COMMUNITY DEVELOPMENT AND JUSTICE STANDING COMMITTEE

INQUIRY INTO THE RECOGNITION AND ADEQUACY OF THE RESPONSES BY STATE GOVERNMENT AGENCIES TO EXPERIENCE OF TRAUMA BY WORKERS AND VOLUNTEERS ARISING FROM DISASTERS

TRANSCRIPT OF BRIEFING
HELD IN NEW YORK, USA
TUESDAY, 24 JANUARY 2012

SESSION ONE

Members

Mr A.P. O'Gorman (Chairman)
Mr A.P. Jacob (Deputy Chairman)
Ms M.M. Quirk
Mr I.M. Britza
Mr T.G. Stephens

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Briefing commenced at 9.00 am

JACOBS, PROFESSOR GERARD A.
Director, Disaster Mental Health Institute,
The University of Southern Dakota:

The CHAIRMAN: Thanks, Gerry, for coming to meet with us. I will explain who we are. Margaret and I are two of the members—I am the Chair—of the Community Development and Justice Standing Committee of the Western Australian Parliament. We have 17 portfolios and one of those happens to be emergency management. There are five members on the committee: three opposition members and three government members. The government members and one of our opposition members cannot be with us at this time. We decided to do an investigation of the adequacy of the services that our government agencies provide to both career and volunteer people who are first responders to incidents. Most of our incidents are cyclones, bushfires, flooding, but there are also people who turn out to car crashes on a regular basis. In our remote and regional areas they are primarily volunteers, so we have a concern about making sure their mental wellbeing is looked after all the time because we want them to keep doing what they are doing. The purpose of the inquiry is to see if we can make some policy recommendations for the best way to go forward. You will notice that we are recording. I just want to reassure you that it will not be published. It is just for our benefit so we can recap and get some information back from the interview. Again, thanks for coming. I will give you an opportunity to introduce yourself and give us a bit of background.

Prof. Jacobs: I started in disaster psychology in 1989. One of my colleagues and I responded to a mass casualty incident and began providing psychological support, and when the Red Cross arrived they found us already in place and, basically, just incorporated us. We proposed the development of the national plan in the United States. The Red Cross is the leader of the national plan in the US. I served for the first eight years of that operation as national consultant for disaster mental health, and I really have been working in that area pretty exclusively since 1989.

Most of my work since 1996 has been overseas, working with other countries around the world—mostly developing countries. I spent about three years in your part of the world following the Indian Ocean tsunami on behalf of various organisations, working with six or seven different countries, and I worked with Japan in developing their psychological support program. The economic recession severely affected our institute. In 2009 all of our funding ended, the logic of the university being that if you do not make a profit you cannot have a budget. I said that our charter is humanitarian, and they said, "We don't care. If you don't make a profit, you don't get money."

So our activities are much more limited now, but we have had a lot of acclamation, winning several international awards in our last three years of our full operation, and I think we are well respected. The National Biodefense Science Board committee on disaster mental health was founded by presidential order in 2008, and our Institute is the only facility in the nation that had two of the 12 experts appointed to that committee, so I think our standing in the national system is pretty well respected, as well as our work with the World Health Organization and the International Federation of Red Cross and Red Crescent Societies.

The CHAIRMAN: Thank you. Can you tell us a bit about the types of things that you recommend to put in place for first responders following a critical incident?

Prof. Jacobs: In the prepared materials I gave you I have a bit of an explanation of the difference between community-based psychological first aid and disaster mental health, and I think that both aspects are important. Disaster mental health is the psychological support provided by mental health

professionals who receive special training in traumatic stress and crisis response. Then community-based psychological first aid is a model that teaches individual groups how to support one another.

In the United States the dominant system for a number of years was the Critical Incident Stress Debriefing model by Jeff Mitchell and his colleagues, but the body of research— although the research, frankly, is fairly sloppy— seems to pretty consistently indicate that about 10% of first responders are actually harmed through the use of this technique. So you get 90% acclamation and everybody is really positive, but the other 10% are quietly getting worse in the corner, so we have seen a very strong move away from that among the professionals in mental health.

The recommendations of both the Institute of Medicine, which is part of our National Academy of Sciences and of the National Biodefense Science Board, following extensive, six months of pretty much full-time discussion was that Critical Incident Stress Debriefing was not a model that we wanted to endorse, but that community-based psychological first aid was. I have included on your CD the documents from the National Biodefense Science Board, and I gave Dr Worth a hard copy of the findings of the Institute of Medicine; it is not something I am allowed to reproduce. The recommendations are pretty clear that the first responders would benefit more from teaching them all how to support one another and when to make a referral to a mental health professional, which is pretty rarely necessary.

The CHAIRMAN: So that is really the peer support program that we have been using?

Prof. Jacobs: It is peer support, but you hear the same thing about Critical Incident Stress Debriefing. They also now call their work psychological first aid, trying to get under that aegis. The training for community-based psychological first aid probably takes a similar length of time, but the idea is to train everyone, and it is not something that is done on a timed basis. As we are trying to ferret out what might be the harmful aspects of Critical Incident Stress Debriefing it seems like part of it is telling people, "Now you have to debrief and you are going to process your emotions now." Well, every individual is different and forcing people to process in a group and before they are ready, or not quick enough sometimes, is problematic.

Ms M.M. QUIRK: Some of these cultures of police or firefighters are a bit inimical to looking into this stuff in terms of assessing their peers. Have you any ideas about how we manage that issue?

Prof. Jacobs: It is a question of how you present it to them. We have done a lot of work over the years with first responders, and when we educate them about traumatic stress we try to point out that if they are experiencing a traumatic stress reaction then it affects their ability to think clearly and make good decisions in a crisis, and because of that they are endangering their colleagues and they are also endangering themselves in the process. The other hook that we find really gets them invested is to point out that when they complete an operation and they are feeling all that stress, they take it home with them to their families; that also tends to speak to them.

Ms M.M. QUIRK: On that point, you said you have done work in Japan; in terms of cultural differences in various countries are there any subtleties there in how you approach this issue?

Prof. Jacobs: There are subtleties for sure. I am probably much more impressed over the years with how similar things are in different cultures. You have some of the top people in the world in Australia, and the work they do, I think, is fully applicable here in the US— I cannot say in reverse. But there is the work of Mark Creamer in Melbourne and Kevin Ronan in Queensland— they are both really superb people in the field— as well as others. There are certainly cultural differences and part of the concept of community-based is that you always sit down with the community that you are going to serve and they tell you what their strengths are and you build a program with them. That is part of why we have been able to work so successfully in countries around the world.

The CHAIRMAN: Can you explain the concept of community? How far and wide does it go? If I can give you an example of a remote location in Western Australia where we have three guys on a fire engine who go out and pull somebody out of a crash, and they do that on a regular basis. What

community are you working with? Is it just those three guys? Is it their partners, their wives, their kids? Is it the broader community? How far and wide does it go? Can you answer that?

Prof. Jacobs: In my dreams it includes all of that. My preference when I am working with countries is to encourage them to start looking at training the entire population, but realistically we are more often going to be brought in to try to help in individual units, so I would probably look at all the people who were in that particular fire service; then we might also have separate training for their families. South Dakota is about 400 by 600 kilometres and we have 700,000 people; we have far more rabbits than we do anything else, so I understand remote rural areas. We are one of the four frontier states in the United States, which is less than 10 people per square kilometre, so we understand the remote rural areas and the volunteer fire services.

The CHAIRMAN: I think we are about one person per square kilometre.

Prof. Jacobs: We come up at about four.

The CHAIRMAN: So it is pretty remote. Can you give us an idea of the training you give communities to prepare them? What do you actually talk to them about?

Prof. Jacobs: The usual approach is to first of all find a core committee of people who are willing to listen, and we start with that. We sit down with them and talk with them about the issues and why this might be something profitable to pay attention to. The key is that if anyone is experiencing traumatic stress, whether it is among those who are directly affected by an event or by those who are indirectly affected, their experience of the traumatic stress inhibits the ability of the individual and the community to recover. So if one person is having difficulty, it gets in the way of everyone in that community recovering, and we can demonstrate that.

Basically, we teach people that this is a way of building on the strengths they already have. We know that people already turn to each other in an effort to help one another. I guess I did not put a copy in mine, but you have the colour copy of Revel's model, which is a database model. Jean-Pierre Revel is a physician who started the Federation [IFRC] program in psychological support, and he developed a theoretical model of who people turn to for their psychological support. We then did an empirical test of this on an international perspective. This is, who people say they turn to, and of course you can see the huge majority of it is family and friends. Then you have primary care providers and spiritual leaders, and then you start getting in people with more training. From our perspective, the place to invest is where most people turn, so we build on the strength of the people. This is what they are doing now: the family and friends are where they turn for help. It is a question of showing them that we are not trying to tell them that they do not know what they are doing, but rather we are trying to enhance the skills they have and help them to understand when someone might need a professional.

The CHAIRMAN: Are we really just talking about building communities again?

Prof. Jacobs: I certainly think that the outcome of it is that people have stronger communities. Again, it is mostly in the wider literature in that it is not so much in journal reports but rather in the NGO reports about how this has worked in various parts of the world. What we find is, indeed, that people begin to take greater pride in their community and there tends to be a stronger community because of it, but that is not specifically what we are going in there to do. We are going in there, rather, to try to help people to support one another in the process.

Ms M.M. QUIRK: This probably does not apply to family but obviously it does to friends: it seems to me that the further out from the critical incident, the extended associates of the person affected would start to think, “It’s about time you pulled yourself together and got over it.” I would have thought that might be a contraindication of recovery.

[9.15 am]

Prof. Jacobs: Well, in the process of the training we do with traumatic stress to help people understand traumatic stress we help them to see that it takes a year or two to really process that and move beyond it, but we also have guidelines in terms of when it is time to make a referral and what some of the signs would be that they might need some professional assistance. Part of the process is when we educate people about that and we help them to understand traumatic stress, they are less likely to see the stigma associated with the mental health care. David Clark holds the Maudsley Chair in London. That is usually the top mental health person in that part of the United Kingdom. He did some research a couple of years ago which unfortunately he published in a book and not a journal. It is really fantastic, and it shows that the best predictor of long-term problems is people who believe their traumatic stress reactions are a sign of personal weakness. It is an order of magnitude greater predictor than anything else that has ever been reported, which is enormous statistically; it is a huge difference.

So education about traumatic stress is the best way to get people to stop thinking of themselves as weak when they have an ordinary reaction to an extraordinary event. Part of it is to help with that. The issue you speak to is very real, though. Sometimes the friends and family get tired of hearing it, which is part of why you want to have everybody in the community trained, so if one person gets tired of listening, he has somebody else that you can turn to and lean on.

The CHAIRMAN: Can you tell us that name again?

Prof. Jacobs: Sure; it is David Clark.

The CHAIRMAN: You would not happen to know the book.

Prof. Jacobs: Actually the reference is in the 2007 award-winner paper.

The CHAIRMAN: That is all right. If it is in there, we will find it.

Prof. Jacobs: It is in the references, because I quote the importance of it, although I have to tell you that the book does not do justice to the research. I was asked to be the leader of the delegation that went over when the British Government asked for assistance following the 7 July [2005] bombings. We talked about his research in those meetings and I was very, very impressed.

Ms M.M. QUIRK: Our Committee, when we make our recommendations, we tend to have sort of systemic recommendations and also micro-level recommendations. One of the things we heard from the support unit that had been set up in New Orleans by retired firefighters was that they give people a little card which has the signs to look out for and some numbers to call and what have you. I actually thought that was quite a good idea in just, again, de-stigmatising it. Everyone has the card; you are not singling anyone out. Also I think it sets out the range of things that they could anticipate they might experience. Do you think that is worthwhile, or does it bring out the hypochondriacs?

Prof. Jacobs: Not so much. Because of the stigma attached to mental health, people are not real eager to do that. But I think it is more important to use the card as an adjunct to training. So, if you help them to understand the issues more thoroughly, then the card is a good reminder as opposed to just distributing the cards, which Sweden did back in the early nineties. That almost caricatured the understanding of traumatic stress. If you have it as an adjunct to good training, then it is a good reminder that people can turn to. I think that makes a lot of sense. The State of Minnesota has done something similar. They are in the process of training lots of the population in psychological first aid [see www.health.state.mn.us/oep/responsesystems/pfa.html]. They also give out cards to everybody when they finish their training. I think it is an excellent model.

Ms M.M. QUIRK: Presumably, the psychological first aid extends to community-wide depression and everything else.

Prof. Jacobs: It certainly can.

Ms M.M. QUIRK: If you are giving community-based education, it also has some good other collateral benefits.

Prof. Jacobs: The core skill of community-based psychological first aid is active listening skills. With that goes an understanding of training in traumatic stress and then some more practical kinds of things about problem solving and when to make referrals and also self-care. The research on part of the richness of active listening skills is that good active listening enriches your personal life, your romantic life, your professional life. So you can use the skills on a daily basis and that way it does not become something stale. The feedback we get from people we train is that, "You know, this is actually useful", and that makes it a more rewarding kind of thing and keeps the skills fresh for those who take part.

Ms M.M. QUIRK: Is there any qualitative difference between an earthquake, a flood or a motor vehicle accident in terms of the symptoms that are experienced, or are there any different issues?

Prof. Jacobs: There are different issues. The reactions do not tend to differ very much unless you have human-caused or intentional accidents. Those tend to be a more emotional process for adults. For children, actually, natural disasters are more difficult. Somehow having the earth shake— the earth is not supposed to shake— really challenges their whole world concept. But for adolescents moving into adulthood, the technological disasters, human-caused disasters are more difficult. Earthquakes tend to be one of the most difficult. In large part we were just talking about [inaudible] at Columbia. Part of what they were talking about was, "So what about aftershocks?" One of the people there was from New Zealand, where my daughter, by the way, is a seismologist. He was talking about the aftershocks which have really been shaking up his family. Absolutely, the aftershocks are just something that treats people quite nastily.

Ms M.M. QUIRK: We actually were over in Christchurch in November. We were talking recently when they had the one a month or so ago. We were all saying how affected we personally felt; it was not just another news item.

Prof. Jacobs: And that was 100 times smaller than the original.

Ms M.M. QUIRK: Yes.

The CHAIRMAN: My impression was that that whole community is not quite recovering. They are still going through the aggravation process at the moment.

Prof. Jacobs: Absolutely. It has been a very difficult time for them. I consulted a little bit at distance on that one. We had been there just a few months before, and places where we stayed are not there anymore. It brought the incident shockingly home.

Ms M.M. QUIRK: Where is your daughter based?

Prof. Jacobs: She is based in Wellington.

The CHAIRMAN: I think the other issue that is keeping it going for them is that they are still in the process of demolishing [buildings].

Prof. Jacobs: Absolutely.

The CHAIRMAN: They are being very cautious about it. They are not imploding buildings. They are just about taking them down slab by slab and brick by brick, and that is causing frustration, because nobody can get in and start rebuilding so you can start rebuilding the community.

Prof. Jacobs: The [NZ] Government is not sure how much rebuilding they want to do is my understanding as well. The Government is deliberately kind of slowing the process so they can try to get their strategies together.

The CHAIRMAN: From this psychological first aid and working with the community, can you actually predict that certain people may have particular reactions following disasters? If everybody

is working and it is all going well, does it sort of become apparent that this guy over here is going to react really badly or, based on his past experience, he has probably had too much?

Prof. Jacobs: It is hard to do with individuals. It is easier to do with categories of people. Even people that have had psychological difficulties, their initial reaction to a traumatic event is usually positive. They do better than other people because they are used to dealing with chaos in their lives. But in the long run their coping skills max out and they start to decline more quickly, so in the end they wind up worse off. It is hard to predict how individuals will respond because there are such broad differences in individual perceptions of traumatic events. That is part of the trick.

My mentor was Charlie Spielberger [see http://psychology.usf.edu/faculty/cspielb/], who is one of the world's leading authorities on stress and reactions to stress. He pioneered the concept of predicting individual differences and looking at individual differences. If you let me do a psychological assessment of each of those people, yes, I can predict which ones will likely respond, but your sense of who is going to have difficulty is not very accurate because the individual perceptions and what they bring in terms of their beliefs, their physical condition, their coping strategies all make a difference.

The CHAIRMAN: Can you talk a bit about first responders as victims? It is something that did not occur to me until we went to Christchurch and spoke to the Red Cross and the Police. They told us that there they were responding to the major incident right in the city, but at the same time their families were out in the suburbs, and they have been affected—that sort of guilt about, "I should be out with my family" or "I should be here pulling people out of the rubble." and how that affects the recovery process.

Prof. Jacobs: It is extremely difficult.

The CHAIRMAN: I think that is kind of a new concept. Before, you had a first responder come in, look after the incident and then they go away, but in Christchurch and here in New York, those people were there and they were there for extended periods of time—now in Christchurch, nearly a year, and will be a lot longer.

Prof. Jacobs: I was in charge of (psychological) support for rescue and recovery here at the attacks on the World Trade Center for the Red Cross operation. It was a very delicate dance between the full-time paid mental health professional within the fire service, who wanted to keep outsiders out. We were getting requests from the fire stations, "Please help us, because the institutional support is not what we need." You have to deal with the politics and all that, but again the folks here were in often for months at a time. Their normal operation, as you know, is a couple of hours. They go in; they are out in a few hours; they go back home. But when you are looking at an operation that goes on for months, the number of casualties that you experience because of that accelerates dramatically.

One of my faculty, Dr Beth Boyd, who was also appointed to the Presidential (NBSB) Committee On Disaster Mental Health, she is an EMT. One of my students is a paramedic, and one of my former students is a paramedic. She was placed at Ground Zero on night shift. She was not used to first responders coming and asking for psychological support, but she experienced that through the night, every night. Of course they got to know her and they would seek her out. It was people who normally do not seek that psychological support, who suddenly find that it is a critical kind of factor for them and they recognise themselves struggling with the issues. If the system is not providing the support, then somebody else has to. I think there are some real tragic stories that came out of this, because of the attempt by a few people to look good in terms of "I have taken care of my people, so nobody else can talk to them, because I have done it". That is not a real good strategy.

Ms M.M. QUIRK: So in terms of why the officers regarded the FDNY's response as unsatisfactory, what was it about it that was not meeting their needs?

Prof. Jacobs: It was much too structured and formal. When you have something that is exclusively within the fire service, there is always a fear that every time you talk to somebody it gets reported in their file. Volunteers especially do not want that. The research shows that the volunteer services have more difficulty than the full-time professionals, at least in our country. In our country the full-time professionals get much more training and they feel much more prepared for the operations. We still definitely refer to the volunteers as professionals, but we also know that they respond more; they have more difficulty with events.

[9.30 am]

Ms M.M. QUIRK: One of the things that have occurred to me is that there is a lot of downtime for firefighters, so they are sitting around at the station waiting for the call a lot of the time when they are not on the, necessarily, crisis stuff, but just the day-to-day stuff. If they are captive and they have to be at the station, there is a great opportunity to work with them in that context, whereas I think for other professions it might not be able to be done in that kind of low-key way.

Prof. Jacobs: Right; I think that is certainly true. Again, when the service is coming from each other, then it is an easier way to get that happening. Now, in our fire service that downtime is also repairing the equipment, cleaning the equipment—

Ms M.M. QUIRK: Yes, yes.

Prof. Jacobs: — but they are always working side by side, and so they do talk about things. That is part of why they tend to be receptive to this idea, because it is just a question of knowing a little bit more about what you are talking about. Indeed, that does make it, I think, a more receptive process.

The CHAIRMAN: What would you make of the comment that ‘a little knowledge is a dangerous thing’?

Prof. Jacobs: I agree to a certain extent. But we were just talking, yesterday— some of the folks in my classroom were from Sri Lanka, and part of what we were talking about is that Sri Lanka came to us and they asked us to develop training for them. They asked us how long it would take to do a training of trainers, and we said it is a full week program. They kept whittling it down, and they finally wound up that they wanted to have a four-hour training session, and it was like, “No, we won’t do that, because that’s going to be more harm than good, to try to train trainers in such a small amount of time.” They wanted to go down to an hour’s training for people in psychological support; that is not going to help. All that is going to do is tell them what they need to learn, and that is not going to help them. We try to hold fast at eight hours for the general first-aid training for the public or for a group— professionals in this case. We try to keep that at eight hours. In eight hours we can get the job done.

Ms M.M. QUIRK: Then a week or so for trainers?

Prof. Jacobs: Yes.

Ms M.M. QUIRK: Are there any gender differences that you have come across in your work?

Prof. Jacobs: Absolutely. We know that women admit to more difficulties. We are not sure they have more difficulties; that is a lot more difficult to figure out. That is not just among responders; that is in general. We think that is more a matter of women are more willing to talk about the stress of the experience, but we always— this is around the world— get far higher numbers for women than for men.

The CHAIRMAN: Yesterday we asked, I think, the Red Cross that question, and they said that women who might be in the fire services or in predominantly male-dominated roles actually morph into the macho-type thing, where they might be admitting that they might be having problems but they are not talking about it anymore because they are seen as weak.

Prof. Jacobs: I would think that that is true, and that is the part of the reason that it is a multi-tiered approach. You do not want to just have the service within; you also want to have the ability to reach out and go outside the system to get the support they need.

The CHAIRMAN: Can you tell us how supportive and responsive the Fire Department and people like that—the Police—have been to psychological first aid? Are they embracing it, or are they still trying to hold you back?

Prof. Jacobs: We are hearing from various places around the country that are starting to implement this that it has been very well received. In the current model—which is dominant— which is Critical Incident Stress Debriefing, typically they have response teams that come from somewhere in the area but they are not actually members of the same house as the fire service that is affected. So, although, yes, they understand the fire service, they are not their peers, they are somebody else, and outsiders are not nearly as effective typically. My colleague Beth Boyd had just done a training for the regional EMT service— emergency medical technician service— in our region, and they came from various houses around the region asking if we will do training for them because they are trying to get rid of the critical incident stress system where you have people coming from some other town to take care of you. It is like, "Let us deal with it ourselves." That makes a lot more sense to them.

In Minnesota, where they have been implementing it now for a number of years, they have told me— I have not seen data— that the first responders are eagerly taking it on. In fact, one of the folks who took part in the training of trainers that I did for Minnesota was himself a critical incident stress teacher, and he threw that over in favour of the psychological first aid once he had been trained. He said, "Yes, this does make more sense."

The CHAIRMAN: You said you had spent some time down in the Indian Ocean area; can you give us an idea of some of the lessons that you have learnt from the Indonesian tsunami and also the London bombings?

Prof. Jacobs: The London bombings— we were not being told much what was going on; we were simply consulting. So, we were off in a farmhouse in remote rural England somewhere.

Ms M.M. QUIRK: Nice!

Prof. Jacobs: And they told us the neighbours did not know it was a secret place, and it was like, "Yes, right, the farmers never notice 100 cars coming and going." So, we were not really told much about what was taking place— we were being asked questions and things— so I do not have much that I can say about that.

The CHAIRMAN: Did they have greater problems dealing with that particular bombing, because the IRA has been operating in London and the whole of England and Ireland for many, many years, and they have had bombings and shootings and all that there for many, many years; did they not have the experience and systems in place to deal with it after all those years?

Prof. Jacobs: Not with psychological support. The NICE commission—the institutional recommendations of the Government say that you do not start supporting traumatic stress until 30 days after the incident because it is not psychopathology until then, but that is such a short-sighted perspective because you do not want it to become psychopathology; you want to take care of people and help them through the difficult time. One of the (government) ministers who spoke with us was recounting the incident and said, "If you can believe this, people came up out of the Tube and were asking for mental health— can you imagine that?" I said, "Well, yes, if they came up out of the subway in New York, there would be mental health there", and she said, "What?" I said, "Well, you had EMTs there— right?" And she said, "Well, of course"; so how is that different? If that is what the people are asking for, that tells you something about what they need. They did not have that preparedness.

The British Red Cross does not do this kind of work. Each national Red Cross society has a little different task. In this country the Red Cross is chartered to provide support in every disaster, and with our recommendations in 1989, by 1991 they started providing psychological support as a formal part of disaster response. England, at that time, was not there; they have been working on and looking at whether or not that needs to change.

Ms M.M. QUIRK: These incidents, like 9/11 or the London bombings, are very politically charged, and there are lots of debates in the media and stuff like that.

Prof. Jacobs: Absolutely.

Ms M.M. QUIRK: Leaders are obviously out in the media, talking about the incident. Are there things that prominent people, leaders, say that actually compound people's psychological wellbeing?

Prof. Jacobs: Oh, sure.

Ms M.M. QUIRK: What sort of things are they?

Prof. Jacobs: Well, a couple of examples here: in the aftermath of the crash of Flight 800, which was a 747 that crashed off the coast here after taking off from JFK [airport], there were bitter battles between Mayor Giuliani at the time and Governor Pataki, and they did that in the media, which just stirred everything up.

Ms M.M. QUIRK: In terms of attributing blame?

Prof. Jacobs: Yes, and accusing the other one of interrupting the recovery and stuff. But Mayor Giuliani was meeting with me behind the scenes on a regular basis to say, "This is what I think my next move is going to be; will this help or harm the people who have been affected?" That just impressed the heck out of me— nobody ever heard that. But on September 11 [2001] he did not talk to me, and that was fine with me; he has also got very good people on his staff.

But Flight 587 crashed two months later in Queens [November 12, 2001], and I happened to be here in New York and was asked to set up the psychological support for it, and Mayor Giuliani called me. Again, I thought he had forgotten about me, but he just had not bothered to talk to me when he saw me on September 11. But he has talked extensively about when the [9/11] terrorist attack started that morning that he screamed to his staff, "Where is my mental health professional?" One of his staff, who is a superb disaster psychologist, stepped up and literally this is what he [Mayor Giuliani] says, "I told him, 'You will stand by my right shoulder 24 hours a day for the rest of this operation.'"

What that did for the rest of the staff was— the rest of his senior staff were going, "Where is my psychologist?" They recognised the importance of that when the chief indicated it was important. So he had support for himself, but also guidance in his decisions in terms of the ramifications. That does not mean you are always going to go the way that is going to be most profitable, but you are at least getting advice on those decisions.

The CHAIRMAN: When we were in Christchurch we spoke to one of the local members over there who had no official role, but as things went on she took on a role for her community—east Christchurch, if I remember, which was a much lower socioeconomic area—because she felt they were not getting the services put back in as quick as they should have been, and other areas were.

Prof. Jacobs: That is often true.

The CHAIRMAN: So she took on the role and went out and fought for it. It is similar for us; we do not have a role officially in disaster management, but by the same token we are well-known people in our communities who can take a role.

Prof. Jacobs: Sure.

The CHAIRMAN: What is the best role for you to take? The last thing you want to do is to cause more stress and strife for people, but the thing you want to do is actually make sure that the services are getting delivered as quickly as possible.

Prof. Jacobs: Yes, and in terms of disaster I think the time to put in that energy and leadership is in preparedness, because preparedness makes life so much simpler. The morning that the [WTC] Towers were struck here, I was literally closing my suitcase when the second plane struck to go to the opening of the National Center for Disaster Preparedness, which was to open on September 12, and I was one of the keynote speakers. The mission of the Centre is to prepare for terrorist attacks against the United States. I opened my suitcase back up and took out all my lecture clothes— we call it the 'psychologists' costume' in South Dakota— and put in all my response clothes, because I knew we would be in a different role. But the preparedness aspect is so important. We knew we had 4,000 mental health professionals trained, we had policies, procedures and experienced leadership who were in place, and we knew we could handle this. I had no doubt about that. I was not on the initial response team, although the initial response faltered within a couple of days and we were asked to come anyway and to step in. We had to drive 1,200 miles across the States—

[Interruption.]

Ms M.M. QUIRK: That was nice and clear and precise, wasn't it?

[9.45 am]

Prof. Jacobs: Yes. I was in a disaster meeting in Auckland when the fire alarms went off and nobody was leaving. I said, "You know, we are professionals in disaster; you're supposed to pay attention to these things. Let's get out." Sure enough, the building was on fire! It is like you get so used to the tests, you do not respond any more.

The CHAIRMAN: The reason I ask is because during the Bali bombings—that is our holiday isle, if you like, for most of Australia—and that night I got I cannot remember how many calls from parents and relatives of people who were in Bali. The call was that we've been contacted by our son or daughter or whatever it was, but how can they get out of there? They need to be on a plane. [indistinct] between us, and we were ringing up trying to get people on flights and stuff, and that went on most of the night. It was not something that I was prepared for; I had no idea, and I was getting the phone calls at my house.

It was odd to me, and I was not going to answer the phone calls until I actually saw it on the TV, because that same day we had a big concert at the oval close by, and I had been getting calls all day from people complaining about the noise. But then when I got this call at about—I think it was midnight or 10 o'clock or something, and it was a mother saying, "It's my son's first time leaving Australia and, yes, I've managed to contact him, but how do I get him back?" That just struck me; it was never something I envisaged as being my role until then. And that is why I keep asking. I think we have a role, but we need training for that role, and we need some guidance and things to actually know what to do because we can panic people by doing the wrong thing.

Prof. Jacobs: Yes. A good example: just after the September 11 attacks we had anthrax attacks that took place. The perpetrator has never been identified; they have never managed to locate them— him or them, her, whatever; we do not know. Somebody got kind of labelled as the likely suspect, who committed suicide, but I know some people who were very close personal friends of his that said there is no chance that he would have done that, so I do not know. But the Postmaster General of the United States was on the air every day, because the anthrax came through the mail, and he was making outrageous statements: "Be afraid; be very afraid; your mail may be contaminated. Open it in the backyard, wear masks and gloves."

Literally in the middle of one of his press conferences, a hand came into the camera, pulled him off the stage, and he was replaced with a spokesperson from the postal service, who said, "Let's get this in perspective. There have been 12 pieces of mail delivered that were contaminated out of 16 billion

a day" or something like that. He said, "You don't need to wear gloves. You don't need to wear a mask. Only a couple of facilities were affected in any way", and the whole country went, "Oh; okay". So, indeed, having a calm reaction, a calm presence, is helpful. But part of the recommendation of the National Biodefense Science Board is for civic officials in the United States to also be trained in the concepts of disaster mental health— not in disaster mental health services, but in psychological first aid and the concepts of how disaster affects people. That is something that Mayor Giuliani strongly endorses. I realise he is not Mayor any more, but everybody still calls him mayor.

Ms M.M. QUIRK: It is interesting that you say that, because the kinds of messages he was talking about and his public persona were very much clear, precise, you know, and structured, I think, so it is interesting to know the background to that.

Prof. Jacobs: Yes, and he had a superb mental health professional standing directly behind him.

Ms M.M. QUIRK: One of the things that we have heard a bit about is that in some services like the police and the firefighters, there is a personality predisposition to going into that sort of work, which means that their job is their identity, so that if they are unable to perform it because of critical incident stress, that compounds the issue.

Prof. Jacobs: I think that is true, and that is part of the motivation in helping them to get the protection against that happening.

Ms M.M. QUIRK: Is there any merit in— for example, both of those branches of the service get some psychological testing when they join up. Is there any merit in structuring some of that psychological testing so that there is some indication of people that can be more vulnerable in that regard, or is that not feasible?

Prof. Jacobs: I do not know. In our country you can only do testing for screening if you can demonstrate that it is necessary to the daily operation of the job. I do not know that we have—

Ms M.M. QUIRK: I mean, you would not want to label people as being potentially vulnerable, but there may well be— you do not want a whole police force or a whole fire service crippled with critical incident stress. I mean, you have got to have a functioning fire service, so I would think you would want diversity in terms of your people.

Prof. Jacobs: Well, I think that is true, but I think a more practical way to get there indeed is to train them in how to take care of themselves and each other. I do not think the empirical data exists to be able to say, yes, this will identify that this person will have difficulty. I think that is a harder task scientifically.

The CHAIRMAN: The tsunami in Indonesia, you consulted on that as well?

Prof. Jacobs: Quite a bit.

The CHAIRMAN: Any lessons learnt from that?

Prof. Jacobs: Well, I think one of the things that I did find encouraging is that they decided they needed to have indigenous professionals, and so the University of Indonesia began a master's program in disaster psychology and the Indonesian Red Cross brought our team in to do a formal training program. We have a graduate certificate in disaster mental health and we customise it for different countries. They brought us in to train a new cohort of the next generation of professionals in disaster, so we came in and taught four doctoral courses there.

It was encouraging in terms of other things. It was encouraging to me to see the war that had gone on for decades end in that moment because people said, "You know what? There's more important things in life", and the conflict ended. Aceh, the district that was most directly affected, had been the heart of the conflict, and that ended and people who were trying to kill each other the week before were working together to try and rebuild the community. I think that is pretty encouraging;

people understand that there are times to put that kind of thing aside. The issue in Aceh—we could talk a lot about recovery issues and political things that perhaps went awry here, but they were careful in who they allowed to come in to be part of the disaster response. In Sri Lanka, the government initially let anybody and their brother in, and there were all kinds of bizarre NGOs that came in. There was a German NGO that brought in a trailer truck that was a mobile swimming pool, and they were going along the coast teaching children how to swim, saying that would protect them from future tsunamis, and there were things like that going on. In Indonesia, they were slower to allow help in; it took months for organisations to be able to go in to provide support, and that is not ideal. But when they did let people in, they were knowledgeable, secure, professional organisations, and I think that helped.

The CHAIRMAN: They have learnt that lesson now, I assume, that they are prepared, and if something happens again, they are pre-approved, if you like.

Prof. Jacobs: Indeed. There are a lot of political things. For instance, in Sri Lanka they began to become more careful, and now, from what I have heard, they have actually begun to keep people out. The Government has changed now, and they rather brutally ended the civil war there, and they do not want anybody going in and assessing the traumatic stress that may have resulted from the end of the civil war. So you have different government things that have happened in different countries in the aftermath. Hopefully, they will be more prepared.

I applauded their being more careful about who came in, but now they have clamped down so tightly that they are trying to avoid scrutiny, basically. There is some of that that takes place within Indonesia, but we conducted a study in Indonesia on torture survivors. Of course, the torture had been done by the Government, and the Government allowed us to do that and allowed us to publish it. It was a delicate dance, but they did not turn their back on that; they acknowledged that that has been something they have done. So, governments can be very responsible in that process, but indeed having an idea beforehand of who is authorised to come in if there is a major event. Now, I reviewed the history of Western Australia, and it does not seem like you have had huge events in the past, and hopefully that will be predictive of the future.

The CHAIRMAN: If we can talk about some of the things that may happen for us in Western Australia, bushfires are—

Ms M.M. QUIRK: I think it is the frequency rather than the magnitude that is an issue.

The CHAIRMAN: Because we have got the urban fringe now getting right into those bushed areas.

Ms M.M. QUIRK: Interface, yes.

The CHAIRMAN: The urban interface. So that is causing a bit of a problem, and our second last bushfire took out 79 houses, no loss of life. So we were reasonably well prepared. There were a few things that went wrong, but they are being addressed, I think.

The other thing that I think we are going to face in the future is with the build-up of our LNG facilities and our extensive mining, we are putting a lot more people into those remote areas. Lots of those people are fly in, fly out; they are not familiar with those areas. So, if we do get cyclones and things like that— which we do, we get three to five a year; I think in a bad year we will get five, but most years we get about three— intensity is an issue; we do not know what the intensity will be. So far the evacuation and planning have been reasonable, but there is going to be a point where something might fall down, and it is a long distance to respond to from where we would send most of our responders.

So, I think what we need to be doing is getting prepared, and part of that is this psychological first aid and the mental wellbeing of those people that are up in those areas. You can never predict, and I think what we have learnt on this trip is do not prepare for what you already know; prepare for what is the worst you could imagine. Hopefully, when we write this report, we will get that message across without panicking people as well.

[10.00 am]

Prof. Jacobs: Right. I proposed the development of a national system for aviation incidents, and that now has been made into Federal law. After September 11 the law was adapted to become for all mass casualty and terrorist attacks against the United States. But when we were developing the aviation team, I was put in charge of the committee to develop the worst-case scenario for aviation, and one of the members [interruption]—

Ms M.M. QUIRK: Aviation incidents.

Prof. Jacobs: One of the committee members said, "Well, what's the largest aircraft in the world? How many passengers?" and we replied, and he said, "Okay; so that crashes and we're done, so let's finish the meeting." I said, "Well, no; wait a minute. What if two of them hit in a mid-air collision and fall on a nuclear facility?", and they are like, "Oh my God! What do you do at night?" And it is like, "No, no. It's just that you have to think about these things." You talked about the LNG. One of my nightmares—very real situations—is a terrorist attack on gas storage facilities, which tend to be very inadequately protected in this country; I am not sure about other countries.

The CHAIRMAN: Very inadequate, and very remote.

Prof. Jacobs: The remote is not as interesting to them; they are more interested in the ones in the harbour. But, thankfully, that has not happened anywhere in the world yet, and I hope we will keep on with that. But I do think you need to plan for how bad can things be. We thought we were well prepared for the events of September 11 and we were able to handle everything that took place using the disaster mental health model. I helped develop that; I helped implement it; but I became quite aware as I was helping manage the response here that we were at the absolute limits of what we could deal with in the mental health model, because there are only so many mental health professionals, and getting them to the people in need is very tricky when you have large numbers of people.

So at that point we started to talk— I had been doing psychological first aid internationally with the International Federation of Red Cross and Red Crescent for a number of years at that time, and so we started looking at how we could add that model to the disaster mental health model in order to be prepared for those larger events. Similarly, with biohazard, when you have infectious diseases, you may have areas quarantined; you cannot get people in there. At that point you need to have a different way of providing the psychological support. If it is coming from your friends, your family and your neighbours, they are already there.

Ms M.M. QUIRK: Just to get back to aviation, is the outcome going to have a direct correlation with critical incident stress? For example, we saw in this conference we were at New Orleans one of the survivors from the crash in the Hudson, which everyone survived.

Prof. Jacobs: Great.

Ms M.M. QUIRK: Now, if you are an emergency worker at that and it is a favourable outcome, does that mean you are, by definition, going to have less critical incident stress, or is it the potential that lives could be lost that causes the anxiety?

Prof. Jacobs: There is certainly some anxiety, but we know that human beings respond differently to mass casualty. Now, what you define as a mass casualty is trickier. But when lots of lives are lost, especially when the lives of children are lost, it is a much more difficult thing. If you have a loved one of yours die in a single car crash; if you have a loved one die in a mass casualty incident, the stress from the mass casualty incident will be dramatically higher. We try to teach people about this, and every time we go on a mass casualty, you have people that are on their first one, even though they are specially trained, and they say, "This is different." You say, "Remember we spent an entire day telling you how different it was." "Yes, but this is different." You say, "Yes, you got it; it is different."

So, yes, the number of deaths that occur makes a real difference, and, again, the deaths of children spectacularly increases the stress. In any society that I have been in, the deaths of children are not supposed to happen. So when that occurs— if an old guy like me dies— it is like, "Yes, he had a good life; move on." You have a four or five-year-old child, it is just not the same.

Ms M.M. QUIRK: Now, every individual is different, but is there some sort of flow chart or has there been any diagrammatic representation of what kind of things you can see as the critical incident stress develops?

Prof. Jacobs: In terms of a sequence of events over time?

Ms M.M. QUIRK: Yes, or when symptoms are likely to arise or when they are likely to abate.

Prof. Jacobs: Yes. There are a couple of models, not as much for the professional contacts with critical incident stress but, rather, for communities. With communities, we generally have a very short period of time— usually a couple of days— that is considered the 'impact period'. This is characterised by people just doing extraordinary things to protect one another. I certainly heard some of that in the discussion of the Victorian bushfires.

The last time I was there [Australia] was for the international congress, and a lot of the discussion was about the bushfires, and the stories that people told were quite remarkable. In that short period you have these wonderful attempts to reach out and help people and protect folks. You enter from that into a period that we refer to as the 'honeymoon phase', and this typically lasts about two weeks. It can be shorter; it can be longer, depending on the incident and upon the response. And this is a period where people are elated to have survived the event. You hear people saying, "Well, you know, it's not important that we lost everything we own because we all survived and that's what's important."

You always hear those statements, and they are very genuine at the time, but after a couple of weeks and all the help that is coming has come and you realise that you have still lost everything, you have still got a long way to go to recovery; you are still tearing down buildings, much less rebuilding, and at that point then you get into a phase where you have a real downfall of spirits. This moves into a 'dangerous phase' (the stage of disillusionment). This is when people are likely to have the most problems, and if those problems are not caught, they can get much worse. So it moves from there, and I often say that the task of disaster on mental health is to move people from that phase into the 'recovery phase'. That is really our mission. That is a pretty tried and true process, and we kind of know that overall that is going to happen, but it is not very predictive for individuals.

Ms M.M. QUIRK: And survivor guilt— we heard a bit about this yesterday—

Prof. Jacobs: A major issue.

Ms M.M. QUIRK: — talking with the Port Authority people, because they were so intimately affected by 9/11, so can you explain a bit about the specific issues there and how they are best addressed?

Prof. Jacobs: Yes. Survivor guilt is a very real issue and very common one. In our rural/frontier State we had severe flooding in 1993 and 1994, and we were asked to direct the psychological support for that. This was an area that was about 300 by 400 kilometres that was severely affected by flooding. The Federal authorities kept coming in and saying, "So who's getting help?" and they could not understand why more people were seeking help who were not flooded than people who were.

Ms M.M. QUIRK: That is interesting.

Prof. Jacobs: The people who were asking for psychological support were the neighbours of the people that were flooded. It is a very interesting process. We know this exists; we have documented it many times. But in this particular case, they were actually more the issue than the people directly affected. We certainly saw a lot of survivor guilt in the September 11 attacks. The Mayor's

emergency response team was housed in the Towers. Some of his top staff members were killed in the collapse of the Towers, as well as the elite response team of the fire service and the law enforcement. So their highest trained, most respected people died in that event, and for the other folks it is like, "Well, jeez, if they are the absolute best and they died, why am I still here?" And that was a very real phenomenon, not only among the professionals, but also among the folks that worked in the Towers.

We had a chart in the Red Cross disaster response headquarters of the Towers and of where we had survivors, and it just made no sense. If you look at that diagram, you would think, "Well, everybody on the lower floors should have survived, and the people on the upper floors…"— it did not work that way. There were people who found the one staircase that was still working and made it down. There were people on other floors who went up, thinking they could escape, and it just did not make sense, so the survivor guilt was very real. There were people who worked in the same office who had one group say, "We want to go up" and the other group said, "No, we think we have to go down", so they split, and, of course, the people that went up died. In those situations you have a lot of survivor guilt, and it is dealt with really the same way— the same kind of psychological support.

Ms M.M. QUIRK: So in terms of, say, a fire station where half the colleagues die or whatever, were there special measures or anything brought in in that context, or not, as part of the overall treatment?

Prof. Jacobs: The support would be the same really, and, in fact, that would be a very difficult thing in terms of direct impact of traumatic stress because of the death of colleagues. That is a closeness that really can have a very tough impact. In this country we call them "line of duty"— they do not even say the word death; they just say it is a line of duty— and when you have those occur, it is very difficult. Those are major events that we assume we are going to have to have some serious responses to.

Ms M.M. QUIRK: You have talked about, for example, quarantine examples where you are not able to get mental health professionals in, or, in our case, it may well be a remote incident. How effective is phone counselling as an alternative?

Prof. Jacobs: It is not going to be as effective, but given the options of anything else, it is a fairly good strategy. We have also seen the implementation of things like Skype, which has now become such good quality that even in remote areas, you can often have effective Skype communications. Just having the visual really helps to strengthen that sense that the person is there for you.

The CHAIRMAN: People with this scale of survivor guilt, do they get over it all the time, most of the time?

Prof. Jacobs: The huge majority of the time. When we talk about how many people are affected— that is one of the questions that Dr Worth had sent to me— we generally figure about 10% of those who are directly affected will need some support in working through the event. In mass casualty, that number jumps to 30%; it triples. There have been some studies coming out now, and we are trying to understand the implications, that are suggesting that 45% of people in some incidents now have needed some assistance in working through it, including some contradictory research here in New York that 45% of those who witnessed this event, which was millions of people, wound up seeking some form of psychological support from professionals, and we think that that has something to do with well-publicised free services being available. There is not a street corner in New York where you would not turn around and see a poster for the free support services that were available after the September 11 attacks. So we think that that is more of what is happening, but the 10% and the 30% is longstanding, very solid research, but it gives you an idea of how that mass casualty thing bumps the numbers up.

The CHAIRMAN: So do numbers go up as well for post-traumatic stress— not just the survivor guilt, but just post-traumatic stress?

Prof. Jacobs: Post-traumatic stress disorder, as a diagnosis, is a more debatable kind of process, but I would suggest indeed that the percentage of people who have the diagnosable disorder tends to increase proportionally to those who just need some support in getting through. It is hard for me to say based on empirical data, but from clinical experience I would say that that is true.

[10.15 am]

The CHAIRMAN: You mentioned Minnesota, and a couple of other States earlier are well into implementing psychological first aid. Did they actually put a budget on?

Prof. Jacobs: I have not been involved at that level but it has been sponsored by the State Government, so there has to be a budget line that is supporting that. I know in Minnesota they have a full-time mental health professional that does nothing but advance that training. There are not a lot of positions in the country that are full–time psychological support positions for disaster, but it is becoming more common. We have seen those numbers increase. We have had Federal legislation passed that every hospital has to have a disaster mental health plan in place. One of the things that has done for us is to make our students very, very happy in terms of finding jobs. We are the only program in the country that does a Doctoral Specialisation in Clinical/Disaster Psychology. I regret that— we are not trying to keep it to ourselves, but it is hard to maintain. Our students are sought after intensely for positions.

The CHAIRMAN: Very early on when you started talking you said we had some well-respected people in the field.

Prof. Jacobs: Sure.

The CHAIRMAN: Can you give us those names again of people we should probably talk to?

Prof. Jacobs: The two who stand out to me are [Professor] Mark Creamer in Melbourne. I always have trouble with the name, but I wrote it down in case you asked. The Australian Centre for Posttraumatic Mental Health in Melbourne. He is one of the world's leaders. You have some others up in Queensland; I am blanking on some of their names right now. There is a lot of literature that comes out of Australia largely because of the bushfires, but really wonderful work that comes out of there.

[Professor] Kevin Ronan, when we were in Melbourne last, had just been selected as the new head of the disaster psychology program for the Australian Psychological Society. Kevin actually is from Sioux Falls, South Dakota, about 70 miles from where I live. Kevin has worked with us fairly closely both when he was in New Zealand and also in Queensland. I would suggest talking with the Australian Psychological Society because they are trying to look at how they can promote the development of good psychological support in the country. That might give you some avenues locally as well. Kevin Ronan would be a good person also because he spearheads that for the Australian Psychological Society.

Ms M.M. Quirk: In terms of first-line responders and getting psychological assistance that they need, is there any correlation between age of those people and being prepared to accept that help or seek it out?

Prof. Jacobs: Yes. It is a curve that has age, on both ends, having more trouble. The younger folks tend to have more difficulty. The folks in the middle tend to do better. The more senior folks start to have more difficulty.

The CHAIRMAN: That is more difficulty with post-traumatic stress or more difficulty seeking any help?

Prof. Jacobs: More difficulty with the stress. Those two things tend to go hand in hand. The people who seek out the help tend to do better, and so you often do not see them as having troubles.

I think some of these data are an artifact in terms of the older, more experienced folks having more trouble. The artifact is cumulative stress. **Stress is additive**. If you experience stress because your dog was barking in the morning and then you had a car accident and then you had trouble at work, all that combines together. If you do not have good resolution, good psychological support, cumulative stress can build to the point that it is just as problematic as the stress from a critical incident. If we have some of those older professionals who have not been taken care of for the many, many incidents they have dealt with, I suspect that part of the reason we see that effect is because of cumulative events more than their inability to deal with a specific event.

Ms M.M. QUIRK: So it is not some sort of macho generational thing, that it is a sign of weakness or anything; there is no evidence that is an issue?

Prof. Jacobs: I think that is more why you see the difficulty with the younger. There are a lot of artifacts in the data. One of the things that we know happens is that the younger folks who cannot handle it, rush out. That does not happen in the first three days— it takes a couple of years. They go through a couple of events and go, "Life is too short" and they find a different line of work. For the folks, as you said, who have some characteristics of an adrenaline junkie, that kind of thing, they want that rush. They are going to stay in that job, and also the people who learn good coping strategies stay in the job. That works with you up to a point. There are a lot of artifacts in the data but I think in the younger folks who we tend to see not wanting to admit stuff, the more senior folks begin to realise that, "Hey, this is part of the job you have to deal with." You will often hear them giving that advice to the younger firefighters.

Ms M.M. QUIRK: In a number of States in the United States there is what is called presumptive legislation for firefighters, so if they get certain forms of cancer that is presumed to have been acquired on the job. That short-circuits the steps that the injured officer has to make in terms of proving that it was acquired on the job. Is it possible that that sort of approach could be taken to post-traumatic stress or are there too many external factors that could have caused it?

Prof. Jacobs: I think absolutely so. One of the tragedies I think in the history of our fire service in this country is that in the aftermath of the terrorist bombing of the Murrah Building in 1995 in Oklahoma City—168 people killed, many of those young children, so the stress level was off the wall— and very, very dangerous recovery effort by the fire service, although nobody was killed other than a civilian volunteer in the recovery process. It was a very long, very dangerous recovery and some of the firefighters very definitely had difficulties in recovering from it.

In Oklahoma, they could not get support for psychological issues. It was not allowed, period. That law has been changed now. That kind of thing is really sad to me now. In New York, it has been a little bit the opposite. Even though the law, theoretically, was passed giving them support here, there has still been a process where they are trying to make them prove that their cancer is because of carcinogens in the recovery effort. How can you prove that? They made this big deal about how now everybody was going to get supported. I was covered because I was also at Ground Zero. It is like, "Oh, that's good news." Then it is like, "Prove that it's from this event." How in the world do you do that? Even though a lot of that presumptive stuff sounds good, sometimes there are 'catch 22s' in legislation.

Ms M.M. Quirk: I do not know that it is in in New York, is it? I certainly know it is in a number of States here.

Prof. Jacobs: But sometimes there are little 'catch 22s' in there. But their mental health here was covered. The firefighters who struggled with that at least had that kind of support. Again, some of the laws require that support to be within the system (that is, withing the fire service). That makes it tougher. The American Red Cross moved in with a large set of funds in Oklahoma City and provided a lot of the psychological support, long-term care outside the system which, I think, was significant. I was one of the people who had to oversee that and make sure the money was used judiciously. I indeed think that having that kind of a presumptive situation and having that long-

term care is important. I feel pretty strongly we need to protect the people who risk their lives to protect us.

Ms M.M. Quirk: Certainly in the fire service there is a requirement for annual medical check-ups which tend to be physical. My feeling is that it would not take a lot more to include a mental health wellbeing within part of that component which then again does not make it out of the ordinary and is just seen as a continuum of the whole wellbeing issue. Does that work well? Is that something that could be worked up?

Prof. Jacobs: There are some very real social political obstructions to that in this country. One of the keys is that they do not want individuals to be identified. I can understand that to a certain extent. On the other hand if it is a law enforcement officer carrying a weapon, I would like to know if it is that one. I proposed a model some years ago which has not been adopted yet. It has been talked about in a number of places but has not yet had anybody buy into it, but we can have an online anonymous process that looks at unit readiness to respond so individuals are not tracked, but individuals can actually receive feedback that is available only to them so that they know: "Is this something I need to worry about? Am I having unusual reactions?" We can then give unit or higher level indications of readiness to respond and fitness to respond. For instance, if you find that this district is having difficulties, maybe you sponsor more psychological support programs in that area. I do think that is fully feasible; it can be done online; it can be done anonymously. It depends on what you consider anonymous in terms of the level of identification, whether it is a district or a state or something more. I think that can definitely be done. The politics of doing it may be a different story.

The CHAIRMAN: I think we have exhausted; probably you as well.

Prof. Jacobs: This is what I do for a living.

The CHAIRMAN: I thank you again very much for putting the kit together for us.

Ms M.M. Quirk: Also travelling what is a vast distance even by our standards.

Prof. Jacobs: This is routine for us. I was national consultant, so I would fly in to Washington for a one-hour meeting and fly back home.

Briefing concluded at 10.28 am