

Principles for responding to people's psychosocial and mental health needs after disasters

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A note about this report

This occasional paper has been developed from an earlier draft document that was written in 2009, but not formally published. The contents reflect the work of Professor Richard Williams as the Presidential Lead for Disaster Management for the Royal College of Psychiatrists from 2008 to 2014.

The authors have extensively revised the 2009 draft document in the light of scientific advances, particularly in the past 5 years, and on the basis of their experience in using its contents to advise national governments, local authorities and practitioners. They have responded to key developments in the field and expanded the contents in the light of comments from governments, other organisations and people who have seen and used the 2009 draft to inform their policies. The contents and the appendices reflect evolving knowledge and topics of contemporary concern.

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| Foreword

The origin of this document lies in two streams of work that have created national and international guidance on how communities, regions, countries and groups of countries might respond to the threats to people's psychosocial well-being and mental health that are posed by emergencies, major incidents, disasters of all kinds and conflict as well as terrorism.

In 2007, Verity Kemp and I were asked by the Department of Health in England to lead an international group of experts, drawn from the North Atlantic Treaty Organization's (NATO's) member nations, tasked with developing guidance on psychosocial and mental healthcare for people who are affected by disasters and major incidents for presentation to NATO's Joint Medical Committee. The recommendations were adopted by NATO and published as its non-binding guidance in 2009.

We also developed Department of Health guidance for healthcare systems in England. In 2009, the then director of emergency preparedness and the national clinical director for mental health in England adopted the policy that resulted from this work.

In parallel, Professor Jon Bisson and colleagues in Europe gained funding from the European Union (EU) to support The European Network for Traumatic Stress (TENTS) project that ran from 2007 to 2009. It created a wide network of expertise on treating survivors of disasters who develop post-traumatic stress or post-traumatic disorders, examined which interventions are effective and their availability across Europe and produced an evidence-based model of care.

I was appointed Presidential Lead for Disaster Management by the Royal College of Psychiatrists in 2008. That role has given me opportunities to continue the work that I began for the College in 2005 and for NATO and the Department of Health in England in 2007. Early on, Jon Bisson, Verity Kemp and I decided to pool our learning with a view to creating a set of principles for psychosocial and mental healthcare and that led to the first, draft version of this document.

Jon Bisson and I took part in the subsequent TENTS Training and Practice (TENTS-TP) project that was also funded by the EU. That project used our draft summary of the principles. It developed the TENTS network with the aim of implementing evidence-based interventions to prevent trauma survivors from developing post-traumatic disorders and interventions to promote their early recovery. I led the work on psychosocial resilience including creating two e-learning modules that are founded on the evidence.

Recently, Jon Bisson, Verity Kemp and I came together to review the principles. They have been well received and now underpin guidance on responses to emergencies of England, Scotland, Wales and Ireland.

We have reviewed, updated, revised and expanded the principles on the basis of developments in science and practice in the 5-year interval. The scientific support for the core principles and the model of care has strengthened. We now put greater emphasis on certain aspects as a consequence of research that has been published since 2009. Thus, in this, the first formally published edition, we focus attention on the importance of effective communications, connectedness, social networks and community support to reducing the psychosocial risks and to people's mental health needs. We also emphasise the importance of supporting people who intervene in disasters as responders, carers, aid workers, health carers and mental health services staff. Their good leadership remains core.

All of the principles that we summarise should be taken into soundly constructed, well-informed and evidence-based national and local government policies, strategic service design and high-quality plans for, and practice in, delivering services. We continue to advise that everyone involved can benefit from psychosocial care and a minority of people who are affected require high-quality mental healthcare. Therefore, our position is that all mental healthcare interventions should be based on a sound platform of psychosocial care.

Professor Richard Williams

Presidential Lead for Disaster Management 2008 to 2014

Chapter 1: Rationale

This report is intended to assist the governments, non-governmental organisations and professional organisations across the nations in preparing effective responses to the psychosocial and mental health consequences for their populations following emergencies, major incidents and disasters of all kinds and causes. These responses should be led by national policies that enable the responsible authorities to plan services that are based on a common strategy and which are fully integrated into wider disaster planning and preparedness and response systems.

This report updates and builds on previous guidance (Williams *et al*, 2009) that was informed by work conducted for NATO and the Euro-Atlantic Partnership Committee (NATO/EAPC, 2009) and the EU (TENTS Project Partners, 2008) through incorporation of new evidence that has emerged in the past 5 years. The previous guidance has been widely used to inform national policy in, for example, England (Department of Health, 2009), Ireland (Health Service Executive, in press), Scotland (Scottish Government, 2013) and Wales (Health Emergency Preparedness Unit, Welsh Government, 2011).

We have identified the common principles and recommendations from a number of sources that are based on research evidence and/or experience. Therefore, we determined to bring them together to provide a consensus of opinion, which is accepted broadly, about the nature of people's psychosocial and mental health needs and the responses that the communities in which they live and work require when they are affected by disasters and major incidents of all kinds.

We recognise the Inter-Agency Standing Committee (IASC) *Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (IASC, 2008), the guidance offered by the European Federation of Psychologists' Associations (EFPA, 2008) and the World Health Organization's *Guidelines for the Management of Conditions*

Specifically Related to Stress (WHO, 2013). The principles that are offered as guidance in this document are compatible with and informed by these documents. The themes raised here are discussed in more detail in *Conflict and Catastrophe Medicine* (Williams *et al*, 2014).

The core principles in this guidance are directly relevant to national policies and strategies and local operational practices. This document is aimed at the national policies and strategies that are required to underpin the psychosocial and mental healthcare that is provided by countries for populations that are affected. The operational practices summarised here relate to delivering services to meet the needs of populations of 250 000 to 500 000 people. They can be adapted for larger or smaller populations and for small and larger geographical areas.

Values and principles

The approach expounded in this document recognises that nations have differing cultural values and expectations as well as different organisational patterns for the services for which they are responsible.

We propose principles and a model of care that:

- endorse the primary principle of 'first, do no harm'
- are informed by ethical principles
- take account of the importance of the potential resilience of people and communities
- acknowledge the importance of anticipated reactions, resilience and the natural healing potential of people, families and communities
- are empirically based (i.e. based on the best evidence that is available)
- are flexible across events, cultures and time periods

- provide a framework to better meet the needs of groups of people who are vulnerable and at risk, including families, relatives of people who have been directly involved and other carers at the time that disasters strike and in the recovery phase that follows
- recognise the importance of meeting the psychosocial and mental health needs of professionals who provide rescue services and who deliver care and many other services prior to events, at the time and immediately afterwards, and in the medium- and longer-term during the recovery phase after disasters of all kinds
- are realistic in terms of the extent to which they can be implemented in emergencies, given the personnel and resources that are available
- take account of population dynamics, including age and cultural differences, that may affect populations that are involved, first-responders and staff of services
- are capable of evaluation and provide the basis for creating frameworks of governance
- provide the rationale for improving high-quality research.

Psychosocial and mental health needs of disaster survivors and aiders

The principles contained in this document distinguish people's psychosocial reactions to emergencies that are very common, and not necessarily pathological, from reactions that are symptomatic of mental disorders, and the care that is appropriate to people's personal needs. Needs for care that arise from the former are termed psychosocial and needs that relate to mental disorder

are termed requirements for mental healthcare. 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.

Orientation

This document begins by summarising key themes from research that should influence policy and strategy for all aspects of disasters and practice of psychosocial and mental healthcare for everyone who is involved before, during and after disasters and major incidents. It identifies four phases in planning and delivering services to support communities' emergency preparedness, resilience and response (EPRR) before focusing on core principles that should underpin governments' policies, strategy and service design, and operational practice.

It continues with sections on governance, research and evaluation, communications and psychosocial resilience. Chapter 8 outlines a strategic model of care. Chapter 9 covers translation of the principles and the strategic model into government and strategic policies whereas Chapter 10 translates the principles and the model into the matters which practical services should focus on. Importantly, it focuses on immediate responses, responses that are required in the first 3 months and services that are required beyond the short and medium term. Chapter 12 outlines key matters in management.

An important principle of policy and practice after disasters is that of doing no further harm. One of the key implications of this is that people who act as rescuers, responders or carers before, during or after disasters and major incidents should be adequately cared for. Chapter 11 introduces that theme and the checklists in Appendix 3 support the information in this document.

Chapter 2: Key findings from the evidence

Several factors influence the philosophy of psychosocial and mental healthcare in this document.

- **The substantial resilience of persons and communities.** Although psychosocial resilience is the expected response of communities to disasters and major incidents, it is by no means inevitable. It can be developed, but it can also be compromised.
- Often, the emotional, social, cognitive and somatic experiences of resilient people can be difficult to distinguish from symptoms of stress disorders and later post-traumatic disorders. Therefore, there are **risks of underestimating and overestimating the prevalence of disorders** unless first responders and staff in the healthcare, social care and welfare services are provided with at least a basic minimum of education and training (Drury *et al*, 2013).
- In many cases, **secondary stressors** follow from the disruption and dislocations in people's lives as a consequence of the primary events. Depending on the circumstances, some of the secondary stressors that emerge as people endeavour to reconstruct their lives, attachments, families, homes, employment, communities and recreation may be as impactful as the primary event and, as a consequence, some people may require assistance and support over extended periods of time (Lock *et al*, 2012).
- Disasters and major incidents affect whole communities and populations directly or indirectly and so public health approaches, including psychosocial care, are required to reach everyone who is affected. However, the majority of people who develop mental disorders require **specific, programmed and personalised mental health and social care services**. Therefore, people who develop

disorders are likely to require both psychosocial and mental healthcare.

There is a broad spectrum of ways in which people who experience disasters and major incidents, either directly or indirectly, react psychosocially.

- People's psychosocial reactions are shown by their emotional, social, relationship, behavioural, cognitive and physical experiences in anticipation of, during and after events.
- Distress after disasters and major incidents is very common, but it is not necessarily indicative of people developing mental disorders. In most cases, distress is transient and not associated with dysfunction.
- Some people's distress may last longer and is more incapacitating.
- The majority of people do not require access to specialist mental healthcare, although a substantial minority of people may do so.
- Surveillance and clinical assessment are required by a proportion of survivors who are thought to be at particular risk. (Surveillance describes observing groups of people who are thought to be at risk with the intention of facilitating early identification of persons who are likely to require more formal assistance.)
- A small proportion of affected persons may require long-term mental health services in response to their needs.

The psychosocial and mental health responses that occur most frequently are presented in Appendix 1.

The ways in which people respond to emergencies and disasters fall into four main groups.

- 1 People who are not upset at all (resistant people) or who are mildly, temporarily and

predictably distressed in the immediate aftermath (if they recover with the support of family members, friends or other people, they are considered to be resilient).

- 2 People who are proportionately distressed, but able to function satisfactorily in the short and medium term (they are resilient people who experience greater distress, of longer duration than people in the first group but which does not amount to a mental disorder).
- 3 People who are disproportionately distressed or distressed and dysfunctional in the short to medium term (this group includes people who may recover relatively quickly if given appropriate assistance, befriending and other interventions as well as those who may develop mental disorders; therefore, people in this group require a thorough assessment).
- 4 People who are mentally disordered in the short, medium or longer term (these are people who require specialist assessment followed by timely and effective mental healthcare).

People who are at increased risk of dysfunctional distress and substantial social and mental health problems following disasters include women, children and adolescents, older people, people who have pre-existing health problems and disorders

and those who are socially disadvantaged. At even more risk (Ozer *et al*, 2003; Brewin *et al*, 2000) are those who:

- perceive that they have experienced high threats to their lives or the lives of significant others
- are physically injured
- are faced with a circumstance of low controllability and predictability
- have to live with the possibility that the disaster might recur
- experience disproportionate distress or dissociation at the time
- have experienced multiple losses of relatives, friends and colleagues to whom they are close, and losses of property that is important to them
- have been exposed to dead bodies and grotesque scenes
- have endured higher degrees of community destruction
- perceive that they have limited social support
- are exposed to subsequent life stress
- have been exposed to a major traumatic event previously
- have had a mental disorder previously.

Chapter 3: The phases of preparation and response

This document recognises that preparations for and responses to emergencies, major incidents and disasters pass through a series of phases. Frequently, these phases are blurred depending on the nature and extent of events, the degrees of disruption and how people who are directly and indirectly involved (and responders) react. Therefore, these phases are not to be regarded as distinct or separate.

The phases are as follows.

- 1 Preparation before events.
- 2 Coping with the onslaught of an emergency or disaster and the immediate aftermath.
- 3 Recovery after matters settle (but note that the goal of recovery is seldom that of return to the circumstances preceding the disastrous events or circumstances).
- 4 Review and learning from events to inform a strategic approach to disaster risk reduction by promoting adaptability of people and agencies in the light of lessons learned.

The principles in this document adopt an approach to psychosocial and mental healthcare that is compatible with these phases.

Chapter 4: Core principles

Managing the psychosocial needs of affected populations

There is evidence that how people's psychosocial reactions are managed may define the extent and effectiveness of communities' recovery overall (NATO/EAPC, 2009). An important corollary of this principle is that all actions taken after disasters and major incidents must do no further harm.

Values, ethics and human rights

Values, ethics and human rights must be central to governments' development of policies for EPRR and they are key to strategic design and delivery of services. Often, disasters and major incidents are events and circumstances that test governments' and people's values and the moral architecture of the services that they deliver. Therefore, well-designed services' responses to people's psychosocial and mental health needs should be based on, and promote awareness of, human rights and ethical principles for both public mental health and personal healthcare (Department of Health, 2007; Welsh Assembly Government, 2007).

Definitions

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.

In the text that follows, for example, 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 develop as a consequence of

their exposure to disasters and major incidents. **'Response'** refers 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.

Integrated preparation for and responses to disasters

It is important that policies for and practice of psychosocial and mental healthcare are fully integrated into the broader plans for disasters and with disaster preparedness at national, regional and local levels. Furthermore, psychosocial and mental healthcare plans and services should be fully integrated within the totality of planning to deliver healthcare at primary, secondary and tertiary levels.

Integrated emergency management is a cyclical process that has six core elements:

- 1 anticipate
- 2 assess
- 3 prevent
- 4 prepare
- 5 respond
- 6 recover.

Psychosocial and mental healthcare should be included as core topics at each of these six levels when the persons who are responsible for emergency preparedness, providing services and disaster risk reduction make plans.

Anticipation, planning, preparation and advice

Thus, a core principle 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. This requires understanding of the dynamic shifts that occur with the passage of time, as well as the clarity about how these services are to collaborate with other services that offer humanitarian aid and responses to people's welfare and psychosocial needs after disasters and major incidents. Knowledge about how people may react psychosocially to disasters and major incidents is likely to assist responsible people in making effective decisions before the events and when they are making decisions while under strain during events.

Recognising, evaluating and managing the stressors that create psychosocial needs for affected people

Primary stressors

Stress and anxiety for the people who are directly involved, their relatives, friends and colleagues and the practitioners and staff who intervene are inherent in all emergencies and disasters. The worries stem directly from the events. These sources of stress, worry and anxiety are called primary stressors.

Secondary stressors

Secondary stressors are, by contrast, circumstances, events or policies that are indirectly related to the disastrous events or are not inherent to but consequential on them. All too often, secondary stressors, such as failure of countries to deal effectively with people losing their homes, livelihoods or their financial stability, may persist after the events have subsided and their impact may be long term and devastating. Depending on the circumstances and the effectiveness of responses, their effects may be as great as or greater than the disaster itself.

Therefore, key to ensuring emergency preparedness, resilience and effective responses are the processes of risk assessment and risk management. They include assessing the risks to persons, families, communities and agencies of both primary and secondary stressors that arise from emergencies in particular areas. The information

gained should be used to inform plans, to respond effectively and to mitigate the immediate inherent impact of disasters. It is also important that longer-lasting secondary stressors are recognised and medium- and longer-term interventions are put in place at the behest of the people who are affected to assist them to avoid secondary stressors and, particularly, those stressors that are persistent. It is a good principle to review people's and communities' situations to seek out previously unrecognised or unresolved secondary stressors if people continue to experience distress.

Planning for families and communities

All aspects of psychosocial and mental healthcare should only be provided with full consideration of people's wider social environments, the cultures within which they live and especially their families and the communities in which they live and work. The service responses that are provided from within societies and, in the case of disasters and major incidents that cause great 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 multilayered support that is provided afterwards. The stepped model should have its roots in providing basic services, 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 and ascertainment of people's needs.

Effective communications

There is a wide array of reasons for including, securing and sustaining effective communications within the core principles for psychosocial and mental healthcare. They include:

- giving the public information (before their exposure to a threat) that is intended to:
 - reduce public fear or apprehension
 - align the public to a wise course of response to threat

- align the public to evidence-based responses to or interventions for events
- building the resilience of persons and communities
- promoting community and personal self-help and self-efficacy
- keeping people well by taking active steps to sustain their resilience after the event
- providing information as part of a wider package of psychological first aid after the event
- providing information as part of wider intervention and treatment programmes for people who have developed a mental disorder
- meeting a 'right', for example a right for freedom of information
- responding to the media.

Good communications within and between teams of people and between agencies that are involved and which respond to emergencies, major incidents and disasters are fundamental to high-quality responses. Similarly, research shows that good communications with people who are affected and with the concerned public are fundamental to sustaining their resilience, building the opinions of the public about the legitimacy of the responders and the authorities and, therefore, their cooperation with advice provided by the authorities (Carter *et al*, 2014).

Effective communications are vital to delivering psychosocial and mental healthcare and they are an important component of psychological first aid (WHO *et al*, 2011).

Developing, sustaining and restoring psychosocial resilience

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 people, families and communities.

This principle means that actions taken, including those that determine how services respond to the needs of communities and people for psychosocial and mental healthcare, should actively maximise

participation of local, affected populations whatever the degree of devastation in each area.

Restoring first, the functioning and second, the social fabric of communities is highly important in how effectively societies, communities and services respond 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 supportive humanitarian and welfare arrangements in the immediate aftermath, according to their needs
- the effectiveness of the responses depends on utilising community leaders' prior knowledge of affected communities and the resilience and vulnerabilities of people in affected areas.

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. 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:

- humanitarian aid
- welfare services
- services that are able to assist people and communities to develop and sustain their resilience
- timely and responsive mental health services.

Building on existing services and skills

Taken together, the principles summarised here mean that services' responses to meet the needs of affected populations for psychosocial and mental healthcare should build on the capabilities of people and the available resources.

Services that provide psychosocial care and mental healthcare should be capable of responding to a variety of types or causes of disasters and major incidents, and should build on the existing clinical skills and preparedness within each community. This raises matters for planning and training as well as for sustaining knowledge and skills.

However, we recognise that there is no common pattern across different countries about how aid, welfare, responses to people's psychosocial needs, continuing support and mental healthcare are provided. Therefore, the focus of this document is on the psychosocial and mental healthcare responses that people affected by disasters and major incidents require from other people and/or formal services, and the common factors that affect service design irrespective of which nations are involved.

Integrating psychosocial and mental healthcare responses into policy, humanitarian aid, welfare, social care and health care agencies' work

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:

- 1 government policies
- 2 strategic policies for service design
- 3 service delivery policies
- 4 policies for good clinical practice.

Each of these four aspects of policy should be influenced by the contents of this document. This means that there are important roles for practitioners who are skilled in mental healthcare 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 disasters.

The Madrid Framework (see Appendix 2) can be used for benchmarking how well policies at all four levels deal with the values that are inherent in designing and delivering responsive services.

Government policies

Government policies relate to how countries, regions and counties are governed. The policies required at this level set the overall aims and objectives for responses to disasters and major incidents. They should specify the need for the design, development and delivery of services that offer psychosocial and mental healthcare 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.

Strategic policies for service design

Government policies should require the responsible authorities to set strategic policies. Strategy to design services should be developed by bringing together evidence from research, past experience, knowledge of the area, its population and risk profile. Authorities are also responsible for evaluating and managing the performance of those services to meet the identified objectives.

Service delivery policies

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.

Policies for good clinical practice

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.

Policy at each of the four levels should be informed by culture and values as well as by evidence and experience gleaned from practice.

Standards

Everyone who is involved in emergency preparedness, building the resilience of people, communities and organisations, responding to people's needs and promoting their recovery, including planners, incident response commanders and responders, practitioners, volunteers, researchers and evaluators, should agree to work to a common set of standards.

In certain circumstances, especially those in which there is widespread devastation, high standards may not be achievable until basic community functioning and resources, including clean water, sanitation, food supplies, shelter and protection, communications and healthcare, have been restored. Situations of this kind should be anticipated and covered by planning. The plans should

consider the minimum standards in a range of different circumstances (e.g. the Sphere Project (2011) has published a humanitarian charter and standards for services that cover a wide range of people's needs after disasters).

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 agreed and planned before disasters occur.

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. 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.

In these ways, effective psychosocial and mental healthcare responses can contribute powerfully to disaster risk reduction.

Chapter 5: Principles of governance

Information-gathering, research and evaluation are vitally important if lessons are to be learned from public mental health and clinical practice in disasters and major incidents that will contribute to saving lives, minimising suffering and reducing risks to staff in other disasters and major incidents (Williams *et al*, 2008).

There is a particular requirement to internationally agree definitions of what constitutes and differentiates information-gathering, research, evaluation and monitoring as applied to psychosocial and mental health intervention programmes. 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 running the programmes
- reinforce fidelity of programme delivery with what is required by the populations involved and the programmes' designers intentions.

The experiences gained and the findings of all who are involved in research and evaluation should be used to prepare curricula for training relevant people in the skills of designing and delivering services as well as interpreting the findings of evaluations of psychosocial care and adapting them to local situations.

Plans should be made in advance for information-gathering, research and evaluation and should deal with the pressures that services may be under during disasters or major incidents and the restrictions that researchers face in meeting methodological standards in these circumstances. 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.

Therefore, it is important to design information-gathering, research and evaluation programmes from the beginning (i.e. from the time when each disaster and major incident plan is being designed, developed, tested and rehearsed), and base the process of designing and implementing research and evaluation on agreed guidelines.

Chapter 6: Communications

Advice about communications with the public about risks is available in the literature, for example in Bish *et al* (2011).

Communications should:

- involve people – communication is more effective in influencing people when the public feels involved by:
 - acknowledging the gravity of events
 - recognising public concern
 - assuring the public that officials are doing all they can, provided that is true
- express coherent and consistent messages
- be open and honest about:
 - the likely course of events
 - how events are being handled
 - what people can do to minimise further harm
- provide clear, simple and brief information by:
 - explaining new terms
 - being sensitive to cultural differences
 - ensuring messages are scientifically accurate
- provide information by:
 - including quantitative risk estimates in numbers rather than percentages
 - framing ambiguous messages about risk negatively (i.e. by erring towards pessimism when the information that is available leaves room for uncertainty)
 - presenting information visually as well as in text
- provide summaries of possible protective actions
- acknowledge uncertainty
- commit the authorities to earning and keeping public trust.

Chapter 7: Psychosocial resilience

Resilience has been the subject of study over a substantial portion of the 20th and into the 21st century. The term is widely used by a variety of the agencies that are engaged in providing aid to communities affected by disasters. However, not all define the meaning of resilience and the context suggests that not all agencies use the term to mean the same thing.

Psychosocial resilience describes how people, groups of people and communities may spring back to effective functioning after disasters. This paper shows that many people who are affected by major incidents suffer distress. Most recover quite quickly given social support from relatives, friends and colleagues. Thus, good psychosocial resilience is not about absence of short-term upset or brief distress, but how people adapt and recover afterwards. The corollary is that people who show resilience after major incidents should not be assumed to be unaffected psychosocially.

The qualities that enable people to be resilient are of both genetic and environmental origins (Amstadter *et al*, 2014; Wertz & Pariente, 2014). The many environmental factors include: people's past, recent and contemporary experiences and relationships; situational factors (NATO/EAPC, 2009); the levels of injury, community devastation and adversity; the resources available; and the responses of communities and countries. Wide variations in these factors may well explain why the same people may respond differently in different circumstances.

This report is based on the powerful influences on how people cope with emergencies and disasters of their: social identities; family, school, work and social relationships; the relationships they develop with strangers who share their circumstances and fate; and the social support that they are offered and which they perceive as helpful. These potentially positive influences should inform

how authorities and services develop interventions intended to enhance people's psychosocial resilience when they face emergencies and disasters.

Past research has focused on learning about the personal attributes of people who appear to cope well with the primary and secondary stressors consequent on disasters. More recently, psychosocial resilience has been considered to be a systemic, dynamic process in which people's social identities play a strong part. Thus, resilience describes social processes by which people act singly or together to mitigate, moderate or adapt to the effects of events.

The literature suggests (Williams *et al*, 2014) that people who have good psychosocial resilience:

- perceive that they have, and actually receive, support – the abilities of people to accept and use social support and its availability are two of the core features of resilience
- tend to show acceptance of reality
- have belief in themselves that is supported by strongly held values
- have abilities to improvise.

Social support consists of social interactions that provide actual assistance, but also embed people in a web of relationships that they perceive to be caring and readily available in times of need (Haslam *et al*, 2012; Williams *et al*, 2014).

On the basis of our adaptation of Omand's approach (Omand, 2010), we identify:

- **first-generation resilience:** the ability to cope well with events and their immediate aftermath
- **second-generation resilience:** the ability to recover from events
- **third-generation resilience:** the ability of people to become adaptable in the light of lessons learned from events.

Chapter 8: A strategic model of care

A strategic stepped model of care

The strategic stepped model of care recommended in this document links the impact of events with the core components of psychosocial and mental healthcare that populations of people, communities and particular people require through the modalities of screening, surveillance, triage, assessment and intervention. (Screening is a strategy that is used to identify persons who are at high risk of developing, or who have already developed, psychosocial consequences that are likely to require more formal assistance.) It is intended as a conceptual and practical resource for planners.

This model of care has six main components that fall into three groups.

Strategic and operational preparedness

- 1 **Strategic planning:** comprehensive multi-agency planning, preparation, training and rehearsal of the full range of service responses that may be required.
- 2 **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

- 3 **Families, peers and communities** provide responses to people's psychosocial needs that are based on the principles of psychological first aid. This component also includes community-building.
- 4 Assessment, interventions and other responses that are based on the principles of psychological first aid that are delivered by **trained lay persons**, who are supervised by the staff of the mental healthcare services, and social care practitioners.

Personalised psychosocial and mental healthcare

- 5 Access to **primary mental healthcare services** for surveillance, assessment and intervention services for people who do not recover from immediate and short-term distress.
- 6 Access to **secondary and tertiary mental healthcare services** for people who are thought to have mental disorders that require specialist intervention.

Chapter 9: Developing government and strategic policies

General principles for policy

The minimum objectives that are required of plans for psychosocial and mental health service responses to disasters are as follows.

- Integrating psychosocial and mental health-care responses to people's needs within the grand plan for preparing for, and responding to, disasters.
- Fully integrating psychosocial care and mental health service responses to people's needs, usually sequentially but also simultaneously.
- Appointing psychosocial and mental health advisers to incident response commanders to assist them to include people's psychosocial and mental health requirements among the needs that are assessed as requiring intervention after major incidents and disasters. These advisers should be made available during development of emergency preparedness planning and exercises. Their services should be retained during actual events so that they can provide real-time advice during incidents as well as in the later recovery phase.
- Empowering communities and individuals.
- Ensuring that staff are capable of working with diverse values and cultures.
- Attending first to the basic needs of the populations that are affected.
- Developing and enacting 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 and stratified according to need, of sufficient duration and well coordinated.
- Allocating and managing roles for mental health professionals.
- Ensuring that staff of all organisations that respond to disasters and major incidents are well led, managed, supervised and cared for.
- Promoting learning by planning and managing knowledge acquisition and its transfer, evaluation and performance management.

Preparedness: strategic and operational

Strategic preparedness supports people's psychosocial resilience and is also likely to improve responses to their psychosocial needs and reduce the risks of severe distress and mental disorder. Effective planning and coordination of service responses is likely to maximise the collective resilience of the public and communities and the personal resilience of affected persons and responders.

The building blocks of good planning are:

- preparedness (strategic, tactical and operational)
- timeliness
- flexibility
- integration
- good communications
- timely and trusted sharing of information with the public and among the responding agencies
- efficiency and effectiveness.

Disaster and major incident plan

Every jurisdiction requires an integrated disaster and major incident plan. This means that every jurisdiction and every area within it should have a disaster and major incident plan that is appropriate to its national, regional and local governance structures that makes provision for responses to people's psychosocial and mental health needs and which 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:

- sufficient population-oriented humanitarian aid, welfare, psychosocial care and public mental health services that are balanced by personalised healthcare and mental health services that are available according to survivors' assessed needs
- organisations that deliver rescue, humanitarian aid and welfare services
- social care systems
- voluntary and non-governmental organisations
- military systems
- military aid to civil powers.

Decision makers must understand how people respond to disasters and major incidents and the risk factors that affect the likelihood of people coping well or otherwise with the psychosocial effects of disasters or of people developing mental disorders. This means they must understand: the anxieties that anyone who has been involved, directly or indirectly, and their relatives, friends and many other people are likely to experience; people's transient and short-term distress, which is anticipated; the risks to well-being and mental health faced by people after disasters; the dysfunctional emotional, social, cognitive and somatic reactions that some people may experience; and the mental disorders that people may develop (NATO/EAPC, 2009).

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 call for medium- and long-term mobilisation of resources
- governments, organisations and services should recognise people's inherent resourcefulness, but also their needs for informally provided support as well as responsive services
- attending to basic needs (safety, security, food, sanitation, shelter, interventions for 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 the public 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
- it is important to avoid the corrosive effects of rumour.

The plan should recognise that people who are affected by disasters and incidents may be able to function well for some time after the events, but they may experience greater psychosocial problems or mental disorders later, sometimes after a long period of time. Services should be designed

to recognise these common findings by providing responses immediately after events and until families' and communities' effective functioning appears to have been re-established.

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

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 that is regularly updated. Existing psychosocial services should be mapped fully and incorporated into local psychosocial and mental health plans.

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 participate in regular, realistic management training and exercises.

Each emergency, disaster and major incident planning team should include a senior representative of the agencies that are designated to deliver psychosocial and mental healthcare responses. This person should chair a multi-agency, psychosocial and mental healthcare expert advisory subcommittee that is appointed to advise the emergency planning committee.

The psychosocial and mental healthcare plans should be laid out, 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 professionals and managers of mental health services.

Care providers (volunteers and professional practitioners of all disciplines who are involved in

responding to emergencies and in providing services to support the short-term recovery of people and communities) should be recruited in advance, if possible, and screened for suitability.

First responders

First responders are a mix of people with differing capabilities. They face a range of profiles of psychosocial risk and needs for education, training, social support and peer support (Alexander & Klein, 2009; Misra *et al*, 2009; Drury *et al*, 2013). They include members of the public who are first on the scene as well as rescue and emergency staff, but 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. 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 who are offered these facilities must include the volunteers.

All professional responders, including first responders in the police, ambulance, fire-fighting, 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.

Training of response staff

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 healthcare is prepared for their roles and responsibilities. All staff who provide care should have undergone formal training and receive ongoing training,

support and supervision (IFRC Reference Centre for Psychosocial Support, 2009; Drury *et al*, 2013; Welton-Mitchell, 2013). The content and level of training should correspond with their roles and responsibilities in the stepped model of psychosocial and mental healthcare.

Senior trained and experienced members of the staff of the social and mental healthcare agencies should be appointed as formal advisers to commanders and managers at the strategic,

tactical and operational levels during planning, training and rehearsal, execution of plans in real time and review of plans and regeneration after the event.

This role requires clinical skill and training in psychosocial and mental healthcare relating to major incidents and disasters, awareness of the concepts and practices of strategic leadership and management, and training in decision-making, consultation and supervision.

Chapter 10: Operational policies for delivering services and good clinical practice

General principles

All actions, interventions and other service responses should promote a sense of safety, self-efficacy and community efficacy, empowerment, connectedness, calm and hope (Hobfoll *et al*, 2007). They should also deal explicitly with people's human rights and facilitate appropriate communal, cultural, spiritual and religious healing practices. Responses should provide general support, access to humanitarian aid, welfare services, financial services, legal advice, social support, physical support and psychological support for all of the people who are involved.

- 1 Responses should focus on families. This means enabling people who are involved to contact their families, reuniting families as soon as possible, and providing humanitarian aid, welfare services and psychosocial support for families.
- 2 Local community leaders who are aware of local cultures and particular communities should be involved in local groups for planning psychosocial and mental healthcare responses.
- 3 Efforts should be made to identify the most appropriate supportive resources (e.g. families, communities, schools, friends).
- 4 Specific formal interventions, such as single-session individual psychological debriefing for everyone affected, should not be provided. Such interventions have not been shown to be effective and may cause harm for some participants (Rose *et al*, 2002).
- 5 Formal screening of everyone affected should not be conducted, because there are, as yet, no measures of sufficient sensitivity and specificity (Bisson *et al*, 2010). However, responders should be aware of the importance of identifying as early as possible those people who have problems. Therefore, we recommend surveillance rather than screening.
- 6 Prioritisation and triage should be based on the needs of the people who are involved directly or indirectly.
- 7 Responses should include educational services regarding reactions to disasters and major incidents and how to manage them. Furthermore, making arrangements for children to return to school when it is safe to do so, even if in temporary facilities, is often an extremely important part of recovery plans.
- 8 General practitioners (GPs) and local doctors should be made aware of possible psychosocial experiences and psychopathological sequelae because they should be directly involved in delivering the first level of formal mental healthcare.
- 9 Responding organisations should provide access to specialist psychological and mental health assessments, intervention and management when it is required.
- 10 Detailed planning should occur with existing services, local authorities and governments

including the funding and appropriate extra provision to augment local services for several years following disasters or major incidents.

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

Together, these general principles predict a series of actions that may be described as psychological first aid (WHO *et al*, 2011). Psychological first aid is less a prescribed and particular therapeutic intervention and more a collective title afforded to activities that draw people who are affected by disasters into effective communications, ensure that they are offered social support, restore their agency, and endeavour to return them to connectedness with other family members and, thereby, begin to restore communities. Thus, psychological first aid is also a series of normalising actions.

Specific components of the initial responding services

Services required within the first week of a disaster or major incident

The initial responses that are required include practical help and pragmatic support provided in an empathic and flexible manner.

Providing information

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.

Written leaflets containing appropriate information and details about where to seek help, if necessary, should be provided. However, written materials cannot be relied on alone and they should not be the main form of communication given the variations in levels of literacy and reading comprehension that are evident even in high-income societies. Therefore, telephone helplines staffed by trained personnel should be launched to provide emotional support. Additionally, disaster and major incident plans should include arrangements for preparing websites and social media accounts

concerning humanitarian, welfare and psychosocial matters. They should be kept shrouded until they are required, when they can be adjusted to the circumstances and made available online rapidly.

Providing assistance and care

Humanitarian assistance centres or one-stop shops should be established at which a range of the humanitarian aid, welfare and psychosocial care services that are potentially required are based.

Psychosocial reactions should be normalised 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.

Staff who oversee the initial psychosocial care response services should work closely with the media, adhering to a coordinated communications strategy for the entire disaster/major incident response.

Services required within the first month of a disaster or major incident

People who have high levels of distress during the first month after a disaster or major incident, and especially people who have dysfunctional levels of distress or distress of longer duration, 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.

Formal assessment for health and/or social care services should be made of the needs of people who have psychosocial problems that do not remit given adequate humanitarian aid, welfare services and social support from their families and communities.

Treatment with trauma-focused cognitive-behavioural therapy (TF-CBT) should be available for people who have post-traumatic stress disorder (PTSD) (Roberts *et al*, 2009; WHO, 2013) and evidence-informed interventions should be available for people who have other mental disorders.

Services required 1–3 months after a disaster or major incident

People who have high levels of distress (see previous section) within 3 months of a disaster or major incident should be identified so that the services are able to maintain contact with them. Further contact should be offered to people and their families who continue to experience distress at any substantial level that continues for more than 1 month or who are dysfunctional on account of distress 1 month or more after events.

Formal assessments should be offered by professional practitioners of primary healthcare, occupational health and/or social services to people who have psychosocial problems that continue or develop 1 month or more after a major incident or disaster. Assessment should take place before any specific intervention is offered and should consider people's emotional, social, physical and psychological needs.

Treatment with TF-CBT should be available for people who have PTSD because it is the treatment of choice (National Collaborating Centre for Mental Health, 2005). Other treatments for PTSD with a supporting evidence base, such as eye-movement

desensitisation and reprocessing (EMDR) and stress management, should be offered when TF-CBT is not available or is not acceptable to the person (WHO, 2013).

Evidence-informed interventions should be available for people who have other mental disorders.

Services required beyond 3 months after a disaster or major incident

People who have psychosocial problems that continue or develop 3 months or more after a major incident or disaster should be formally assessed by trained professional practitioners of primary healthcare, occupational health and/or social services. Assessment should take place before any specific intervention is offered and should consider people's emotional, social, physical and psychological needs.

Evidence-informed interventions should be available for people who have mental disorders.

Work and rehabilitation opportunities should be provided to enable those who require them to re-adapt to the routines of everyday life.

Chapter 11: Caring for responders and people who intervene

Research shows that the extent and frequency of the psychosocial and mental health impacts of emergencies and disasters on rescuers and the staff of aid and healthcare agencies that respond to disasters fall between the impacts on people who were directly involved and similar impacts on people who were not involved.

There are many reasons for taking seriously the risks to the mental health of rescuers, aid workers and healthcare staff who become involved. They are covered in more depth by Williams & Greenberg (2014), as are understandings drawn

from scientific evidence about what should be done to provide training and support for people who intervene. That textbook also contains checklists of the important actions that leaders and staff should take to prepare responders before they become involved, while they are working in a disaster area and afterwards. A summarised version of the checklists is in Appendix 3.

Core to supporting people who respond and intervene are the vital necessities of ensuring that they are well briefed, well led and offered sufficient peer and social support.

Chapter 12: Managing delivery of the strategic model of care

Managing the stepped model of care that forms the core of the approach recommended in this document requires the following.

- 1 Effective command, control and coordination before, during and following a disaster or major incident.
- 2 Appointing psychosocial and mental health trained advisers at the strategic, tactical and operational levels of command to assure full integration of the services that respond to communities' and people's psychosocial and mental health needs within disaster and major incident plans.
- 3 The responsible authorities, incident response commanders, service managers and all professional practitioners to adopt an ethical framework for planning and delivering services.
- 4 The responsible authorities, incident response commanders, service managers and all professional practitioners to adopt a framework for good decision-making.
- 5 Commanders should ensure that appropriate services are made available in each phase of response and recovery. This requires services that offer:
 - immediate humanitarian aid and welfare services for everyone who needs them
 - service responses that recognise 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 the likelihood of their developing more serious psychosocial problems or mental disorders
- 6 The responsible authorities, incident response commanders, service managers and all professional practitioners should adopt pre-planned frameworks for corporate governance and clinical governance.
- 7 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, statements of the likely expectations of them, opportunities for training and rehearsal, and increased supervision and social support.
- 8 This (i.e. point 7) means that all rescuers, responders and other staff involved should have:
 - clear roles and responsibilities that are agreed in advance
 - professional standards and expectations that are clear, practical and realistic
 - effective leadership
 - access to the support of colleagues.

Appendix 1

The psychosocial and mental health effects of disasters

Direct effects on people who are affected

Primary and secondary stressors cause stress and, often, distress.

1. Immediate and short-term:
 - resilient/non-disordered responses including short-term distress
 - acute stress reactions
 - neuropsychological changes in response to acute stress.
2. Medium- and longer-term:
 - persisting distress maintained by secondary stressors
 - grief
 - mental disorders (nb: these are very frequently comorbid with other disorders)
 - substance use disorders
 - adjustment disorders
 - post traumatic stress disorder
 - anxiety disorders
 - depression
 - impact on personality.

The direct effects of complex, sustained or repeated disasters on people who are at higher risk

1. Distress (see above):
 - direct effects of complex multi-event disasters on people who are at higher risk
 - sustained distress that has an impact on functioning
2. Exacerbations of previous mental disorders of many kinds
3. Onset of first episodes of mental disorders

Indirect effects

Disasters increase medium- and longer-term psychiatric and physical morbidity because they change the secondary stressors, have short-, medium- and long-term effects on social relationships, income and resources, and change the social conditions that shape mental and physical health through:

1. increased poverty
2. changed social and societal relations
3. threats to human rights
4. domestic and community violence.

Appendix 2

The Madrid Framework^a

1	Health and wellbeing	The protection of health is the <i>raison d'être</i> of all health policy, the ultimate goal of which is to enhance the capabilities of citizens to live a full life.
2	Equity and fairness	Inequalities in health, in the probabilities of disease, and in the quality of, and access to services are found within and between all societies. They are largely determined by social factors, income, age, ethnicity, education, housing and so on, such that pursuit of health and social justice become inextricably entwined.
3	Choice	What is deemed best for a population is only randomly best for its sub-groups or for individual people. Choice and equity constitute one of the fundamental political fault lines in the landscape of health policy.
4	Democracy	In order to engender confidence in health policies, all stakeholders, and, especially, citizens and patients, need to be actively engaged. Health policies succeed in relation to the sense of solidarity and shared values that they foster.
5	Stewardship	Health is a vital public resource requiring investment by government. Traditionally, governments have been deemed to have three key duties: the defence of the realm; law and order; and the stability of the currency. In the twenty-first century, a fourth duty, to protect and enhance health, emerges as of at least similar importance.
6	Evidence	Successful policies require good data that is comparable over time and locations. All data are socially constructed. It is, therefore, important to consider not only statistical, but also the ethical and political values that are embedded in evidence.
7	Efficiency	Governments have dual accountabilities: to protect and improve health; and to ensure the optimal use of the public resources entrusted to it. Allocative efficiency is concerned both with the effectiveness of interventions and the priority afforded to them. Operational efficiency is concerned with the optimal use of resources to obtain the maximum benefit at the level of management. Efficiency in health policy is, thus, a matter of sound finance, sound science and sound ethics.
8	Synergy	Health policy and governance require cooperation between governmental agencies and a wide variety of other elements of civil society. When they interact so as to produce new ways of working, new functioning networks can be created, intractable problems can be redefined, and unanticipated solutions found.
9	Sustainability	Since most health policies are long-term exercises, provisions must be made to sustain political, organisational and individual motivations over the course of time, and of successive governments.
10	Inter-dependence	Policy and services at both global and local levels must take account of concerns that transcend national boundaries such as workforce mobility, the environment, and international agreements. At every level, there are biological, social and political interdependencies.
11	Creativity	Health policy and governance are not securely predictable and linear exercises. Successful policies and implementation require imagination, experimentation, innovation and flexibility.

a. The Framework was created from the text on pp. 2–5 in Marinker (2006). Reproduced with permission from Radcliffe Publishing.

Appendix 3

Checklists for deployed staff and their leaders^a

Checklist 1: The responsibilities and actions of deployed staff

Be honest with leaders about your previous experiences and personal needs and ask yourself the following questions:

- What are my expectations of the mission?
- Why am I going?
- Where am I going?
- What information do I need?
- Have I got the professional skills that are required?
- Can I take care of myself?
- What is involved in taking care of myself?
- What should I do to attend to my personal safety?
- What do my relatives think about me deploying and who will support them?
- Whom am I going with?
- Have I reviewed my relationships with colleagues in my team?
- Have I taken opportunities to develop good relationships and attended to any problems between me and other people in the team?
- How will I recognise if I have a problem while I am deployed or after my return?

Checklist 2: The responsibilities and actions of leaders

General responsibilities and actions of leaders include providing:

- effective strategic, tactical, operational, and practical day-to-day leadership
- adequate information for all team members
- a psychosocial support plan for the team (which should be practised in exercises and training before deployment)
- advice and support for team members if a crisis should occur during deployment (e.g. if the team is attacked, a relative of a team member becomes critically ill, or if a team member becomes persistently distressed)
- adequate social support for all team members
- psychosocial mindedness for the team.

a. Williams & Greenberg (2014). © Springer. With kind permission of Springer Science+Business Media.

Checklist 3: Preparing for deployment

In the preparation phase, it is important to create and take opportunities to align team members' and organisations' expectations to the realities that they are likely to face.

The particular responsibilities of leaders in the preparation phase include:

- Planning
- Selection: although predicting who is likely to cope well with deployment on psychosocial criteria is difficult, people are likely to cope better if they:
 - have the capacity and capability for adapting reasonably well to changing situations
 - have reasonable social capabilities
 - do not have a serious mental disorder at the time or have not had such an illness recently
- Briefing
- Team building
 - briefing
 - team training
- Training
 - personal
 - teams
- Reminding team members to attend to the anticipated needs of their families before leaving, while they are away, and when they return
- Preparing team members' families by:
 - briefing them about the risks
 - informing them about where and from whom they can get information and support during the deployment
 - briefing them about what to expect when their relatives come home
- Assisting team members to get their affairs in order before leaving and preparing for separation from home.

Checklist 4: Dealing with the realities during deployment

Team members should be offered the following facilities and services while they are deployed:

- team maintenance
- professional supervision
- managerial supervision
- physical safety and a safe environment
- adequate healthcare responses
- information and briefing
- active listening
- peer support
- facilities and opportunities for staying in contact with people at home.

Team members should NOT be offered:

- single-session critical incident stress debriefing.

During deployment, the families of team members should be:

- provided with information about progress with the mission
- provided with information about their deployed relatives if communications are poor and direct contact is not possible
- offered social support
- provided with information about whom to contact, how and where should a substantial family crisis occur during deployment.

Checklist 5: Actions for leaders to take if concerns arise during deployment

The actions of leaders should include:

1. Assessing the situation
 - assessment includes that of: the environment; affected team members' needs; and whether or not actions are required to improve the psychosocial care and supervision of the team as a whole
 - sensitively assess any impact on patients' care and safety
2. Providing informal support – provide active listening and informal support for the affected people
3. Providing advice
 - remind distressed team members to take adequate breaks and sleep, eat regularly, stay in touch with other team members and only drink alcohol in small amounts
 - remind the team to adhere to effective team duty rotas, and access to recreation, if possible
 - discuss with affected team members whether their contacts with their families at home are adequate or contributing to their worries
4. Ensuring access for the team to formal peer support
5. Reviewing the needs and safe practice of affected staff at regular intervals

This means that leaders must:

- explore indicators of stress, distress and dysfunction
 - listen actively
 - assess at intervals the ability and capacity of affected staff for work and their safety to others in doing their work
 - remember the core principles for intervening
 - arrange consultation with health services if staff members' distress persists or gets worse.
-

Checklist 6: Adjusting to coming home after deployment

- Review team members' potential for developing problems against common risk factors
 - Provide technical debriefing
 - Offer opportunities for decompression
 - Attend actively to team dissolution
 - Provide active listening
 - Do NOT offer single-session critical incident stress debriefing
 - Attend to the impacts on families of team members
 - Support team members in renewing their family relationships
-

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