery and renewal.

Multiple stresses are also a norm, so there is rarely a simple picture. People may be challenged by different priorities at different times. There is a need to recognize these and assist people to manage priorities in their “finite pool of worries”, ie. you can only focus on a certain number of concerns at one time. It is also important to help people to do this so that multiple stresses do not become a “tipping point” into negative coping and mental health vulnerabilities.

People and communities have great strengths and resilience. It is important to assist people to recognise and utilise their strategies for getting through tough times, to help them build on achievements and especially to become actively engaged in practical actions for their own recovery and that of their community. Connectedness to sources of support in family, social network and community also assist, linking into the “social capital”, resilience and community development. It is important to remember that connectedness takes many forms, including mobile phones, texting, internet, and social networking sites such as Facebook.

Disaster effects are prolonged. Recovery takes place over time and may require a strong commitment to sustainability in the face of new or emerging needs, stressors, or ongoing health and mental health problems. Clinical care as well as practical and welfare

support need to take these factors into account. These are exemplified by “triggers” which may bring back intense anguish; anniversaries and reminders of the loss; failure of empathy by others; ongoing practical difficulties related to accommodation, work and the basic resources one was used to and that give dignity to living.

Health problems may be complex and multiple. Physical health effects related to the stresses of the acute disaster or ongoing, or new stressors as well as changed health behaviours, difficulties accessing care have been associated with significant problems (see Section I). Ongoing monitoring by GPs for health and mental health can take into account these complexities and ensure a response which. The aim is to protect health and mental health positively and to treat and refer as appropriate.

General Practitioners play a central role in recognizing and managing health impacts of disaster in all their complexities. They will need good documentation and support systems, and a network of clinical back-up and support for these specific issues.

Complexity the Norm

1. Disruption of normal systems – link in to systems in order to help
2. Deal with disillusionment, anger and grief when these predominate
3. Multiple stresses are the norm. Help people address priorities and utilise positive coping skills.
4. Strengths and resilience should be supported, particularly by people taking actions for their own and their community's recovery and connecting for mutual support
5. Disaster health effects are prolonged and vary over time. Help make do-able strategies for managing this.
6. Health problems are complex. Physical health and mental health need monitoring and care in the prolonged post-disaster period.
7. GPs play a central role in addressing and managing health complexities, and need their own back-up systems for this.

Section VI

Children and Adolescents

Children of all ages can be profoundly affected by disasters such as the fires; through the trauma, grief, destructions of the sense of safety and security, loss of home and school networks. A useful resource dealing with children affected by disasters is LaGreca et al's comprehensive volume (2002). Many excellent resources have been developed and are being used to support response in this bushfire disaster.

Most important is support and guidance for parents and assistance for their needs as well as information to help them respond to their own children's issues. Children and adolescents' needs can also be systematically addressed through their school systems, communities and other groups. Network based resources are available at www.earlytraumagrief.anu.edu.au, and www.earlychildhoodaustralia.org.au, and other sites. Specific programs are being developed in close partnership with school organizations and in partnership with the Australian Child and Adolescent Trauma Loss and Grief Network.

Children's reactions will be influenced by:

- How directly they were affected by the fire
 - close experience: terror and fear
 - parents or family members died
 - losses of significant others
 - home, neighbourhood, school, community were damaged or destroyed
 - loved pets, toys etc were lost
- If they were separated from parents at the time; parents' reactions both immediately and subsequently will be important for the child, as will be their capacity to support and respond to the child afterwards. The broader family and social network are also important.
- Too much TV viewing of traumatic images of the disaster
- Child's stage of development. Young children may be particularly vulnerable
- Ongoing disruptions, including not being able to return to school, accommodation insecurity, ongoing life and family disruptions (McFarlane 1987, McDermott & Palmer 2002, McDermott et al 2005).

Children's reaction can show in different ways, depending on their age, experience and ongoing circumstances.

Children may have ongoing fears regarding safety, security and separation from parents. These fears may present as follows:

- Young children – regression, clinging, sleep difficulties
- Older children – bravado, withdrawal, emotional problems, behavioural problems
- Adolescents – acting out, caregiving, arousal, depression, drugs

Children may experience grief with the losses that have occurred and show withdrawn behaviours, seeking comfort from other family members, clinging to attachment objects, asking questions repetitively.

- Young children – may not understand the finality of death, may feel abandoned
- Older children – may “attach” to others, seek security, experience guilt
- Adolescents - may show a range of grieving emotions or denial, anger, guilt, pseudomaturity

Children may develop trauma syndromes eg. PTSD:

- High arousal, sleep difficulties, irritability, can't concentrate
- Numbing, avoidance
- Re-experiencing

Children may develop traumatic grief

- This is a mixture of trauma and grief and is common in such circumstances.

Children are vulnerable to multiple stressors: Chemtob et al (2008) have highlighted that the particular vulnerabilities of children when there are multiple stressors. This is particularly problematic in the current disaster. He has also demonstrated impacts for pre-school children in such circumstances.

Children may be quiet, good and compliant early after the disaster, until they regain some sense of a secure world, and only later show the impact, (even 6 months or more afterwards).

Common symptom patterns include:

- Increased fearfulness about any threat
- Clinging, and possibly regressed behaviours, fearing separation
- Sleep difficulties
- General bodily complaints eg. Stomach pain, headache
- Difficulties concentrating at school
- Withdrawn, sad, and even depressed response
- Aggressive, acting out, even conduct problems

Disasters may impact on development through the severity of the children's experience, their reactions, and the degree to which they are able to be supported adequately. However it's important to remember children's resilience and to recognize and assist this.

Helping children involves also helping parents and families deal with their own grief and trauma and providing them with advice about children's needs and how to support them is one of the main issues. For instance, children need reassurance:

- That they are loved
- That they will be safe and secure
- That they can share any of their feelings
- That they can ask questions that will be answered simply and honestly

- That they will be comforted and looked after now and in the future

General Practitioners can monitor children and adolescents' health and wellbeing.

This should be specifically done, as well as supporting parents and family members for their own needs and those of their children. Support in ongoing ways over time is important.

What the GP can do:

- Provide advice, information and support to manage fears
- Monitor symptoms and behaviours over time and:
 - discuss with parents and advise
 - with high levels of increasing distress / behavioural change persisting beyond the first month – discuss with parents, reassure, seek expert advice and refer if necessary
 - refer for assessment by a skilled mental health professional who can provide specific assessment and care

The needs of children after disasters are well addressed by Pynoos et al (2007) who emphasise a public mental health approach. They have outlined stages of post-disaster intervention.

- ***Psychological first aid*** (National Child Traumatic Stress Network and National Center for PTSD). Brief supportive interventions for children and families in the early weeks including emotional support, social support, practical assistance, information gathering and provision, and linking with collaborative services.
- ***Skills for psychological recovery*** (FEMA and CMHS in the USA). These skills are relevant for adults and children and help to build on resilience. See below:

Skills for psychological recovery

(FEMA and CMHS in the USA).

These skills are relevant for adults and children and help to build on resilience.

- Assistance with problem-solving and coping to deal with ongoing post disaster stresses
- Strengthening capacity to manage ongoing trauma and loss reminders
- Focused assistance with particularly troubling aspects of the disaster experience
- Helping to restore family functioning and normal routines
- Assisting children and families in managing ongoing grief reactions and emerging depressive responses
- Promoting linkage with mental health, health and social services
- Promoting child, youth and family developmental progression, taking into account the new "normalities"
- Enhancing information for ongoing safety personally and for health
- Promoting constructive activities for personal and social resilience

The primary therapeutic foci are traumatic experiences; trauma and loss reminders; trauma –related bereavement; post-disaster adversities; and assisting developmental progression.

- Tier 1 – broad interventions to promote adaptive adjustment, normal developmental progression, and prevent the onset of problems
 - Tier 2 – specialized interventions to reduce psychological distress, promote normal developmental progression and adaptive adjustment for children and adolescent who have been moderately to severely affected, and to prevent as far as possible severe and persisting mental health problems.
 - Tier 3 highly specialized interventions by expert mental health professionals to reduce severe psychological distress, high risk behaviours and to treat severe mental health problems and their associated functional impairments
- **Specific treatments:** treatment strategies utilizing the evidence are outlined below for children and adolescents who have developed significant disorders and for whom there may be an exacerbation of pre-existing problems and co-morbidity of trauma or grief syndromes with other mental health problems.

Evidence of what works

- Cognitive behaviour therapy programs focused on children's fearful trauma-related symptoms, particularly child PTSD can be provided and will assist (Pynoos et al 2007, McDermott et al 2005).
- Traumatic grief has been effectively managed after disasters with specific initiatives such as 8 or more sessions of trauma and grief focused interventions in schools (Pynoos et al 2007), or others delivered through specific programs provided in clinical or other settings (Cohen et al 2006). These programs are important because they have been applied directly to disaster-affected populations and build on earlier trials.
- Programs integrated into school settings, for instance with a bushfire related workbook for children to fill in with linked risk-assessment and intervention option (McDermott et al 2005, McDermott & Palmer 2002)
- Group and individual interventions with 10 session manualised treatment for grief and trauma have been evaluated positively for a disaster-affected population, 4 months after Hurricane Katrina. (Salloum and Overstreet, 2008)
- School based programs have been shown to be effective in a number of studies, particularly building on the work of Chemtob et al (2002).

Reference & Resources

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