AUSTRALIAN EMERGENCY MANUAL
DISASTER MEDICINE

SECTION FIVE

RECOVERY

CHAPTER TWENTY-FIVE

MENTAL HEALTH

INTRODUCTION

25.01 In the last two decades the major psychological impact of disasters has been better understood. As with any traumatic stress a range of possible reactions should be identified.

25.02 In general, there are very few acute psychological emergencies that arise in disaster settings. Many people will respond in highly adaptive ways and only a small minority will experiences extreme panic and few of these will require specific assistance at the time of the disaster. In general such behavioural disturbance is of importance because it could disrupt their chance of survival. An adaptive response at the time of the disaster does not predict the absence of difficulties in the longer term.

REACTIONS AND OUTCOMES

25.03 IMMEDIATE POST-DISASTER REACTIONS

In the immediate aftermath of disasters, the majority of victims and emergency service workers will experience a range of acute stress reactions. The symptoms will include intrusive and distressing memories of the event which may occur as nightmares, sleep disturbance, difficulties with concentration, a range of anxiety symptoms and an increasing avoidance of traumatic reminders. Other victims who have sustained major losses may experience acute states of grief. Psychotic reactions are very uncommon.

25.04 LONGER TERM OUTCOME

According to the nature and severity of the disaster, it is predictable that as many as 25% of the population will experience prolonged adverse mental health effects. Post-traumatic stress disorder is the most characteristic problem which will emerge. This is characterised by a typical set of symptoms, including intrusive recollections of the disaster, disordered arousal and a pattern of estrangement and avoidance.

25.05 A range of other psychiatric disorders can emerge in the aftermath of a disaster such as major depression, panic disorder and alcohol abuse. These will tend to be associated with those who have post-traumatic reactions.

25.06 Those who have lost family members and whose homes have been destroyed may need assistance with a range of other interpersonal difficulties Parents particularly, may need specific advice about the management of children and dealing with a range of somatic health complaints which are often indirect manifestations of their psychological traumatisation.

MENTAL HEALTH AGENCIES AND SERVICES

25.07 The provision of mental health services is the responsibility of the State and Territory Health Departments. Other agencies which satisfy the professional requirements of the relevant Health Departments may be called on for support. The responsibilities include de-briefing, counselling (of health workers, combat and support organisations and disaster victims), and bereavement counselling and ongoing therapy.

25.08 Mental health services can be offered to other departments, authorities and agencies, but it is recognised that some of these have their own in house arrangements.

MENTAL HEALTH INTERVENTIONS

25.09 PREVENTION

Given the wide range of responses a range of therapeutic skills are necessary to deal with the loss, trauma and anxiety that arise in the aftermath of a disaster. Preventative interventions, including education, should be directed towards those who have a particularly high probability of developing symptoms. This would include people who have intense exposure or who may have sustained significant injury or loss.

25.10 PEER DEFUSING

Peer defusing occurs when the team leader or nominee facilitates the expression of feelings about the operation within a safe, non-threatening environment. It may occur on-scene or on return to base. It is mandatory and should form part of the agencies' Standing Operating Procedures. It can be described as 'opening the cork of the champagne bottle and letting the bubbles escape'.

25.11 DE-BRIEFING

The important ingredients of de-briefing include confrontation with the experience, education about patterns of response as well as a direct expression of affects and cognitions about the experience. The aim is also to facilitate the development of the practical mastery of these situations. Similar techniques are used in individual interventions.

25.12 CRITICAL INCIDENT STRESS DE-BRIEFING (CISD)

The process referred to as Critical Incident Stress De-briefing (CISD) is a formal process designed to help groups of emergency workers, or others involved with the disaster, including those who have been direct victims. It should be conducted by professionally qualified mental health workers as part of the health response.

25.13 COUNSELLING

Counselling aims to help people come to terms with the trauma, loss and other distress they may have suffered in the disaster and its aftermath.

25.14 THERAPY

There is often a reluctance to recognise and refer on to mental health specialists, people suffering from psychological problems or psychiatric disorders after the disaster. It is essential that such referral is made in a supportive manner, otherwise there may be undue and prolonged suffering for those affected.

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CHAPTER TWENTY-SIX

RESTORATION OF NORMAL FUNCTIONS

INTRODUCTION

26.01 During recovery activities it is vital that work be undertaken to restore the infrastructure of the community and provide for the affected people to return to their normal lifestyle as quickly as possible

26.02 The desire of affected people to 'return home' will add considerable pressure to people working in the restoration, however it is important that areas be considered safe before affected areas including houses are re-occupied.

26.03 RIGHTS OF ACCESS

Emergency workers need to consider the rights of affected persons to have access to their property to recover personal belongings and the need to allow insurance assessments to take place

26.04 SAFETY ASSESSMENT

An assessment of the safety of an area may include

a. immediate danger arising from the disaster,

b stability of the buildings;

c. safety of roads and bridges:

d. availability of water;

e. accessibility of disaster area for emergency workers to provide services; and

f. availability of sewerage or alternative liquid waste disposal

GENERAL PRINCIPLES

26.05 SENSITIVITY AND CONSULTATION

When people and communities face the tasks of putting order in their lives, restoring their losses and establishing normal living patterns, their capacities to recover using their own resources will vary depending on the specific circumstances of the disaster. Consequently the responders have to adapt the assistance provided, to most appropriately meet the needs of those affected. This requires sensitivity to the situation and extensive consultation with affected people and communities

26.06 EMOTIONAL IMPACT

Typically, emergencies result in the destruction of property such as homes, personal possessions, income earning assets and community facilities. These physical losses are usually accompanied by emotional distress and feelings of disorientation.

26.07 Together, the physical and emotional impact of an emergency may diminish the recovery capacities of individuals, families and communities to the extent that assistance from outside is usually required.

26 08 However, it is important that such assistance does not overwhelm affected people and detract from their involvement in managing their own affairs. Assistance commonly includes material aid, temporary accommodation, financial assistance, counselling and personal services, information and community support.

26.09 **THE RECOVERY PROCESS**

Having regard to the above, the recovery process may be complex, as people and communities will have a variety of needs which will require numerous recovery measures involving a wide range of agencies Such measures will be dynamic, to the extent that needs will constantly change over time as difficulties are overcome and new issues arise, and protracted, given that the full recovery process may take several years to complete

26.10 Experience demonstrates that recovery is best achieved when affected communities exercise a high degree of self-determination. It should be seen as a developmental process through which communities attain a proper level of functioning

SPECIFIC RESTORATION REQUIREMENTS

26 11 Specific restoration requirements will vary greatly depending on the type of disaster eg. in the event of a flood, major infrastructure work including the restoration of sewerage and water services is likely to be necessary

26.12 **FLEXIBILITY**

As each disaster will be different, emergency workers must be flexible and alert to the priorities and the needs of the affected population during the recovery stage.

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CHAPTER TWENTY-SEVEN

POST-DISASTER ACTIVITIES

INTRODUCTION

27.01 There are a number of activities which may need to continue well after the response phase of a disaster Many of these are initiated during the response, but some such as research may continue for many years. In the recovery process, there is an obligation to minimise the impact of the emergency upon the physical and emotional health of the community and to ensure the rapid return to optimum community standards The Health Department in each State and Territory has a legislated responsibility for the health of the community. Attention is drawn to the Australian Emergency Manual - Disaster Recovery on this subject which is currently in the process of development

EQUIPMENT

27 02 REPLACE AND REPAIR

Equipment disposed of during the response must be immediately replaced, damaged items repaired, and equipment lists reviewed in the light of recent experiences

27 03 POST-DISASTER REQUESTS

Following every disaster requests will be received for additional equipment. These must be critically evaluated as the next disaster may be different

DEBRIEFING

27.04 Health professionals are involved in both single service and multi service operational de-briefs As well as initiating psychological de-briefing and defusing for their own service, they may be asked to assist with other responders and victims.

REVIEW OF PLANS

27.05 Health professionals must be involved in the review of both main and functional plans following activation. Procedures should be reviewed and modified as required and disseminated to all users.

DOCUMENTATION

27.06 Quality documentation is essential not only for medical legal requirements, but more importantly clinical management and research. Research should include mortality/morbidity studies. Tools such as Injury Severity Scoring (ISS) and the Abbreviated Injury Scale (AIS) could be considered as beneficial parameters for research and clinical audits.

EDUCATION AND TRAINING

27.07 The lessons learned from each disaster should not be filed away, but widely disseminated and incorporated into future planning and educational initiatives. Information should be shared both nationally and internationally. Appropriate research should be encouraged and funded. The results of validated research should then be used to enhance education and training.

REHABILITATION

27.08 Early involvement of appropriate experts in rehabilitation is very important for the management of both the individual and groups of victims.

POST-DISASTER INQUIRIES

27.09 Following a disaster there may be a wide range of inquiries requiring input from health professionals. These include governmental, judicial, forensic, and insurance investigations. This reinforces the importance of timely and accurate recording and the storage of all documentation for the required length of time.

AUSTRALIAN EMERGENCY MANUAL
DISASTER MEDICINE

SECTION SIX

SUPPORTING INFORMATION

GLOSSARY

TERM **DEFINITION**

Ablutions
Includes showers, laundries, hand-washing basins and toilets facilities

Alert
That period when it is believed that resources may be required which enables an increased level of preparedness

Ambulance Casualty Officer
An ambulance officer supervising the Patient Treatment Post, until the arrival of a Medical Triage Officer.

Ambulance Commander
The senior ambulance officer on-site who assumes command of all ambulance personnel and resources and liaises with the Medical Commander.

Ambulance Controller
Usually a Senior Ambulance Officer, located distant from the disaster site at a Medical or Ambulance Control Centre, responsible for controlling all ambulance operations at a disaster. Receives input from the on-site Ambulance Commander and liaises with the Medical Controller.

Ambulance Co-ordination Centre
(See Ambulance Control Centre)

Ambulance Control Centre
Usually a pre-designated site in State or regional disaster plans from which ambulance operations a disaster can be coordinated. May be the same operations room used for normal ambulance dispatching, a separate room in the same facility, or a geographically distinct centre linked with a State Emergency Operations Centre.

Ambulance Holding Point
An area which may be set aside at which ambulances and other patient transport vehicles are marshalled until required to collect patients from the Patient Treatment Post Prevents congestion at the Ambulance Loading Point.

Ambulance Loading Area
(See Ambulance Loading Point)

Ambulance Loading Point
The area, adjacent to the Patient Treatment Post, from which patients are loaded onto ambulances or other vehicles for transport away from the disaster site

Ambulance Marshal
An person designated to supervise parking and movements of ambulances from a designated Ambulance Holding Point.

Ambulance Marshalling Area
(See Ambulance Holding Point)

Ambulance Transport Officer
An Ambulance Officer on-site who manages ambulance functions until replaced by more senior personnel, when he/she will mange the effective loading of ambulance vehicles

Basic Life Support
The provision of basic interventions to protect the airway, assist breathing and maintain the circulation without the use of drugs, defibrillation or advanced techniques. Normally refers to a combination of expired air resuscitation and external cardiac compression to provide cardiopulmonary resuscitation.

Biological Hazards
Includes infectious and cytotoxic waste.

Call-out
The executive command to deploy resources

Casualty
An injured person (See also Patient)

Casualty Clearing Area
(See Patient Treatment Post)

Casualty Clearing Post
(See Patient Treatment Post).

Casualty Collecting Area
A safe area close to the disaster/incident site to which casualties are brought by rescuers. May be the same as the Patient Treatment Post or an intermediate staging area from which casualties are collected by ambulance personnel not involved directly in rescue.

Casualty Collecting Officer
(See Ambulance Casualty Officer)

Clarification
Removal of suspended matter from water. (See also Disinfection).

Communications Centre
(See Medical Control Centre, State Emergency Operations Centre).

De-brief
Post-activity evaluation

Department of Health
Normally refers to State or Territory Departments of Health unless otherwise specified.

Disaster Medical Control Centre
(See Medical Control Centre)

Disaster Medicine
The study and collaborative application of various health disciplines to the prevention, preparedness, response and recovery from the health problems arising from disaster. This must be achieved in co-operation with agencies and disciplines involved in comprehensive disaster management (adapted Gunn, 1990)

Disaster Victim Identification (DVI) team
A police team responsible for identification of deceased disaster victims

Disinfection
Destruction of disease-causing organisms

Emergency Medicine
The study of emergency medical conditions and their management.

Environment
The complex of physical, chemical and biological agents and social factors which may impact on a person or a community.

Environmental Health Officer
Terminology used which includes Health Inspector/Surveyors, Public Health Officers, Sanitary Inspector/Engineers, Hygiene Officers and Preventive Medicine Officers.

Field Medical Commander
(See Field Medical Controller)

Field Medical Controller
Usually a senior medical officer who commands all medical aspects at the disaster site and liaises with Ambulance Commander and other emergency services Commanders on-site, and the Medical Controller at a distant Medical Control Centre (when operational).

Field Medical Team Leader
A doctor nominated as the leader of each Field Medical Team sent to a disaster site (there may be more than one) Responsible to and reports to the Field Medical Controller. (Same as Medical Team Leader).

Field Medical Teams
A team of experienced doctors and nurses, usually sent from a hospital, to provide on-site assessment and emergency treatment of casualties prior to transfer. One member of each team is appointed Medical Team Leader.

Hazard
A potential or existing condition that may cause harm to people or damage to property or the environment.

Hospital Medical Commander
(See Hospital Medical Controller)

Hospital Medical Controller
Usually a senior medical officer who commands all medical aspects of disaster response in a hospital.

Intelligence
Information that has been evaluated.

Medical Commander
(See Field Medical Controller)

Medical Command Post
A command post situated near to the Patient Treatment Post at which Medical and Ambulance Commanders can liaise and communicate with receiving hospitals and any remote Medical Control Centre. (May also referred to as Forward Command Post, or Mobile Field Control Unit).

Medical Controller
Usually a senior medical officer, located distant from the disaster site at a Medical Control Centre, responsible for controlling all medical aspects of the disaster

Medical Control Centre
A control and co-ordination centre normally remote from the disaster site and the location of the Medical Controller.

Medical Teams
(See Field Medical Team)

Medical Team Leader
A doctor nominated as the leader of each Field Medical Team sent to a disaster site (there may be more than one team). Responsible to and reports to the Field Medical Controller (Same as Field Medical Team Leader)

Medical Triage Officer
The most appropriately experienced health professional, appointed by the Field Medical Controller, who undertakes triage of patients entering the Patient Treatment Post.

Mobile Field Control Unit
A mobile communications vehicle usually used as an on-site command centre.

Multi-modal Redundant Communications
Denotes communications which use multiple modes (eg. radio, telephone, microwave, satellite) and have in-built redundancy (if one link fails there are alternative routes). Example: telephone lines through separate exchanges)

Nuclear Hazards
All hazards existing form the use of, and exposure to, radioactive substances.

Patient
A casualty in receipt of medical care (See also Casualty).

Patient Treatment Post
An area located at the disaster site, but in a safe location, for undertaking triage emergency treatment of casualties prior to transport away from the disaster scene (Also often referred to as Casualty Treatment Post, Casualty Clearing Post or Casualty Clearing Area)

Police Commander
The police officer at the disaster site responsible for commanding police efforts, as defined in disaster plans.

Potable water
Water fit for human consumption.

Putrescible
Wet waste, for example, food waste.

Regional Medical Controller
Similar to State Medical Controller, where disaster plans prescribe the provision of health resources by health region.

Remote Area
Is an area where because of distance, time or circumstance, the medical resources required to adequately manage the event are delayed to the potential detriment of the casualties

Rolling boil
Vigorously boiling hot water, a term used to denote water at 100° Celsius for the purpose of sterilisation.

Sanitation
Is the application of measures and techniques aimed at ensuring and improving environmental health in a community, including the collection, evacuation and disposal of rain and used liquid and solid wastes, with or without prior treatment. (Gunn, 1990)

Sanitary Land-fill
Controlled deposition of waste on land

Site
The area in which the emergency or disaster has occurred

Stand-by
Is the period normally following an alert when deployment of resources is imminent. Personnel are placed on stand-by being ready to respond immediately

Stand-down
That phase where an agency's response is no longer required, and services are wound back. Site teams are returned to base, and additional staff called in are released from duty.

State Medical Controller
A Senior Medical Officer, usually a representative of, or nominated by, State Health Departments, responsible for liaison and providing resources to meet all medical needs of a disaster.

Sullage
Waste water from sinks and ablutions.

Treatment Area
See Patient Treatment Post.

Triage
The process by which casualties are sorted, prioritised and distributed according to their need for first aid, resuscitation, emergency transportation and definitive care.

Triage Area
An area which may be set aside at the entrance to the Patient Treatment Post specifically for triage of casualties as they are brought to the area

Triage Labels
(See Triage Tags)

Triage Tags
A form of casualty medical documentation, usually in the form of labels which can be attached to the casualty, which clearly identify the individual's priority for treatment and transport, and on which basic details of assessment and treatment are recorded. (See Chapter Eighteen on Documentation, paragraph 18.06)

Universal Precautions
Precautions for prevention of transmission of HIV, Hepatitis B and other blood-borne pathogens and to prevent contamination of healthcare workers by all blood and body substances from all patients (including faeces, urine, vomitus and other secretions)

Vectors
Insects capable of transmitting disease. Includes flies, fleas, lice, mites, mosquitoes and ticks

Vector Control
Control of insects capable of transmitting disease.

Vermin
Rodents and animals capable of transmitting disease. Includes rats and mice.

Victim
A person directly affected by a disaster.

Zoonoses
Diseases transmitted from animal to human.

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ABBREVIATIONS

AEM	Australian Emergency Manual
AEMI	Australian Emergency Management Institute
ADF	Australian Defence Force
AIEH	Australian Institute of Environmental Health
AIS	Abbreviated Injury Scale
AHMAC	Australian Health Ministers' Advisory Council
AMDCG	Australian Medical Disaster Co-ordination Group
AME	Aeromedical Evacuation
ARC	Australian Red Cross
ATLS	Advanced Trauma Life Support
BLEVE	Boiling liquid expanding vapour explosion
BTS	Blood Transfusion Services
CISD	Critical Incident Stress De-briefing
DGEMA	Director General, Emergency Management Australia
DHSH	Department of Human Services and Health (Commonwealth Government)
DOD	Department of Defence
DSLOs	Disaster Service Liaison Officers
EMA	Emergency Management Australia (Formerly Natural Disasters Organisation)
EMST	Early Management of Severe Trauma
FAST	Fly-Away Surgical Teams
ICRC	International Committee of the Red Cross
ISS	Injury Severity Score
NDR (H) C	National Disaster Relief (Health) Committee
NEMC	National Emergency Management Committee
NEMCC	National Emergency Management Co-ordination Centre
NH & MRC	National Health and Medical Research Council

PPRR	Prevention, Preparedness, Response and Recovery
RAAF	Royal Australian Air Force
RAN	Royal Australian Navy
RCBTS	Red Cross Blood Transfusion Service
RFDS	Royal Flying Doctor Service
SGADF	Surgeon General Australian Defence Force
SJAA	St John Ambulance Australia
TMCC	Trauma Nursing Core Course
WHO	World Health Organization

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Accident and Emergency Associations

Ambulance Organisations

Australian Health Ministers' Advisory Council (members of Australian Medical Disaster Co-ordination Group)

Australian Council on Health Care Standards

Australian Council of the Royal Flying Doctor Service (all Sections)

Australian Defence Force - Office of the Surgeon General

Australian Institute of Environmental Health

Australian Medical Association

Australian Nursing Federation

Australian Red Cross

Australian Resuscitation Council

Counter-Disaster Authorities (Chairman and Executive Officers, all States and Territories)

Emergency Management Australia

Health Authorities (all States and Territories)

Institute of Ambulance Officers (Australia)

Learned Medical Colleges

- The Australasian College for Emergency Medicine
- The Royal Australasian College of Physicians
- The Royal Australasian College of Surgeons (inc. Early Management of Severe Trauma Committee)
- The Royal Australian and New Zealand College of Psychiatrists
- The Royal Australian College of General Practitioners
- The Royal Australian College of Medical Administrators

National Disaster Relief (Health) Committee (members of the various committees and working parties)

Selected individual experts in a wide range of related disciplines

MEMBERSHIP OF THE NATIONAL CONSULTATIVE COMMITTEE ON DISASTER MEDICINE

Dr Raoul Tunbridge O A.M.	Chief Medical Commander, Medical Displan, Victoria **(Chairman)**
Dr Kingston Kinder	formerly Secretary-General. Royal Australian College of General Practitioners **(Deputy Chairman)**
Dr Richard Ashby	President, The Australasian College for Emergency Medicine, c/o Royal Brisbane Hospital
Mr Trevor Barnes	Professional Development Officer (Nursing), Illawarra Area Health Service, New South Wales
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Dr Stephen Langford	Medical Director, Royal Flying Doctor Service of Australia, WA Section
Dr Duncan Mansie	Representing - Victorian Academy of General Practice
Mr Duncan Moore	Chief Environmental Health Officer, City of Croydon, Victoria
Mr Anthony Oxford	Regional Staff Officer/Paramedic, St John Ambulance Australia (NT) Inc., Alice Springs. N.T.

Mr Eric Williams	Executive Administrator, Medical Displan, Victoria
Mr Don Withers	Secretary, National Disaster Relief (Health) Committee, Commonwealth Department of Human Services and Health, Canberra **(Secretary and Convener)**