

NHS Emergency Planning Guidance

Planning for the psychosocial and mental health care of people affected by major incidents and disasters: Interim national strategic guidance

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This material should be read in conjunction with the NHS Emergency Planning Guidance. All material forming the guidance is web based and prepared to be used primarily in that format. The web-based versions of the Guidance including underpinning materials have links to complementary material from other organisations and to examples of the practice of and approach to emergency planning in the NHS in England.

The web version of the guidance is available at:

www.dh.gov.uk/emergencyplanning

Foreword

This Guidance describes arrangements for planning, preparing and managing psychosocial and mental health services to meet the needs of people who are affected by emergencies, major incidents and disasters that are provided by the appropriate people.

This is an area of work in which many people and organisations have an interest and responsibilities. It is also an area in which myth may loom larger than fact. We have, therefore, described an approach that focuses on the needs of people. It encompasses the whole of the pathway, which the people who are affected are likely to follow and how their needs can be met through partnership between professionals and different services. It is founded on the best available evidence and practice

We have not described the detail of how services might be organised; rather we leave that to local determination. We have tested our emerging findings with leading experts in the field. We believe that our proposals will be warmly welcomed by the NHS and contribute significantly to the ability of services to plan and respond to the psychosocial needs of people affected and for the NHS to play its appropriate part in planning, preparing and delivering the services that are required.

We should like to express our personal gratitude to all who contributed their knowledge, experience, time and energy to the process of producing this guidance and its outputs. In particular, we thank Professor Richard Williams, Professor of Mental Health Strategy in the University of Glamorgan and the Aneurin Bevan Local Health Board and the Scientific Adviser on the Psychosocial and Mental Health of Disasters and Major Incidents to the Department of Health. We are most grateful to him for his considerable input and energy in developing this guidance and its content and for his continuing support to us in this area of work.

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Executive Summary

1. Disasters, terrorism and traumatic events, whatever their source or scale, bring with them the potential to cause distress. Sometimes that distress is severe. Every person who is directly or indirectly involved in such an event may be affected and many may need psychosocial support. A sizeable minority of people may develop other psychosocial conditions and/or mental disorders for which they require more substantial and, sometimes, sustained intervention, including treatment.
2. While the overall world incidence of military conflicts and terrorism is high, there is also evidence that the numbers of persons affected by natural disasters have increased though the numbers of people killed by these events have fallen. This guidance recognises the national and international dimensions of disasters, terrorism and traumatic events as they involve, for example, commuters, visitors, tourists, relatives and the ripple effect of events.
3. This guidance is built on best practice and shared knowledge and the material on which this guidance is based is evidence-informed and values-based. It is also acknowledged that in certain circumstances restrictions or limitations of normal standards of care will be inevitable. It is intended to provide a standard platform for NHS organisations to undertake major incident and emergency planning and to provide information on associated activities that may also be required. In the context of this guidance, the terms NHS organisation and NHS Acute Trust includes NHS Foundation Trusts and all organisations commissioned to provide NHS services.
4. Throughout this guidance the term emergency is used as in the CCA, i.e. to describe an event or situation that threatens serious damage to human welfare in a place in the UK or to the environment of a place in the UK, or war or terrorism which threatens serious damage to the security of the UK. To constitute an emergency this event or situation must require the implementation of special arrangements by one or more Category 1 responders.
5. The responses outlined in this guidance should only be considered appropriate in the event of emergencies that comply with the definition above. Under no circumstances should any NHS organisation seek to initiate or adapt these in order to respond to a problem arising from staff shortages, waiting list pressures, management failures or other local institutional deficiency.
6. Under the auspices of the Department of Health, expert input has been provided by the Royal College of Psychiatrists including representatives of its users and carers group, the British Psychological Society, the Royal College of Nursing, the Ministry of Defence, the Faculty of Occupational Medicine of the Royal College of Physicians, Disaster Action, the British Association for Immediate Care, the Royal College of General Practitioners, the Department for Culture, Media and Sport's Division of Humanitarian Assistance.
7. This guidance draws on many authoritative sources. Of particular importance within a wide range of such sources is work led by the Department of Health for the North Atlantic Treaty Organisation (NATO) Joint Medical Committee¹ and work conducted for the European Union (EU) by the European Network for Traumatic Stress" (TENTS) programme². In 2009, the

¹ North Atlantic Treaty Organisation (NATO). Annex 1 to EAPC(JMC)N(2008)0038 Psychosocial care for people affected by disasters and major incidents: a model for designing, delivering and managing psychosocial services for people involved in major incidents, conflict, disasters and terrorism. Brussels: NATO, 2009.

² TENTS Project Partners. The TENTS guidelines for psychosocial care following disasters and major incidents. Downloadable from <http://www.tentsproject.eu>

authors of the NATO/EAPC guidance and TENTS guidelines brought together in a single document the common principles and recommendations of both sets of guidance.³ The guidance in this document uses and adapts text from those documents in order to provide advice and recommendations that are consistent with those from international authorities.

8. The NHS Emergency Planning Guidance 2005 gives the Chief Executive Officer of each NHS organisation responsibility for ensuring that their organisation has a Major Incident Plan in place. That plan should be built on the principles of risk assessment, co-operation with partners, emergency planning, communicating with the public and information sharing. The plan should link into each organisation's arrangements for ensuring business continuity as required by the CCA. Planning for the provision of psychosocial care for people affected by emergencies forms part of that responsibility. Chief Executives of all NHS organisations, SHAs and Primary Care Organisations should ensure that arrangements made within their boundaries and with neighbours are adequate and appropriate to local circumstances.
9. This guidance is presented as an interim version. It is issued to enable the responsible organisations in the NHS to review the services that they provide and to initiate implementation. Further developments to its contents will be made in due course and it is likely that a further edition will be issued as the Department of Health becomes aware of matters, including knowledge, evidence, best practice and effective and efficient management of services that will be of benefit to the responsible organisations in the NHS.

³ Williams R, Bisson J, Ajdukovic D, Kemp V, Alexander D, Hacker Hughes J, Rooze M, Bevan P. Guidance for responding to the psychosocial and mental health needs of people affected by disasters or major incidents. At: <http://www.healthplanning.co.uk/principles>

Introduction

10. This document provides best practice guidance for National Health Service (NHS) organisations in planning, preparing and managing psychosocial and mental health services in response to traumatic events and all types of emergencies that arise from any accident, infectious epidemic, natural disaster, failure of utilities or systems or hostile act resulting in an abnormal situation that poses any threat to the health of the community or in providing services for psychosocial care for people involved in such events. It is interim national strategic guidance.
11. Its principles apply to the needs of children, young people, and adults of all ages, older people and those people who have pre-existing mental health problems. It aims to provide a model of care that integrates approaches and actions needed to promote the resilience and psychological wellbeing of survivors, indirectly affected persons and staff of the responding services before, during and following major incidents.
12. This guidance has been prepared under the auspices of the Department of Health's Emergency Preparedness and Mental Health Divisions.
13. The purpose of the document is to provide a framework for those people who have responsibility for emergency planning. This includes people who commission and manage mental health services to enable them to design and plan a coordinated response and to provide preparatory training for the staff of services required in the event of major incidents and to link with wider area planning, response and recovery procedures. It suggests a model for the psychosocial and mental health care of people affected by disasters and major incidents that acknowledges that provision of services to support the model will come not only from the healthcare sector but also from those people who are involved in humanitarian assistance, social care and the third sector.
14. This guidance must be used in conjunction with the NHS Emergency Planning Guidance 2005 including the associated relevant underpinning sections of the Guidance:
 - Strategic Health Authorities (SHAs);
 - Immediate medical care at the scene;
 - Primary care organisations;
 - Ambulance services;
 - Acute and Foundation Trusts; and
 - Non acute and Specialist Trusts.
15. The NHS Emergency Planning Guidance 2005 and its underpinning documents provide general guidance, information and context for NHS organisations. This includes an overview of important related legislation including the Civil Contingencies Act 2004 (the CCA) and its categorisation of organisations as Category 1 or Category 2 responders. In brief the responsibilities of each category of responder and the designation of NHS organisations is shown below.

Category 1: those organisations at the core of the response to most emergencies and subject to the full set of civil protection duties.

For the NHS these include NHS Acute and Foundation Trusts, Ambulance Trusts and Primary Care Trusts (but not general practice). The Health Protection Agency (HPA) is also a Category 1 responder.

Category 2: co-operating bodies less likely to be involved in the heart of planning work but will be heavily involved in incidents that affects their sector. Strategic Health Authorities are Category 2 responders in the NHS

16. The purpose of the NHS Emergency Planning Guidance 2005 is therefore to describe a set of general principles to guide all NHS organisations in developing their ability within the context of the requirements of the CCA to:
 - respond to a major incident or incidents or emergency; and
 - manage recovery whether the incident or incidents or emergency has effects locally, regionally, or nationally.

Expectations and Indicators of Good Practice Set for Category 1 and 2 Responders

17. The document, Expectations and Indicators of Good Practice Set for Category 1 and 2 Responders, published by the Civil Contingencies Secretariat in 2009, summarises certain statutory requirements on responders in Categories 1 and 2 in England that arise from:
 - duties within the Civil Contingencies Act 2004;
 - the Contingency Planning Regulations 2005 (Regulations) and guidance;
 - the National Resilience Capabilities Programme; and
 - emergency response and recovery.
18. It also raises issues for responders to consider and indicators of good practice. It aims to encourage and support responders in continuing to develop their capabilities in civil contingencies and emergency preparedness and touches on some elements of response and recovery, where relevant, by highlighting indicators of good practice.

The Scope and Purpose of this Guidance

Intentions and Origins

19. This guidance is intended to assist NHS organisations to prepare effective responses to the psychosocial and mental health consequences for people following emergencies, major incidents and disasters of all kinds and causes. This guidance will enable local planning to be integrated into existing services, but with a common national strategy.
20. This guidance has been developed from several international sources of expertise that have been approved and adopted by several nations. It represents professional and managerial opinion that has already been accepted broadly at an international level, concerning the psychosocial and mental health needs of people and communities in response to major incidents and disasters. These sources include work led by the Department of Health for the North Atlantic Treaty Organisation (NATO) Joint Medical Committee⁴ and work conducted for the European Union (EU) by the European Network for Traumatic Stress" (TENTS) programme⁵. In 2009, the authors of the NATO guidance and TENTS guidelines brought together in a single document the common principles and recommendations of both sets of guidance.⁶
21. In addition, this guidance takes into account to the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings⁷ and the guidance by the European Federation of Psychologists' Associations (EFPA)⁸.
22. Furthermore, this guidance has also been informed by the consultation document that has been published by the Department of Health in July 2009 on a new vision for mental health services - *New Horizons: Towards a shared vision for mental health*.⁹ The consultation document identifies a number of important themes:
 - **prevention and mental health** - recognising the need to prevent as well as treat mental health problems and to promote mental health and well-being through public mental health;
 - **stigma** - strengthening England's focus on social inclusion and tackling stigma and discrimination;
 - **early intervention** - expanding the principle of early interventions to improve long-term outcomes;
 - **personalised care** - ensuring that care is based on individual person's needs and wishes, leading to recovery;

⁴ North Atlantic Treaty Organisation (NATO). Annex 1 to EAPC(JMC)N(2008)0038 Psychosocial care for people affected by disasters and major incidents: a model for designing, delivering and managing psychosocial services for people involved in major incidents, conflict, disasters and terrorism. Brussels: NATO, 2009.

⁵ TENTS Project Partners. The TENTS guidelines for psychosocial care following disasters and major incidents. Downloadable from <http://www.tentsproject.eu>

⁶ Williams R, Bisson J, Ajdukovic D, Kemp V, Alexander D, Hacker Hughes J, Rooze M, Bevan P. Guidance for responding to the psychosocial and mental health needs of people affected by disasters or major incidents. At: <http://www.healthplanning.co.uk/principles>

⁷ Inter-Agency Standing Committee. IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Checklist for Field Use. Geneva: IASC, 2008.

⁸ European Federation of Psychologists' Associations. Psychological Aid for Victims of Terrorism. Report to the European Commission Directorate General Justice, Freedom and Security. EPFA: Brussels, 2008.

⁹ http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_103144

- **multi-agency commissioning/collaboration** - working to achieve a joint approach between local authorities, the NHS and other, mirrored by cross-government collaboration;
 - **innovation** - seeking out new and dynamic ways to achieve our objectives based on research and new technologies;
 - **value for money** - delivering cost-effective and innovative services in a period of recession; and
 - **strengthening transition** - improving the often difficult transition from child and adolescent mental health services to adult services, for those people who have continuing needs.
23. This guidance is based on values and intentions that are similar to those in New Horizons. At the core of the approach taken in this guidance is the evidence for believing that there is no health without mental health. Both New Horizons and this guidance focus on building personal psychosocial resilience and the collective psychosocial resilience of families and communities. Both agree that this is everybody's business and not solely an NHS responsibility.
24. New Horizons seeks to continue transformation of existing specialist mental health services and to create a public mental health framework. Thus, there are continuities between the philosophy and contents of the New Horizons initiative and the approach taken in this guidance and its contents. Implementing the shared vision that constitutes New Horizons and the contents of this guidance should be mutually supporting. New Horizons should see developments in the general resilience of people and communities and implementation of this guidance, albeit for specific situations and purposes, should inform and contribute to delivering the vision within New Horizons.
25. Another influence on this guidance comes from the requirement that falls to the NHS to provide services, including mental health services, for veterans from Her Majesty's Forces. The contents of the Positive Practice Guide relating to veterans in the series for the NHS in England on Improving Access to Psychological Therapies (IAPT) have been taken into account in preparing this guidance.¹⁰
26. As a result of the wide range of sources that have informed it, this guidance is compatible with, and supported by a variety of sources. It proposes a model of care that:
- is empirically based (i.e. based on the best evidence available);
 - is flexible across events, cultures and time periods;
 - takes account of the potential resilience of people and communities;
 - accommodates the needs of vulnerable and at-risk groups of people, including family relatives and other carers and people from professional organisations who provide support;
 - is realistic in terms of the extent to which it can be implemented in emergencies, given the personnel and resources that are available;
 - takes account of population dynamics, including age and cultural differences, that may affect populations that are involved, first responders and staff of services;
 - is capable of evaluation;

¹⁰ <http://www.iapt.nhs.uk/2009/04/veterans-positive-practice-guide/>

- acknowledges the importance of anticipated reactions, resilience and the natural healing potential of people, families and communities; and
- endorses the primary principle of, first, do no harm.

The Psychosocial Approach

27. This guidance adopts what is termed 'the psychosocial approach' to responding to the needs of people who are affected by major incidents, disasters and other emergencies. Herein, the term psychosocial refers to the psychological, emotional, social and physical experiences of particular people and of collectives of people (in families, communities, and leisure, education and work groups as well as groups of strangers who are thrown together) in the context of particular social and physical environments. It is an adjective that is used to describe the psychological and social processes that occur within and between people and across groups of people. In the context of this guidance, the focus is on these processes as they occur before, during and after events that may be variously described as emergencies, disasters and major incidents.
28. These events may be sudden and short-term (the so called 'big bang' events) or prolonged, drawn out and/or repetitive (so called 'rising tide' events). The guidance provided is intended to provide frameworks for planning, delivering, leading and managing integrated psychosocial approaches to a very wide range of emergencies. The common ones include disasters that are due to flooding, high winds and earthquakes, the consequences of technological accidents and incidents, terrorism, pandemics and epidemics, and the consequences for humans of outbreaks of animal diseases. The advice contained in this document also applies to the psychosocial and mental health needs in the medium and longer-terms of the veterans of armed conflict and military service.
29. The psychosocial approach that is adopted by the Department of Health is based on a broad range of approaches to include major incidents of all kinds. The approach must include healthcare responses to people's mental health needs as well as social, welfare, other non-healthcare and non-medical responses.
30. The approach adopted in this guidance is broad and comprehensive. Only certain components of the wide range of responses required by people who are affected by major incidents and disasters fall to the NHS as lying within its prime responsibilities. Therefore, providing comprehensive responses requires the responsible agencies in each area to work together to plan and, in particular, to agree which of the actions falls to which of the agencies to lead delivery, and, also, to keep under review together the adequacy of their joint plans. Thus, this guidance is based on certain of the service responses being provided by each agency, and other responses being delivered by particular agencies on the basis of explicit inter-agency agreements, while other responses require several agencies to work together directly in order to deliver them.

Scope

31. This guidance considers that most people are resilient when faced with adversity. This means that, despite obvious distresses that occur commonly after disasters, which may be of short, medium or long-term durations, most people are able to recover over time.
32. Nonetheless, the nature of resilience is such that everyone affected can benefit from social support. This should be the core component of all humanitarian aid, welfare, social and healthcare responses to disasters.

33. None of this should be taken to imply that the authorities should be in any way complacent about the severity and seriousness of the experiences of people who are affected by disasters and major incidents. A minority of them may develop serious mental disorders for which expert care and treatment is required over lengthy periods.
34. One of the challenges lies in the difficulty of distinguishing who is suffering short- or medium-term distress that should resolve given adequate support from families, communities, schools and workplaces, and differentiate these individual people from other people who are more likely to develop a mental disorder or have already done so. The similarity of the experiences of people who are involved does not necessarily indicate the outcome. The guidance recognises this, and sets out to provide an effective but strategic stepped model of care that offers assessments and interventions of increasing specialisation that are inclusive of individual people's needs.
35. The principles contained in this document distinguish people's psychosocial reactions to emergencies that are very common, and separate these people from those people who are likely to go on to develop a mental disorder.
36. The term psychosocial encompasses the full spectrum of people's emotional, cognitive, social and physical reactions and needs to disasters and major incidents. Within that spectrum lies a sizeable minority of people whose needs border on or include them having diagnosable mental disorders or needs for specialised mental healthcare.
37. In reality, the majority of people who are affected by disasters have psychosocial needs in the short-, medium- or long-terms. Most are met by families and communities and research shows that affected people's preferences are to receive support in these ways. A substantial minority of people requires assessment in primary care if their experiences persist and, within that group of people, is a smaller though not insubstantial proportion who will require referral for specialised mental healthcare. All of them require continuing psychosocial support.
38. In other words, it is important to recognise that people who have psychosocial needs may not have needs for mental healthcare, but that the smaller number of people who require mental healthcare are also highly likely to have wider needs for psychosocial care too.
39. There is evidence to suggest strongly that the quality of the ways in which affected people's psychosocial and mental health needs are responded to has a significant correlation with the quality of the emergency responses overall. Therefore, the Department of Health is keen to accept NATO's advice which is to see psychosocial and mental health care services fully integrated into all major incident plans.

Purpose

40. This guidance identifies, from among the wide range of responsibilities for meeting the psychosocial and mental health needs of people who are affected by major incidents and disasters, the contribution of the NHS in England by providing responsive and effective mental healthcare services.
41. Those services should be designed and delivered in the full knowledge of the wider spectrum of people's experiences, responses and needs. Responsibility for providing psychosocial care falls to all relevant agencies. This means that it is not a specific responsibility of the NHS to provide all of the psychosocial care that affected populations require. However, the NHS must liaise closely and plan jointly with all of the other statutory and non-statutory

agencies that respond to disasters in order to ensure that each area has available a full response to the psychosocial and mental health needs of the people who are affected.

42. Principally, humanitarian assistance, welfare and social care services are delivered by multiple appropriate agencies and each should be able to deliver psychosocial care but have access, through primary healthcare services, to specialist mental healthcare services. Reciprocally, the NHS should be able to recognise the psychosocial needs of affected people and be in a position to offer signposting and referrals to people who require assistance from the humanitarian aid, welfare and social care services.
43. This guidance begins by providing summaries that add detail to the outline provided in this chapter. It describes a strategic, stepped model of care that is evidence-based but inclusive of the humanitarian values identified here. In the second half, this guidance deals in more detail with the specific responsibilities of the NHS for providing mental healthcare and for providing advice to commanders of responses and the other agencies that have complementary roles in delivering care.
44. In particular, this guidance recommends that each of the Strategic Health Authorities would be well advised to establish a team to advise it on actions to be taken to implement the guidance in this document. Locally, the Primary Care Trusts, NHS Trusts, Foundation Trusts and Mental Health Trusts are recommended to create teams to advise them and lead on delivering the mental healthcare services that are the primary responsibility of the NHS.
45. In addition, the NHS should be mindful of the psychosocial support needed by its own staff who are required to deliver the services that are recommended within this guidance.
46. The annexes provide tools to support acquisition of knowledge about and skills in the topic areas covered here and implementation of psychosocial and mental healthcare services that are well integrated with services commissioned and provided by local authority partners, the police services and the third sector.

Definitions

47. In this guidance, the word *reaction* is used to describe the experiences, difficulties, problems and disorders that may affect people after disasters and major incidents. *Need* is used to refer to requirements for assistance from relatives, other people, and formal services that people may require as a consequence of their exposure to disasters and major incidents. *Response* is used to refer to the ways in which societies, communities, relatives, and formal services should act to meet communities' and people's needs after disasters and major incidents.

A Summary of Key Recommendations

48. Research, work undertaken in preparing this guidance and past experience indicate broad conclusions about psychosocial and mental health aspects of major incidents and disasters. The principles that can be extracted from the literature, and from professional and managerial consensus are summarised in a recent document for which the origins are described in paragraphs 20, 21, 22 and 25. These principles can be found at: <http://www.healthplanning.co.uk/principles>¹¹

¹¹ Williams R, Bisson J, Ajdukovic D, Kemp V, Alexander D, Hacker Hughes J, Rooze M, Bevan P. Guidance for responding to the psychosocial and mental health needs of people affected by disasters or major incidents. At: <http://www.healthplanning.co.uk/principles>

49. These principles provide helpful prompts to NHS organisations and their partners for their preparations to meet the psychosocial and mental health challenges posed by emergencies, major incidents and disasters. They include:

- People may show a broad spectrum of psychosocial responses to major incidents and disasters;
- Strategic preparedness supports resilience and reduces risk;
- Strategic planning of services should be continuous during an incident;
- Recovery after major incidents or disasters may be defined by how well the psychosocial responses of affected populations are managed;
- The social fabric of communities is critical to the extent and impact of psychosocial and mental health effects;
- Co-ordination of services is vital to success;
- Every area should have a major incident plan within which psychosocial care is integrated;
- Senior staff who have responsibilities for leading and managing major incident planning and execution of those plans are likely to be greatly assisted if they understand the psychosocial and mental health risk factors;
- Senior officers, and decision-makers, in particular, should have available to them experienced advisers who are training on the psychosocial and mental health aspects of major incidents and disasters;
- Professional responders are also vulnerable to the psychosocial impacts of major incidents and disasters;
- Both rapid, short-term responses and long-term services are required in meeting the psychosocial and mental health needs of people who are affected by major incidents and disasters;
- It is important to distinguish resilience, distress, and mental disorder when designing robust responses to the psychosocial and mental health needs of people who are affected by major incidents and disasters;
- The Department of Health recommends strategic preparedness of populations, if possible, combined with public psychosocial and mental health services and personalised mental healthcare for people who need it;
- The cornerstone of responding people's psychosocial needs after major incidents and disasters is to support their resourcefulness;
- Services should be based on the principles of psychological first aid;
- The first responders to people's psychosocial needs are usually the people involved;
- A stepped model of care is required;
- It is important to manage properly the stepped model of care;
- Execution of major incident plans depends on good leadership, management and care for the staff who provide the psychosocial services; and
- Information gathering, research and evaluation are vital.

Psychosocial Resilience and the Psychosocial and Mental Health Needs of People Affected by Emergencies, Major Incidents and Disasters

The Challenge of Disasters and Major Incidents: Psychosocial Myths and Realities

50. There are many common myths about human behaviour and sensitivities before, during and after disasters and major incidents. Planners as well as practitioners should understand these myths if they are to make arrangements to train adequately first professional responders and all staff and to design appropriate psychosocial care for survivors, people who are indirectly involved and, not least, for first responders and the staff of emergency and health agencies. This section identifies three common myths and provides a substantial commentary on panic.

Immobilisation by Fear

51. The first myth is that people who are rendered victims are immobilised by fear and helplessness and feel hopeless. While this may occur in some large-scale events that destroy the infrastructure of large areas, it is far from the general case. Many people directly involved are first to take action; they are the first responders.

Chaos within Responding Agencies

52. Another myth is that disasters create chaos within responding agencies. Often, disasters and major incidents create unity and improve inter-agency cooperation rather than disorganisation. It is also important to realise that there can be little easy division between the needs of first responders, including professional and emergency staff, and the needs of the survivors whom they are seeking to assist. Everyone in the dynamic is at risk of psychosocial impacts. This is the reason for this guidance referring to survivors as well as victims.

Panic

53. The subject of how people behave after disasters and major incidents is of considerable importance when planning for disasters because it has implications for:
 - how societies and communities plan and prepare for disasters of all kinds including the public education they provide and their approaches to developing collective resilience;
 - how and what governments and the responsible agencies communicate with the public and when before, during and after major incidents;
 - how agencies respond in the immediate, short and medium terms; and, particularly, how the responsible agencies manage the scene in the immediate aftermath of events.

54. However a pervasive myth concerns panic. Indeed, this is one of the most persistent myths that appears resistant to researched evidence. The evidence is that panic occurs infrequently despite there being widely-held beliefs that panic after single-incident major events is common. Panic is defined as an '*acute fear reaction marked by loss of self-control followed by non-rational and non-social flight*'.¹²
55. Research and common experience show that, contrary to belief, panic, as defined here, occurs less frequently than many people suppose. If panic does occur it is most likely when people:
- feel trapped and helpless;
 - think there is no effective leadership or management; and
 - believe that resources will be provided on a first come, first served basis.
- This is likely to be a particularly pertinent factor in relation to CBRN incidents.
56. However, there is a volume of evidence from many events of differing natures which show that, while people are stunned in the immediate aftermath of a potentially traumatic event, they often show remarkable altruism and behave in rational and selfless ways, even to the extent of putting themselves at greater risk in order to care for strangers. Recently, these findings have been described by research on people who were directly involved in the bombings in London on 7 July 2005.¹³
57. An informative research review of panic in respect of terrorism and CBRN releases is provided by Sheppard et al.¹⁴ This guidance quotes from that because it covers a number of matters that have important consequences for governments, planners and responders.
58. Sheppard et al summarise the situation by saying that "*Evidence from [our analysis of] five such incidents suggests that the public is not prone to panic, although people can change their behaviours and attitudes to reduce the risk of themselves being exposed to a terrorist incident. Sheppard et al continue "By evaluating public reactions to terrorism or CBR releases in a limited number of case studies, this paper ... [proposes] that panic remains rare in these scenarios. Instead, we suggest that although the public may change their behaviours or attitudes, in ways that might be viewed as irrational by public authorities, to reduce their risk of being personally exposed or threatened by terrorism, these actions tend to have an internal logic and as such are amenable to change. Assumptions of panic may therefore be counterproductive.*
59. The matter of amenability to change of public reactions to disasters and major incidents has substantial implications for societies' and communities' plans for developing their resilience prior to any emergency and the authorities' contributions to those plans. Furthermore, this aspect of the topic also emphasises the key importance of how and in what ways the media are engaged in emergency preparedness and for strategies for effective public communication prior to, during, and after all kinds of disastrous events.
60. A second point illustrated by Sheppard et al relates to cultural dimensions that impinge on how people respond to disasters. They say "*While our discussion centres on providing a wide-ranging perspective of the public's response, it needs to be kept in mind that social and cultural backgrounds between and within countries may influence the behavioural responses to terrorism, and this should be factored to ensure effective terrorism risk communication*

¹² Quarantelli EL. The disaster recovery process: what we know and do not know from research. Preliminary Paper 286. Disaster Recovery Center; 1994.

¹³ Drury J, Cocking C; 2007. [www.sussex.ac.uk/affiliates/panic/Disasters%20and%20emergency&20evacuations%20\(2007\).pdf](http://www.sussex.ac.uk/affiliates/panic/Disasters%20and%20emergency&20evacuations%20(2007).pdf)

¹⁴ Sheppard B, Rubin GJ, Wardman JK, Wessely S. Terrorism and dispelling the myth of a panic prone public. *Journal of Public Health Policy* 2006; 27:219-245.

strategies. Rather than one cohesive 'public', there are many different sectors within societies based on different demographic, social, psychological, and medical characteristics".

61. In respect of the protective actions that people and the public may take, Sheppard et al say that *"Behavioural responses may be divided into acts of omission, such as not making unnecessary journeys, and acts of commission, such as taking prophylactic medication despite the inherent risk of side effects. Evidence suggests that the public are aware of these differences, and tend to adopt responses proportionate to the risk. Drawing upon the literature in the social and natural sciences, our discussion encompasses differing risk perceptions of terrorist threats and consequences of attacks"*. Therefore, they find that *"During an emergency evacuation ... the presence of heightened anxiety and distress among the evacuees combined with a fear of dying is not sufficient to label them as panicking"*.
62. Sheppard et al state that *"Panic in this sense demands four additional factors: a hope of receiving apparently scarce or dwindling resources; a focus on achieving personal safety instead of assisting others; a degree of contagiousness; and the adoption of irrational behaviours"*.¹⁵
63. The matter of whether or not, in an emergency, the public complies with what the responsible authorities predict will occur, with what they would prefer to occur, or with their plans or instructions often appears to frame the factors that bring influential people, including planners, responders and journalists, to use the word 'panic' in respect of apparently non-compliant behaviour of persons or groups of people. In this regard, Sheppard et al say *"This ... irrational, element is particularly important, but is often misapplied. One set of behaviours might be construed as the best actions by emergency planners, journalists, or public health officials in possession of all the relevant information, with sufficient time to make an informed choice, and possibly also the benefit of hindsight, but these behaviours will not necessarily appear to be the best actions to someone denied these resources and having to make rapid decisions under intense stress. Incorrect decision-making due to incomplete information or insufficient resources is not the same as irrational decision-making and as such is not sufficient to categorise someone as panicking"*.¹⁶
64. Much of the research into how people behave after disasters has focused on studying particular people. Recently, very promising lines of enquiry have been developing that consider the social psychology of disasters. That research has thrown further light on how groups of people behave together as disasters unfold and afterwards. These enquiries also challenge assumptions made about panic showing that, for example, people trapped together during the bombings in London on 7 July 2005 formed bonds rapidly with strangers and that they were more likely to display altruistic behaviours rather than panic in either the technical sense that has been adopted here or in the more colloquial ways in which that term is often, inaccurately, used.¹⁷
65. Similarly, there are anecdotal reports of victims' and survivors' experiences in the two years after the floods in England in 2007 suggesting that secondary stressors, such as concerns about further flooding and substantial and distressing problems with rebuilding homes, sustained collective psychosocial resilience and that altruistic relationships between affected people were maintained over lengthy periods.

¹⁵ Keating JP. The myth of panic. *Fire Journal*. 1982:57-147.

¹⁶ Keating JP. The myth of panic. *Fire Journal*. 1982:57-147.

¹⁷ Drury J, Cocking C; 2007. [www.sussex.ac.uk/affiliates/panic/Disasters%20and%20emergency%20and%20evacuations%20\(2007\).pdf](http://www.sussex.ac.uk/affiliates/panic/Disasters%20and%20emergency%20and%20evacuations%20(2007).pdf) and <http://www.london.gov.uk/assembly/resilience/2006/77reviewnov22/04u-univ-sussex.pdf>

The Realities of How People React to Disasters and Major Incidents

66. There are several conclusions that stand out from the literature.
- Based on the variety of estimates in the literature, NATO estimates that up to 80% of people who are directly or indirectly affected by disasters and major incidents may experience at least short-term mild distress, 15 to 40% medium-term, moderate or more severe distress, 20 to 40% a mental disorder or other psychological morbidity associated with dysfunction in the medium-term, and 0.5 to 5% may have a long-term disorder.
 - People and communities show remarkable psychosocial resilience. Up to approximately 75% of people recover psychosocially without requiring expert intervention given the care, assistance and good relationships with their families and friends and the support of their communities. However, this proportion changes with the nature of the disaster or major incident and the circumstances of particular people.
 - Resilience allows for optimism but it must not allow complacency. The potential for immediate and short- to medium-term distress is great and a high percentage - around 25-40% - of people who are involved experience long-term health complaints after their exposure to traumatic events. The risks are substantial for a sizeable minority of people to develop a mental disorder or other psychological morbidity and dysfunction in the medium- or long-terms. The range of services required by people who suffer these problems are disproportionately high.
67. The psychosocial impact of disasters and major incidents also produces ripple effects and psychosocial responses are usually required on a wider scale than may be predicted initially. Major incidents and disasters may occur in one location, but they often have far wider effects on people and communities. Commuters may be involved in travel-related incidents as are tourists and visitors. Survivors and responders have relatives, work colleagues and other highly concerned people who are not directly involved. Additionally, planners should be aware of the convergence of staff of aid and relief agencies, offers of assistance and advice and materials in the aftermath of major incidents. Not least, there needs to be active and positive engagement with the media. Thus, even local events may have national and international effects.

Psychological Trauma

68. Major incidents and disasters challenge our beliefs about ourselves, our families and friends and the world. Ordinarily, people make three fundamental assumptions:
- the world is essentially a good place;
 - life and events have meaning and purpose;
 - they are valuable and worthy.¹⁸
69. Psychological trauma occurs when events challenge these assumptions and take a person beyond their tolerance. Occasionally, events are so hurtful that people question and alter their fundamental views of the world. These events cause damage not only because of the immediate harm caused, but also because of the continuing need for people to re-evaluate themselves and the world.

¹⁸ Janoff-Bulman, R. *Shattered assumptions: Towards a new psychology of trauma*. New York: Free Press; 2002.

70. Put in another way, psychological trauma occurs when the coping resources of a person, family or community are overwhelmed, or are threatened to be overwhelmed, by a particular event. The event may be a single, acute incident, it may be a prolonged one or there may a series of events occurring over a period of time.

Stress

71. There are challenges in defining stress (see Annex C of the NATO/EAPC guidance).¹⁹ This guidance uses the term to describe the challenge to people and groups of people that may arise from untoward events that are of such a nature and/or severity as might cause them psychosocial trauma.
72. Thus, most of the people who are involved in traumatic events experience stress and it may have effects that range from enhancing people's resilience and personal skills through to provoking serious mental disorders. In other words, stress may be alerting and galvanising, improve resilience and raise performance, but it may also cause the emotional experience of distress, reduce performance to the point of temporary and, sometimes, more sustained dysfunction, and particularly if the stress is sustained, provide a risk to mental health. Often, the differences in people's reactions depend on personal characteristics, developmental experiences, life experiences, training, family, team and group memberships, and the leadership and social support offered to people.²⁰
73. Primary stressors are inherent in particular major incidents, disasters and emergencies and arise directly from those events. The primary or inherent stressors include:
- exposure to the events and changed circumstances;
 - exposure to on-site dangers;
 - exposure to affected people's suffering and their relatives' stories; and
 - feelings of powerlessness - inability to provide help at the level and at the time that it is needed.
74. Secondary or non-inherent stressors follow from and are consequential on what has taken place. Often, they involve dislocation of transport systems, problems with buildings and structures, and impacts on services. All too frequently, they stem from challenges in the recovery phase. Non-inherent stressors include:
- lack of materials (supplies, equipment);
 - unclear expectations;
 - conflict with and mistrust in and between responding teams and organisations; and
 - poor communications (within teams, agencies and with families).

Distress

75. Distress is the term that describes the experiences and feelings of people after external events that challenge their tolerance and adaptation. It is initiated and maintained directly by primary and secondary stressors and subsides if the stressors disappear or as people adapt to the changed circumstances. Distress is an anticipated human emotion, not a disorder, when it and any associated psychosocial dysfunction emerges and persists in proportion to

¹⁹ North Atlantic Treaty Organisation (NATO). Annex 1 to EAPC(JMC)N(2008)0038 Psychosocial care for people affected by disasters and major incidents: a model for designing, delivering and managing psychosocial services for people involved in major incidents, conflict, disasters and terrorism. Brussels: NATO, 2009.

²⁰ Alexander DA. Stress among police body handlers. A long-term follow-up. *British Journal of Psychiatry* 1993; 163:806-808.

external stressful situations. Differentiation between distress and disorder is evaluative because it is not defined by objective standards and differences are open to cultural considerations and differing personal perceptions and values.

Dysfunction

76. Dysfunction means any impairment or abnormality, however caused, of function in the social, emotional, physical and/or cognitive domains.

Mental disorder

77. The term disorder is used when people's experiences, emotions and behaviours are more intense, frequent, sustained or incapacitating than might be expected of the general population or when these features deviate from an anticipated norm and culturally sanctioned responses to external circumstances and situations. Recent developments advise using the term when internal psychological dysfunction(s) are implied that may reflect, be mediated by, or result from neurochemical disorder.
78. Figure 1 compares the characteristics of distress and disorder and uses the work of Horwitz.²¹

Figure 1: Distinguishing distress and disorder

<p>Distress</p> <p>Distress implies an external and usually temporary cause of great physical or mental strain and stress</p> <p>People who are distressed have emotional responses that:</p> <ul style="list-style-type: none">• are referable to the advent of a stressor• are proportionate to the impact of the stressor• tend to improve or resolve with withdrawal of the stressor
<p>Disorder</p> <p>People who have a mental disorder experience feelings and dysfunction that:</p> <ul style="list-style-type: none">• are disproportionate to the anticipated impact of the stressor• persistent after removal of the stressor• are taken to indicate an anatomical, physiological or psychological abnormality of a particular person

Psychosocial Resilience

79. It is essential to understand the psychosocial resilience in order to be able to plan to meet the needs of staff. Psychosocial resilience is a multi-dimensional construct. It is *“the capacity of individuals, families, communities, systems and institutions to anticipate, withstand and/or judiciously engage with catastrophic events and/or experiences, actively making meaning out of adversity, with the goal of maintaining ‘normal’ function without fundamentally losing their identity”*.²²
80. There are two components within resilience; personal and collective psychosocial resilience.

²¹ Horwitz, A.V. (2007). Distinguishing distress from disorder as psychological outcomes of stressful social arrangements. *Health*, 11, No. 3, 273-289

²² Almedom, A.M. (2008). Resilience research and policy/practice discourse in health, social, behavioral and environmental sciences over the last ten years. *African Health Sciences*, 8,S:1-4.

Personal psychosocial resilience describes “a person’s capacity for adapting psychologically, emotionally and physically reasonably well and without lasting detriment to self, relationships or personal development in the face of adversity, threat or challenge”.²³

Collective psychosocial resilience refers to the way in which groups of people and crowds of people “express and expect solidarity and cohesion, and thereby coordinate and draw upon collective sources of support and other practical resources adaptively to deal with adversity”.²⁴

81. There is a broad spectrum of ways in which people who experience disasters and major incidents, either directly or indirectly, react psychosocially.
82. Psychosocial resilience is not about avoiding short-term distress. It is about recognising:
 - how people adapt to, and recover realistically from adverse events and/or circumstances;
 - that the abilities of people to accept and use social support and the availability of it are two of the most important features of resilience; and
 - there is evidence that adequate support reduces the effects of exposure to challenging events and emergencies.

An Overview of How People of All Ages Respond Psychosocially to Traumatic Events

83. Figure 2 shows the experiences of people in the immediate aftermath of major incidents and disasters. Their experiences may be of very variable intensity, duration and meaning. Provided these experiences are short-lived, they might be considered to be anticipated and not necessarily indicative of sustained ill health.

Figure 2: Anticipated immediate reactions

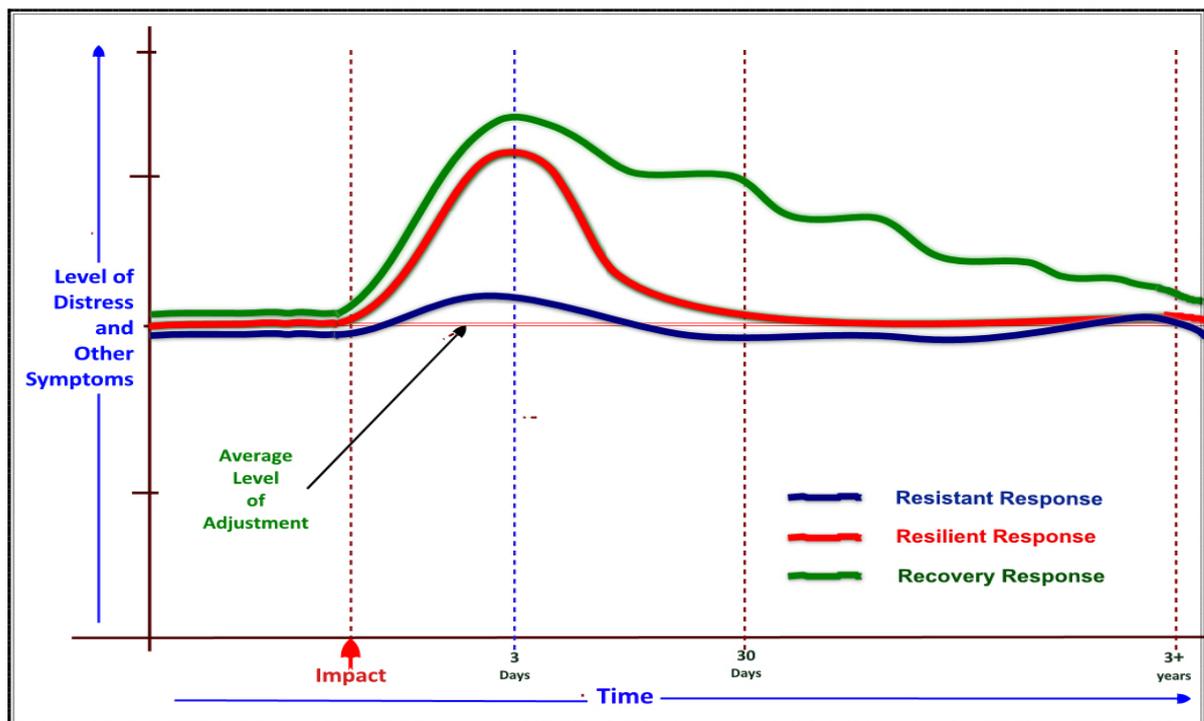
Emotional Reactions	Cognitive Reactions	Social Reactions	Physical Reactions
Shock and numbness	Impaired memory	Regression	Insomnia
Fear & anxiety	Impaired concentration	Withdrawal	Hyperarousal
Helplessness	Confusion or disorientation	Irritability	Headaches
Hopelessness	Intrusive thoughts	Interpersonal conflict	Somatic complaints
Fear of recurrence	Dissociation or denial	Avoidance	Reduced appetite
Guilt	Reduced confidence or self esteem		Reduced energy
Anger	Hypervigilance		
Anhedonia			

²³ in Williams R. The psychosocial consequences for children of mass violence, terrorism and disasters. *International review of psychiatry*, 2007, 19; 3; 263-277.

²⁴ Williams R and Drury J. Psychosocial resilience and its influence on managing mass emergencies and disasters. *Psychiatry* 2009, DOI: 10.1016/j.mppsy.2009.04.019.

84. NATO²⁵ has estimated that after major incidents and disasters, perhaps, as many as 80% of survivors of disasters show no mental disorder, but have transitory, short-term or medium-term psychological experiences. Those reactions are best described as distress and, sometimes, it is accompanied by dysfunction. Other people, who have similar experiences may go on to develop a mental disorder shortly afterwards or later.
85. Figure 3 shows other features that distinguish resistance, resilience and recovery. It shows how people who are resilient or likely to recover and people who go on to develop mental disorders may, initially, have similar experiences. This means that the narrative of how people respond over time is the best method of telling apart people who are resilient but experiencing temporary distress from the people who experience more sustained distress from which they are likely to recover and, again, other people who may suffer more serious and sustained disorders.

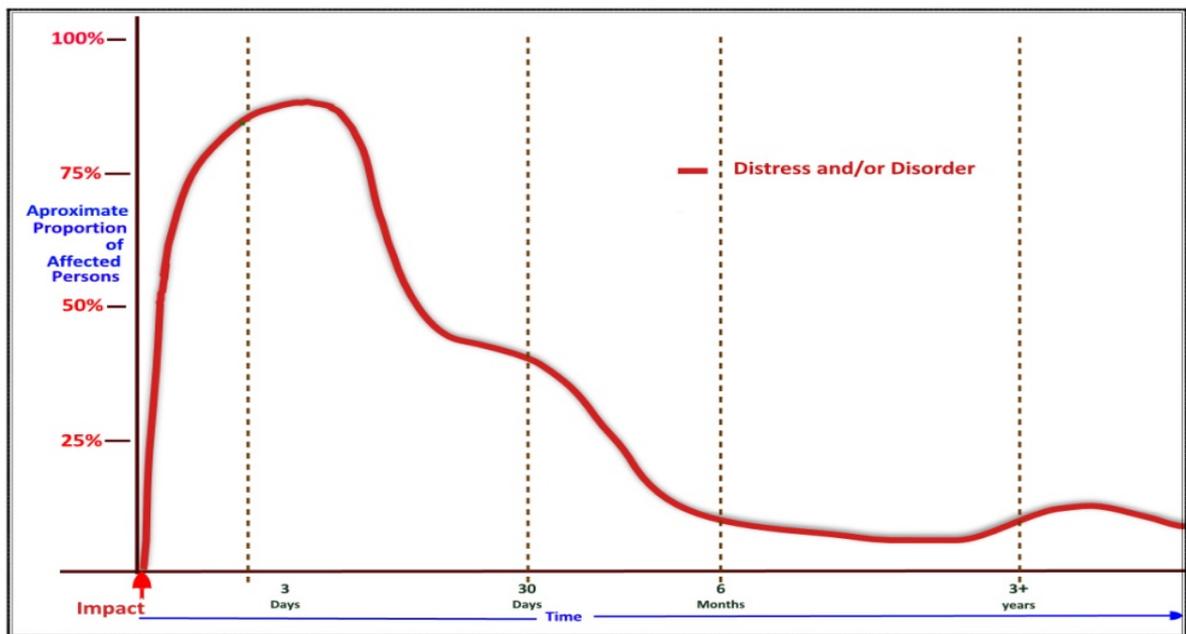
Figure 3: Resilience, Distress and Recovery over Time



86. Figure 4 shows diagrammatically how a hypothetical population of people who are affected psychosocially by a major incident or disaster may respond over time.
87. The curve in Figure 4 shows a variety of features that describe how populations of people who have been affected by major incidents or disasters respond over time. It portrays the high frequency of people responding with proportionate distress very soon after a disaster or major incident. Resistant people show the least debilitating responses. Most resilient people are capable of being involved in rescue work and recover rapidly in the following days provided they are offered support. However, a proportion may take longer to recover. Some of them develop an acute stress disorder and require more substantial intervention. A smaller number of people go on to develop a longer-term mental disorder. Some people may not develop these conditions until several years after the event.

²⁵ Annex 1 to EAPC(JMC)N(2008)0038 Psychosocial care for people affected by disasters and major incidents: a model for designing, delivering and managing psychosocial services for people involved in major incidents, conflict, disasters and terrorism. Brussels: NATO, 2009.

Figure 4: Psychological responses to major incidents²⁶



88. The picture of people's responses over time may be, however, be more complicated than this generalised pattern in that it varies considerably with the nature of events and the circumstances in which they occur. Current knowledge about resilience, risk and protective factors shows that it is difficult to predict who is likely to recover from their immediate reactions or from distress with support from families or provision of community and welfare services and who may have more sustained distress or develop a mental disorder. For these reasons, the generalised picture, summarised here, of how people respond psychosocially to traumatic events is intended to underpin planning, preparing and strategic management of services rather than to suggest that there is a single orthodoxy of clinical provision.
89. Experience shows that the occurrence of secondary stressors may lengthen the time of impact of any major incident and disaster, but also produce continuing distress and greater risk of people developing mental disorders. Thus, in the case of flooding, for example, that involves people's homes and workplaces, the primary stressor is evident, but people's lengthy displacement from their homes and the stress involved in rebuilding them may create grave secondary stress over lengthy periods. In these circumstances, it is not surprising to find that the timelines that are used as guides in Figures 3 and 4 and in this guidance become stretched. Another way of putting this is to say that secondary stressors may sustain people's distress for longer periods than are indicated here.
90. At clinical and operational management levels, there is an international consensus that how people progress during the first month provides the most helpful basis for predicting people's prognosis. Of course, caveats relating to the effects of non-inherent stressors should be taken into account in assessing people's needs and prognoses. However, in general terms, if distress is diminishing four weeks after exposure to a major incident, the people concerned are more likely to continue to recover. But if their distress is continuing, is increasing or is causing substantial problems for them or other people, an assessment of their mental health needs is required.

²⁶ reproduced with permission from Williams R and Alexander DA. Psychosocial resilience and distress in the face of adversity, conflict, terrorism or catastrophe. In Mahoney PF, Hawley A, Burris DG, Hopperus-Buma A, Ryan J, (editors). Conflict and catastrophe medicine: a practical guide. 2nd ed. Guildford: Springer-Verlag; in press 2009.

Grouping People's Psychosocial Responses after Major Incidents and Disasters: the Implications of the Evidence

91. The strategic stepped model of care explained later in this guidance and which lies at its core is built on an understanding of the ways in which people respond to traumatic events in general terms and on their evolving patterns of need. Primarily, the model is intended to be a tool for planners rather than for clinicians because responses to each person's need requires the seamless integration of services.
92. Despite the variability of individual and group responses to major incidents, it is possible to plan for sufficient psychosocial services provided flexibility is built in to allow adjustments as the nature of events clarifies. As an example, psychosocial reactions after flooding may not follow the speed of development that has been set out so far; distress may be prolonged, develop more slowly and peak later (at around nine months after the event and as community life begins to return to more usual patterns after flooding of people's homes, for example).
93. The ways in which people respond fall into four main groups. This guidance distinguishes people who are:

Group 1: Resistant people who show transient distress

People in this group are minimally or not upset. They are described as resistant people.

Group 2: Resilient people

There are two subgroups of resilient people who are distressed.

People in the first sub-group are proportionately, mildly, temporarily, and predictably upset in the immediate aftermath of traumatic events, but their distress is not associated with any substantial level of dysfunction. They are resilient people.

Other people in this group are more substantially distressed, but are able to function satisfactorily in the short- and medium-terms. They are resilient people who have greater distress, but not amounting to a mental disorder, of longer duration.

Group 3: People who have more sustained or persistent distress associated with dysfunction and/or impairment

People in this group are disproportionately distressed or distressed and dysfunctional in the short- to medium-terms (this group includes people who may recover relatively quickly if they are given appropriate assistance, befriending and other interventions as well as people who may develop mental disorders - people in this group require a thorough assessment).

In summary, there are two subgroups.

- people who are likely to recover, but whose recovery takes more time;
- people who may be in the course of developing a mental disorder.

Group 4: People who develop a mental disorder

People in this group are those who develop a defined mental disorder in the short-, medium- or longer-terms. They require specialist assessment followed by timely and effective mental healthcare.

94. In general terms, the needs of people who have been involved in disasters and major incidents become greater and potentially more complex in passing from Group 1 to Group 4, while the numbers of people involved decreases. Accordingly, there is a progression in the level of expertise required to deliver responses.
95. Therefore, this guidance is based on providing a stepped programme of responses in which services are titrated against the needs of the people affected and their progress over time. This means providing:
- empathic, practical and pragmatic support for everyone that is delivered by and through families and community groups and augmented by responders who should be aware of the principles of psychological first aid;
 - access to services that are based on the principles of psychological first aid for people who have more sustained distress;
 - assessment of people who remain distressed at around a month after events accompanied by access to psychological therapies as required;
 - access to the full range of mental health services for people who develop a mental disorder or who have severe symptoms earlier than 28 days; and
 - access to services for responders and staff of the rescue, recovery, welfare and health services because of their direct and indirect exposure to risk.
96. In addition, the NHS has roles in advising on and contributing to preventative services, advising on risk and its management through providing advice to communities, and relevant agencies through what are termed here public mental health programmes.

Populations at Risk

97. NATO has reported that people who are at increased risk of dysfunctional distress and more substantial problems including developing mental disorders following disasters include: women; children and adolescents; older people; people who have pre-existing health problems and disorders; and socially disadvantaged people. Populations at risk also include staff of health and social care services, vulnerable people, children, young people, older people, people who have substantial pre-existing healthcare problems and needs, people who have sensory impairments, poor and disadvantaged people and those people who are subject to adversity. The populations at risk also include rescuers, first responders and staff of the emergency, humanitarian aid, welfare and healthcare services and personnel of the armed forces. Evidence shows that people in each of these groups are more vulnerable than the general population or carers who are not exposed to disasters or major incidents to suffering the welfare, psychosocial and mental health effects of catastrophes.
98. Persons who are at particular risk include people who:
- experience high perceived threat to life (to themselves and/or significant others);
 - are physically injured;
 - have been exposed to dead bodies and grotesque scenes;

- have experienced multiple losses, losses of relatives and friends to whom they are close, and losses of property that is important to them;
 - have their illusions of safety undermined;
 - are faced with a circumstance of low controllability and predictability;
 - have experienced the limitations of their power to protect themselves;
 - have to live with the possibility that the disaster might recur;
 - experience disproportionate distress at the time;
 - have endured higher degrees of community destruction;
 - have limited social support; and
 - have had a mental disorder previously.
99. The strategic stepped model of care that is presented in this guidance applies to all populations. However, the key to responding to populations that are at particular risk lies predominantly in being aware of them and their particular needs. This requires planning and rehearsal, and use of tools such as targeted mapping of local populations so that special groups may be accommodated within universal major incident plans.
100. The crucial factors in designing post-disaster psychosocial and mental health services that are able to respond adequately to people at particular risk include:
- understanding the cultural, ethnic and socio-economic factors involved in working with particular populations;
 - being aware of the prevalence of any concurrent or pre-existing psychosocial conditions or mental disorders and of declining quality of life;
 - conducting hazard-mapping to identify vulnerable geographical and social areas; and
 - offering education services to community workers, rescue services staff, service armed services personnel, responders and healthcare staff.
101. The wide occurrence of populations that are at risk emphasises the importance of:
- being aware of the composition of communities and groups of people;
 - training community staff and the personnel of the armed forces;
 - promoting public health activities and prevention measures;
 - taking active steps to promote coping within communities;
 - being aware of cultural expression, rituals and ceremonies;
 - designing services of adequate duration; and
 - planning adequate rehabilitation services into responses.

Children's Reactions to Major Incidents and Disasters

102. Trauma in children can be defined as any condition, which seems to be unfavourable, noxious or drastically injurious to development. There is no hierarchy of atrocity for those involved. The literature reports recurrent findings of greater repugnance felt by most societies when children are involved in or affected by violence and when they are its perpetrators.

103. Children are as inherently vulnerable as are adults. However, while children are remarkably resilient to traumatic events, they are also recognised as highly vulnerable. This apparent paradox relates to children being affected by a variety of routes and because, even if they are personally resilient, they are usually dependent on adults who may be injured, killed, pre-occupied with coping with events or forcibly separated from their children. Thus, children are likely to be multiply affected because they may be:
- directly involved; or
 - indirectly involved (as a result of indirect effects and parental burden, as described above).
104. Put in other words, children's vulnerability depends on a complex mixture of personal and circumstantial variables. They include their personal resilience, whether or not they have been affected by trauma previously, the direct and indirect effects, the burden that falls on their parents or caretakers, their age, level of development, their capabilities for forming attachments and the nature of the psychosocial support and parenting available to them as well as any lasting effects on their development.²⁷ Given their relative dependency on the care of others, children are particularly vulnerable to the indirect effects of trauma on their development and to the secondary effects of burden resulting from the care provided by their parents being compromised.
105. This also means that children's reactions to disaster and other traumatic events are individual and vary according to their:
- age and developmental level;
 - proximity to the events;
 - exposure to events that impact on family members whether family members have been directly affected or not;
 - personal, family and material losses; and
 - family and community responses.
106. Commonly, they exhibit short-term reactions as a component of their resilient response:
- stunning and numbness;
 - anxiety and fear;
 - horror and disgust;
 - anger;
 - loss of trust;
 - demoralisation, hopelessness and helplessness; and
 - survivor and performance guilt.
107. Children's and young people's reactions also vary with the time that has elapsed after an event. For a short time, children and young people may regress behaviourally and/or emotionally immediately after traumatic events but they usually recover fairly promptly. The short-term behaviours that are listed above are considered to be anticipated reactions. Usually they describe distress and improve with time and provision of adequate family, peer, school, and community support.

²⁷ see, for example, Pfefferbaum B, North C, Doughty D, Pfefferbaum R, Dumont C, Pynoos R, Gurwitsch R, Ndetei D. *Death Studies* 2006; 30(6):561-577.

108. Children and young people are particularly vulnerable to the indirect effects of major incidents of all kinds. Their development may be affected and this may have long- and very long-term consequences. They can be readily affected by adults', and, particularly, their parents', caretakers' and teachers' own experiences of disaster and their capacities to cope. Children and young people are also burdened by the worry and care that they feel for their parents and other close family members and friends.
109. The concept of complex trauma can be applied to child abuse. It has within it exposure and adaptation as dual problems. It is the experience of multiple or chronic and prolonged, developmentally adverse traumatic events. Often these are of an interpersonal nature, including sexual or physical abuse, war and community violence. The settings within which these events occur and the cumulative impairment that results make children particularly vulnerable to further disasters and major incidents.
110. Contrary to past beliefs, there is evidence that pre-school children are not protected by their early level of development from the psychosocial impacts of disasters. They too are directly affected and also affected indirectly by their parents' compromised abilities to care for them. Pre-school children in New York City who were exposed to high-intensity events, on or after 9/11, had sleep problems and showed anxious and depressed behaviours. The children who had previously been exposed to other traumas were at greater risk.
111. Adolescents who have been exposed to terrorist events show higher levels of alcohol and cannabis use compared with their peers. These effects appear to be independent of symptoms of depression or post-traumatic stress. However, other research has shown that some Israeli adolescents reported benefits to their resilience and development after their contact with terrorist events.
112. Another observation is that the symptoms of distress that children commonly experience in the aftermath of disasters and traumatic events may be difficult to distinguish from the poor concentration and overactivity that occur in attention deficit/hyperactivity disorder (ADHD). This may be because the arousal systems in the brain are involved in both conditions. Care is advised in diagnosing and prescribing for children and young people who are referred with apparent ADHD when they have suffered significant psychosocial trauma.
113. Factors that mediate or moderate children's recovery include:
- frequency of exposure to reminders of traumatic events;
 - frequency of exposure to reminders of loss;
 - type and severity of secondary stresses and adversities;
 - impairment in the functioning of caregivers;
 - quality of family functioning;
 - overcrowded or adverse living conditions;
 - nature of school and community milieu;
 - quality of peer relationships;
 - physical injury, disability, and rehabilitation; and
 - intercurrent trauma and loss.
114. Schools can and should play important roles in restoring and normalising community life for children and families. Authorities should include schools in the plans made to respond to the psychosocial needs of populations after disasters, terrorism and major incidents. Therefore,

education providers as well as disaster planners require advice on matters pertaining to children's psychosocial needs and care from professionals who are trained and experienced in working with children. Schools should be encouraged to play their full roles in assisting children and families after disasters and major incidents. The support of teachers and other staff who are familiar to them are usually very effective and experienced by children as an extension of ordinary life. Often, therefore, the risks from disruption that accrue from introducing counsellors into recovery scenarios, albeit that they are trained, outweigh the advantages. It is better that trained people work indirectly through advising and supervising adults with whom children are familiar.

115. In summary, children and young people are frequently involved in major incidents of all kinds. The kinds of services that they require are similar to those required by people of all ages. The strategic stepped model presented in this guidance is fully applicable to them. The psychosocial response services for children should not be separated from those that are provided for adults given the community and family orientation that is recommended in this guidance. However, planners, commanders of responses to major incidents and practitioners should be aware of the increased vulnerability of children to the indirect psychosocial effects of catastrophes of all kinds and to the communicated effects on them of their parents' own experiences. They should modify their plans accordingly.
116. The agencies that deliver psychosocial response services should employ professionals who are trained and experienced in working with children and young people to advise others and provide specialist services.

The Impact of Disasters and Major Incidents on Older People

117. While the volume of research on the differential vulnerability of older people to disasters is limited, there is some evidence about how older people respond. One study of older adults who were inundated by flooding showed that flood exposure was related to increases in depressive, anxiety and somatic symptoms 18 months afterwards. Men, people of lower occupational status, and people aged 55 to 64 were at greater risk of psychological symptoms. Another study has considered the effects over time and shows that careful consideration should be given to the gap between the event and the onset of symptoms. The survey showed that the major impact of a hurricane on older adults diminished in about 16 months.
118. Older people are particularly vulnerable to physical danger and injury. There is also evidence that frail older people who live alone or in long-term care settings are particularly vulnerable to bioterrorism and other emergencies due to their complex physical, social and psychological needs.
119. About 80% of older adults have at least one chronic condition that makes them more vulnerable than healthy people during a disaster or major incident. These conditions often stem from physical infirmity and injury, and they may have sequelae that are not direct consequences of the disaster. Chronic conditions, especially when they are combined with the physiological, sensory, and cognitive changes experienced as part of aging processes, often result in frail older adults having special needs during emergencies. Planning and coordination are essential to meet these needs.
120. The features of services that help to prepare responders and practitioners to protect and assist older adults during a disaster include:
 - enabling professionals from diverse fields to work and train together;

- ensuring that advocates for older adults participate in community-wide emergency preparedness; and
 - using community mapping to identify the areas in which many older adults live.
121. Research shows that approaches that integrate humanitarian aid, welfare provision, and psychosocial and mental health care in which domestic, community and institutional interventions are brought together are more likely to be effective for older people than single approaches that are planned and delivered separately. Again, this resonates with a principle that is core to this guidance.
122. Older people are frequently involved in major incidents of all kinds. The kinds of services that they require are similar to those required by people of all ages. The strategic stepped model presented in this guidance is fully applicable to them. The psychosocial response services for older people should not be separated from those that are provided for adults of working age and children given the community and family orientation that is recommended in this guidance. However, planners, commanders of responses to major incidents, and practitioners should be aware of the increased vulnerability of older people to the direct and indirect psychosocial effects of catastrophes of all kinds and to the communicated effects on them of their families' experiences. They should modify their plans accordingly.
123. Community resources for older people can and should play important roles in restoring and normalising community life for families. This potential should be reflected in actively including them in the plans made to respond to the psychosocial needs of populations after disasters, terrorism and major incidents. Therefore, planners require advice on matters pertaining to older people's psychosocial needs and care from professionals who are trained and experienced in working with them.
124. The agencies that deliver the psychosocial response services should employ professionals who are trained and experienced in working with older people to advise others and provide specialist services.

Veterans

125. The Positive Practice Guide relating to veterans and Improving Access to Psychological Therapies (IAPT)²⁸ states that there are around 200,000 regular serving personnel in the armed forces (HMF), 100,000 of whom are in the Army and 50,000 each in the Royal Navy and RAF. There are around 35,000 personnel in the reserve forces, a significant proportion of whom have been deployed since 2003 on active service alongside the regular forces. The paragraphs that follow in this section are taken from the IAPT Positive Practice Guide.
126. The great majority of regular and reserve armed forces personnel do not experience mental health problems either during or after service. Approximately 20,000 personnel leave the regular forces each year. There are about 1,600 medical discharges, of which about 150 are due to mental health problems. It is not known how many leave HMF with an unrecognised mental health problem.
127. It is estimated there are about five million veterans in the UK, and about 7 million family dependents. The most obvious potential risk to the mental health of service personnel are violent or traumatic experiences of combat. Other risks to their mental health may include;
- frequent or prolonged deployments;
 - disruptions or instability in home life;

²⁸ <http://www.iapt.nhs.uk/2009/04/veterans-positive-practice-guide/>

- making the transition from service to civilian life; and/or
 - the consequences of the excessive drinking culture that is often found among service personnel.
128. Commissioners need to understand the demographic profile of their local populations in order to provide Improving Access to Psychological Therapies (IAPT) that are appropriate for the whole population, including veterans, and to include them in needs assessment work.
129. Of the three services, soldiers are most at risk of both physical and mental health problems, particularly young single infantrymen. This may relate to both their pre-service vulnerability as well as their exposure to high levels of direct combat.
130. There is a growing body of good quality mental health research on personnel of the UK's armed forces, for whom the most common disorders are depression, anxiety disorders, substance misuse (mostly alcohol) and psychological trauma-related disorders. Veterans with long-standing mental health problems frequently present with multiple co-morbid psychiatric disorders and highly individualised clinical, social, occupational and relationship problems. There may also be co-morbid physical conditions e.g. orthopaedic problems and chronic pain.
131. Rates of post-traumatic stress disorder (PTSD) in personnel who are still serving are generally low, with figures of between 1% and 8% being reported from recent conflicts. However, recent UK studies have suggested that veterans may be twice as likely as civilians to develop delayed-onset PTSD, which is likely to present within the first year after leaving military service.
132. Commissioners should ensure that IAPT services are effective for veterans from a range of circumstances. Although veterans should be regarded as part of the ordinary community population, commissioners should also be aware that some veterans may have complexities and distinct differences from the rest of the population. Veterans are vulnerable to social exclusion, including homelessness and unemployment, and around 6% of the prison population are reported to be veterans.
133. As regards access to services provided by the NHS, the Positive Practice Guide states that veterans face a number of barriers that prevent them from gaining access to psychological therapy services for their mental health needs. Again, the paragraphs that follow are taken from the guide.
134. High levels of social exclusion can mean that some veterans do not register with GPs and therefore have poorer access to healthcare. Promoting self-referral routes, and accepting referrals directly from ex-service charities, into IAPT services would be a valuable method of removing this barrier for veterans without access to GPs.
135. Veterans' beliefs and behaviours may prevent them from receiving psychological therapies, such as:
- believing that mental health problems are shameful and so deliberately hiding symptoms from health professionals;
 - believing that NHS professionals will not understand them or their service history;
 - believing that the effort, stigma and shame will outweigh the benefits of asking for and receiving help;
 - self-medicating with alcohol in order to mask their moods or problems and stop them being detected;

- mistakenly believing that psychological therapies are not effective for veterans;
 - being disenchanted by previous exposure to mental health services in the military or NHS;
 - having difficulty accessing general health services in the first place.(especially relevant for veterans who are socially excluded).
136. General practitioners and other primary care professionals may, inadvertently, prevent veterans from accessing psychological therapies services because they:
- may not understand that veterans may have specific needs because of past military cultures;
 - may have time constraints in their surgeries that reduce the probability of them diagnosing veterans' mental health problems effectively;
 - recognise symptoms of depression or anxiety disorders, but fail to recognise that they can be treated with psychological therapies;
 - believe mistakenly that psychological therapies are not effective for veterans;
 - believe that treating any physical health problems is a higher priority than treating mental health problems and, consequently, do not refer to psychological therapy services.
137. Specialist mental health services may, inadvertently, prevent veterans from accessing services that provide psychological therapies because they:
- lack confidence in working with veterans;
 - may be fearful that veterans can be violent.

Rescuers, First Responders and Staff of the Humanitarian Aid, Welfare and Healthcare Services

138. Evidence shows that first responders are vulnerable to the psychosocial and mental health consequences of their involvement in disasters and major incidents. First responders may include members of the public who are often first on the scene, and are often ill recognised for their important contribution, as well as frontline rescue and emergency staff. They may also include staff of humanitarian aid, welfare and healthcare services.
139. Responders are at risk through their work on disasters and major incidents. However, some of them may also be indirectly affected through their own losses of loved ones, colleagues and homes, for example. This was the case in the tsunami, the Kashmiri earthquake and Hurricane Katrina.
140. There is, now, an increasing awareness of the needs of first responders and of emergency services staff and research is taking place on how best to manage them and respond to their needs for preparation and psychosocial care at the time and afterwards.
141. However, the psychosocial impacts on the staff who care for people who have multiple and/or major injuries remains less well recognised. Positively, there is evidence that staff who are exposed to trauma on a regular basis and those who work in traumatic and / or stressful environments benefit from regular clinical supervision and psychosocial support. These facilities decrease the staff's lack of feeling that they have made a positive contribution, which is one of the elements of burnout, by promoting awareness of their

feelings and enabling them to reflect on the good work that has been done even if the circumstances are stressful and traumatic.²⁹

142. The frequency of care providers suffering psychosocial problems and mental disorders varies across the literature. Some sources suggest that rescuers, staff of the blue light services and staff of emergency departments are more at risk of developing adverse psychosocial and mental health consequences from their work. Often, features that affect them relate to the frequency with which they come into contact with emergencies and traumatic events that involve death, physical injury and distress, the situations to which they respond, the environments in which they work, and the cultures of the organisations that employ them. Research on ambulances services staff in Scotland, for example, has shown that their mental health and emotional well-being appear to be compromised by accident and emergency work.³⁰ Around one third of these staff had high levels of psychopathology, burnout and post-traumatic symptoms, and they were more likely in staff who had experienced a particularly distressing incident in the previous six months. Recently, however, several sources have called these assumptions into question. A study of the effects of the bombings in Madrid, for example, showed low rates of psychiatric disorders in the police officers who were involved.³¹
143. Given the differences of opinion about the vulnerability of staff and the requirement for more research, this guidance has adopted an interim position. This guidance takes it as reasonable to plan on the basis that the prevalence of mental disorder for staff after major incidents lies between that of the general population and care providers who are not involved in traumatic events, on one side, and the prevalence of similar problems in the survivors and victims of disasters, terrorism, conflict and major incidents, on the other.³² Thus, the rates of PTSD in care providers at some time after a major event varies in the research literature from 10 to 20% and depression and anxiety disorders occur in around 10%. Care providers are recorded as having higher prevalence of alcohol misuse compared with survivors (up to 25% compared with 10%).
144. The experiences of staff and the nature of the distress, problems and disorders that they may develop are similar to the experiences of people who are directly involved in catastrophic events. Staff are also exposed to a gradient of risk and show a gradient of responses. Staff may experience transient distress or develop more sustained problems of distress and dysfunction and, possibly, mental disorders. Employers should be aware that distress may present indirectly and that it may manifest as conflict with managers or superior officers, reduced workplace performance, increased alcohol use, withdrawal, lowered mood, unexplained physical complaints and decline in general health.
145. Whatever the position on the vulnerability of rescuers and emergency staff that is supported by further research, employers should be aware of the cumulative impact of their staff's repeated exposure to traumatising events. The opinion of Cooper is that "*Managing stress at work and developing and maintaining a 'feel good' factor in the workplace should not just be about managing absence or squeezing the last drop of productivity out of employees; in a civilized society, it should be about quality-of-life issues as well, such as reasonable hours,*

²⁹ Hacker Hughes JGH, Collins SM. Caring for the carers. An approach to supporting health care professionals working in stressful clinical environments. *Proceedings of the British Psychological Society* 1994; 2(1):49.

³⁰ Alexander DA, Klein S. Ambulance personnel and critical incidents: impact of accident and emergency work on mental health and emotional well-being. *British Journal of Psychiatry* 2001; 178:76-81.

³¹ Gabriel R, Ferrando L, Corto'n ES, Mingote C, Garcí'a-Camba E, Liria AF, Galea S. Psychopathological consequences after a terrorist attack: an epidemiological study among victims, the general population, and police officers. *European Psychiatry* 2007; 22:339-346.

³² A good review is provided by Speets AM, Keller IM, Smilde-van den Doel DA. Psychosocial consequences of the deployment of uniformed care providers in major disasters and accidents. Amsterdam: IMPACT; 2007.

family time, manageable workloads, some control over one's career, a sense of security at work and being valued by management.³³

146. The background and contextual factors that should be considered include occupational stressors, work relationships and patterns of interpersonal conflict, team morale, workload, shift working and the supporting resources that are available. The specific factors include whether or not staff are exposed to mass disasters, serious incidents, loss of life and injury (particularly involving children and colleagues), seeing people die, and being the subject of verbal aggression or violent attack. The advice offered by Sparks and Cooper is that by identifying the organisational stressors, it is possible to devise a coherent and systematic intervention strategy.
147. On the basis of this analysis, this guidance advocates that all plans should include specific provisions for the psychosocial care of the staff of the services that respond to disasters prior to and in preparation for events, at the time, in the aftermath and in the long-term. This may present some challenges because experience shows that it is easy to identify military personnel and staff who have been in the first line of responses or in prominent roles but much less so to identify the full range of people who are at risk. They include, for instance, mountain rescue teams, body handlers, divers, salvage, engineering and demolition workers. They also include staff of rehabilitative establishments and services that provide longer-term care for people with major injuries and disabilities consequent on trauma and the staff of mental health services. In addition, are staff from the service support and logistic units and departments who are not directly involved in contact with survivors, but are involved in unusual work and exposure to stressing materials, stories and unusual working hours and conditions in support of personnel who are more directly involved. In hospitals, for example, staff of the pathology, radiology and facilities management departments and professional and general managers are all-too-easily overlooked.
148. There are compelling humanitarian reasons for ensuring that staff have ease of access to services in ways that are not perceived as patronising or stigmatising. There are also sound economic and organisational reasons for this approach if services are to diminish attrition caused by excessive demands made on their staff.
149. Additionally, employers have duties of care concerning the health and safety of their staff. Organisations must have clear policies and procedures for assisting their staff. The moral and/or legal duty of care also imposes tasks for occupational health services. The importance of preparing and training staff and providing services for them is covered in the closing section of this guidance.

³³ Cooper CL. Stress prevention in the police. *Occupational Medicine* 2003;53:244-245.

The Principles of Responding to the Psychosocial and Mental Health Needs of People Affected by Emergencies, Major Incidents and Disasters

Core Principles

150. This section identifies the principles for delivering psychosocial and mental health care services for people who are affected by disasters and major incidents. They are common to guidance from the Civil Contingencies Secretariat of the UK Government, the NATO guidance and the EU's TENTS guidelines.

The Importance of Managing Effectively and Efficiently the Psychosocial Needs of Populations that are Affected by Major Incidents and Disasters

151. There is evidence that how people's psychosocial reactions are managed may define the extent and effectiveness of communities' recovery overall.
152. An important corollary of this principle is that all actions taken after disasters and major incidents must do no further harm.

Human Rights

153. Well-designed service responses to people's psychosocial and mental health needs should be based on, and promote awareness of human rights.

Definitions

154. It is important that actions are taken to develop, agree, disseminate and use common definitions of the terms that are in frequent use in the field of designing, delivering and evaluating psychosocial and mental health responses for people of all ages who are affected by disasters and major incidents.

Integrated Resilience Management through Effective Planning

Anticipation, Planning, Preparation and Advice

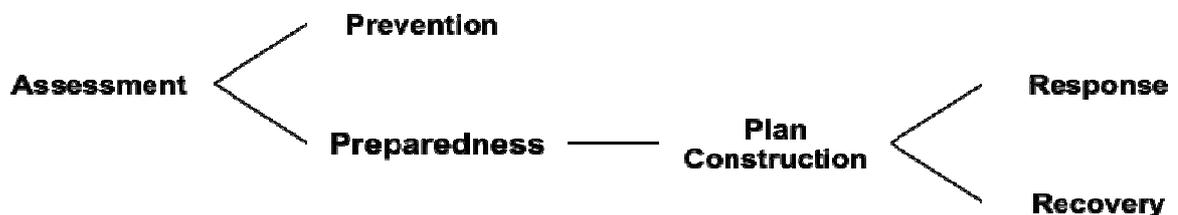
155. A core principle arising from work that was conducted for NATO and the EU and which was used to construct this guidance is that the services, including the psychosocial and mental health services that are required following disasters and major incidents, are much more likely to work effectively if the need for them has been anticipated and defined.

156. This requires understanding of the dynamic shifts that occur with the passage of time and of the clarity about how these services are to interconnect with other services that offer humanitarian aid and responses to people's welfare and psychosocial needs after disasters and major incidents.
157. Knowledge about how people may react psychosocially to disasters and major incidents is likely to assist responsible people in making effective decisions prior to events and when they are making decisions while under strain during events.
158. The paragraphs included here are taken from a document prepared by the Civil Contingencies Secretariat because the principles of anticipation, planning, validation of plans responding and recovering are equally applicable to planning and delivering care for people who have psychosocial and mental health needs as a consequence of major incidents and disasters as to many other aspects of the responses required.

The Planning Context

159. The true measure of any structure's resilience is its ability to absorb and recover from shock or stress. The length, quality and sustainability of the recovery process are, among other inputs, a function of the quality and effectiveness of the contingency planning and management process. It is the skill and commitment that are applied to its response that will, in the end, characterise a success in managing crises. Key to this is the understanding of each of the elements, their relationships and interdependencies, as illustrated in Figure 5 below.

Figure 5: Integrated Resilience Management



160. The components of effective anticipation include the following.
- Anticipation and assessment: professionally conducted risk assessments.
 - Prevention: measures adopted as a result of a rigorous assessment of the risk or risks, which seek to prevent crises occurring or to reduce their severity. These can include strategies for reduction and/or redistribution of risk.
 - Preparedness: preparation of plans that are flexible enough both to address known risks and to provide a starting point for handling unforeseen events. Preparedness includes, for example, the arrangements for identifying and calling out key personnel, together with arrangements for deploying and sustaining key assets, as well as predetermined arrangements for augmenting services. There needs to be clear ownership of the plans, while their effectiveness needs to be tested in regular exercises which feed the lessons learned back to those organisations and individuals to whom they would be of value.
 - Response: usually (but not always) the initial organisational and professional response to an incident is provided by the statutory emergency services and, as necessary, by the

appropriate local authorities, Government Offices for the Regions, agencies, and possibly voluntary organisations.

- Recovery: this phase covers those activities that provide as rapid a recovery as possible, both for the community and for those involved with the response. Organisations should be fully prepared for this phase, which may well be a long and complex one, involving interface and negotiation with a wide range of other organisations and agencies.

161. There is not one model response to crises. Nevertheless, any response has to be a combined and co-ordinated operation. Prevention strategies impact on recovery strategies and so on. As illustrated in Figure 5 above, the development and activation of response and recovery strategies should be treated as parallel activities.

The Planning Process and Validation

162. The planning process is best considered under the following headings:

- Direction
- Information gathering
- Plan writing
- Consultation
- Publication
- Training
- Validation
- Confirmation or revision.

There should be clear evidence that each of these elements has been properly addressed and that the planning process is a dynamic and continuous one, regularly feeding upon new lessons learned and new information as it emerges.

Planning for Families and Communities

163. All of the components in this guidance focus on particular people and on collectives of people, but all aspects of psychosocial and mental health care should only be provided with full consideration of people's wider social environments, the cultures within which they live, and, particularly, their families and the communities in which they live, work and travel.

164. The service responses that are provided from within societies and, in the case of disasters and major incidents that cause greater devastation, the actions that are taken by external countries and organisations should be titrated against awareness of the needs of the people who have been affected. This requires a strategic stepped model of care to underpin a variety of levels of planning and preparation before events and multi-layered support that is provided afterwards.

165. The stepped model should have its roots in providing basic services first, and proceed through responses that are made by communities, families and particular people, to non-specialised but focused services and thence to specialised services. Progression through these levels should be based on knowledge of people's needs.

Developing, Sustaining and Restoring Psychosocial Resilience

166. Plans for how societies and services are to respond to the psychosocial and mental health needs of populations should recognise the considerable resilience of people and groups of people including families, communities and groups of strangers who are thrown together by events. Adversity can bond individual people, families and communities.
167. This principle means that actions taken, including those that determine how services respond to the needs of communities and people for psychosocial and mental health care, should actively maximise participation of local, affected populations whatever the degree of devastation in each area.
168. Restoring, first, the functioning, and second, the social fabric of communities is highly important in how societies, communities and services respond effectively to the psychosocial and mental health effects of disasters and major incidents. This means that:
- restoring the social functioning of communities, and protecting vulnerable people and communities from the psychosocial effects of disasters and major incidents are important components of disaster preparedness, responses to major incidents, and facilitating recovery;
 - restoring the social fabric of communities is another important component of disaster preparedness, responses to major incidents, and facilitating recovery;
 - providing information and activities that normalise reactions, protect social and community relationships, and signpost access to additional services are fundamental to effective psychosocial responses.
 - everyone involved is likely to benefit from effective supporting humanitarian and welfare arrangements in the immediate aftermath according to their needs; and
 - the effectiveness of the responses made depend on utilising community leaders' prior knowledge of affected communities and the resilience and vulnerabilities of people in affected areas.
169. Despite adequate preparation before, and actions taken during an event, there is likely to be a sizeable minority of people who are at high risk of developing mental disorders.
170. If communities are to receive comprehensive responses to their psychosocial and mental health needs after disasters and major incidents, the following types of service are required: (a) humanitarian aid; (b) welfare services; (c) services that are able to assist people and communities to develop and sustain their resilience; and (d) timely and responsive mental health services.

Building on Existing Services and Skills to Develop and Deliver Effective Responses to People's Needs for Psychosocial and Mental Health Care

171. Taken together, the principles summarised here mean that services' responses to meet the needs of affected populations for psychosocial and mental health care should build on the capabilities of people and the resources that are available.
172. Services that provide psychosocial care and mental health care should be capable of responding to a variety of types or causes of disasters and major incidents, and should build upon the existing clinical skills and preparedness within each community. This raises matters for planning, training and for sustaining knowledge and skills.

Integrating Psychosocial and Mental Healthcare Responses into Policy and into Humanitarian Aid, Welfare, Social Care and Health Care Agencies' Work

173. Achieving comprehensive psychosocial care and mental health services for moderate and large scale emergencies requires that lessons learned through research and experience are translated into integrated, ethical policy and plans at four levels. They are:
- governance policies;
 - strategic policies for service design;
 - service delivery policies; and
 - policies for good clinical practice.
174. Each of these four aspects of policy should be influenced by the contents of this guidance. This means that there are important roles for practitioners who are skilled in mental health care and experienced and trained in disaster management to provide advice to the authorities as they develop each of these aspects of policy and as they conduct operations in the face of disaster.
175. Governance policies relate to how countries, regions and counties are governed. Policies at this level are required that set the overall aims and objectives for responses to disasters and major incidents. They should specify the need for services to be designed, developed and delivered that offer psychosocial and mental health care that is integrated into all disaster response plans. Strategic policies are then required that translate political imperatives into the intent and direction of development of specific components of the plans.
176. Governance policies require the responsible authorities to develop strategic policies. Strategy should be developed by bringing together evidence from research, past experience, knowledge of the nature of areas of the country for which they are responsible and of their populations, and the profile of risks, to design services. Responsible authorities are also responsible for evaluating and managing the performance of those services to meet the identified objectives.
177. Service delivery policies concern how particular services function and relate to their partner services and how affected populations are guided into and through them according to the evidence and awareness of the preferences of people who are likely to use them. Service delivery policies include evidence-informed and values-based models of care, care pathways and protocols and guidelines for care as well as processes for demand management, audit and review.
178. Policies for good clinical practice concern how clinical staff take account of the needs and preferences of patients, deploy their clinical skills, and work with patients to agree how guidelines, care pathways and protocols are interpreted in individual cases.
179. Policy at each of the four levels should be informed by culture and values as well as by evidence and experience gleaned from practice. The Madrid Framework can be used as a framework for benchmarking how policies deal with the values that are inherent in designing and delivering services.

Business Continuity Management including Recovery and Restoration

180. The response to a major incident either internal or external to an NHS organisation requires a response incorporating the principles of Integrated Emergency Management (Assessment, Prevention, Preparation, Response, and Recovery). The CCA requires Category 1

responders to maintain plans to ensure that they can continue to exercise their functions in the event of an emergency so far as is reasonably practicable.

181. NHS organisations will wish to ensure that they are aware of the current advice and best practice examples provided by NHS Resilience. Guidance can be found at:
http://www.dh.gov.uk/en/Managingyourorganisation/Emergencyplanning/DH_079649

Standards

182. All planners, incident commanders as well as practitioners, volunteers, researchers and evaluators should agree to work to a common set of standards.
183. In certain circumstances, especially those in which there is widespread devastation, high standards may not be achievable until there has been restoration of basic community functioning and resources including clean water and food supplies, shelter and protection, communications, and healthcare. Situations of this kind should be anticipated and covered by planning. Planning should consider what are the minimum standards in a range of different circumstances.
184. The standards adopted have substantial implications for training, research, evaluation and information-gathering because all of these capabilities should be core parts of all disaster and major incident response plans. This means that the requirement for them is anticipated and standards for research, evaluation and information-gathering should be developed and planned before disasters occur.
185. Research and evaluation should identify the factors that contribute to either the success or failure of particular types of service, their organisation and delivery, and particular interventions.
186. Research and evaluation should include follow up studies that are designed to learn about long-term effects that may be associated with psychosocial intervention programmes a substantial time after they have been completed.

An Integrated Model of Care

Aims

187. The aims of providing psychosocial and mental health care that is sensitive and responsive to the needs of people after disasters, conflict, major incidents, including those due to terrorism, and emergencies of all kinds are to:
- prepare communities to develop and sustain their collective resilience and to diminish the potential disruption and the accumulated psychosocial consequences on them;
 - prepare people to develop and sustain their personal resilience and to diminish the potential psychosocial consequences on them;
 - respond proportionately, flexibly and in a timely way to the phased needs and preferences of people who are affected so as to mitigate the psychosocial and mental health effects on them;
 - ensure a continuum of care provided in an integrated way that recognises that people's needs are immediate, and may also prevail in the short-, medium- long -, and, in some instances, in the very long-terms; and
 - recognise the risks to, and needs of responders by providing services that keep them well-informed and involved, provide training, and provide opportunities for sharing their experiences and access to welfare, aid and healthcare services as required.

Objectives

188. The minimum objectives that are required of plans for psychosocial and mental health service responses to disasters are:
- fully integrating psychosocial and mental health care responses to people's needs within the grand plan for preparing for, and responding to disasters;
 - appointing psychosocial and mental health advisers to commanders of services that respond to needs that are caused by major incidents and disasters during planning and retaining their services to give real-time advice during events and in the, later, recovery phase;
 - empowering communities and people;
 - ensuring that staff are capable of working with diversity of values and cultures;
 - attending first to the basic needs of the populations that are affected;
 - developing and delivering effective public risk communication and advisory plans that involve the public and the media and which provide timely and credible information and advice;
 - ensuring that the psychosocial care and mental health responses are comprehensive and stepped according to need, are of sufficient duration, and are well co-ordinated;
 - allocating and managing roles for mental health professional practitioners;
 - ensuring that staff of all organisations that respond to disasters and major incidents are well led, managed, supervised and cared for; and
 - promoting learning by planning and managing knowledge acquisition and its transfer, evaluation and performance management.

A Strategic Stepped Model of Care

189. The strategic stepped model of care recommended in this guidance links the impacts of events with the core components of psychosocial and mental health care that populations of people, communities and particular people require through assessment and intervention. It is intended as a conceptual and practical resource for planners.
190. Figure 6 shows in a diagram the six levels or steps in the model of care that is recommended by NATO/EAPC. That model is built on in this guidance. It is accepted by the Department of Health as lying at the core of the responses that are required of the NHS in England in response to the psychosocial and mental health needs of people who are affected by major incidents and disasters.

Figure 6: The core components of the strategic stepped model of care³⁴ (© Williams R & Kemp V and reproduced with the permission of the copyright holders)



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191. The strategic stepped model of care described here has six main components that fall into three groups:

Strategic and Operational Preparedness

- **Strategic planning** - comprehensive multi-agency planning, preparation, training and rehearsal of the full range of service responses that may be required in which the roles of the NHS are agreed.
- **Prevention services** that are intended to develop the collective psychosocial resilience of communities and which are planned and delivered in advance of disastrous events.

Public Psychosocial Care

- **Families, peers and communities provide responses to people’s psychosocial needs that are based on the principles of psychological first aid.**
- **Assessment, interventions and other responses that are based on the principles of psychological first aid** and which are, often, initiated by staff of the first professional responding and rescue agencies or offered by trained lay persons, who are supervised by the staff of the mental healthcare services, and social care practitioners where that is agreed as being appropriate.

Personalised Psychosocial and Mental Health Care

- **Access to primary mental health care services** for assessment and intervention services for people who do not recover from immediate and short-term distress or who show sustained distress associated with dysfunction.
- **Access to secondary and tertiary mental health care services** for people who are thought to have mental disorders that require specialist intervention.

192. Figure 7 summarises the three groups and the six main components in the form of a table.

Figure 7: A strategic model of psychosocial care

Intent	Nature of Activity	Actions	Time Scale
Develop and sustain collective and personal psychosocial resilience	Preparedness	1. Strategic planning	Continuing
		2. Develop community resilience	
	Public welfare, social and health care paradigms	3. Humanitarian aid	Immediate & continuing
		4. Psychological first aid	
Deliver responses to personal	Personal psychosocial and health care paradigms	5. Primary care and social care and augmented primary healthcare	Medium term

psychosocial and health care needs		6. Specialist mental healthcare	Medium and long term
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Cross-sectoral and Interagency Roles, Responsibilities, Planning and Service Delivery

The Principles of Integrated, Cross-sectoral Responses to the Psychosocial and Mental Health Needs of People who are Involved in or Affected by Disasters and Major Incidents

193. One of the founding principles on which this guidance is based is that responsibilities for responding to the psychosocial and mental health care needs of people who are affected by major incidents, disasters and other emergencies fall in one way or another to just about all of the sectors of care and the agencies that could and should be involved in responding.
194. The approach adopted in this guidance is broad and comprehensive. Therefore, providing comprehensive responses requires a wide spectrum of the responsible agencies in each area to work together to:
- plan well-integrated, responsive and predictable services;
 - agree which of the actions falls to which of the agencies to lead delivery;
 - keep under review together the adequacy of their joint plans.
195. Thus, this guidance is based on some of the service responses being provided by each agency, with other responses being delivered by particular agencies on the basis of explicit inter-agency agreements, while other responses require several agencies to work together directly in order to deliver them.
196. The corollary of this position is that certain components of the wide range of responses required by people who are affected by major incidents and disasters fall to the NHS as lying within its prime responsibilities. Other responses should be planned and delivered by the NHS as they should by many other agencies. Additionally, other components of a comprehensive local response to people's needs require the NHS to work explicitly with its partner agencies in order to deliver services.
197. The roles and responsibilities of key resilience partners are set out in documents published by the Civil Contingencies Secretariat. The two key documents are:
- Emergency Preparedness: <http://www.ukresilience.gov.uk/preparedness.aspx>
- Emergency Response and Recovery*: <http://www.ukresilience.gov.uk/response.aspx>
- *Please note that this document is being revised and is subject to consultation:
- http://www.ukresilience.gov.uk/news/err_consultation.aspx
198. This section should be used in conjunction with the NHS Emergency Planning Guidance and its sections set out the particular roles and responsibilities of NHS organisations in contributing to cross-agency plans and to delivering comprehensive services according to the strategic stepped model of care that has been described earlier.
- http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4121072

199. Provision of humanitarian assistance is a multi-agency activity and is co-ordinated across a range of agencies, including: local authorities; the National Health Service; police services; commercial organisations (e.g. transport companies); and voluntary organisations. The Department for Culture, Media and Sport (DCMS) is the designated Lead Government Department (LGD) when central government is engaged.
200. A detailed guide to roles and responsibilities in humanitarian assistance published by DCMS can be found at:
<http://www.cabinetoffice.gov.uk/ukresilience/preparedness/ukgovernment/humanitarian.aspx>

The Roles and Responsibilities of Local Authorities

201. The DCMS guide referred to previously details the roles and responsibilities of local authorities in respect of humanitarian assistance. Below is set out the broader range of roles and responsibilities of local authorities in planning, responding and recovering from major incidents and disasters.
202. There are two types of local authority structure in England: single-tier and two-tier. In the two-tier system, a county council and several district and borough councils divide responsibilities for local authority services. County councils are responsible for running children's services which includes children's social services and education, adult social care, Other functions include, strategic planning, regeneration, transport and roads, libraries, refuse disposal, and trading standards. District and borough councils are responsible for leisure, environmental health, housing, planning control and refuse collection. In the single-tier system, one authority is responsible for all local authority functions. This applies to unitary, metropolitan authorities, and London boroughs including all councils in Wales and Scotland. This currently appears in the Cabinet Office's consultation version of the revised Emergency Response and Recovery guidance.
203. Local authorities are responsible for co-ordinating welfare support to their communities in the event of an emergency and play an important leadership role, which includes:
- providing temporary shelter (rest centres) including any transport arrangements needed to help people get to and from these; (District/Borough/Unitary);
 - providing information from the electoral roll to police casualty bureaux to assist in accounting for evacuees; (District/Borough/Unitary);
 - ensuring suitable arrangements are in place to meet welfare needs; (County/Unitary);
 - feeding and providing refreshment for those in temporary shelter; (District/Borough/Unitary);
 - establishing arrangements for local GPs to issue emergency prescriptions at rest centres; (District/Borough/Unitary);
 - meeting needs for temporary accommodation where evacuation is extended; (District/Borough/Unitary);
 - the production and exercising of evacuation and shelter plans, including mutual aid arrangements with other authorities for cross-border and very large-scale incidents; (County/Unitary);
 - leadership during the recovery phase of an evacuation; (County/Unitary);
 - leading the rehabilitation of the community and restoring the environment, with assistance from the Government Decontamination Service if necessary; (District/Borough/Unitary); and

- co-ordinating work to meet the long-term social and welfare needs of survivors, their families and friends. (County/Unitary).

The Roles and Responsibilities of Healthcare Agencies

204. Figure 8 reproduces the four steps or levels in the model of care that concern service provision

Figure 8: Roles of services in delivering the model of care³⁵ (© Williams R & Kemp V and reproduced with the permission of the copyright holders)

APPROACH	HUMANITARIAN AND POPULATION HEALTHCARE		PERSONAL HEALTHCARE SERVICES	
	Level 3	Level 4	Level 5	Level 6
Nature of Problems	TRANSIENT & SHORT-TERM DISTRESS Resistant & Resilient People	MEDIUM-TERM DISTRESS Resilient People	LONGER-TERM DISTRESS OR MENTAL DISORDER People with Persisting Distress that is Sustained by Persisting Stressors and Mental Disorders	MENTAL DISORDER People with Mental Disorders
Nature of Care	Universal Programmes of Prevention and Care	Universal and Selective Programmes of Prevention and Care	Universal, Selective and Indicated Programmes of Care	Universal, Selective and Indicated Programmes of Care
	Restoration of Psychosocial Environment by Normalising Relationships and Services Informed by the Principles of Psychological First Aid	Restoration of Psychosocial Environment by Normalising Relationships and Services Psychological First Aid	Primary Healthcare Mental Health Assessment and Access to Psychological Therapies	Specialist Mental Healthcare
Agents	First Responders, Families, Friends, Neighbours, Communities, Schools and Workplaces	Trained Lay Therapists with Professional Supervision	Primary Care Services Trained Lay Therapists with Professional Supervision Augmented Primary Healthcare Services (primary healthcare teams working with staff of community mental health services)	Specialist Mental Health Services
Hypothetical Indicative Time Line (days post incident, if appropriate)	0 to 14+	3 to 30+	28- to 365+	28- and continuing
Specialised Roles of NHS Practitioners and Managers	Provision of specialised advice to the Commanders of the Response Services at Strategic (Gold), Tactical (Silver) and Operational (Bronze) Levels Provision of a Liaison Mental Health Service for Responders (requires training in disaster mental healthcare)	Direction, Management and Supervision of Lay Therapists Provision of a Liaison Mental Health Service for Responders (requires training in disaster mental healthcare and supervision)	Advice to Primary Healthcarers Direction, Management and Supervision of Lay Therapists Advice to Specialist Mental Healthcare Services Conducting Some Specialist Assessments Supervision of Other Healthcarers (requires training in disaster mental healthcare and consultation techniques)	Delivery of Specialist Mental Healthcare

³⁵ © Copyright for Figure 8 and its associated concepts is asserted by R Williams and V Kemp in 2008 and reproduced with permission.

205. The boxes in the bottom row of Figure 8 show some of the roles of NHS staff in delivering. The paragraphs that follow provide more detail.

Levels 1 & 2: Strategic and Operational Preparedness

Level 1: Strategic Planning

206. Strategic planning comprises of comprehensive multi-agency planning, preparation, training and rehearsal of the full range of service responses that may be required. The role of the NHS should fit seamlessly within such a multi-agency framework.
207. It is important to recognise that strategic planning does not cease when the plan has been agreed and rehearsed. It should be revisited and reviewed regularly.
208. The NHS has key roles in strategic planning in which NHS organisations should:
- develop and test plans for improving the psychosocial resilience of every NHS organisation;
 - develop, in conjunction with partner agencies, a major incident psychosocial and mental health care plan to sit within local major incident plans;
 - establish a team to advise on the psychosocial and mental health aspects of delivering healthcare services in emergencies locally;
 - make arrangements to provide healthcare advice and contributions to plans, where appropriate, to developing the psychosocial resilience of communities.
209. Moreover, strategic planning must continue throughout each incident and afterwards and through the recovery stages because all plans, no matter how comprehensive and excellent, require adjustment, and further development as information about the nature of each event becomes available. This principle is enshrined in the process of command of major incidents that is used in England.
210. The system and the importance of psychosocial aspects of disasters in respect of people's well-being, behaviour and recovery are such that commanders of major incidents at all levels are likely to benefit from skilled advice. The NHS should be engaged in that activity. In particular, arrangements should be put in place for NHS organisations to:
- provide NHS staff to work with NHS organisations and with partner agencies to develop the roles and responsibilities for major incident response advisers on psychosocial and mental healthcare;
 - deploy skilled persons as psychosocial and mental health care advisers to strategic (gold) and (tactical) silver commanders in the anticipatory, response and recovery phases of selected operations; and
 - work in conjunction with the other key agencies to select, train, rehearse and support staff who are made available to act as advisers on the psychosocial aspects of disasters to strategic (gold) and (tactical) silver commanders in preparation for and for the duration of responses to major incidents.
211. The foregoing tasks and those that follow relating to delivering and providing services require good commissioning of the service components and training that are required. This raises another implied role of the NHS which is that of training staff of the NHS strategic and

commissioning organisations on the psychosocial aspects of major incident and disasters that should affect their planning and commissioning activities.

Level 2: Prevention Services

212. Prevention services are intended to develop the collective psychosocial resilience of communities. They should be planned and delivered in advance of disastrous events. The NHS has advisory and contributory roles to play in this wider agenda of activities that are intended to develop the psychosocial resilience and mental well-being of families, local communities, schools, workplaces and other agencies through public mental health programmes.
213. Research shows that the most substantial aspects of psychosocial resilience include:
- the abilities of people to accept and use social support;
 - the availability of social support;
 - a staunch acceptance of reality;
 - belief in oneself buttressed by strongly held values; and
 - the ability to improvise.
214. These findings also fit well with some of the findings from the New Economics Foundation and other aspects of the UK Government's Foresight project relating to well-being.³⁶
215. This means that approaches to developing psychosocial resilience fall into two broad categories:
- general interventions; and
 - disaster and incident specific interventions.
216. The first of these approaches, the general one, fits closely with the evidence that relates to psychosocial resilience and well-being, and with emerging Department of Health New Horizons policy for mental health in which the government is consulting on a vision for creating flourishing and connected communities through promoting well-being and resilience and reducing inequalities.³⁷ Evidently, building psychosocial resilience is seen as everyone's business and this, too, fits with the advice in this guidance in which promoting psychosocial resilience of communities is seen as much broader than a health service responsibility but also as one in which NHS organisations can play important roles.
217. The NHS should, for example, be in positions to provide advice within the healthcare community and to strategic and operational partner organisations on matters that pertain to health inequalities, psychosocial development and the emerging discipline of public mental health.
218. However, on the basis of the best evidence available now, the NHS does not have a role in providing single session debriefing services or routine counselling services in the immediate aftermath of disastrous events for people who are affected by major incidents and disasters.

³⁶ The Government Office for Science, Foresight Mental Capital and Wellbeing Project. Final project report. The Government Office for Science; London, 2008.

³⁷ http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_103144

Levels 3 & 4: Public Psychosocial Care

Level 3: Families, peers and communities provide responses to people's psychosocial needs that are based on the principles of psychological first aid

219. The NHS has indirect roles to play in supporting families at critical times. Usually, for example, the first people who are engaged in rescue activities at the outset of a major incident are other people who are involved and not staff of agencies of which the prime role is rescue. This results in substantial additional responsibilities for the staff of those rescue agencies who become engaged to, initially, recognise, respect, support and augment the interventions that are already under way. The first professional responders also, by dint of their being early attenders at the scenes of untoward events, are required to attend to the initial distress of survivors and victims and this demands awareness of the psychosocial impacts and certain skills for initial intervention. The chapter on organisational and workforce development contains more information on the knowledge and skills that first professional responders require in the psychosocial arena.
220. This situation creates an implied task for the NHS to provide appropriate training, supervision and support for its frontline staff. Additionally, the NHS may have contributions to make to the training required by first responders who are not primarily healthcare staff and staff who are not NHS staff.

Level 4: Assessment, interventions and other responses that are based on the principles of psychological first aid

221. The core of interventions at level 4 lies in responses to people's distress after events that are delivered by non-healthcare staff. Increasingly, access is being made available to talking therapies and other psychological interventions that are provided by trained and supervised lay persons. Depending on arrangements agreed locally, it might be agreed that social care practitioners, and staff of the mental healthcare services may take on explicit roles in training, supporting and supervising lay therapists.

Levels 5 & 6: Personalised Psychosocial and Mental Health Care

222. The roles of NHS organisations in levels 1 to 4 of the strategic stepped framework recommended in this guidance are related to planning, advising, training, resilience building, and early recognition of people's needs. These are tasks that the NHS shares with its strategic and operational partners. However, the tasks in levels 5 and 6 are ones on which the NHS has leading responsibilities for providing personalised healthcare interventions.

Level 5: Access to primary mental health care services

223. The core of the role of the NHS at level 5 is to provide assessment and intervention services for people who do not recover from immediate and short-term distress after major incidents, disasters and other emergencies. Thus, the NHS locally should work with partner agencies and lead on:
- delivering primary mental healthcare and augmented primary mental healthcare services for people who develop mental disorders as a consequence of major incidents and disasters; and
 - ensuring staff with the required skills are available from the specialist mental healthcare services to work with staff in primary care to develop their knowledge skills and resilience.

Level 6: Access to secondary and tertiary mental health care services

224. The core of the role of the NHS at level 6 is to provide timely, appropriate and responsive specialist mental healthcare services for people who require them because they have developed or are thought to have mental disorders that require specialist intervention as a consequence of their exposure to major incidents or disasters. This may require medium-term and long-term specialist mental healthcare. This means that:
- the NHS should work with partner agencies and lead on delivering specialist mental healthcare services for people who require them;
 - identified staff in the specialist mental healthcare services should be made available to work with and offer supervision and advice to staff in primary care after disasters or major incidents in order to augment primary healthcare responses;
 - identified staff in the specialist mental healthcare services should be made available to deliver liaison mental healthcare services for responders of all agencies according to agreed thresholds for referral.
225. In an earlier chapter, people were conceived as falling into four main groups on the basis of how they respond psychosocially to major incidents and disasters. Those groups are:

Group 1: Resistant people who show transient distress

People in this group are minimally or not upset. They are described as resistant people.

Group 2: Resilient people

There are two subgroups of resilient people who are distressed.

People in the first sub-group are proportionately, mildly, temporarily, and predictably upset in the immediate aftermath of traumatic events, but which is not associated with any substantial level of dysfunction. They are resilient people.

Other people in this group are more substantially distressed, but are able to function satisfactorily in the short- and medium-terms. They are resilient people who have greater distress, but not amounting to a mental disorder, of longer duration.

Group 3: People who have more sustained or persistent distress associated with dysfunction and/or impairment

People in this group are disproportionately distressed or distressed and dysfunctional in the short- to medium-terms (this group includes people who may recover relatively quickly if they are given appropriate assistance, befriending and other interventions as well as people who may develop mental disorders - people in this group require a thorough assessment).

In summary, there are two subgroups.

- People who are likely to recover, but whose recovery takes more time.
- People who may be in the course of developing a mental disorder.

Group 4: People who develop a mental disorder

People in this group are those who develop a defined mental disorder in the short-, medium- or longer-terms. They require specialist assessment followed by timely and effective mental healthcare.

226. It is highly likely that people from each of these groups may seek consultation with healthcare practitioners. Thus healthcare practitioners should have a general awareness of how people react to major events so that they are able to reassure people who consult them, but also identify their needs and distinguish people who could and should receive humanitarian aid and welfare assistance from agencies that are identified as responding to those needs in the local major incident plan from other people who also require healthcare interventions including assessment and treatment.
227. The thrust of this guidance is that the requirement on the NHS to provide assessments is most likely for people whose reactions fall into groups 3 and 4. People in those groups may also require complementary, simultaneous or sequential assistance from other agencies.

The Agencies Working Together

Lead Agency and Lead Practitioner

228. In the aftermath of a disaster or traumatic event, coordination of service delivery by agencies and professionals may well be difficult. Nonetheless, the principles underpinning delivery of care are the integration and coordination of agencies delivering mutually agreed models of care and/or case management, particularly when inter-agency planning is required. This guidance proposes that, where there is more than a single agency involved, they should agree among them which is the lead agency for each component of service. This promotes clarity, particularly for first professional responders who are involved in a disaster or major incident, about which agency to approach first if things go wrong or if plans do not work as anticipated.
229. The lead practitioner is the person from the lead agency who is responsible for managing each case and coordinating delivery of the care that each person requires. This lead role might pass in a negotiated way over time between practitioners and between the agencies to reflect changes in circumstances.
230. Agencies that are responsible for delivering care to people who are involved in a disaster or major incident should come together to agree mechanisms for care and case management.

General Principles of Case and Care Management

231. Inherent in this framework is better management of the services that are provided for people who need them, particularly when several agencies are required to work together to conduct effective assessments and intervention. Such an approach is particularly important if people have multiple or complex needs that should be reflected in coordinated multi-agency plans.
232. Care planning and case management activities should:
- promote coordination of service components that may be required from various sectors and agencies working together to meet the spectrum of needs of people who have been involved in a disaster or major incident; and
 - promote effective handling of transitions between service components and sectors of care.
233. The agencies and people within them who are responsible for planning and for case and care management should:
- develop and agree cross-agency assessment processes;

- arrange meetings to discuss, for example, specific cases or improving peer relationships;
- achieve an agreed and common approach to inter-agency assessment and case management;
- identify needs as early as possible;
- avoid duplication and gaps among agencies;
- agree between them how affected people are to be provided with appropriate sources of information, advice, assessment and intervention; and
- appoint a lead practitioner to be accountable for service delivery for each affected person.

234. The following principles are important in this process.

- The preferences of patients and their carers should be heard; they should be fully engaged in agreeing their programmes of care.
- It is necessary to assess and respond to the full range of people's needs. Problems that appear peripheral and are not dealt with may become secondary stressors and, thereby, maintain people's distress, psychosocial problems or mental disorders. This can result in their unresponsiveness to primary interventions.
- The importance of bringing sectors of care and agencies within them together to deliver comprehensive packages of care.
- Developing and maintaining effective relationships with third sector and non-governmental organisations.
- Ensuring that interfaces between different services do not result in discontinuities of care.
- Planning for people's transitions to other services when that is indicated.

Confidentiality, Information Sharing and Record-Keeping

235. Delivering the integrated services that are necessary to support affected people requires attention to information sharing. Some of this, for instance about service plans, roles, availability and accessibility is non-controversial but still requires continuing attention. Other matters such as sharing information about identifiable people presents more demanding challenges. Nonetheless, sharing information in a timely way is the cornerstone of agencies working together effectively.

236. Appropriate information sharing is a core principle to ensure that all services are able to work to the best advantage of people affected by disaster and other traumatic events. This requires agencies in each area that provide services to negotiate effective protocols for how they might share information where this is appropriate. Negotiations should take place while planning and well before disastrous events.

237. A European Union policy paper, proposes that the needs of all people affected and the general public interest are the prime criteria for information management.³⁸ It recommends that collection, registration, processing, assessment, verification, storage and communication of data must observe rules of professional and medical confidentiality, and respect for privacy, democratic rights and liberties should govern the whole process of information handling. Here, the principle of informed consent can be a general guidance. This has to be balanced against the legitimate demand for information in order to allow adequate management of the incident response, and the interests of the public and media.

³⁸ European Union. Concerning different aspects of psycho-social support for people involved in major accidents and disasters: psycho-social support in situations of mass emergency; 2001. <http://ec.europa.eu/environment/civil/pdfdocs/cpact03h-en.pdf>

238. The EU policy paper considers the needs and rights of the people who are affected with regard to information management. It proposes that providing affected people with accurate, factual information on the incident itself is essential in helping them to come to terms with what has happened. For example, people need access to updates on recovery of people who are affected directly, on their identification, and the disposition of personal effects. Ideally, this information should be communicated to relevant people before it is released to the media. Protection of personal privacy needs to be considered and should be part of a code of professional ethics for psychosocial workers that complements existing legal regulations.

Strategic Implementation of the Stepped Model of Care in the NHS

Strategic Preparedness

239. Strategic preparedness supports psychosocial resilience and is, thereby, likely to improve responses to people's psychosocial needs and reduce the risks of severe distress and mental disorder.
240. Effective planning and co-ordination of service responses is likely to maximise the collective resilience of the public and communities and the personal resilience of affected persons and responders.
241. The building blocks of good planning are:
- strategic, operational and tactical preparedness;
 - timeliness;
 - flexibility;
 - integration;
 - good communications;
 - timely and trusted sharing of information with the public and among the responding agencies; and
 - efficiency and effectiveness.
242. Every jurisdiction requires an integrated disaster and major incident plan. This means that every jurisdiction and area within it should have a disaster and major incident plan that is appropriate to its national, regional and local governance structures which makes provision for responses to people's psychosocial and mental health needs that is fully integrated into wider disaster planning and preparedness. Therefore, a coordinated approach is essential across the emergency response systems and rescue services. Integrated planning is required to support:
- a balance of population-orientated humanitarian aid, welfare, and health services with personalised healthcare services;
 - organisations that deliver rescue, humanitarian aid and welfare services;
 - social care systems;
 - voluntary and non-governmental organisations;
 - military systems; and
 - military aid to civil powers.
243. Decision-makers should understand how people respond to disasters and major incidents and the risk factors that affect the likelihood of people coping well with the psychosocial impacts of disasters or of people developing mental disorders. This means that they must understand the:

- anticipated distressed, and the dysfunctional emotional, social, cognitive and somatic reactions that people may experience;
- anxieties that anyone who has been directly involved or affected indirectly, including relatives, friends and many other people, is likely to experience;
- the psychosocial risks that are faced by people after disasters and major incidents; and
- the nature of the mental disorders that people may develop.

244. The cornerstone of the plan should be to support people's resourcefulness. This means that the responses that are provided should recognise the importance of sustaining people's resilience in assisting their recovery. Psychosocial plans should be based on the principles of psychological first aid. The abilities of people to accept and use social support and the availability of it are two of the key features of resilience, which is a process built on people's endogenous capabilities and experiences and their social relationships. Therefore:

- people who are affected by disasters and major incidents require rapid, effective action followed by sustained service responses that may require medium and long-term mobilisation of resources;
- organisations and services should recognise people's inherent resourcefulness, but also their need for informally provided support as well as responsive services;
- attending to basic needs (safety, security, food, shelter, acute medical problems, etc) is the first and highest priority;
- the emphasis of psychosocial interventions should be on empowering affected people and communities;
- the public should be actively engaged in delivering responses to communities' and people's psychosocial needs after disasters and major incidents;
- the public must be trusted with accurate information that is provided regularly by credible persons because they should be regarded as part of the response and not solely as part of the problem;
- services that offer psychosocial and mental health interventions should be made available to support resilience and to complement personal and collective resilience;
- it is important to take a positive and co-operative stance to responding effectively to enquiries from the media; and
- it is important to avoid the corrosive effects of rumour.

245. The plan should recognise that people who are affected by disasters and incidents may be able to function well for some time after events, but they may have greater psychosocial problems or develop mental disorders later and, sometimes, a lot later. Services should be designed to recognise these common findings by providing responses immediately after events and until families' and communities' effective functioning appear to have been re-established.

246. Continuing strategic planning is required throughout emergencies because all plans are likely to require adjustment and development in detail as incidents progress. This means that strategic and operational planning must continue throughout the response and recovery phases.

247. Developing and managing the psychosocial and mental health components of disaster and major incident plans should be the responsibility of the agencies and persons who are responsible for all of the planning and preparations for disasters and major incidents. This

means that every area should have a multi-agency psychosocial and mental health plan for all emergencies that is incorporated into the overall disaster/major incident plan and regularly updated. Existing psychosocial services should be mapped fully and incorporated into local psychosocial and mental health plans.

248. There should be explicit arrangements for designing, developing, testing, rehearsing and managing the psychosocial and mental health components of all disaster and major incident plans. Politicians, government officials and senior staff of the agencies that are to be involved should be involved in regular, realistic management training and exercises.
249. Each emergency, disaster and major incident planning team should include a senior representative of the agencies that are designated to deliver psychosocial and mental health care responses. This person should chair a multi-agency, psychosocial and mental health care expert advisory subcommittee that is appointed to advise the emergency planning committee.
250. The psychosocial and mental health care plans should be developed, managed and monitored by the psychosocial expert advisory subcommittee. The committee should include persons who have been affected by past disasters and major incidents, mental health professional practitioners and managers of mental health services.
251. Care providers (volunteers and professional practitioners) should be recruited, in advance if possible, and screened for suitability.
252. First responders are a mix of people with differing capabilities. They face differing profiles of psychosocial risk.
 - They include members of the public who are first on the scene as well as frontline rescue and emergency staff.
 - They also include staff of humanitarian aid, welfare and healthcare services, and military personnel.
 - Evidence shows that some first responders may be vulnerable to the psychosocial and mental health consequences of their involvement in disasters and major incidents while others are hardier.
253. The planning group should ensure that processes are established to monitor people who deliver care for possible secondary traumatisation and experiences of burnout. The people concerned should include volunteers.
254. All professional responders, including first responders in the police, ambulance, fire and rescue, humanitarian aid, welfare, social care and health services should work to agreed minimum standards. This requires that they should all have a basic understanding of: the psychosocial and mental health effects of disasters and major incidents on people who are directly or indirectly involved; how to assist people within the first week; awareness of the possible longer-term psychosocial, welfare and mental health consequences; and accurate information about the arrangements that are available for people who require more specialised assessment and care.
255. A training programme should be in place in every area to ensure that everyone who is involved in planning or delivering the responses to people's needs for psychosocial and mental health care is prepared for their roles and responsibilities. All staff who provide care should have basic training and receive ongoing training, support and supervision. The content and level of additional training should correspond with their roles and responsibilities in the stepped model of psychosocial and mental health care.

256. Senior trained and experienced members of the staff of the social and mental health care agencies should be appointed as formal advisers to commanders and managers at the strategic, operational and tactical levels during:

- planning, training and rehearsal;
- execution; and
- review of plans and regeneration after events.

This role requires:

- clinical skill and training in disaster psychosocial and mental health care;
- awareness of the concepts and practices of strategic leadership and management; and
- training in decision-making, consultation and supervision.

Regional Major Incident Psychosocial Resilience and Mental Health Service Development Teams

Outline Roles of the Teams

257. The Strategic Health Authorities should develop plans and ensure that staff are trained to offer psychosocial and mental healthcare services in their areas in response to disasters and major incidents. This guidance recommends that they should consider drawing together suitably skilled and experienced practitioners, researchers, and managers to create regional teams to advise and assist them in implementing this guidance. The SHAs may wish to consider including an ethicist with their teams as inclusion of a person with skills of this nature is seen as an advantage.

258. These multi-disciplinary teams should be composed of clinical staff and managers. These teams should have responsibilities for advising on strategy and local implementation. Therefore, they should have members who are fully conversant with the requirements and challenges of mounting operational services and practised in delivering psychosocial and mental health care after disasters and major incidents.

259. The intention of the Department of Health is to create across England a network of regional teams that have the ability and expertise that is required to inspire the development of local capacity and capability. In this way, each team should be known to each other team. Their core objectives are to offer:

- advice on regional strategy;
- advice on standards and their interoperability;
- a regional lead on developing services;
- the capacity for cross-regional mutual aid and support in the event of large-scale incidents;
- communication with more distant areas from which at least some affected persons may come in order to ensure that psychosocial and mental healthcare services are available in the medium and long-terms close to where people live; and
- consultation and advice.

Achieving the Team's Objectives

260. It is not the intention of this guidance to prescribe how the teams that are recommended in this chapter are created or composed. Some regions may, for instance, choose to recruit suitable people to form an expert panel whereas others may wish to allocate specific tasks and activities to identified persons while others still may wish to consider constituting some form of standing resource. Neither is it intended that the Regional Teams should be large groups that also provide the operational services that are likely to be required by people who are involved in or affected by disasters. This guidance takes the view that how the teams are created and how they do their work is a matter for regional discretion.
261. It is essential that the clinical members of each team should be skilled in trauma-focused assessments and interventions and enabled to maintain those skills. The Regional Teams should be available to advise local services and NHS organisations within the regions on their implementation of this guidance. Thus, the core intention of this guidance is that certain functions are achieved by the Regional Teams and this requires that their members know each other, have confidence in each other's knowledge and skill and that they, therefore meet at suitable intervals.
262. The intention of this guidance is that the Regional Teams should be a strategic, service developmental, advisory and training resource that are led by function rather than structure. Therefore, the remainder of this chapter provides more information on the roles that are envisaged for the teams that are described in outline here.

The Roles and Responsibilities of Teams

263. The strategic responsibilities of the Regional Teams should include the following capabilities.
- Preparing and training staff to deliver real-time strategic and operational advice on the psychosocial and mental health aspects of disasters and major incidents of all kinds to the commanders of the responses to those incidents at the strategic, tactical and operational levels (often referred to as gold, silver and bronze levels).
 - Providing real-time and authoritative advice to responding agencies about their delivery of effective responses to the psychosocial and mental health needs of affected populations.
 - Advising local agencies and services on the development of effective plans for responding to the psychosocial and mental health aspects of disasters and major incidents of all kinds that are fully integrated with the major incident plans for each agency and area.
 - Advising local agencies and services on their development of effective plans for developing the psychosocial resilience of communities.
 - Advising local agencies and services about developing and executing effective public communication strategies that relates to the risks of disasters and major incidents and the ways in which the public are advised to respond to them.
 - Developing relationships with all category one and category two agencies in their area of responsibility with the intention of promoting integration of responses to the psychosocial and mental health needs of affected populations of people with the major incident plans for the same populations.
 - Providing advice to all category one and category two responders about how best to integrate humanitarian aid and welfare service responses to disasters and major incidents with effective responses to the psychosocial and mental health needs of affected populations.

- Acting as strategic communication hubs that are able to interact with the other Regional Teams with the intention of promoting better medium and long-term responses to the needs of populations that have been affected by disasters and major incidents and who may come from other regions in England and especially so in circumstances in which affected populations may come from dispersed areas across the UK.
- Providing training on the potential psychosocial and mental health aspects of disasters and major incidents for:
 - commanders of the responses to major incidents at all levels;
 - emergency planning staff;
 - selected staff of category one and category two responders;
 - selected staff of services that are designated as providing humanitarian aid and welfare services in response to disasters and major incidents;
 - selected staff of social care and education services;
 - staff of primary care teams and general practitioners; and
 - staff of specialist mental health services.
- Providing advice on the potential psychosocial and mental health implications of disasters and major incidents for the staff of the NHS and, in particular, advising the human resources departments of the responding agencies and managers of the staff who are involved in responding to emergencies.
- Providing training on how best to respond to the potential psychosocial and mental health implications of disasters and major incidents for the staff of category one and category two responding agencies and their needs.
- Providing advice to agencies within their regions on researching the psychosocial and mental health impacts on affected populations.
- Providing advice to agencies within their regions on the ethical considerations relating to service delivery in response to disasters and major incidents and on researching affected populations.

Developing and Delivering Psychosocial and Mental Health Services for People who are Affected by Emergencies, Major Incidents and Disasters

The Scope of this Chapter

264. This chapter deals with, mainly, operational matters that relate to implementing the strategic stepped model of care.
265. By no means does it cover all aspects of operational leadership and management of the NHS contribution to delivering cross-sectoral and comprehensive services for people who need them as a consequence of their direct or indirect involvement in major incidents, disasters or other emergencies. Still less does this guidance provide a clinical guideline, guidance on best clinical practice, or a clinical vade mecum.
266. Rather, this chapter provides a resumé or summary of a selection of matters that are of signal importance to designing, commissioning, and delivering the NHS components of services that are required. Therefore, it summarises:
- an approach to responding to people's needs that is based on the concepts of psychological first aid;
 - screening and triage;
 - programmes of care - this section provides:
 - an approach to systematising programmes of care that identifies interventions as universal (for the whole population at risk), selective (for people who are vulnerable or at particular risk), and indicated (for people who have already developed problems and mental disorders); and
 - a brief description of the broad composition of certain interventions; and
 - specific components of responses that are required to meet the needs of people who are affected within certain timeframes that are drawn from wide experience.
267. So far as is possible, the contents of this chapter are based on recent evidence.

The Psychosocial Approach and Psychological First Aid

268. It follows from the psychosocial approach that is at the core to the philosophy of this guidance that all actions, interventions and other service responses provided for people in preparation for, during, and after major incidents and disasters should promote:
- a sense of safety;
 - connectedness;

- calm; and
- hope.

They should empower individual persons and communities to take their own appropriate action. They should also deal explicitly with people's human rights, and facilitate appropriate communal, cultural, spiritual and religious healing practices.

269. Responses should also provide:

- general support;
- social support, physical support and psychological support for all of the people who are involved, as individuals, and as family and community groups; and
- access to humanitarian aid, welfare services, financial services and legal advice,

270. Responses should focus on families. This means enabling people who are involved to contact their families, and re-uniting families as soon as possible

271. The psychosocial approach also means that local community leaders, who are aware of local cultures and particular communities, should be involved in local groups for planning psychosocial and mental health care responses and that efforts should be made to identify the most appropriate supportive resources (e.g. families communities, schools, friends, workplaces, leisure groups etcetera).

272. Responses should include education services that are intended to promote awareness of how people react to disasters and major incidents and how to manage their reactions. Furthermore, making arrangements for children to return to school, when it is safe to do so, even if in temporary facilities, is usually an extremely important part of recovery plans that are based on the psychosocial approach.

273. Memorial services, and cultural rituals should be planned in conjunction with the people who have been affected.

274. Psychological first aid (PFA) lies at the core of the psychosocial approach. PFA is not a single intervention or treatment; it is a group of responses that are designed to respond to people's psychosocial needs after major incidents or disasters, whether or not those needs arise from ill health provoked by, or exacerbated by events or otherwise, which comprises of a number of element.^{39 40} It applies to staff as well as to people who are directly affected and to their families.

275. PFA is the part of the psychosocial approach that is intended to reduce people's initial distress in the immediate aftermath of traumatic events, foster adaptive functioning and help them to begin the process of recovery. PFA underpins all levels of care that are described in the NATO/EAPC model and the strategic, stepped model of care that is described in this guidance. A summary of its main components can be found in the NATO/EAPC guidance as Figure 19 on page 91. PFA is, therefore, also commended as being at the core of local plans for staff care.

276. Thus, the key effects of PFA are:

- providing comfort and consolation;

³⁹ Raphael B. When disaster strikes: how individuals and communities cope with catastrophe. New York: Basic Books; 1986.

⁴⁰ Brymer M, Jacobs A, Layne C, Pynoos R, Ruzek J, Steinberg A, Vernberg E, Watson P. Psychological first aid: field operations guide 2nd edition. National Child Traumatic Stress Network and National Center for PTSD; 2006. Also at: www.nctsn.org and www.ncptsd.va.gov.

- protecting people from further threat and distress;
- providing immediate physical care;
- encouraging goal orientated and purposeful behaviour;
- helping people to reunite with loved ones;
- enabling voluntary sharing of experiences;
- linking survivors with sources of support;
- facilitating a sense of being in control; and
- identifying people who need further help (e.g. through triage).

277. A core feature of PFA relates to providing the public with timely and accurate information. Initially, the extent of the danger may not be known clearly and early information is likely to be incomplete, fragmented and even contradictory.
278. Communication of health risk is essential and it is most useful to provide consistent messages that are delivered by knowledgeable and credible people, who listen and respond to the concerns of the public. Statements should avoid the appearance of defensiveness or concealment. For example, experience from the US following 9/11, the anthrax attacks, and the sniper attacks in the Washington DC area, demonstrate the value of daily or twice daily scheduled briefings with the media and the public, even if there is no substantially new information to disseminate. Providing opportunities for people to ask questions and responding with straightforward answers is an important factor in building confidence and trust in the public.
279. Ørner R & Schnyder U (2003) summarise an approach to holistic responses to people after incidents and their list contains the main components of PFA.⁴¹ It is reproduced in as Figure 19 in the NATO/EAPC guidance.
280. Figure 19 in the NATO guidance also illustrates the impossibility and inadvisability of separating psychosocial care and interventions from all other responses, at least in the immediate response phase, because the concepts that underpin them are intertwined.
281. The principles and techniques of PFA meet four basic standards. They should be:
- consistent with research evidence on risk and resilience following trauma;
 - applicable and practical in field settings;
 - appropriate for developmental levels across the lifespan; and
 - culturally informed and delivered in a flexible manner.
282. The psychosocial approach, and, within it, PFA, can be taken as the core elements of an overall approach that brings together sectors and agencies that are given statutory, or mandatory status by the Civil Contingencies Act 2004 and duties that are adopted voluntarily by the same and other agencies. However, it follows from the analysis of the roles of the NHS that is covered in a previous chapter (on Cross-sectoral and Interagency Roles, Responsibilities, Planning and Service Delivery) that implementing such a psychosocial approach falls to the sectors and agencies together.

⁴¹ pages 269-270 in Ørner R & Schnyder U. *Reconstructing early intervention after trauma: innovations in the care of survivors*. Oxford: Oxford University Press; 2003.

283. By inference, the psychosocial approach and the strategic, stepped model of care recommended in this guidance implies that first responders and rescuers are also the people who provide the initial psychosocial responses that are vital in the immediate aftermath of major incidents. They, therefore, require awareness raising, basic training and supervision in order to recognise and discharge these wider roles.

284. An earlier chapter conceived that people are likely to fall into four main groups on the basis of how they respond psychosocially to major incidents and disasters. Those groups are:

Group 1: Resistant people who show transient distress

Group 2: Resilient people

Group 3: People who have more sustained or persistent distress associated with dysfunction and/or impairment

This group includes:

- people who are likely to recover, but whose recovery takes longer;
- people who may be in the course of developing a mental disorder.

Group 4: People who develop a mental disorder

This group includes people in those who develop a defined mental disorder in the short-, medium- or longer-terms. They require specialist assessment followed by timely and effective mental healthcare.

285. It is highly likely that people from each of these groups may seek consultation with healthcare practitioners. Thus, healthcare practitioners should have a general awareness of how people react to major events so that they are able to reassure people who consult them, but also identify their needs and distinguish people who could and should receive humanitarian aid and welfare assistance from agencies that are identified as responding to those needs in the local major incident plan from other people who also require healthcare interventions including assessment and treatment.

286. The thrust of this guidance is that the requirement on the NHS to provide assessments is most likely for people whose reactions fall into groups 3 and 4. People in those groups may also require complementary, simultaneous or sequential assistance from other agencies. In addition, the NHS has roles in contributing to prevention and risk apprehension and management within the psychosocial arena through public mental health programmes.

287. In other words, the NHS has contributions that it could, should or must make to ensure that the psychosocial approach taken in each area is comprehensive. Therefore, the sections of this chapter that follow focus more on the roles of the NHS.

Screening and Triage

Screening

288. Screening is the term used when a specific investigation is offered on a large scale to the population for tracing certain conditions at an early stage. Effective screening could promote more effective targeting of services. However, people who are responsible for planning services for communities or populations wish to avoid pathologising anticipated and transient distress and do not want to use scarce and expensive clinical resources for people who are likely to recover spontaneously or with minimal assistance. Thus, screening of people who

have been affected psychosocially by disasters and major incidents is an important consideration for planners of responses to disasters and major incidents.

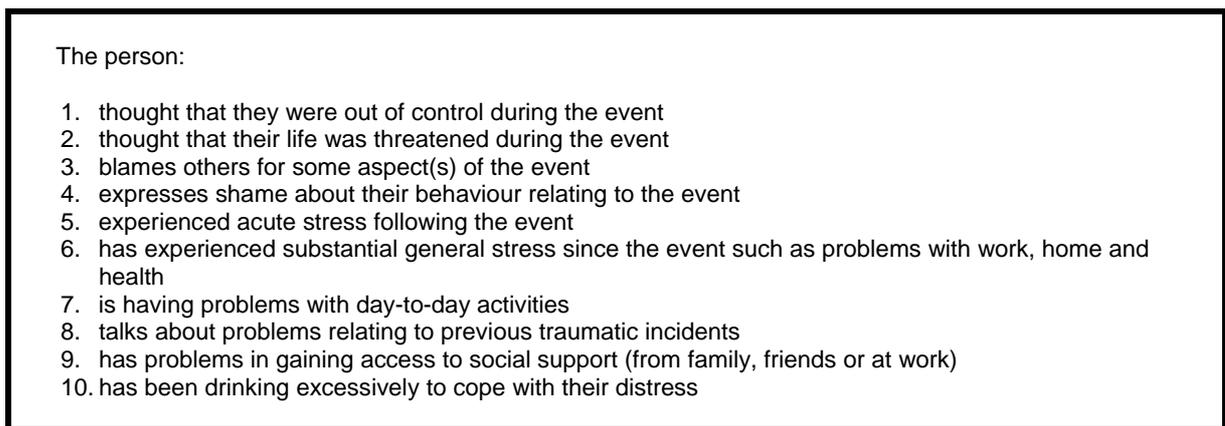
289. The conclusion of this guidance is that, at present, it is not appropriate to screen populations of people for symptoms in the immediate aftermath (days) of a disaster or traumatic event. This is because there is a lack of valid and reliable screening methods for assessing the psychosocial needs of populations of people who are affected by disasters and major incidents. Also, research indicates that levels of experiences or symptoms that are assessed as present very soon after an event do not accurately predict their future courses or their risks of developing disorders.
290. Despite the current situation, assessing people's functioning and pragmatic needs is the basis for knowing how and when to provide assistance. A balanced view is that the primary goals of screening in the first two weeks are to identify from within the groups of people who have been directly exposed to traumatic events:
- the few people who may need emergency hospitalisation or immediate referral to a mental health service (less than one person in every 1,000 in the first week); and
 - people and groups of people who are at elevated risk for developing disorders over time.
291. It is important to be sensitive to people's unique experiences so as to maximise the acceptability of screening and their engagement for further follow-up. Additionally, developmental and cultural matters must be addressed in setting up screening protocols.
292. All assessments should be practical, achievable, and implementable at the local level, and informed by an entire system of care. Therefore, it is best to put systems in place prior to an incident, with planning being coordinated at appropriate, international, national, regional and local levels. Brewin has published a review of screening instruments.⁴² Recent evidence has enhanced the weight that should be afforded to cultural factors and other platforms for understanding people's experiences after disastrous events.
293. Research after several terrorist events, including those that took place on 9/11 2001, suggests that survivors who were directly involved insofar as they were at risk of loss of life or limb may have been underserved in respect of assessment, referral to specialist services and subsequent monitoring. Two goals emerge from the research: (a) responding to people's immediate and short-term needs; and (b) responding to the needs of people who have persistent symptoms that suggest possible psychopathology. The screen and treat model that was set up after the London bombings in 2005 focuses on the latter through identifying, following up and screening all trauma-exposed persons to determine who develops persistent psychopathology and, then, arranging evidence-based interventions. The London model involved establishing a central programme to identify all of the people who were affected, screen them for mental disorders using validated measures, refer them for evidence-based treatment if appropriate, and monitor outcomes using standardised instruments.⁴³
294. In essence, the screen and treat model proposes that: (a) immediate intervention is restricted to providing information, psychosocial support, psychological first aid, and education rather than crisis counselling; and (b) people who are involved should be followed up to detect people who have persistent symptoms who can be treated with empirically supported interventions. This approach is adopted in the model of care in this guidance, with the addition that the people who are followed up should be those who experience distress that has not diminished despite adequate humanitarian and welfare aid or who show dysfunction.

⁴² Brewin CR. Systematic review of screening instruments for adults at risk of PTSD. *Journal of Traumatic Stress* 2005; 18:53-62.

⁴³ Brewin CR, Scragg P, Robertson M, Thompson M, d'Ardenne P, Ehlers A. Promoting mental health following the London bombings: a screen and treat approach. *Journal of Traumatic Stress*, 2008; 21(1):3-8.

295. There are several psychosocial assessment programmes that can be provided by non-healthcare staff who have been trained to assess how people are dealing with their experiences at the time and for a month or so afterwards.
296. There is an international consensus that how people progress during the first month provides important information for predicting the prognosis of the psychosocial effects of traumatic events on particular people. This premise is the basis for the approach adopted by Trauma Risk Management (TRiM) programme that is being adopted in the UK's armed services.⁴⁴ Reference to this programme is not included to suggest that the NHS should necessarily adopt it as a screening programme; but, it is an example of the feasibility of employing trained volunteers rather than healthcare staff.
297. Figure 9 lists the 10 risk factors that are assessed by military personnel, who are appointed, after training, as TRiM practitioners, during small group or personal interviews three days after a single-event trauma. The personnel make comparative assessments by rechecking these risk factors 28 days later. In this way, they monitor each person's trajectory of response. Those appointed as practitioners do not have to be members of the armed forces healthcare or psychological professional services, but are selected from within military units and provided with a three-day training course.

Figure 9: Risk factors (From TRiM)



298. TRiM practitioners assess distress (or stress which is item 6 in Figure 10) on the basis of the 10 items in Figure 10. Having more than transient problems with sleeping, significant use of alcohol and lack of access to, or use of available supporting social relationships are indicators for concern and particularly so if those findings are recurrent.

⁴⁴ Greenberg N, Cawkill P, March C, et al. How to TRiM away at post traumatic stress reactions: Traumatic risk management – now and the future. J R Nav Med Serv 2005; 91:26-31.

Figure 10: Indicators of stress (From TRiM)

- The person:
1. Has upsetting thoughts or memories about the event that come into mind against the person's will
 2. Has upsetting dreams about the event
 3. Acts or feels as though the event is happening again
 4. Feels upset by reminders of the event
 5. Has bodily reactions when reminded of the event
 6. Has difficulty falling or staying asleep
 7. Is irritable or has outbursts of anger
 8. Has difficulty concentrating
 9. Is overly aware of potential dangers to self or others
 10. Is jumpy or is startled at something unexpected

Triage

299. As well as providing information in the immediate aftermath and acute phases, rescuers, staff of the emergency services, trained volunteers, humanitarian aid and welfare workers, and healthcare staff have roles in psychosocial triage.
300. This is, above all, a matter of identifying affected people who have mental disorders or serious clinical symptoms that require further assessment, diagnosis and/or treatment. Initially, psychosocial triage, is based on the judgement of volunteers and professionals involved in rescuing people, and on primary and secondary level practitioners, but, also, on the judgement of the affected persons themselves. Psychosocial triage should also take place at a later phase when, for example, a person who has been affected consults a care giver.
301. Psychosocial triage that is conducted outside the first two weeks after an incident should distinguish the following groups of people.
- Affected people who do not have mental disorders or serious clinical symptoms - this is likely to be the largest group.
 - Affected people whose experiences and symptoms are thought as possibly indicating that they have serious clinical symptoms that might amount to mental disorder - information and advice should be given to people in this group and, in addition, practitioners should arrange follow-up meetings with the people affected.
 - Affected people who have mental disorders or serious clinical symptoms, for whom appropriate diagnosis and treatment should be offered straightaway.

A System for Describing Programmes of Healthcare

302. The programmes for the care that is required are categorised as:
- universal programmes;
 - selective or targeted programmes; and
 - indicated programmes.
303. Universal programmes are the interventions that should be available to communities before a major incident and everyone who has been directly and indirectly involved in a major incident, including responders, irrespective of whether they develop a mental disorder.

304. Targeted programmes are offered to a group of people who are selected on the basis of readily ascertained information about the risks they are running for developing adverse outcomes and, particularly, mental and other disorders, on the basis of what is known about their resilience and their potential for developing more sustained distress or a disorder.
305. Indicated interventions are made available to people who have developed substantial levels of distress, and, particularly, if their distress is more sustained or associated with dysfunction, or a disorder or comorbid disorders.
306. A guideline for early psychosocial interventions after disasters, terrorism and other shocking events is provided by IMPACT.⁴⁵
307. Universal programmes should be offered unselectively to everyone who is in the relevant population. Provision of the two other categories of programmes is based on selection. Usually, selection for targeted programmes is conducted on the basis of apprehending the risks that particular people or groups of people are running: whereas offers of access to indicated programmes are based on assessment of personal need.

Universal Programmes

308. Approaches to developing psychosocial resilience fall into two broad categories:
- general interventions; and
 - disaster and incident specific interventions.
309. Universal programmes that fall into the first of these categories, the general one, include:
- programmes that are aimed at developing and sustaining community resilience;
 - general responses that offer interventions that are based on the basic principles for promoting personal resilience and recovery.
- Programmes in the universal category include, therefore, a wide range of mental health promotion programmes.
310. There is no evidence that formal psychosocial interventions that are targeted at everybody involved in traumatic events are effective. However, immediate practical, social and emotional assistance is widely agreed as being important. Such support is likely to be primarily provided by families, friends and communities, but all emergency responders should have the basic ability to:
- respond to traumatised people;
 - promote resilience and recovery;
 - provide immediate practical, social and emotional support; and
 - identify people who require more specialised attention.

Basic Principles for Promoting Resilience and Recovery

311. Research and experience in the last decade has suggested better ways to promote people's resilience and recovery. They are represented by three levels of intervention:

⁴⁵ ICT. Multidisciplinary Guideline: Guideline for Early psychosocial interventions after disasters, terrorism and other shocking events. Amsterdam: IMPACT; 2007.

- individual persons;
- families; and
- communities including workplaces and schools.

312. Depending on the nature of an incident, some of the sociological features of good healthcare practice may be sustained and accentuated while others may have to be modified or even curtailed. The Johns Hopkins model considers that resistance and resilience are facilitated by expectancy and experience and its four strategies are:

- providing realistic preparation;
- fostering group cohesion and social support;
- fostering positive cognitions; and
- building self-efficacy and hardiness.⁴⁶

313. The model anticipates that certain mechanisms may need to be put in place to enhance resilience. The measures that underpin the proposed model are:

- providing credible and competent leadership that is perceived as such;
- setting appropriate anticipatory guidance and expectations;
- providing realistic training;
- identifying common purposes;
- identifying a higher ideal;
- providing orientation to the impact and acute phase;
- providing stress management training; and
- providing family support.

314. Following a disaster or major incident, the following steps may well be required:

- assessment of need;
- sustaining credible information flow;
- providing comfort and immediate practical help;
- reassurance for survivors and responders that their emotional reactions are understandable, given the unusual experiences they have endured;
- listening to, and absorbing people's accounts of the incident as well as helping to piece together their experiences of the disaster;
- giving information on how to deal with problems arising from the incident, for example family difficulties, travel fears, insomnia, work problems;
- working with grief and emotional responses that are precipitated by the disaster; and
- providing psychological triage to identify people who are at highest risk and assessing their needs for more formal interventions.

⁴⁶ Kaminsky M, McCabe OL, Langlieb AM, Everly GS. An evidence-informed model of human resistance, resilience and recovery: the Johns Hopkins outcome-driven paradigm for disaster mental health services. *Brief Treatment and Crisis Intervention Advance Access* originally published online on December 7, 2006. *Brief Treatment and Crisis Intervention* 2007 7(1):1-11; doi:10.1093/brief-treatment/mhl015

315. The NHS has contributions that it should make to working with its partner organisations in other sectors to delivering functions that are summarised in the two previous paragraphs.
316. The model proposed here is consistent with these recommendations, but it has the advantage of incorporating endeavours to promote resilience and rapid recovery into a stepped model of activities that does not identify anyone as having a problem until such a time as that is necessary and helpful.
317. However, there is no evidence that providing formal interventions for everyone who is involved in traumatic events are effective at reducing initial distress or preventing the development of more serious conditions. Moreover, their introduction may impede the natural healing and recovery of persons, families and communities.

Selective or Targeted Programmes

318. Selective or targeted programmes include:

- psychological first aid; and
- peer support.

Psychological First Aid

319. This guidance has described PFA as an evidence-informed approach that is designed to reduce the initial distress caused by traumatic events and to foster short- and long-term adaptive functioning and coping. However, it is also referred to by some authorities as a particular intervention or programme of interventions. Therefore, PFA is both a description of a universal approach to providing psychosocial support for many people who are affected by major incidents and disasters, but also it can be taken to describe the basis for structuring common interventions for people who may be at greater risk after major incidents and particularly for those people whose distress does not appear to diminish quite soon after events.
320. The importance of PFA is that it does not assume that all survivors develop mental health problems, more serious disorders, or long-term difficulties in recovery. Instead, it is based on understanding that survivors of disasters, and other people who are affected by major incidents, experience a broad range of early reactions (for example, physical, psychological, behavioural, and spiritual). Some of these reactions cause enough distress to interfere with adaptive coping, and people's recovery may be helped by support from compassionate and caring responders.
321. Most people require responses that are guided by the broad approach that constitutes PFA. However, when people appear to continue to be distressed after general interventions, it is often appropriate to review their circumstances with them more formally using items from the kind of list that appears in Figure 19 of the NATO guidance as the basis for semi-structured interviews in order to ensure that key items have not been overlooked. These assessments are most often conducted by non-healthcare agencies. However, awareness of PFA and its constituents are likely to be helpful to practitioners in primary healthcare when they assess people after emergencies, major incidents and disasters.
322. In addition, PFA, using the term in its more formal sense, is manualised for children.⁴⁷ The approach is suitable for children and adolescents, adults, older adults, survivors who have

⁴⁷ Brymer M, Jacobs A, Layne C, Pynoos R, Ruzek J, Steinberg A, Vernberg E, Watson P. Psychological first aid: field operations guide 2nd edition. National Child Traumatic Stress Network and National Center for PTSD; 2006. Also at: www.nctsn.org and www.ncptsd.va.gov.

disabilities, families and also for responders and other staff. According to the manual, the basic objectives of PFA are to:

- establish a human connection in a non-intrusive, compassionate manner;
- enhance immediate and ongoing safety, and provide physical and emotional comfort;
- calm and orientate emotionally overwhelming or distraught survivors;
- help survivors to tell others specifically about their immediate needs and concerns and gather information as appropriate;
- offer practical assistance and information to help survivors to address their immediate needs and concerns;
- connect as soon as possible survivors to social support networks including family members, friends, neighbours and community resources;
- support adaptive coping, acknowledge coping efforts and strengths, and empower survivors;
- encourage adults, children and families to take an active role in their recovery;
- provide information that may help survivors to cope effectively with the psychosocial impacts of disasters; and
- be clear about the availability of responders who are able to help and, when appropriate, link survivors with disaster response teams, local recovery systems, mental healthcare services, other public-sector services and other relevant organisations.

Debriefing and Peer Support

323. An important question is whether or not people who are affected by major incidents and disasters and responders should be offered routinely Critical Incident Stress Debriefing (CISD).⁴⁸ This intervention became particularly popular in the 1980s and 1990s. Initially, it was intended as a group intervention (but not a treatment) for emergency service personnel. The aim of its originators was to reduce distress and to provide prophylaxis against longer-term mental disorders. Since then, however, evidence has called its psychoprophylactic value into question. Moreover, according to the NICE Guidelines for PTSD, one-off debriefings that focus on people's emotional experiences are contra-indicated. Proponents of CISD have challenged the legitimacy of some of the evidence that has been used to question the value of CISD.
324. The position taken by this guidance in respect of routine practice is that it is not advisable to provide a single-session intervention that focuses on people's emotional reactions to the events in which they have been involved. This is because forcing people to revisit their experiences in memory, when they are not ready so to do, risks re-traumatising them and it may obstruct the benefits to them of receiving social support from other persons.
325. However, it is important to be clear that this statement does not mean that voluntary and less formal discussion should not take place within the context of families, peers, schools, workplaces and community facilities and groups. The people who offer this form of peer support should be aware of, and able to intervene in response to the incipient or actual mental health problems that go beyond anticipated reactions or those which represent anticipated reactions that do not resolve. These opportunities are important and some sources, perhaps confusingly, refer to them as 'natural debriefing' rather than peer support.

⁴⁸ Mitchell JT, Everly GS. *Critical incident stress debriefing: CISD*. Ellicott City: Chevron Publishing; 1995.

326. Furthermore, the caution about CISD expressed here does not mean that responders and other rescue services staff should not engage in reviewing, auditing and learning from how their services performed. This type of review might be termed technical, operational or managerial debriefing and its adoption is good practice.

Indicated Programmes

Access to Primary and Secondary Healthcare Services

327. General practitioners and local doctors should be made aware of possible psychosocial experiences and psychopathological consequences because they should be directly involved in delivering the first level of formal mental health care.
328. Responding organisations should provide access to specialist psychological and mental health assessments, intervention and management when they are required.
329. Detailed planning should occur with existing NHS services and local authorities about delivering the mental healthcare contributions within the psychosocial and mental health plan. This should include consideration of funding for providing appropriate augmentation of local services for several years following a large disaster or major incident that has affected the local population.

Specific Services

330. The paragraphs that follow present the core principles for intervention from an NHS perspective against a timeline that covers, in sequential sections, the first week, the first month, one to three months and beyond three months after a major incident.
331. These time domains are not hard and fast; rather they are indicative and intended to offer a framework for planning, training, and service preparatory purposes. They should be interpreted in the light of what is known about the nature of events, the people who are involved and the needs of people who are affected.
332. Earlier, this guidance referred to primary and secondary stressors. Primary stressors are inherent in particular major incidents, disasters and emergencies whereas secondary stressors follow from and are consequential on what has taken place. Often, they involve dislocation of transport systems, problems with buildings and structures, and impacts on services. All too frequently, they stem from problems that people face in the recovery phase.
333. Experience shows that the occurrence of substantial numbers of secondary stressors may lengthen the time of impact of any major incident and disaster, but also produce continuing distress and greater risk of people developing mental disorders. Thus, in the case of flooding, for example, that involves people's homes and workplaces, the primary stressor is evident, but people's lengthy displacement from their homes and the stress involved in rebuilding them may create grave secondary stress over lengthy periods. In these circumstances, it is not surprising to find that the timelines that are used as guides in the following paragraphs become stretched. Another way of putting this is to say that secondary stressors may sustain people's distress for longer periods than are indicated below.

Specific Components of the Initial Responding Services that are Required within the First Week of a Disaster or Major Incident

334. The initial responses that are required by many people who are affected by major incidents and disasters include practical help and pragmatic support provided in an empathic and flexible manner.
335. Information regarding the situation and people's concerns should be obtained and provided for them in an honest and open manner, and at levels that they can understand.
336. Written leaflets containing appropriate information and where to seek help, if necessary, should be provided, but they must be tailored to the average reading comprehension age of the general community. This also means that written materials cannot be relied on and neither should they be the main form of communication given the levels of problems with literacy and reading comprehension that are evident in even the most developed of societies.
337. Therefore, telephone helplines should be launched that are staffed by trained personnel, to provide emotional support. Additionally, disaster and major incident plans should include arrangements for preparing websites concerning humanitarian, welfare and psychosocial matters. The latter should only be made available when they are actually required, and must be continually updated to suit rapidly changing circumstances.
338. Humanitarian assistance centres or one stop shops should be established at which are based an appropriate range of the humanitarian aid, welfare and psychosocial care services that are potentially required.
339. Psychosocial reactions should be anticipated and considered normal during initial responses to disasters and major incidents. People should be neither encouraged nor discouraged from giving detailed accounts; they should provide them if and when they feel ready to do so. The evidence shows that, usually, people who are involved prefer to talk to people who they know well including, particularly, relatives, friends and colleagues at work.
340. Staff who oversee the initial psychosocial care response services should work closely with the media.

Specific Components of the Responding Services that are Required within the First Month of a Disaster or Major Incident

341. While stress is to be expected, people who have high levels of distress, and especially people who have dysfunctional levels of distress, or distress of longer duration, during the first month after a disaster or major incident should be identified so that the services are able to maintain contact with them. This means, for example, that further contact should be offered to people who are distressed for more than a fortnight and to their families.
342. Formal assessment should be made of the needs of people for health and/or social care services who have unwelcome, and distressing psychosocial experiences or problems that do not resolve given adequate humanitarian aid, welfare services and social support from their families and communities. It should cover people's emotional, social, physical, and psychological needs. Any psychological or psychiatric interventions of a more formal nature should be offered on the basis of people's assessed and agreed needs.
343. While NICE recommends a period of observation and assessment for most people who have high levels of distress, treatment with Trauma Focused Cognitive Behavioural Therapy (TF-CBT) should be available for people who are assessed as having stress-related disorders.

That and other evidence-informed interventions should be available for people who are assessed as having other mental disorders.

Specific Components of the Responding Services that are Required One to Three Months after a Disaster or Major Incident

344. Further contact should be offered to people and their families who continue to experience distress at any substantial level that continues for more than a month or who are dysfunctional on account of distress a month or more after events.
345. This requires professional practitioners within services, including primary healthcare and the social care and voluntary sector services, to:
 - maintain contact with people who have high levels of distress within three months of a disaster or major incident so that their needs can be identified;
 - offer formal assessments to people who have high levels of distress or psychosocial problems that continue or develop a month or more after a major incident or disaster.
346. Formal assessment should be made of the needs of people for health and/or social care services who have unwelcome, and distressing psychosocial experiences or problems that do not resolve given adequate humanitarian aid, welfare services and social support from their families and communities. It should cover people's emotional, social, physical, and psychological needs. Any psychological or psychiatric interventions of a more formal nature should be offered on the basis of people's assessed and agreed needs.
347. Treatment with TF-CBT should be available for people who have post-traumatic stress disorder because it is the treatment of choice. However, other treatments for post-traumatic stress disorder with a supporting evidence-base such as Eye Movement Desensitisation and Reprocessing (EMDR) and stress management should be available for people when TF-CBT is not available or is not acceptable to them. Similarly, evidence-informed interventions should be available for people who have other mental disorders.

Specific Components of the Responding Services that are Required beyond Three Months after a Disaster or Major Incident

348. People who have substantial psychosocial problems that continue or develop three months or more after a major incident or disaster should be formally assessed by professional practitioners. Assessment should take place before any specific intervention is offered and consider people's emotional, social, physical, and psychological needs.
349. Evidence-informed interventions should be available for people who have mental disorders. Additionally, work and rehabilitation opportunities should be provided to enable people who require them to re-adapt to the routines of everyday life.

Managing Mental Healthcare for People who are Affected by Emergencies, Major Incidents and Disasters

General Principles

350. Managing the stepped model of care that forms the core of this guidance, requires effective command, control and coordination before, during and following a disaster or major incident.
351. Appointing psychosocial and mental health trained advisers at the strategic, tactical and operational levels of command is likely to ensure that the better integration of the services that are designated within disaster and major incident plans to respond to the psychosocial and mental health needs of individual people, families and communities.
352. The responsible authorities, incident response commanders, service managers and professional practitioners should adopt an ethical framework for planning and delivering services, and also a framework for good decision making. Such a framework is provided by the ethical principles developed by the UK Committee on the Ethical Aspects of Pandemic Influenza (CEAPI).⁴⁹
353. Commanders should ensure that appropriate services are made available according to need in each phase of response and recovery and this requires services that offer:
- immediate humanitarian aid and welfare services for everyone who needs them;
 - recognition of the responses of individual people, and recognition that the intensity and duration of people's exposure to stressors, certain prior experiences, and the availability or otherwise of social support are related to their likelihood of developing more serious psychosocial problems or mental disorders;
 - long-term and persistent follow-through; and
 - care for responders.
354. The responsible authorities, incident response commanders, service managers and professional practitioners should adopt pre-planned frameworks for both corporate governance and clinical governance.
355. Execution of psychosocial and mental health care plans depends on effectively managing and caring for staff. Staff and agencies should be provided with clear plans that state the expectations that are likely to fall on them.
356. Staff and agencies should be given opportunities for training and rehearsal in order to execute these plans, and should be given increased supervision and support in the event of these plans being actioned.

⁴⁹ http://www.dh.gov.uk/en/Publichealth/Flu/PandemicFlu/DH_065163

357. This means that all rescuers, responders and other staff involved should have defined roles and responsibilities agreed in advance that are clear, practical and realistic, and that these roles and responsibilities have expectations that meet professional standards of care and responsibility.
358. All rescuers, responders and other staff involved should have effective leadership and be able to gain access to the support of their colleagues.

Developing Services to Implement This Guidance

359. The lessons learned from the Severe Acute Respiratory Syndrome (SARS) near-pandemic in 2002-2003 provide a good example of the range of services and actions that are required to mount a substantial response to the psychosocial and mental health needs of affected people. In particular, the lessons suggest that the following are key elements.
- Consultation with and involvement of each community in achieving collective preparedness.
 - Planning the contributions of the health and social care systems to disaster responses and major incident plans.
 - The education and school systems, employers and welfare organisations in each area are involved in achieving preparedness.
 - Consultation and advice on managing the psychosocial consequences is provided by trained and appropriately qualified people for:
 - leaders at all levels;
 - first responders;
 - health and social care providers;
 - people who are required to manage the behavioural and psychosocial responses of groups of people to health interventions for populations; and
 - staff who brief and work with the media and other communication systems.
 - Attention is directed to developing screening so that it can be validly and reliably incorporated in the model of care as it is developed, tested and evidence of its effectiveness becomes available.
 - Triage is conducted of the people who are affected so that appropriate and needs-led services can be provided.
 - Groups of people who are at high-risk are identified for surveillance and intervention according to their needs.
 - People who develop acute and longer-term psychosocial sequelae are offered assessment to determine their needs and intervention to meet those needs.
360. Earlier, this guidance has recommended development of teams at SHA level charged with advising on and facilitating implementation of this guidance and achievement of the range of services that is required within the NHS and in the NHS working in conjunction with its partner agencies.
361. It follows from that advice and the contents of this chapter that there is much to do to develop services locally. Areas of England vary in the extent of their preparation for dealing with the psychosocial and mental health aspects of disasters. There is also the requirement to ensure that local developments complement and are integrated with recent endeavours to develop mental health services for veterans.

362. In addition, there is likely to be much to do to develop plans for psychosocial and mental health services that are integrated with local major incident plans, and tested and rehearsed. In many areas, staff require training and consideration should be given to how services of the kinds that are described in this guidance are to be developed, led, managed and delivered.
363. Across England, the PCTs, Foundation Trusts, NHS Trusts and Mental Health Trusts should give thought about how they come together to address the recommendations in this guidance. In many areas, the local health organisations may well decide that there is advantage to be gained from drawing clinical, managerial and supporting staff together into part-time teams through which service developments can be achieved.
364. Where this is the course taken, local teams should have effective and close contacts with the regional teams that are recommended in this guidance to ensure good communications between strategic, commissioning, operational, and clinical expertise with the intention of harmonising service developments across SHA areas.

Information-gathering, Research and Evaluation

General Principles

365. Information-gathering, research and evaluation are vitally important if lessons are to be learned from clinical practice in disasters and major incidents that will contribute to saving lives, minimising suffering, and reducing risks to staff in subsequent emergencies, disasters and major incidents.
366. There is a particular requirement to agree, internationally, definitions of what constitutes and differentiates information-gathering, research, evaluation and monitoring as applied to psychosocial and mental health intervention programmes.
367. Well-designed and well-conducted information-gathering, research and evaluation should:
- clarify the intentions, design, and effective conduct and delivery of specific programmes;
 - be beneficial to the communities served by the programmes that are being evaluated;
 - promote effective practice by the staff of programmes; and
 - reinforce fidelity of programme delivery with what is required by the populations involved and the intentions of the programmes' designers.
368. The experiences and findings gained by all who are involved in conducting research and evaluation should be used to develop curricula for training relevant people in the skills of designing and delivering services and interpreting the findings of evaluations of psychosocial care and adapting them to local situations.
369. Plans made for information-gathering, research and evaluation should be made beforehand and deal with the pressures that services may be under during a disaster or major incident and the restrictions that researchers face in meeting methodological standards in these circumstances.
370. Well-designed and well-conducted information-gathering, research and evaluation should be conducted according to overt, transparent, acceptable and agreed ethical standards. Ethical procedures and standards should not be compromised.
371. Therefore, it is important to:
- design information-gathering, research and evaluation programmes from the beginning (i.e. from the time when each major incident plan is being designed, developed, tested and rehearsed); and
 - base the process of designing and implementing research and evaluation on agreed guidelines.

Research and Knowledge Development

372. It is important that the Regional Teams are able to advise other agencies about research on the psychosocial and mental health aspects of disasters. Additionally, their training and advisory roles depend on their staff being as up-to-date as possible on the evidence relating

to the psychosocial and mental health needs and best practice in responding to caring for people who are involved in or affected by disasters and major incidents.

373. Therefore, each Regional Team should develop and maintain good relationships and ease of access to suitable academic departments in the higher education institutions and with professional standard setting bodies (e.g. the medical Royal Colleges [and particularly, the Royal College of Psychiatrists], the British Psychological Association, the British Association of Social Workers etc, etc).

Evaluation

374. The Operating Framework for the NHS for 2009/10 established that one of the five national priorities for the NHS remains:

“ ... preparing to respond to a state of emergency, such as an outbreak of pandemic influenza ...”

In the section on emergency preparedness, the Operating Framework states:

“PCTs should work with NHS organisations, other contracted healthcare providers, local authorities and other local organisations to put plans in place to enable an effective response to major incidents, such as train derailments, natural disasters, terrorist attacks, or public health incidents. In addition, PCTs, together with local partners, were required to produce robust pandemic influenza plans by December 2008. During 2009/10 and beyond, these plans must be tested, reviewed and improved, as appropriate, to take account of lessons learned and of developments in the national arrangements for pandemic influenza preparedness”.

375. It is intended that this guidance will assist PCTs and the other NHS organisations to achieve what is required by the Operating Framework with respect to planning for and being able to deliver the NHS responsibilities within the wider strategic framework for responding to the psychosocial and mental health needs of people who are affected by emergencies, major incidents and disasters.

Organisational and Workforce Development

Organisational Development

Building Service Capacity and Capability

376. Every NHS organisation should have a major incident plan that makes provision for a fully coordinated and integrated psychosocial and mental health service response to emergencies, major incidents and disasters. The psychosocial and mental health service component of this plan should include, at least, each of the three following elements.
- Its development should be undertaken and monitored by a multi-agency psychosocial expert advisory committee that should include mental health professionals.
 - All rescuers, responders and other staff involved should have clear roles and responsibilities that are agreed in advance and they should be provided with appropriate training and supervision to undertake their roles.
 - All appropriate front-line agencies should provide a lead on psychosocial matters in the early stages of the response to a disaster as well as planning and delivering psychosocial care interventions in the aftermath of a disaster or traumatic event.
377. While it is not possible to plan and train for every eventuality, the general principles of good psychosocial care and service organisation can be stated, planned into service contingencies, trained and rehearsed.
378. There is a particular requirement to increase public awareness, including that of the media, about the spectrum of psychosocial responses to traumatic events. Key facts to communicate widely are that routine intervention is not required for everybody, that a minority of people needs more specialised services, and that there are effective interventions available.
379. Training is highly advisable, in advance of events and major incidents, for key groups of staff such as first professional responders. It should be conducted realistically and tested through exercising the psychosocial and mental health service components required to be included in all major incident plans.
380. Responsibilities for training fall upon a wide range of staff in any organisation including general and professional managers, corporate and clinical governance managers, human resources departments, training departments, occupational health services and public relations staff. Discharging these responsibilities requires each organisation to develop a plan to coordinate their actions.
381. In particular, all mental health professionals should have a good understanding of the emerging discipline of disaster mental healthcare so as to contribute appropriately to the development of systems to cope with people following emergencies, major incidents, disasters, terrorism, and conflict.

Workforce Development and Protection

382. This chapter of the guidance has been developed from the NATO/EAPC guidance on psychosocial care for people affected by disasters and major incidents that was published in 2009.⁵⁰ That guidance can be accessed at <http://www.healthplanning.co.uk/nato>

383. This section deals with two topics:

- developing the skills and capabilities of the NHS workforce to enable staff to provide services of improving quality in response to the psychosocial and mental health needs of people who are affected by major incidents and disasters; and
- actions that should be taken by employers to sustain the psychosocial resilience of NHS staff and, thereby, to protect them and also to enable them to recover rapidly after events.

Developing the Workforce

384. This section offers frameworks that planners and agencies that are responsible for delivering services could adopt to ensure that staff who command, plan and deliver services in response to the psychosocial and mental health needs of people who are affected by major incidents and disasters receive the training that they require. It is important that their initial and continuing education are role-related if they are to function with confidence and develop, retain and enhance the capabilities that are appropriate to the jobs that they are asked to undertake.

The Essential Shared Capabilities

385. In 2004, the National Institute for Mental Health in England developed the Ten Essential Shared Capabilities for all staff of mental health services. These are also the capabilities that are required of staff in services for people who have been involved in a disaster or traumatic event. They are:

1. working in partnership;
2. respecting diversity;
3. practicing ethically;
4. challenging inequality;
5. promoting recovery;
6. identifying people's needs and strengths;
7. providing service user-centred care;
8. making a difference;
9. promoting safety and positive risk taking; and
10. personal development and learning.

386. In order to achieve these capabilities, staff require effective systems of education, mentoring and reflective supervision if they are to cope well, learn from their experiences and assist their patients maximally. The work involved in delivering the services portrayed in this guidance is stressful and demanding on the inner personal resources of the staff. It is not sufficient to create a plan to develop services. Workforce development strategies should be developed that deal with recruitment and retention of staff and their education, training,

⁵⁰ Annex 1 to EAPC(JMC)N Psychosocial care for people affected by disasters and major incidents: a model for designing, delivering and managing psychosocial services for people involved in major incidents, conflict, disasters and terrorism. Brussels: NATO, 2009.

mentoring and supervision. This also requires attention to creating the most appropriate cultures within organisations and provision of persons, facilities and resources to enable staff support and care to be offered.

Developing the Attitudes, Knowledge and Skills of the Workforce

387. Staff who deal with people who are affected by disasters require a common core of skills and knowledge. This includes:

- the procedures and steps necessary for staff to protect their own health, safety and well-being and that of their teams and the community;
- understanding about the impact of an event on their own mental health and that of their families, teams and others;
- their roles as regards communication and processes concerning response partners, media, the general public and others;
- the ability to follow procedures for assignment, activation, reporting, and deactivation;
- limits to the skills, knowledge, and abilities as they pertain to the role of their organisation;
- understanding how to support transitions;
- their role in multi-agency working; and
- their role in sharing information.

388. All of the people who work in psychosocial and mental health and related services have a potential role to play in supporting people who have been involved in a disaster or traumatic event. Many staff have the necessary competencies as part of their current role even if they require adaptation to different demands and circumstances. Others need specific training to contribute appropriately, for example by gaining competence in aspects of PFA. Commissioners and providers of education and training should consider how this might most appropriately be achieved.

389. Implementing this guidance and planning, preparation for, and delivering its stepped model of care requires a similarly strategic stepped approach to apprehending and developing the knowledge and skills of NHS staff so that they are able to deliver the services envisaged here.

390. When disaster strikes or a major incident begins, the stepped programme of responses and the continuum of knowledge and skills begins at the scenes of incidents. Thereafter, the knowledge and skills required should be titrated against the needs of the people affected and their progress over time. This means providing:

- empathic, practical and pragmatic support for everyone that is delivered by and through first professional responders responders, families, and community groups whose actions and interventions should be in accordance with the principles of psychological first aid;
- assessment of people who remain distressed at around a month after events accompanied by access to psychological therapies as required;
- access to the full range of mental health services for people who develop a mental disorder or who have severe symptoms earlier than 28 days;
- management of staff, their working environments, and their training so as to sustain and develop their psychosocial resilience and reduce the potential psychosocial impacts on their health and wellbeing; and
- access to services for responders and staff of the rescue, recovery, welfare and health

services because of their direct and indirect exposure to risk.

391. Achieving the Department of Health's philosophy of psychosocial response depends on all professional persons seeing the psychosocial needs of people involved in emergencies as falling within their remit for conducting, at least, initial assessments and initiating effective responses. The guidance has implications for the training of staff who practice at the scenes of emergencies and for their leadership and management.
392. Guidance on the role of Medical Emergency Response Incident Teams (MERITs) in providing immediate medical care at the scene of an incident is in preparation. During the work that has been undertaken to inform this policy, the emerging guidance, and its implementation, the competencies and capabilities of MERITs were agreed as including initial psychosocial assessment and intervention. Stakeholders have advised DH that members of MERITs should be able to:
- interact effectively with distressed persons;
 - calm people whose behaviour at the scene presents risks to themselves and other people;
 - include the psychosocial circumstances and impacts in their assessment of risk; and
 - conduct first-line assessments and initiate management of people who may have acute confessional states or other common psychiatric disorders.
393. The importance of members of MERITs avoiding becoming casualties themselves has been identified as another important matter. The risks include those to their psychosocial well-being and mental health.
394. However, consultation with key stakeholders has identified that, although they are persuaded of the importance of discharging the roles identified here and are keen to do so, many practitioners assert that they require more training and practical support to do so effectively. There is also concern about how best to reduce the psychosocial risk for staff.
395. Discussion has revealed the following topics and areas of skill are included within the needs of first-line NHS staff for training and practice support:
- common myths about emergencies, disasters and major incidents;
 - definitions of key terms;
 - the nature of psychosocial resilience:
 - personal;
 - collective;
 - common psychosocial responses of people who are affected by or involved in emergencies, major incidents and disasters;
 - the Department of Health model of psychosocial care after emergencies, major incidents and disasters;
 - the nature of distress;
 - identifying the people who are most at risk of developing mental disorders;
 - the principles of psychological first aid;
 - effective assessments and early interventions that should be conducted by first responders including:
 - actions that should be taken by first-line staff at the scenes of emergencies to manage the psychosocial context and improve psychosocial outcomes;

- active listening skills;
- distinguishing distress from disorder;
- actions to avoid adverse psychosocial reactions including panic;
- effective communications with the public in order to manage well the potential psychosocial effects;
- the roles and practice of psychosocial assessment and triage;
- the psychosocial aspects of teamwork;
- psychosocial care for staff.

396. Research and experience indicate that these and other teams of first responders acquire psychosocial risks and needs as a consequence of the nature of their work. Additionally, teamwork is an essential feature that indicates the success or otherwise of these services. Therefore, training in the required competencies, practice support, interventions to promote teamwork and precautionary actions to sustain capability, hardiness and psychosocial resilience are required by the teams that are involved in responding major incidents.

397. Staff of agencies that provide mental health services require familiarity with public mental health and psychosocial health interventions and their roles in supporting their application.

A Framework for Education and Training

398. This guidance proposes that NHS organisations should consider organising the curricula and the training required by incident response commanders, managers and professional staffs according to a four-tier model. The levels are:

Tier 1: General training in core knowledge, attitudes and skills (required by all professional responders who work in the context of disasters and major incidents).

Tier 2: More advanced training for those who deliver psychological first aid, basic psychological therapies and assessment of people who may require more specialised mental healthcare.

Tier 3: Specialist training required by staff who deliver the functions of Levels 3 and 4 in the Model of Care. This includes training to supervise staff whose work includes delivering psychosocial care at Levels 1 and 2 in the strategic stepped model recommended by this guidance.

Tier 4: Advanced specialist training for professionals who are appointed to provide advice to major incident response commanders at strategic, operational and tactical levels. These appointments require not only disaster-related training in psychosocial and mental health care but also training in major incident management, consultative skills and selected aspects of strategic leadership and management.

Sustaining the Workforce Before, During and After Major Incidents and Disasters

399. The contents of this section are taken and adapted from guidance, Pandemic Influenza: Psychosocial care for NHS staff during an influenza pandemic, issued by the Department of Health in July 2009.⁵¹

400. The NHS has a long history of responding effectively to emergencies and major incidents and staff are renowned for their resilience and resourcefulness under pressure. In

⁵¹ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_103168

emergencies, major incidents and disasters, the expectation is that the service and staff will respond in this way, but there may be small numbers of staff who require support because they find their experiences overwhelming.

401. This part of the guidance focuses on two tasks: (a) sustaining the psychosocial resilience of the staff; and (b) providing more substantial support and interventions for those staff members who need them. It provides an evidence-informed and values-based approach to emergencies of all kinds that takes the psychosocial resilience of persons and the collective psychosocial resilience of staff as the anticipated responses, but not as inevitable. It provides guidance on developing people's personal resilience and the collective resilience of teams before events occur and of supporting their resilience during the course of a major incident or disaster.
402. There are seven occupational factors that influence the physical, psychosocial and mental health of staff in differing combinations.⁵² They are:
- perceived job control;
 - career development;
 - workplace climate or culture;
 - the job and workload;
 - the home-work interface;
 - role clarity; and
 - relationships at work.
403. In an emergency, NHS staff are called on to cope with stressors that are inherent in the ways in which widespread disease intersects with their jobs. Those inherent stressors include:
- exposure to events;
 - exposure to on-site dangers;
 - exposure to affected people's suffering and their relatives' stories; and
 - feelings of powerlessness - inability to provide help at the level and at the time that it is needed.

Non-inherent stressors include:

- lack of skills or training needed to do the job;
- lack of materials (supplies, equipment) needed to do the job;
- poor role definitions and unclear expectations;
- poor organisation of work;
- lack of support at work;
- unnecessary agency policies and practices;
- unnecessarily poor conditions;
- poor scheduling of work (long hours, few breaks, lack of leave time);
- lack of opportunities for recreation;

⁵² Sparks K, Cooper CL. Occupational differences in the work-strain relationship: towards the use of situation specific models. *J Occup Organ Psychol* 1999;72:219-229.

- arbitrary leadership and/or management practices;
- conflict and mistrust within and between teams; and
- poor communications (within teams, agencies and with families).

404. The recovery phase is swifter for staff and services if staff feel supported and are confident about the overall plans that are in place to manage major incidents. Employers should be aware of, and endeavour to prevent staff from developing and plan to assist staff to mitigate the inherent and non-inherent stressors by taking active steps to develop collective psychosocial resilience of staff teams.

405. NHS staff and other healthcare staff are also family members and, during a major incident or disaster, they have to balance their professional values and obligations with the needs of their families. Decisions in these situations can be challenging. However, there is evidence that absenteeism in these kinds of scenario are lowered if managers recognise and respond effectively to the professional, psychosocial and leadership needs of staff.

406. The leadership and management required do not consist only of responses to challenging events. It includes preparatory responses and training that are intended to build personal and collective resilience and, thereby, prevent longer-term consequences.

Implementation and Monitoring

407. This guidance contains a summary of the tasks that are pertinent to training and supporting staff with the intention of reducing the psychosocial impacts on them of working in a pandemic. Implementation requires four types of activity:

- Strategic planning, preparation and leadership. This includes clarification of what is expected of staff and consideration of any impact on the availability and standards that are to be applied to services in a major incident or disaster.
- Provision of real-time supervision and support for staff during the response and recovery phases.
- Actions to make available clinical services for the minority of staff who may develop sustained psychosocial problems during or after a major incident or disaster.
- Activities that are to be undertaken in the recovery phase in order to enable staff to transition back to ordinary working practices and to learn lessons from their experiences.

408. Figure 11 provides a summary of actions to support implementation and monitoring. The steps or levels and actions refer to the strategic stepped model of care in this guidance and paragraphs that appear later in this chapter.

Psychosocial Resilience

409. Psychosocial resilience is not about avoiding short-term distress. It is about recognising:

- how people adapt to, and recover realistically from adverse events and/or circumstances;
- that the abilities of people to accept and use social support and the availability of it are two of the key most important features of resilience; and
- there is evidence that adequate support reduces the effects of exposure to challenging events and emergencies.

Figure 11: Recommended best practice actions to support and monitor implementation

Step or Level	Actions	
1	Strategic Planning	<p>Each SHA is to convene a strategic planning group to oversee planning for supporting the psychosocial resilience of staff in their area</p> <p>Each SHA, or PCTs that are delegated by SHAs, is to identify a lead professional to provide input to and advice about psychosocial planning</p> <p>Each SHA is to include implementation of this guidance in its performance management of NHS organisations</p>
2	Develop the Collective Psychosocial Resilience of Organisations and Their Staff (e.g. through teambuilding)	CEOs to ensure that HRDs, or such persons as they appoint, lead planning in their organisation in the context of the SHA-wide approach
3	Provide Real-time Professional Supervision and Social Support for Staff	HRDs are to lead development of an appropriate model for their organisation by working with occupational health, mental health and other professionals and other appropriate partners
4	Provide Interventions based on the Principles of Psychological First Aid	HRDs to lead implementation based on the SHA's approach
5	Provide Access for Staff to Augmented Primary Healthcare Services	NHS organisations to agree a local lead person and an approach and a model that is appropriate to local circumstances
6	Provide Access for Staff to Specialist Mental Health Services	Referrals to be made as appropriate according to needs of individual members of staff

410. Plans for sustaining the resilience of staff during the course of an event or events should be based on:

- reducing inherent stressors so far as that is possible;
- planning to recognise and intervene to mitigate non-inherent stressors;
- providing training and social support; and
- basing interventions for people who are more than mildly distressed on the principles of psychological first aid and access to more specialised services that are related to need.

The Aims of Psychosocial Care for NHS Staff

411. The aims are to: (a) ensure that staff are prepared to cope with long-sustained demand; and (b) provide care for staff that is sensitive and responsive to their needs staff before, during and after emergencies.

412. Figure 12 provides a summary of actions that are recommended to support staff in each of the six levels that form the crux of the strategy in this guidance. It is reproduced from the

guidance, Pandemic Influenza: Psychosocial care for NHS staff during influenza pandemic, issued by the Department of Health in July 2009.⁵³

Figure 12: The NATO Strategic Stepped Model of Care `s Applied to Staff of the NHS (© Williams R, and Kemp V, 2009)

Intent	Nature of Activity	Step or Level	Actions	Timescale
Develop and sustain collective and personal resilience	Preparedness through Strategic Leadership and Management	1	Strategic Planning	Continuing
	Collective and Team-based Paradigms to Deliver Operational Leadership, Management and Setting Standards for Practice	2	Develop the Collective Psychosocial Resilience of Organisations and Their Staff (e.g. through teambuilding)	
	Day-to Day Leadership and Management of Staff and Services	3	Provide Real-time Professional Supervision and Social Support for Staff	Immediate and continuing
Deliver responses to personal psychosocial and healthcare needs	Personal Psychosocial and Mental Healthcare Paradigms	4	Provide Interventions based on the Principles of Psychological First Aid	
		5	Provide Access for Staff to Augmented Primary Healthcare Services	
		6	Provide Access for Staff to Specialist Mental Health Services	Medium and long-term

Frameworks for Delivering Psychosocial Care for Staff

413. Figure 13 provides further information about the matters that are summarised in this guidance. Thus, it provides an agenda for action whereby the intentions of this guidance for NHS staff can be implemented and its intentions achieved. The levels in Figure 13 relate directly to the steps or levels in the strategic stepped framework in Figures 6, 7, and 8 and to their application to sustaining staff in Figures 11 and 12.

⁵³ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_103168

Figure 13: The Six Level Framework of Actions to Support Staff

LEVEL 1	Strategic Leadership and Management Planning, leadership, management and training sustains services and promotes teamwork and therefore helps to prevent unnecessary anxiety for staff by creating confidence in the plan
Strategic planning and preparation	Making arrangements for strategic leadership and planning to continue throughout and after each emergency. Although designing and testing a plan for psychosocial care prior to events is very important, no general plan can be assumed to be appropriate to each situation. Usually, plans require adjustment in the light of events in each major incident and review afterwards is also important in order to learn lessons for the future.
Logistic and resource planning	Ensuring that comprehensive planning, preparation, training and rehearsal of the full range of service responses that may be required is undertaken familiarises staff with the plans, builds their confidence in those plans, allows staff to be engaged through suggesting changes, and builds their resilience.
Developing models of care	Staff should have confidence in the models of care that are to be offered in a major incident or after a disaster. This involves reviewing services available to ensure all the relevant providers of care and agencies work to jointly agreed models of care and case management. This includes working to minimise gaps and to develop clarity about mutual responsibilities.
Managing public and professional expectation	Planning and enacting a good public risk communication and advisory strategy that involves staff, the public and the media and which provides timely and credible information and advice also supports staff confidence and psychosocial resilience.

LEVEL 2	Operational leadership, service management and setting standards for practice Translating plans into action requires excellent tactical management. Plans should be templates that are used to initiate services and later be adjusted to fit better with events as they unfold. This requires good intelligence, leadership and review.
Clarify expectations of practice and practitioners	It is necessary to develop clarity about practical and professional expectations of staff and realistic standards for practice and practitioners during a major incident or disaster. This requires effective leadership, recognition of the potential impacts of a pandemic on the standards of care and negotiation of mechanisms for decision-making when services are under pressure.
Develop an ethical and professionally acceptable triage system and ethical frameworks for clinical and managerial decision-making	<p>Triage should be based on the judgement of professionals at preliminary, primary, secondary and tertiary level, and also on the judgement of the affected persons themselves. Thorough training is necessary to achieve effective triage. Staff should have confidence in the triage systems that are put in place.</p> <p>The ethical framework for commissioners, services and practitioners, devised by CEAPI has been summarised in the NATO guidance. It contains the principles of good decision-making.</p> <p>Psychosocial triage should distinguish the following groups of affected people:</p> <ul style="list-style-type: none"> • those people who do not have mental disorders or serious clinical symptoms but who are distressed – this is likely to be the largest group of people who are affected; • those people whose experiences are thought as possibly indicating that they might have serious clinical symptoms that might amount to mental disorder - information, and advice should be given and follow-up should be arranged for people in this group; • those people who have mental disorders or serious clinical symptoms, for whom appropriate diagnosis and treatment should be offered straightaway.

LEVEL 2 (continued)	Operational leadership, service management and setting standards for practice
Educate, train and rehearse plans	The psychosocial plan to support staff should be included in exercises to test the strategy and practice delivery of the plans. Strategic advice on psychosocial and mental healthcare for patients and staff is required by planners when they design, test and implement the plans and by incident response commanders at strategic, tactical and operational levels.
Develop ethical guidelines and staff competency framework	Commissioners, services and practitioners should adopt an ethical framework for planning and delivering services. Professional and general managers should also be clear about the competencies required of practitioners, managers and others during a major incident or disaster. Many staff have the necessary competencies as part of their current role, but others require specific training if they are to contribute appropriately.

LEVEL 3	Day-to-day leadership and management of staff and services Ensuring the psychosocial welfare of all people involved directly with delivering any response to the pandemic is a key part of that response. Risks to psychosocial wellbeing can be minimised by planning and implementing good management procedures and by ensuring that staff have adequate supervision and access to advice.
Provide accurate up-to-date and relevant information about the situation	Staff must have confidence in the plans for day-to-day service delivery that are made, and this requires that they are fully informed about them and their anticipated roles. The feeling of being ill informed is a factor that can most erode psychosocial resilience. Conversely, if staff are well-informed, consulted and involved, their confidence in the plans and their equipment is enhanced, their uncertainties are reduced and their psychosocial resilience is augmented.
Provide opportunities for operational and technical and personal discussions	Less formal discussion about clinical experiences ordinarily occurs in workplaces. In challenging circumstances, the support that comes from having access to team members, peers and others for discussion and advice and to share challenges and frustrations is invaluable. It is important to ensure that opportunities for informal peer support are valued and continue to be made available during a major incident or disaster. More formal peer-based reflection on and reviews of practice should also be encouraged.
Ensure staff take rest, adhere to duty rotas and have opportunities for recuperation	Whenever possible, staff (particularly senior staff with substantial responsibilities) must be enabled to take rest and work to realistic rotas to avoid them becoming overtired and 'burned out'
Monitor practice and provide enhanced clinical advice and supervision	The work of staff should be monitored so that they have access to clinical supervision; this is likely to become more rather than less vital in stressful situations when critical and sometimes controversial decisions may have to be made.

LEVELS 4, 5 and 6	<p>Psychosocial and mental healthcare for certain members of staff</p> <p>Occasionally, some members of staff may develop distress that is, most usually, short-term, but, much less often, temporarily disabling or of longer duration. A much smaller number may develop more substantial problems with their mental health. Therefore, facilities should be available to support staff who are distressed or to enable access to mental healthcare according to need by providing appropriate psychosocial support and pathways to mental healthcare in the few instances in which it is anticipated that those services are required. Such a stepped approach should include:</p> <ul style="list-style-type: none"> • approaches that are based on psychological first aid; • assessment and intervention services for people who do not recover from immediate and short-term distress; and • access to primary and secondary mental healthcare services for people who are assessed as requiring them.
Level 4: Psychological First Aid	PFA is an approach that is intended to reduce people's initial distress in the immediate aftermath of traumatic events and foster adaptive functioning. PFA assumes that the majority of people who are affected emotionally by events, such as a major incident or disaster, are not likely to develop mental health problems, more serious disorders, or long-term difficulties in recovery. Instead, it is based on an understanding that survivors of disasters, and other people who are affected by major incidents, experience a broad range of early reactions (for example, physical, psychological, behavioural, and spiritual). Some of these reactions cause enough distress to interfere with adaptive coping, and people's recovery may be helped by support from compassionate and caring responders.
Level 5: Offer health assessment and intervention in primary care	The care pathway should rely, initially, on support provided by people's families, communities, colleagues in workplaces and then progress, according to need, to the primary or occupational health and social care services and voluntary agencies. Assessment and intervention procedures should take account of local circumstances.
Level 6: Deliver specialist mental health services for staff	Despite estimates that the numbers of staff who will require referral being small, arrangements should be negotiated in advance for staff to have access to appropriate specialist healthcare, including mental healthcare according to their assessed needs.

414. Figure 14 provides a schematic presentation of the contents of Figure 13 and it reproduces Figure 20 on page 114 in the NATO/EAPC guidance.

415. A systematic approach for implementing action to deliver the agenda contained in Figures 11, 12, 13 and 14, which is based on four dimensions and three temporal domains, has been identified by the Antares Foundation. It has been tested in healthcare organisations in emergencies.⁵⁴

416. The dimensions, as adapted for this guidance, are:

- identifying and responding to the needs of particular staff members whereby each member of staff is encouraged to maintain his or her own resilience;
- building teams to develop trust and mutual support;
- selection of managers and professional leaders by agencies on the basis of their abilities to maintain team cohesion, and to provide training on monitoring staff members' stress and to provide support, as needed; and

⁵⁴ See Antares Foundation for more details of a scheme that has informed the approach recommended here on: <http://www.antaressfoundation.org>

- strategic and operational consideration within and across agencies of the possible challenges that organisations, departments, teams and staff may face in returning to delivering more ordinary services after the emergency, major incident or disaster is over.

417. The three temporal domains are:

- preparation and planning before a major incident or disaster;
- actions taken during a major incident or disaster;
- actions taken to promote transition back to ordinary circumstances and to promote recovery of services and their staff after the major incident or disaster has receded.

The Roles of Occupational Health Services

418. In addition to the systemic approach described here, this guidance identifies roles that are important to organisations in planning and acting to sustain their staff. They include:

Preparation and planning before a major incident or disaster:

- providing executive directors with strategic advice;
- providing senior managers with advice about health practices in workplaces;
- providing advice on staff management policies;
- contributing to employees' professional development.

Actions taken during a major incident or disaster:

- providing advice on sustaining collective and personal resilience;
- assisting in identifying staff who may be at greater risk;
- providing managers with advice about monitoring the exposure of staff to traumatic situations;
- training managers to recognise distress;
- providing a skilled team that can provide intervention services for staff.

Actions taken to promote transition back to ordinary circumstances and to promote recovery of services and their staff:

- advising and monitoring staff who are returning to work after their exposure to debilitating distress and dysfunction.

419. Healthcare organisations are likely to find that their occupational health specialists and departments can assist with, or advise them about discharging these tasks.

Figure 14: A framework for promoting the psychosocial and mental health of responders and staff (reproduced with permission from Williams and Alexander)

