After the fires: looking to the future using the lessons from the past

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Victims of previous disasters have helped us learn much that can help those suffering now

The horror and tragedy of the recent Victorian bushfires have affected all Australians, evoking both compassionate response and practical support. Alongside other members of their communities, doctors, nurses and other health professionals have all been directly affected, experiencing horrendous threats to life, loss, grief, and dislocation from their homes and way of life.

General practitioners, community nurses, social workers and others will be called upon to provide care and to deal with the extensive mental health issues that arise in the aftermath of such incidents. It is important that any response is informed by the most up-to-date research findings in shaping the care provided. Studies, mainly by Australian researchers, have shown that the most important early responses involve protecting and comforting those most directly affected, linking them to loved ones and sources of support, and ensuring assessment and follow-up.

A crucial issue is the central role of the GP in the provision of post-disaster services, as shown in a study of all the registered victims of the 1983 Ash Wednesday bushfires in South Australia.[1] Local communities have a preference for their GP's services in the post-disaster period, but they are also likely to need access to community recovery services for practical assistance and resources. Where possible, such services provided after the fires in Victoria should be linked to local clinics to facilitate access to health care.

For the GP, assessing patients in terms of the nature of their experience of the disaster will be important — for instance, whether they were directly exposed to the fire, and whether they have lost family members or others close to them, or their home, property or other physical resources. A brief physical health check is important, alongside assessing levels of distress,[2] providing guidance about health and wellbeing strategies, and assuring contact and outreach. Formal counselling is most effective after the early weeks, particularly for those with ongoing levels of acute distress related to the horror and life-threatening nature of the experience. Skilled management of bereavement in the early stages requires allowing patients to talk of their loved ones, and assisting them through any disaster victim identification and other formal processes. Follow-up over the months ahead is important for both physical and mental health needs in the post-disaster period.

It is important to remember that the affected communities already carry a level of existing morbidity, which needs to be encompassed in planning a response. The magnitude of this problem is reflected in the 2007 National Survey of Mental Health and Wellbeing, which showed that 20% of Australian adults had a psychiatric disorder in the previous 12 months. Post-traumatic stress disorder (PTSD) was the most common disorder, with a 12-month prevalence of 6.4%.[3] These findings suggest that the prevalence of traumatic events is much greater than is generally recognised in our community. Those already suffering are particularly at risk, but a further significant proportion may develop problems such as complicated grief, depression and PTSD as a direct consequence of the bushfire disaster.[4]

A lesson from the Ash Wednesday fires is that victims often delay seeking care for at least 18 months, despite experiencing considerable suffering.[5] When they do present to GPs, it is often with physical symptoms,[6] and the significance of these is missed. A recent treatment study after the London terrorist bombings that provided help by directly screening the high-risk victims found that many had presented to and requested help from GPs, who had discouraged them from seeking care, underestimating their distress.[7] In the aftermath of the Victorian bushfires, one approach that should be considered is the use of screening for depression, PTSD and alcohol misuse in all GP presentations in affected areas. Clinical guidelines demonstrate that this approach leads to better outcomes if the screening is linked to adequate clinical services.[8] However, GPs tend to prematurely terminate treatment, with subsequent loss of the demonstrated treatment gains, highlighting a need in fire-affected regions for continuing education programs that address the issues of diagnosis and treatment.[9]

Members of the emergency services also deserve particular attention because of the prolonged intensity of their exposure, particularly in light of the high number of fatalities.[10] The community owes them a special duty of care. Active screening programs linked to occupational health services that are expert in managing traumatic reactions and grief should be instituted, as currently occurs in the Australian Defence Force.

The willingness of victims of previous Australian disasters to participate in disaster research has resulted in the capture of many lessons and should be acknowledged. This knowledge needs to be used in the coming months so that the lessons already learned do not have to be rediscovered, as is too often the case after disasters. Future studies should build on what we already know, rather than simply replicating what has been studied before. Research that makes demands on people who are suffering has no role if it is not innovative.

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