

of international initiatives, both the government and the private sector in Bangladesh have become keen to invest in the specialty. A psychiatrist from India mentioned the possibility of a reverse brain drain due to changes in the visa process making migration to the UK more difficult, improvements in postgraduate training and increases in salary. However, this psychiatrist acknowledged that the caveat to growth and improvement was unequal distribution.

Conclusion

Although relatively few participants were involved in the study, theoretical saturation was achieved. It could be that different issues might arise in other regions, although it does not seem likely that these findings could be influenced by geographical context.

For low- and middle-income countries to retain psychiatrists, prevention of emigration appears to be far more effective than encouraging expatriates to return. Since there are a number of inherent incentives for psychiatrists to remain in their own country, and the idea to emigrate generally starts to develop only after graduation, an improvement in training and job opportunities could have a drastic impact on retention. Although in a number of countries this is complex and reliant on numerous external factors, this study highlighted many positive findings. Almost all psychiatrists intended to contribute to psychiatric training and raising the profile of psychiatry in their country of origin, and therefore their emigration may have long-term

benefits. It could even help break the cycle between a lack of understanding, lack of demand for mental health services and a lack of training. Consequently, emigration could encourage funding to train allied mental health specialists, to build psychiatric hospitals and to campaign to raise public awareness of mental health. It should therefore be an ethical obligation of UK employers to facilitate this approach further through formal contractual agreements offering migrant psychiatrists time and support to continue to contribute.

References

- Chatterjee, S., Leese, M., Koschorke, M., *et al* (2011) Collaborative community based care for people and their families living with schizophrenia in India: protocol for a randomised controlled trial. *Trials*, 12, 12.
- Goldberg, D. & Gater, R. (1996) Implications of the World Health Organization study of mental illness in general health care for training primary care staff. *British Journal of General Practice*, 46, 483–485.
- Gureje, O., Hollins, S., Botbo, M., *et al* (2009) Report of the WPA Task Force on Brain Drain. *World Psychiatry*, 8, 115–118.
- Jenkins, R., Kydd, R., Mullen, P., *et al* (2010) International migration of doctors, and its impact on availability of psychiatrists in low and middle income countries. *Plos One*, 5, E9049.
- Kohn, R., Saxena, S., Levav, I., *et al* (2004) The treatment gap in mental health care. *Bulletin of the World Health Organization*, 82, 858–866.
- Saraceno, B., Van Ommeren, M., Batniji, R., *et al* (2007) Barriers to improvement of mental health services in low-income and middle-income countries. *Lancet*, 370, 1164–1174.
- World Health Organization (2001) *Atlas: Country Profiles of Mental Health Resources*. WHO.



Psychological support and recovery in the aftermath of natural disaster

David Forbes PhD, Mark Creamer PhD and Darryl Wade PhD

Australian Centre for Posttraumatic Mental Health, Department of Psychiatry, University of Melbourne, Australia, email dforbes@unimelb.edu.au

Natural disasters can result in a range of mental health outcomes among the affected population. Appropriate mental health interventions are required to promote recovery. In the aftermath of the 2009 bushfires in Victoria, Australia, a collaboration of trauma experts, the Australian and Victorian state governments and health professional associations developed an evidence-informed three-level framework outlining recommended levels of care. The framework was underpinned by an education and training agenda for mental health professionals. This framework has been successfully applied after further natural disasters in Australia. This paper outlines the steps included in each of the levels.

Disasters involving widespread loss of life and property may result in a range of mental health outcomes among the affected population (Norris *et al.*, 2002). A proportion will show a 'resistant' trajectory of recovery, reporting few or no clinically significant symptoms, while a small minority will develop persistent diagnosable psychiatric conditions. Between these extremes, a large group of survivors are likely to develop mild to moderate clinically significant symptoms (Galea *et al.*, 2002; Norris *et al.*, 2002). It is incumbent upon response agencies to ensure, for reasons of both economic impact and human suffering, that appropriate mental health interventions are provided to promote psychological recovery for this significant proportion of disaster survivors.

In the aftermath of serious and widespread bushfires in Victoria, Australia, in 2009, the Australian and Victorian state governments met with experts in psychological trauma, as well as health professional associations, to develop an evidence-informed framework outlining recommended levels of care, underpinned by an education and training agenda. This framework was applied after subsequent disasters in Australia, such as the floods and cyclone in Queensland in 2011.

The framework identified three levels of response. Level 1 is consistent with current models of psychological first aid (PFA) (Brymer *et al*, 2006); it is targeted at the whole affected population and is designed to enhance the use of adaptive support and recovery strategies. Level 2 involves an intervention called Skills for Psychological Recovery (SPR) (Berkowitz *et al*, 2009), designed for delivery by primary care and allied health providers treating survivors with persisting mild to moderate distress and functional impairment. Level 3 focuses on treatment for the minority of survivors who develop a diagnosable psychiatric disorder.

Level 1: psychological first aid (PFA)

Although most people affected by disasters are likely to experience distress, the majority will recover using their existing coping strategies and social supports. Importantly, there is international expert consensus that, in the first couple of weeks after a traumatic event, the routine use of structured interventions, such as psychological debriefing, is not recommended (Forbes *et al*, 2010a). While survivors who wish to discuss their experiences should be supported in doing so, practitioners 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.

Instead, PFA (Brymer *et al*, 2006), an evidence-informed approach to assisting people in the immediate aftermath of disaster, is now

internationally recognised as the recommended intervention. The PFA model is based on five empirically supported principles to guide post-disaster interventions (Hobfall *et al*, 2007): promoting a sense of safety; promoting calming; promoting a sense of self- and community efficacy; promoting connectedness; and instilling hope.

Psychological first aid is provided in a step-wise manner tailored to individual need. It has eight components (Box 1) and is designed to reduce initial distress and to 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). A detailed manual to guide PFA is available from the website of the US National Center for PTSD (<http://www.ptsd.va.gov>).

In large-scale disasters, early interventions should include a focus on community development. These activities are designed to unite the community and reduce the risk of damaging splits occurring in the emotionally charged aftermath of the disaster. They may include sports events, fetes and barbecues, newsletters and community meetings. They may also include the identification of, and support for, people in the community who are likely regularly to come into contact with the affected population (e.g. hairdressers, bar staff, sports coaches, bank tellers, receptionists).

Level 2: Skills for Psychological Recovery (SPR)

Clinical experience and research data suggest that a significant number of people will continue to experience distress despite their best attempts to cope and the receipt of PFA-type support. For many, these difficulties are limited to mild to moderate distress and include worry, sadness, insomnia, anger, decreased ability to function at work, school or home, or other psychological issues. This level of distress or dysfunction can often be fuelled by practical issues arising from bereavement, the destruction of property and other possessions, relocation and rebuilding. For these intermediate difficulties, training in SPR (Berkowitz *et al*, 2009) is provided.

Skills for Psychological Recovery has a strong focus on structured skills development and is provided by health practitioners or general counsellors. It was developed by the US National Center for PTSD and the National Child Traumatic Stress Network in the aftermath of Hurricane Katrina and was tested in Australia in the aftermath of the 2009 Victorian bushfires. Several hundred health and welfare providers across the state were trained in SPR. It focuses on an evidence-based set of interventions that include a brief needs assessment, problem-solving, activities scheduling, helpful thinking, social support facilitation, and distress management. Where indicated, survivors are also assisted in beginning to address issues of loss. These interventions are provided over one to five sessions in a flexible manner tailored to need. Delivery is not restricted to a 'consulting

Box 1 The eight components of psychological first aid (PFA)

- 1 Initiating contact and engaging with an affected person in a non-intrusive, compassionate and helpful manner
- 2 Providing immediate and ongoing safety and both physical and emotional comfort
- 3 If necessary, stabilising survivors who are overwhelmed and distraught
- 4 Gathering information to determine immediate needs and concerns and to tailor PFA interventions
- 5 Providing practical assistance in helping the survivor address immediate needs and concerns
- 6 Connecting the survivor with social supports by helping to structure opportunities for brief or ongoing contacts with primary support persons and/or community helping services
- 7 Providing information on coping, including education about stress reactions and coping (often in a written format)
- 8 Linking the survivor with collaborative services and providing information about those that may be needed in the future

room'. Indeed, the fact that SPR can be provided in any setting (including community facilities such as church halls, schools and club rooms) makes it an ideal model when there has been widespread destruction.

Data from the implementation of SPR following the Victorian bushfires indicated that health providers from varying disciplines and paradigms perceived it as a useful intervention for disaster survivors with moderate levels of mental health difficulties (Forbes *et al.*, 2010b).

Level 3: psychological interventions for medium-term and long-term problems

Despite the fact that the majority of those affected will recover without long-term mental health issues, a significant minority will continue to experience distress and functional impairment. In such cases, more formal assessment and intervention should be considered. Mental health problems following trauma and disaster may include depression, anxiety disorders (including post-traumatic stress disorder), complicated grief and substance misuse. These disorders may be newly developed in the aftermath of a disaster or exacerbations of existing conditions or vulnerability. An intensive training programme was developed and rolled out for mental health practitioners across Victoria to equip them to provide evidence-based cognitive-behavioural treatments targeted at these post-disaster psychiatric disorders (Forbes *et al.*, 2009).

Pharmacological treatments for traumatic stress disorders are not normally recommended as a first-line intervention: preference is given to trauma-focused therapy unless psychological treatment is unavailable or the distress cannot be managed by psychological means alone. Where medication is considered for post-traumatic stress disorder, depression or other anxiety disorders, selective serotonin reuptake inhibitors are usually the first choice. Specific training for psychiatrists, with an emphasis on pharmacotherapy, was provided following the bushfires.

Conclusion

Mental health practitioners 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 have a normal recovery, however, it is incumbent upon us to provide the best available treatment. Evidence-based interventions for common post-traumatic mental health conditions have a demonstrable track record of efficacy for the majority of those affected.

References

- Allen, B., Brymer, M. J., Steinberg, A. M., *et al* (2010) Perceptions of psychological first aid among providers responding to Hurricanes Gustav and Ike. *Journal of Traumatic Stress*, 23, 509–513.
- Berkowitz, S., Bryant, R., Brymer, M., *et al* (2009) *Skills for Psychological Recovery: Field Operations Guide*. Unpublished draft edition. National Center for PTSD and National Child Traumatic Stress Network.
- Brymer, M. J., Jacobs, A. K., Layne, C. M., *et al* (2006) *Psychological First Aid: Field Operations Guide* (2nd edition). National Child Traumatic Stress Network and National Center for PTSD. Available at <http://www.nctsn.org> (accessed January 2012).
- Forbes, D., Lau, W., Creamer, M., *et al* (2009) *Therapist Resource for the Psychological Treatment of Common Mental Health Problems After Trauma and Disaster*. Australian Centre for Posttraumatic Mental Health.
- Forbes, D., Creamer, M., Bisson, J., *et al* (2010a) A guide to guidelines for the treatment of PTSD and related conditions. *Journal of Traumatic Stress*, 5, 537–552.
- Forbes, D., Fletcher, S., Wolfgang, B., *et al* (2010b) Practitioner perceptions of Skills for Psychological Recovery: a training program for health practitioners in the aftermath of the Victorian bushfires. *Australian and New Zealand Journal of Psychiatry*, 44, 1105–1111.
- Galea, S., Ahern, J., Resnick, H., *et al* (2002) Psychological sequelae of the September 11 terrorist attacks in New York City. *New England Journal of Medicine*, 346, 982–987.
- Hobfall, S. E., Watson, P. E., Bell, C. C., *et al* (2007) Five essential elements of immediate and mid-term mass trauma intervention: empirical evidence. *Psychiatry: Interpersonal and Biological Processes*, 70, 283–315.
- Norris, F. H., Friedman, M. J. & Watson, P. J. (2002) 60,000 disaster victims speak: Part II. Summary and implications of the disaster mental health research. *Psychiatry*, 65, 240–260.

Professor Dinesh Bhugra, past President of the Royal College of Psychiatrists, awarded CBE in the New Year Honours List

Professor Dinesh Bhugra, past President of the College and President Elect of the World Psychiatric Association (WPA), was awarded CBE (the second highest civilian honour) by HM The Queen for services to psychiatry in the 2012 New Year Honours List. Professor Sue Bailey, President of the College, extended her congratulations. Professor Bhugra has been active within the College throughout his career, and was President from July 2008 until June 2011, previously having been Dean from 2003. In 2009 Professor Bhugra founded the RCPsych Awards to recognise and reward excellence in psychiatry and mental health. In 2011 Professor Bhugra became President Elect of the WPA. This recent honour not only recognises the major positive impact that Professor Bhugra has made in the field of mental health, but gives a voice to the one in four of us who will suffer from mental health problems over their lifetime.

