Preparing for Emergencies in the NHS in England

NHS

Responding to the needs of people affected by incidents and emergencies:

A framework for planning and delivering psychosocial and mental health care

NHS England and NHS Improvement

Responding to the needs of people affected by incidents and emergencies: A framework for planning and delivering psychosocial and mental health care

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Contents

1 The purpose of this document

The purpose of this document is to provide a framework and guidance for NHS funded organisations in England for planning, delivering and evaluating psychosocial care and mental health care for people affected by incidents and emergencies.

The approach recommended here is based on that of the World Health Organization (WHO) research and professional opinion. It is important that everyone who is involved in planning for and responding to incidents and emergencies, including healthcare and other responders, should have knowledge about how people who are affected react to and cope with these events. They must also understand the factors that affect the risks that people face and how well they cope, this includes the importance of relationships, social support, leadership and care.

This knowledge should inform all plans for incidents and emergencies, which should include plans for psychosocial and mental health care. The latter plans should include actions to support and strengthen communities before incidents occur and to intensify and maintain community growth alongside personal psychosocial care in the response and recovery phases. Evidence suggests that intervening early for people at risk of developing mental health problems may reduce their severity and chronicity and subsequent impact and related costs, including healthcare costs.[6, 7]

Planning delivery of effective services is a multi-agency responsibility that requires coordination and communication. This guidance supports planning and delivery through all phases of a major incident and across agencies.

2 Who is this document for?

This is strategic national guidance for providers and commissioners of NHS funded services in England, particularly providers of mental health services and general practices. All accountable emergency officers (AEOs) and emergency preparedness, resilience and response (EPRR) practitioners must be familiar with this guidance and ensure that appropriate arrangements are in place for their organisation.

This guidance may also be helpful to partners such as local authorities, police and crime commissioners (PCCs) and voluntary, community and social enterprise sector (VCSE) organisations.

There are two accompanying resources to this guidance:

- Annexes giving a greater level of detail on stress, psychological resilience; the nature of distress after incidents and emergencies that mental health services in particular may find helpful to read
- A number of helpful templates and specimen documents such as protocols, letters and leaflets that are available on ResilienceDirect. These resources are updated regularly

3 Applicable legislation and guidance

This guidance has been developed within the context of existing legislation and guidance and should be used in conjunction with the NHS Emergency Preparedness, Resilience and Response Framework.

This document is informed by:

- Principles for Responding to People's Psychosocial and Mental Health Needs after Disasters by the Royal College of Psychiatrists and other recent scientific publications[4, 8-11]
- A study from the National Institute for Health Research published in 2012, Emergency Planning in Health[12]
- The Inter-Agency Standing Committee (IASC) and the World Health Organisation (WHO) guidance on mental health and psychosocial support in emergency settings [13]
- The requirements in the Sendai Framework for Disaster Risk Reduction 2015–2030 (SFDRR), particularly priorities 3 and 4[14]
- The NICE guideline on post-traumatic stress disorder (PTSD)[15]
- Evidence published in 2018 and 2019 about post-traumatic stress disorder.[16, 17]

4 The framework

The contents of this document are broken down into the following framework (box one):

Box one: the framework

Area/Topic	Sections	Description
Introduction: • Definitions • Background and context (How people cope with incidents and emergencies) • Principles and key approaches	5, 6 and 7	All of these considerations impact on planning well before incidents and emergencies occur and service delivery
Planning for incidents and emergencies	8	How to plan psychosocial and mental health care for incidents and emergencies
When an incident occurs	9	Actions to be taken when an incident or emergency occurs
Immediate actions required	10	Actions required in the immediate aftermath of an incident or emergency
Actions needed in the short, medium and long term	11, 12 and 13	The approach recommended is cumulative meaning that actions instituted in previous time periods should be carried on into the ensuing ones until

		the requirement for particular service elements has declined
Supporting responders and staff	14	Specific information related to meeting the psychosocial and mental health needs of responders and other staff
Annex		Additional information, resources and templates

5 Definitions

Definitions and acronyms used throughout this document are provided in Annex B. Key definitions are provided here for ease of access.

Primary and Secondary Stressors

Primary psychosocial stressors are the stressors that are generated by events. Secondary stressors are generated by circumstances, events or policies that are not inherent in incidents and emergencies but may be provoked or brought out by them (e.g. stressors related to people losing their homes and personal memorabilia, livelihoods and financial stability, infrastructure recovery, problems with insurance).

Psychosocial

The adjective psychosocial describes the dynamic relationship that exists between psychological (emotional and cognitive), social and physical effects. Each continually interacts with and influences the others. Psychosocial health encompasses the mental, emotional, social, physical and spiritual dimensions of what it means to be healthy.

Psychosocial Care

Psychosocial care offers comfort, improves how people cope with adverse events and reduces the risks of them developing psychiatric disorders. Intervening early can reduce the risks of their developing disorders later and there is strong evidence from the social sciences for the effectiveness of restoring people's social integration and providing social (emotional, relational, informational and welfare) support. Other elements of psychosocial care require further development and research into their effectiveness.

Psychosocial interventions

Activities offered to the public in the psychosocial domain are termed interventions in order to reduce any inferences that psychosocial care is synonymous with specialist mental health treatments.

These interventions are intended for people who have short-term distress, persisting distress accompanied by dysfunction or who have symptoms of a mental health problem that do not reach a diagnosis. They offer comfort, reduce the sources and

impact of continuing stress, improve how people cope with adverse events and reduce the risk of them developing mental disorders.

The numbers of people who require interventions to assist them to cope with distress consequent on major incidents is very substantial despite the majority of distressed people not being likely to develop a mental disorder. Most people derive the support they require from their families and colleagues. Many are psychosocially resilient despite their distress. Improtantly, resilient people also benefit from social support.

Mental Health Care

Mental health care describes formal biomedical and psychological treatments for people who have mental health problems. These are treatments that should be delivered by trained practitioners. Often, people who require mental health care also need continuing psychosocial care.

Social Support

Social support is based on people perceiving that they have good social networks and that these networks offer them social support. It has substantial effect sizes in promoting people's wellbeing and recovery in many settings[21]. In this context, social support 'consists of social interactions that provide people with actual assistance, but also embed them in a web of relationships that they perceive to be caring and readily available in times of need'[21,10]. Social support includes informational, operational, and emotional components.

6 How people cope with incidents and emergencies

The following paragraphs briefly summarise the effects of incidents and emergencies on people affected, including first responders and other staff. Additional material on the effects is included in Annex A to this guidance.

6.1 In the immediate aftermath

Study of people's behaviour in the interval between the onset of an incident and the emergency services arriving has shown that, contrary to popular myth, panic is rare; usually people's behaviour remains goal directed and purposeful despite many of them being upset. However, people may weigh the risks and come to conclusions about how they should act (such as re-entering burning buildings, rescuing pets and property etc.) that are at odds with the advice that the emergency services give the public. People may also be influenced by the opinions of the groups they are in at the time.

Often, the attention of people who are directly involved is very focused during incidents and emergencies. Some go through one or more cycles of **delay** and **deliberation** before they arrive at a **decision** point (the three Ds) when they decide to take action. Occasionally, but much less often, people who are affected by large-scale events that destroy the infrastructure, may be immobilised by fear and helplessness and feel hopeless.

On the contrary, many people who are directly involved are first to take action; they are the first responders. There is evidence from many events of differing natures showing that many people are remarkably altruistic in the immediate aftermath; they behave in rational and selfless ways and may put themselves at greater risk to care for strangers. These findings have been described by research on the London bombings on 7 July 2005 and a number of subsequent events.

6.2 In the short and medium terms

There is a broad spectrum of ways in which people involved directly or indirectly in incidents and emergencies react emotionally, cognitively, socially, behaviourally and physically (the components of the adjective psychosocial) before, during and after events. However, there are identifiable patterns and trajectories of response over time.

A large proportion of people who are affected by incidents and emergencies suffer distress in the two to eight weeks after single incidents. These responses may be sustained and complicated by recurrent threats of repeated events and ineffective responses. Distress may also be sustained by secondary stressors including the many welfare and financial, work, educational and social consequences of being involved in an incident.

People may also be affected by developing mental health problems that may emerge within months of an incident or across a substantial period of time, sometimes years, after events. It is important to offer support to people who are distressed but also to monitor how people affected cope so that the symptoms and signs that they might be developing a mental disorder are picked up early with a view to ensuring people's effective care.

6.3 In the longer-term

It is important to understand that people's distress may persist at levels that are below the thresholds for diagnosis of a mental health problem for a substantial length of time. Also, as work with people affected by the 2017 Manchester Arena incident has shown, people may seek assistance with their distress at vaying intervals after the incident. This may be because people have to cope with not only the impacts of the incident that affected them but also with the adversity and family matters that may ensue. People may develop mental health problems as a consequence of their direct or indirect involvement over a number of years.

6.3.1 Trajectories

There are four main paths or trajectories that people follow in the weeks, months and years after their exposure to major incidents. They are that people:

1. Suffer short-term distress (around 60 to 70% of affected people)
2. Suffer more persistent distress and make slower recoveries (around 10 to 15% of all people affected directly or indirectly by the incident)
3. Experience deteriorating responses that often involve them in suffering prolonged stress (around 10% of affected people)
4. Show high stress responses (around 10% of affected people)

People may be described as resilient if the psychosocial impacts on them are brief or minimal. The term resilience is used in this guidance to describe the responses of people who, despite being affected temporarily by distress and mild changes in their coping, tend to recover in succeeding days and weeks given the support and care of their families, friends and colleagues. There is a growing consensus that psychosocial resilience describes the coping patterns of people who follow the first trajectory above. This means that resilience does not indicate the absence of any adverse psychosocial experiences after people's exposure to very stressful events. Social relationships are very important to people's recoveries after their exposure to major incidents.

6.4 A summary of the impacts of incidents and emergencies on the people affected

There is a broad spectrum of ways in which people involved directly or indirectly in emergencies react emotionally, cognitively, socially, behaviourally and physically before, during and after events. However, there are identifiable patterns and trajectories of response over time. Box two summarises the psychosocial and mental health impacts of people's exposure to an incident or emergency.

Box two: 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**
   a. Resilient / non-disordered responses including short-term distress
   b. Acute stress reactions
2. **Medium- and Longer-term**
   a. Persisting distress maintained by secondary stressors
   b. Grief
   c. Mental disorders (NB: These are very frequently comorbid with other disorders)
      i. Substance use disorders
      ii. Adjustment disorders
      iii. Post traumatic stress disorder
      iv. Anxiety disorders
      v. Depression
   d. Impacts on personality

The Direct Effects of Complex, Sustained or Repeated Disasters on People Who are at Higher Risk

1. **Distress** (see above)
   a. Direct effects of complex multi-event disasters on people who are at higher risk
   b. Sustained distress that impacts on functioning
2. **Exacerbations of previous mental disorders of many kinds**
3. **Onset of first episodes of common mental disorders**

Indirect Effects
Disasters, and particularly repeated events, increase medium- and longer-term psychiatric and physical morbidity because they change the secondary stressors, medium- and long-term effects on social relationships, income and resources, and the societal conditions that shape mental and physical health through: **1. Increased poverty** **2. Changed social & societal relations** **3. Threats to human rights** **4. Domestic and community violence**

Short-term distress, which may be accompanied by brief impairment of functioning, is the most common reaction to an incident or emergency. Most people are able to return to their usual activities after an incident and this is a characteristic of the most frequent pattern of coping and adaptation.

A substantial number of people may suffer distress that is persistent and which may be accompanied by social impairment. Often it is sustained by secondary stressors e.g. housing, legal, work and financial difficulties. People whose distress persists require assessment and advice about managing the circumstances that are affecting them. The sudden loss of a loved one is also linked to grief and grief may be prolonged in populations affected by major incidents.

People may increase their use of alcohol, drugs and other substances following a major incident. It may be that some survivors use substances as a means of coping.

6.4.1 Prevalence of mental health problems

The most common mental health diagnoses after incidents and emergencies include:

- Post traumatic stress disorder (PTSD) - estimated at:
  - 30-40% among direct survivors
  - 10-20% among rescue workers
  - 5-10% in the general population
- Depression is highly prevalent post-disasters and is often comorbid with PTSD
- Anxiety, panic disorder and phobias are also common

These prevalence figures are for adults and are indicative only.

Young people exposed to incidents or emergencies may have high rates of psychopathology. Research has reported that:[18]

- 29% experienced a major depressive episode
- 23% developed conduct disorder
- 16% had alcohol dependence.

Between 20 and 30% of young people who are survivors of an incident are at risk of developing a major depressive disorder in the first few months afterwards compared with 4-10% in the general population. The prevalence of PTSD is also high among children directly exposed to an incident or emergency.

These disorders rarely present in isolation and tend to co-occur. Also, the prevalence rates tend to be higher when people are exposed to incidents or emergencies caused by violent or terrorist events and lower after, so called, 'natural' disasters.

PTSD, as defined by the NHS website, is a disorder caused by very stressful, frightening or distressing events and can be caused by events such as serious accidents, sexual assault, mugging or robbery, and military service. The evidence shows that, while it occurs as a consequence of people being affected by emergencies and disasters, its onset tends to come in the medium and longer terms. Also, adjustment and anxiety disorders, depression and substance misuse may be as or more frequent medium and longer-term occurrences.

It is known from research on general populations that only a small proportion of people who have PTSD seek treatment following incidents and emergencies, and often years pass between the onset of symptoms and their seeking treatment.[19,20] Delivering healthcare services is usually challenging in communities after incidents because it usually requires coordination and cooperation among health services, social care services, schools, community organisations, non-governmental organisations and the media. This emphasises the importance of planning across organisations and sectors.

Priority 3 in the Sendai Framework for Disaster Risk Reduction recognises the particular needs of people who have life threatening and chronic diseases. They should be taken into account when local plans are developed. Priority 3 draws attention to the importance of recognising and appraising realistically the circumstances of people who have pre-existing illnesses.

6.4.2 Long term assistance

A growing body of research is making clearer how long the impacts may persist. While the vast majority of people affected are unlikely to need services beyond a year, a small minority of people may require assistance from mental health services and social care services over a much longer period of time. This should be bourne in mind when planning service responses and considering the financial consequences.

6.4.3 Physical symptoms

Primary care services must be included in planning responses in each area. That is because a substantial proportion of people affected by a major incident, including responders, may seek assistance from primary care services for somatic symptoms.

Common symptoms (prevalence range 3 to 78%) are:

- Headache
- Fatigue
- Abdominal pain
- Shortness of breath

Although physical symptoms generally subside over time, some persist for years following an incident. People's symptoms after an incident are often linked to histories of psychosocial difficulties before the incident. This emphasises the

importance of primary care in identifying people who may be distressed and/or require assessment for possible mental health disorders.

6.4.4 Risk factors

The intensity of people's exposure to events and the loss of lives of family members and loved ones are risk factors for their developing mental health problems following an incident.

Perceived threat to life during the incident, experience of dissociation or strong negative emotional responses during or immediately after the incident and lack of perceived social support afterwards are linked to people developing mental health problems after incidents.

Examples of pre-incident risk factors include:

- Pre-existing social problems (e.g. poverty and discrimination)
- Female gender
- Younger age
- Prior exposure to traumatic events
- Past mental health problems
- Past psychiatric disorders

7 Principles and key approaches

7.1 Principles

Incidents and emergencies have both direct and indirect impacts on people, families, communities and responders. It is important to ensure that responses are well coordinated so that people can obtain the right help at the right time. Therefore, responses should be planned, tested through exercises and delivered to:

- Ensure psychological safety
- Provide information about people's general distressed reactions to incidents
- Distinguish people who are distressed and require psychosocial care from those who require mental health care[8]
- Offer early intervention and active outreach with the aims of minimising distress and reducing the numbers of people who are at risk of developing longer-term mental health problems[8]
- Provide assistance for the substantial number of distressed people through lower-intensity psychosocial interventions[8]
- Provide more specific interventions (e.g. evidence-based psychological interventions) for people who are assessed as needing them in a timely and effective manner
- Recognise the important role that GPs have in identifying people in need (including the public and professional practitioners), monitoring and supporting people who are affected and recognising when and how to refer to specialist services

The psychosocial and mental health care responses to an incident should involve:

- Integrated planning and service delivery

- Timely and agile responses
- Restoring physical and psychological safety for people and communities
- Delivering a culturally appropriate approach
- Enabling choice and control (agency) for survivors and their families
- Active outreach
- Evidence-based interventions
- Collaboration across NHS and non-NHS sectors
- Evaluating outcomes and cost effectiveness

Psychosocial care is intended to sustain people in the aftermath, reduce their distress and suffering and reduce the risks of people developing mental disorders so far as is possible. It can be delivered by non-specialist health practitioners, including staff who work in community services, people who work in the voluntary, community and social enterprise (VCSE) sector, and education and social care professionals. It should be available to anyone who is affected by an incident including people who are distressed and those who have mild mental health needs. Practitioners who deliver it should be supervised by practitioners who have experience and training in mental health care.

Mental health care should be provided for everyone who has moderate to severe mental health needs, including those with a diagnosis of a mental health problem or disorder. These interventions are usually delivered by specialists who work within mental health services for children and young people (CAMHS), improving access to psychological therapies (IAPT) services, and mental health services for adults (AMHS).

7.2 Key approaches

The approaches adopted during the planning phase should:

- Provide services for children, young people, families and adults that enable them to develop and maintain their abilities to cope. This means that they should consider the important role of parents and carers, families, work colleagues, other trusted adults and community resources, including schools and colleges
- Planners should be aware that, if parents are affected by the incident, their abilities to support their children and identify when they are at risk may be temporarily reduced
- Establish a plan that sets out clearly the roles and actions to be delivered by primary care, community and specialist services to provide initial support and then to recognise and respond to the need to monitor people whose symptoms persist and to provide screening for people who are thought of as at risk of developing a mental health problem
- Provide clear and consistent messages and routes of communication to the public and all key stakeholders regarding key approaches and access to support, including responses to major incidents that are anticipated
- Ensure approaches are evidence-based and proportionate, flexible and timely
- Ensure that all psychosocial and mental health care responses are provided:
    - As part of a local multi-agency response
    - Within a clear governance framework

    - To support coordinated delivery of care that manages key interfaces and transitions seamlessly
- Include a review of current capacity within local services for delivering:
    - psychosocial care and take steps to address projected gaps
    - specialist mental health care that include assessment and evidence-based treatments that are appropriate for the projected impacts and needs, and ensure any resource gaps are addressed
- Ensure professional practitioners, managers and staff are appropriately qualified and have access to training, good leadership, support, and supervision

Planners, commissioners and practitioners should be aware that:

- A common but erroneous assumption is that everybody involved needs counselling or psychiatric treatment in the immediate aftermath of a major incident
- While social support is a natural and powerful intervention and there is evidence that it can help people, single session stress debriefing and brief interventions that ask people to re-experience the events that they have survived should be avoided. NICE states that psychologically focused debriefing should not be offered 'for the prevention or treatment of PTSD'[15]

8 Planning

This section describes the roles and responsibilities and the actions to be taken in planning psychosocial and mental health responses to an incident or emergency.

8.1 Commissioners and providers of NHS funded services

Commissioners and providers of NHS funded services should work together, through their local health resilience partnerships (LHRP), to ensure that arrangements for delivering psychosocial care and mental health care during and after incidents and emergencies are integrated into the wider planning arrangements for response and recovery. This includes negotiating care pathways for people who experience each of the four major trajectories of reaction to incidents. Planners should also be aware of the timescales in which people who are affected may have needs for continuing psychosocial and mental health care.

Planning requires commissioners and providers of NHS funded services to assess the risks to people, families, communities and staff of both primary stressors and secondary stressors that arise generically from incidents. This analysis should inform plans for effective responses.

The likely impacts on local populations from the range of risks outlined in the community risk register must be identified and used to set common consequences that form the basis of any planning assumptions.

Top-down approaches to delivering services are essential if there is significant and/or rapid devastation and continuing threat, but where possible, commissioners and the agencies delivering psychosocial and mental health care should plan interventions in conjunction with leaders of affected communities because coproduction is more effective.

Services should be reviewed to ensure that there is a common understanding and agreement on models of care that are to be used following an incident as well as clarity about the responsibilities of particular organisations, including primary and community care. The LHRP should ensure, through the multi-agency local resilience forum (LRF), that local planning incorporates the roles and responsibilities of partner organisations, including VCSEs, that may be involved in any response and recovery to incidents and emergencies. This should also include the occupational health arrangements for staff who are affected (see Section 14).

Organisations that deliver psychosocial care and mental health care should plan interventions with leaders of local communities supporting the principles of choice, collaboration and trust. This should include consideration of people's social environments and cultures, and the needs of their families and communities.

This guidance recognises that, presently, there are relatively few practitioners who are trained to provide either psychosocial care or mental health services that are effective. Instead, the pattern has been one of ad hoc learning in the aftermath of events. In order to remedy this circumstance, comprehensive training and exercising

across the full range of service responses that may be required must be in place including, but not limited to:

- Training for responders in recognising and responding to distress and in differentiating anticipated reactions from pathological reactions shown by adults and children and young people and in themselves and colleagues
- Training for service managers and practitioners on how to support staff exposed to incidents and emergencies, including recognising their distress
- Training for responders in understanding and using the local care pathways that have been established before incidents occur
- Understanding the differing requirements for actively responding to survivors' needs of incidents that affect populations local to the site of the incident (concentrated incidents) as compared with incidents (dispersed incidents) that affect people who come from dispersed areas across the UK. This includes events that occurr overseas that affect UK nationals. Dispersed and overseas incidents are likely to require liaison with services in other areas in england and the devolved administrations

Research and evaluation should be an integral part of the response to major incidents and should be set up from the early stages in collaboration with NHS England and NHS Improvement. Planning beforehand facilitates effective research that begins rapidly after events.

8.2 Communication

Managers who are responsible for leading on communications in provider organisations should work closely with the communications teams in NHS England and NHS Improvement to ensure a consistent and coordinated strategy is developed. They should also work with VCSE services, Public Health England (PHE) and other partner organisations in identifying sources of advice and guidance. Advice about communications with the public about risks is available in the literature including the work of Bish et al.[32].

The content of messages, including information leaflets, should, as far as possible, be pre-prepared with the language used being relatable to and accessible for the broad population, including additional formats and languages. The information should reinforce choice, collaboration and the availability of any care that might be required to enhance psychological safety. See, for example, Coping with Stress following a Major Incident – an NHS leaflet for the public. The information provided should include practical information and advice (e.g. acknowledging distress, strategies to support recovery and how to contact services for additional support).

8.3 Resources

During local planning for incidents and emergencies the following matters should be considered:

- Auditing community resources currently available, including the capacity and skills of staff and availability of information about self-help

- Assessing the training needs of the workforce, considering their abilities to provide psychosocial and mental health care after an incident including specialist mental health services for adults and children and young people (CYP)
- Agreeing the framework and escalation process by local and regional commissioners. The response and model of service delivery is likely to be dependant on a number of factors including the existing capacity and capability within current services, the numbers of people affected, the nature of the event and geographical coverage and the needs of complex or diverse populations
- The commissioners should model a number of scenarios so that they are able to respond rapidly during incidents and then adjust their responses as information about the incident becomes available. These response scenarios range from business as usual, for small-scale events to which existing services can accommodate, through to arrangements for resource sharing across multiple commissioners (local and national) and providers for large-scale events
- Local and regional commissioners should identify potential services, such as major trauma centres, where large-scale outreach programmes can be delivered if required, along with the associated resources
- Locally developed integrated care pathways for psychosocial care and mental health care should be developed so that practitioners understand the roles of their own and other organisations following an incident
- The needs of responders and healthcare staff must be recognised within the pathways that are negotiated. These integrated care pathways for psychosocial care and mental health care should be agreed between organisations during their planning and tested in exercises

Planning should appraise the resources required (including the staff, estates and information technology support) to deliver accessible and effective psychosocial and mental health services for people of all ages. This appraisal should include assessing what is required to deliver a programme for assessing and screening the mental health needs of people who are affected.

The plans should cover psychosocial and mental health care required by NHS staff (see Section 14). Every provider of NHS funded services should ensure that they have in place plans for delivering psychosocial care for their stfaff in response to incidents.

8.4 Leadership

Each organisation should appoint a designated lead for planning and delivering psychsocial care in response to incidents and emergencies. This also applies to mental health trusts, which should also be engaged in designing and planning mental health care responses to meet the needs of people involved in and/or affected by incidents.

The commissioners and providers of NHS funded services in each area should agree, through the LHRP, whom from among the designated leads is to be the overall leader of psychosocial and mental health care across all the NHS funded organisations. That person should be responsible during planning for ensuring that the design of responses and delivery of psychosocial care and mental health care for survivors and their families and for staff during and after incidents are appropriate.

They should ensure all organisations are aware of the differing nature, yet equal importance, of providing ongoing physical and psychosocial care.

8.5 Information and data sharing

It is essential that appropriate information is shared across health organisations and with appropriate partner organisations during the planning, response and recovery phases of incidents and emergencies. During the response and recovery phases, this may include the need to share personal data. There should be awareness of the extended timescale of the response phase in meeting people's psychosocial and mental health needs. Continuing collection of information about the demographics (e.g. age, needs of the population affected, including special needs) of groups, families and communities is vital to support the responses available throughout the duration of the psychosocial and mental health responses.

The Civil Contingencies Act 2004 gives an explicit duty to responders to share information that supports the response to an incident. This means that local organisations should agree how relevant data should be collected regarding impact on the public and professionals including information on those injured, deceased (to ensure appropriate support to families), and a list of first responders.

When sharing personal data, consideration of the risks and potential harm that may arise if the information is not shared should be considered. Data sharing should balance the potential damage to individual people and, where appropriate, the public interest of keeping information confidential, against the public interest in sharing the information. In relation to legitimate interests, a UK study identified that most of the people who were surveyed reported they would find it acceptable for their details to be shared in order to facilitate a mental health response to a major incident[22].

The principles outlined in the live consultation document, Data Sharing in Emergency Preparedness, Response and Recovery, can be used as a guide when considering data sharing arrangements[33].

The General Data Protection Regulation (GDPR) must be followed when preparing information sharing agreements. During collection of personal data a statement that the information may be shared should be included, where possible, to inform people about how their information may be used. An agreed template or a memorandum of understanding should be negotiated by relevant organisations to ensure effective information sharing. It should include what information is to be shared, and how it is stored securely and disposed of.

8.6 Health responders

NHS funded organisations and services should identify staff who are likely to undertake a response role during an incident and ensure that they are prepared for their role, and have the knowledge and skills to initiate delivery of psychosocial care for themselves, their patients and the public. Managers must have appropriate knowledge and skills to support the psychosocial care of affected staff. This matter is expanded on in Section 14 of this guidance.

8.7 Developing psychosocial care and mental health care

Mental health services should work with partner organisations, including primary care, local authority, VCSE and the police to develop appropriate local care pathways for delivering psychosocial care and mental health care. This should include referral pathways for the pubic and staff affected. They should be built on graduated, or stepped, responses from initiating psychosocial care through to specialist mental health services for people who are identified as having significant risk factors, existing mental health needs, and/or who show symptoms and signs that may indicate the possibility of their having a mental health problem.

Mental health services should be represented in LHRPs and ensure that coordinated local psychosocial care and mental health care responses are developed and tested in advance of incidents occuring.

8.7.1 Psychosocial care

Providers and trainers should have regard to the general principles for designing and delivering psychosocial interventions in the immediate aftermath of events. The aims of psychosocial care as early as possible are to:

- Sustain people in the aftermath of events
- Reduce their distress and suffering
- Reduce the risks of people developing mental disorders, so far as is possible
- Enable people to regain their sense of choice and control and a perception of themselves as effective people (agency)

The objectives (box three) are to:

Box three: objectives of psychosocial care

1.	**Provide early intervention for everyone who is involved** The early interventions in communities after emergencies should consist of social support and bolstering them. This means ensuring that everyone who is affected has access to early positive social support from their natural social networks, volunteers or professionals
2.	**Ensure that people are provided with practical interventions that offer:** • Informational social support • Emotional social support • Operational social support
3.	**Ensure that people are provided with interventions that are available:** • In proximity to where people are • As soon as possible • With the expectancy that people will recover • As simply as possible

4.	**Base interventions on core actions:** • Provide comfort through active reflective listening if and when people wish to talk about their experiences • Provide survivors and their relatives with honest, accurate and timely information • Help people to place their experiences in context by understanding which reactions are anticipated while being aware that some people develop mental health problems (this may be called 'normalisation') • Advice that enables people to seek further help
5.	**Deliver social support for people by enabling them to sustain the their social identities and restore their agency through:** • Effective and visible community leadership • Restoring and reuniting families and community groups • Re-opening schools • Restoring work opportunities

8.7.2 Mental health services

Service managers should assess existing staff capacity and skills for delivering NICE-compliant treatment for children, young people and adults and access to specialist supervision. Leaders in each mental health service should be trained and able to provide strategic and operational advice during the planning phase and when rehearsing responses.

Mental health services should support work with local providers of emergency care and trauma care to train first professional responders in initial psychosocial care. VCSE, local community services, GPs, social care and education services may require additional training on people's responses to major incidents and evidence-based approaches to support CYP and adults presenting with mild mental health needs.

Managers of mental health services should ensure adequate staff are trained and are mobilised as required. Any gaps in resources (capacity and skills) should be addressed through discussions with local commissioners and training providers (e.g. the Health Education England (HEE) learning collaborative for IAPT programmes).

9 When an incident occurs

9.1 Immediate actions relating to psychosocial and mental health care

Incidents have both direct and indirect impacts on people, families, responders and communities. It is important to ensure that coordinated and accessible support, including information, is available to everyone who may be affected so they can access the right help at the right time.

It is important that everyone who is affected by disasters and their families receives information about common reactions to these events and the actions they might take to protect and support themselves and their families. Survivors of the Manchester Arena incident of 2017 say that they were keen to have soon after incident the name and contact details of someone to whom they can turn later for advice about their experiences and feelings.

As soon as a major incident is declared all relevant commissioners and providers of NHS funded services should implement their planned immediate psychosocial response that focuses on ensuring psychological safety and providing social support for people who are distressed, including staff.

They should:

- Activate the agreed local data-sharing agreements across relevant organisations as soon as a major incident is declared
- Ensure practical support and psychosocial care are universally available and effectively coordinated with the plans made to provide acute medical assessments and treatments
- Ensure that the arrangements for psychosocial care are coordinated with the plans to deliver psychological screening, assessment and mental health care.

9.2 Leadership

The leaders of psychoscial and mental health care should respond to an incident in their area by:

- Activating the agreed local psychosocial and mental health care plans
- Ensuring delivery of psychosocial and mental health services, including support for staff, and ensure that standards and practice are evidence-based and pragmatic
- Ensuring that data-sharing agreements across relevant organisations are activated and monitor the effectiveness of data sharing with and between organisations that are responsible for commissioning and delivering psychosocial and mental health care

9.3 Governance and reporting

Leaders should ensure that the agreed organisational governance response in an emergency setting is activated. This includes notifying key operational and clinical leaders across the system.

9.4 Communication

A variety of platforms should be used to communicate information with the aim of ensuring survivors and the public know who to contact for information and support. In the immediate response to an incident, this may be through established mechanisms, such as NHS 111. It is essential that all services are aware of the potential for increased demand.

Communications departments should engage with local media to maximise responsible media coverage and be prepared to challenge inappropriate, invasive reporting.

9.5 Psychological first aid

Psychological first aid (PFA) is one framework for delivering psychosocial care during and in the aftermath of incidents by reducing survivors and relatives' initial distress and fostering their adaptive functioning. It is not a single intervention or treatment, but an evidence-informed modular approach that is designed to respond to people's psychosocial needs after emergencies.[1,4,5] A summary of the core components of PFA includes:

- Initiating contact and engaging with affected people in a nonintrusive, compassionate and helpful manner
- Providing immediate and continuing safety
- Providing physical and emotional comfort
- Assisting survivors who are overwhelmed or distraught to stabilise their feelings
- Reconnecting survivors with the families and communities
- Gathering information to determine the immediate needs and concerns of people who are affected in order to tailor interventions
- Providing practical assistance to help survivors to address their immediate needs and concerns
- Connecting survivors with people who can provide social support and with services in the community
- Providing information about events and services and about how best to cope
- Linking survivors with more specialised services, if they require them

9.5.1 The CALMER Approach

The CALMER approach to initiating and delivering PFA has been developed and tested by the British Red Cross.[25] Its elements are summarised in box four. The headings provide helpful prompts for holding conversations with very distressed people.

Box four: The CALMER approach

C	Consider	The situation; the needs of the person; your needs
A	Acknowledge	The situation; who you are
L	Listen	Use active listening skills, learn from what people say
M	Manage	Safety; the situation; people's expectations; people's needs; monitor changes
E	Enable	Explanation and empathy; provide information; facilitate decision-making; facilitate contacts with families, friends, colleagues etc, sign-post people to services they require
R	Resources	Know where to get support for the people affected and for yourself

9.6 Mental health services

Specialist CAMHS and AMHS, including crisis and liaison mental health teams, should be available to receive calls from the psychosocial care and mental health leads in all NHS funded organisations about delivering support for the public and staff, including delivery of staff support groups.

10 Actions required in the days immediately after and up to four weeks following an incident

Services and organisations that deliver psychosocial and mental health care should be coordinated through local care pathways and integrated within the wider response and recovery plan including with primary and acute healthcare services.

The principle of evidence-based and appropriate care available at the right time must be followed at all stages of the clinical pathway. It is essential to distinguish between providing lower-intensity psychosocial interventions for the greater number of people who become distressed and mental health treatments for people who develop mental health problems.

The general analysis of the risks to people, families, communities and staff arising from primary and secondary stressors that arise from incidents and emergencies that was conducted in the planning phase should be revisited and revised in the aftermath of an incident in the light of the details of the particular event. The revised analysis may require adjustments to the general plan for effective, responsive and timely psychosocial care and mental health care.

GPs and other primary care practitioners are important in recognising people who may be at greater risk of developing mental health problems. They should offer monitoring for people at risk and support for people who are affected. Information, including advice on plans for assisting people who are affected, and details of how GPs can gain access for their patients to local care pathways for psychosocial and mental health care, should be available to them.

Experience of local incidents shows the importance of providing one-stop centres at which people can obtain up-to-date information, advice about where help can be obtained (welfare, locating missing relatives, social support, specialist care etc.). Commissioners and providers of psychosocial care and mental health care should consider making their services available through centres of this nature depending on the concentrated or dispersed nature of each incident.

People who may be at greater risk of developing mental health problems and who require active monitoring and recurrent screening should be identified and receive a collaboratively developed care plan to ensure that they maintain contact with services.

10.1 Communication

Communications related to the incident must be coordinated between responding organisations and consistent at local, regional and national levels.

Communications should contain appropriate messages for the public to ensure physical and psychological safety using a variety of methods, appropriate to the target audience. Messages should include information about possible risks, and their mitigation, and where to find further information and assistance.

An important part of psychosocial care is messages for the public that are intended to provide people with perspectives on what to expect with respect to their psychosocial reactions to incidents (a process that may be described as normalising). They should provide information on distress and coping mechanisms, and using social networks (family, friends and colleagues) to support recovery. These messages should also identify to whom people should turn for further support and assessment if their distress does not improve within the next two to four weeks. Annex C identifies resources that may be useful to assist with these tasks.
Communications should ensure that people understand that help can be obtained through GPs if distress or other symptoms are persistent. They should make it clear that mental health problems are treatable. They include PTSD, depression and anxiety disorders (generalised anxiety disorder and panic attacks) and develop in a minority of people who are exposed to incidents and emergencies.

It is important to recognise the vital role of parents and carers in supporting children and young people who are affected. It is important for adults to be able to listen to children, provide them with information and re-establish routines.

10.2 Collecting information and community support

Continuing collection of information about the demographics (e.g. age, needs of the population affected, including special needs) of groups, families and communities is vital throughout the response and recovery phases. This information is needed to support and adjust the responses delivered.

Liaison between commissioners and providers of NHS funded services, the local authorities and public health services should ensure that approaches to psychosocial care are established that reach out to everyone affected.

Restoring the functioning and the social fabric of communities is a critical part of a comprehensive response to an incident. It creates optimism and is key to initating people's recovery. It could be carried out through a community engagement plan and should involve:

- Identifying formal and informal leaders and assessing what they may need to support their communities (e.g. information, guidance, resources)
- Making use of community leaders' knowledge of affected communities, their strengths and the risks they face in addition to the impacts of the incident
- Providing information and activities that orientate people's understanding of what to expect with regard to their social, emotional and physical experiences over time, and this process offers emotional support
- Ensuring that there are adequate responses to people's practical needs and protecting social and community relationships
- Signposting people to services that are able to respond to their psychosocial and mental health needs.

Work with multi-agency partners is essential to support communities with important activities such as re-opening schools, community facilities and restoring work opportunities as soon as reasonably practicable. Local authorities should be advised

that, usually, education services, including schools, colleges and universities, should remain open, reopen early or be replaced by interim facilities.

10.3 Leadership

The leader with overall responsibility for local delivery of psychosocial and mental health care provided by all NHS funded organisations should work with the psychosocial and mental health leaders in each NHS funded organisation involved to continue to ensure that services and organisations are coordinated through local care pathways and integrated within the wider response and recovery plan, including with primary and acute healthcare services.

This leader should ensure that psychosocial care and mental health care responses are regularly measured against the needs of the people who are affected. If further resources are required, this should be raised through appropriate incident management arrangements for discussion with local and national commissioners.

The leaders of psychosocial and mental health care should continue to:

- Monitor the effectiveness of the agreed local psychosocial and mental health care plans and care pathways
- Ensure delivery of psychosocial and mental health services, including support for staff, and ensure that standards and practice are evidence-based and pragmatic
- Ensure that data-sharing agreements across relevant organisations are effective within and between organisations that are responsible for commissioning and delivering psychosocial and mental health care
- Review information collection and sharing in order to monitor and ensure services are able to respond to the developing needs of people affected by the incident (public and professionals) and have the capacity (staff and skills) and resources to deliver psychosocial and mental health care as outlined by local pathways
- Monitor the agreed organisational governance response for incidents and emergencies, including notifying key operational and clinical leaders across the system

10.4 Psychosocial care

People should continue to be offered psychosocial care and especially those people who continue to experience distress but do not meet the threshold for referral to specialist mental health services. Survivors should be assessed for the impacts of secondary stressors as a key step towards reducing their impact and enabling survivors to seek further help, when appropriate.

Survivors should also be offered monitoring over time. This reflects knowledge that people present their problems and needs at varying intervals after incidents and emergencies. PFA lies at the core of psychosocial care in the immediate aftermath of events, but tailored psychosocial care is likely to be required throughout the response and recovery phases for similar reasons.

Mental health services should work with VCSE and other partners to ensure that practical and social support and agreed information about emotional reactions and potential mental health problems are available to people who are affected by the incident. This includes providing written information but also opportunities for converstaions by phone and face-to-face.

10.5 Mental health services

The specialist mental health services should ensure that they offer support to primary care, community services and schools and colleges. This includes providing information about what to do if they are concerned about children, young people or their families.

People who have experienced mental health problems or traumatic events before the incident should be recommended to contact the specialist mental health services for an assessment. Services should assess the impact that the incident has had on those people who have had pre-existing mental health problems or psychiatric disorders to ascertain if people in these circumstances have increased levels of need and the possible risks to the continuity of their care due to increased demand on, or dislocation of services and their displacement from their homes. In particular, the mental health services should offer trauma-focused cognitive behaviour therapy (CBT) to people who have acute stress disorder (a syndrome similar to PTSD that is persistent but which occurs before PTSD can be diagnosed a month after the incident) or clinical symptoms of PTSD.

Mental health services should prepare outreach and screening programmes, that are suitable for the population affected. The designated overall leader of psychosocial and mental health care should ensure that mental health teams receive appropriate information including contact details for people who have been affected.

One way of offering monitoring, assessment and screening is to make them available at facilities offered to people who report distress. In this circumstance, the monitoring and screening services should offer access to psychosocial care for people who do not reach the threshold for referral to specialist mental health services and referral for specialist mental health care to people who do reach the threshold.

11 Response in the short term (one to three months)

The services provided should be active and flexible and build on using existing resources that are available within the health system and local communities. They should collaborate with VCSE and other partner organisations. Access to psychosocial care should continue to be available for everyone who is affected and especially those people who do not meet the criterial for referral to specialist mental health care services.

The services should understand that there may be survivors who have unrecognised, or hidden, yet serious problems; they may be reluctant to use the services offered due to stigma, social or cultural concerns or they may not recognise that their experiences and symptoms require assessment and care. Therefore, it is vital that a variety of approaches is employed to identify people who are affected with the intention of signposting them to care that they require. The approach taken should include coordination with local authorities, community leaders and groups, VCSE organisations, schools and religious institutions and the use of social media to allow, everyone including children and young people access to services confidentially.

In the first three months after an incident, it may be unclear whether people who continue to be distressed are taking longer to recover, perhaps because of the secondary stressors that are affecting them, or whether they have a mental health problem. In other words, the trajectory of their experiences may remain unclear. Early recognition and an appropriate referral are particularly important for people who have sustained problems and high levels of stress.

The population affected, including particularly people who are at risk of developing mental health problems and people who have had a problem previously, should be monitored and screened to ascertain those who need specialist assessment.

Pathways should be designed during the planning phase by the mental health services working in coordination with primary care and put into action as soon as an incident occurs so that people at risk can access:

- Early assessment in primary healthcare
- Assessment, monitoring and screening by services created to offer tailored responses after the major incident
- Onward referral to specialist services

These pathways must be agreed with the practitioners involved and publicised.

Routine use of a validated, brief screening tool should be considered for people who are at high risk of developing PTSD one month after the incident. Its use should be repeated in line with the practices of a local screening programme. Assessment, monitoring and screening programmes should be available for everyone who is affected, including staff.

It remains vital to continue to collect information about the people who are affected and to continue to adjust the assessments and interventions offered and the contents

of the care pathways to reflect the impacts and circumstances of particular incidents and the populations they affect.

11.1 Communication, information and data-sharing

Information about where to access psychosocial care services should continue to be made available. Monitoring services and screening programmes should be promoted along with information on how to access mental health screening.

Therefore, it is important that organisations continue to share relevant information during this time. That is because, months two and three after an incident define the time when it is becoming clearer which people have symptoms of mental health problems rather than continuing distress. This circumstance may continue through the next several years and so it is important to sustain efforts to attract people at risk to monitoring, screening and mental health care.

11.2 Resources

This is likely to be the period after an incident when it is particularly important to review resources and ensure adequate planning to deliver mental health treatments for people who are affected in the short to long terms.

It is especially important to ensure that the services do not experience resource gaps. Appropriately, returning to 'business as usual' for the services that deliver psychosocial care and mental health care may take much longer than the commissioning agencies may estimate for the other healthcare components of responses to incidents.

11.3 Leadership

The leader with overall responsibility for local delivery of psychosocial and mental health care provided by all NHS funded organisations should work with psychosocial and mental health leaders in each organisation involved to continue to ensure that services and organisations are coordinated through local care pathways and integrated within the wider response and recovery plan. This includes coordinating care pathways with the primary and acute healthcare services.

The leaders of psychosocial and mental health care should continue to:

- Monitor the effectiveness of the agreed local psychosocial and mental health care plans
- Ensure delivery of psychosocial and mental health services, including support for staff, and ensure that standards and practice are evidence-based and pragmatic
- Ensure that data-sharing agreements across relevant organisations are effective within and between organisations that are responsible for delivering psychosocial and mental health care
- Monitor the agreed organisational governance response in an emergency setting, including notifying key operational and clinical leaders across the system

- Review the information from collection systems in order to ensure services are able to respond to the developing needs of people affected by the incident (the public, practitioners and managers) and have the capacity (staff and skills) and resources to deliver psychosocial care and mental health care as outlined by local pathways
- Report relevant information to local resilience forums regarding sustaining services to meet the needs of people who are affected and the capacity within the system

11.4 Psychosocial care

People should be offered psychosocial care and especially those people who continue to experience distress but do not meet the threshold for referral to specialist mental health services. They should be offered monitoring over time.

PFA continues to lie at the core of psychosocial care in the aftermath of events. PFA is likely to be required throughout the response and recovery phases. This advice reflects the experience that people present their problems and needs at varying intervals after incidents and emergencies.

Everyone who continues to be distressed should be assessed for the impacts of secondary stressors with a view to taking steps to reduce their impact and enabling survivors to seek further help, if appropriate. People who are thought to be experiencing secondary stressors should be offered opportunities to explore their wider social, educational, employment and recreational needs. Suitable non-healthcare interventions may be required.

11.5 Mental health services

Mental health services should provide early specialist intervention that involves screening, clinical assessment and referral for treatment. This approach enables significant, positive developments including:

- Having an easily accessible, all-age, single point of contact for information and advice
- Ensuring that everyone who is affected has the opportunity to talk about their experiences and is referred to appropriate, more specialised services, according to their needs and pre-agreed pathways of care in a timely and appropriate manner
- Enabling access to the range of specialist mental health services that are available to the affected population as close to home as possible
- Ensuring that screening and assessments are undertaken by staff who have specific training, expertise and experience with those tasks
- Enabling a fast-track to mental health care within the care pathways for people who require it
- Multi-agency collaborative working and appropriate information sharing
- A coordinated, family-based approach for children, young people and their parents or carers who may be affected; this is important because parental mental health needs and responses to the incident are key factors that

influence their childen's and young people's responses to treatment[26]. This collaborative approach should include ensuring that practitioners are engaged who are trained and experienced in working with children, young people and adults

In summary, services should be established to monitor and initiate brief screening and assessments for people who:

- Have unmet needs
- Experience sustained distress due to secondary stressors
- Require psychosocial interventions
- Need assessment by a specialist mental health service

These services may be delivered by a purpose specific facility designed and established for the purpose or by several services working together.

Screening for impaired functioning, increased substance use, symptoms of PTSD, depression and anxiety, and risk to self or others and which is followed by specialist assessment, for people who require it, should be available for people whose distress and dysfunction persist at substantial levels for four weeks after an event, or earlier if they worsen over time[17].

It is important to be aware that parents and carers of children and young people may not always be able to provide accurate accounts of their children's mental health because of their own distress or stigma. Screening should therefore be undertaken through direct assessment of each child or young person who is considered to be at greater risk[27].

Monitoring and screening may need to be recurrent for up to five years after an event. During the first year, screening should take place every three months, every six months in the second year, and once a year in the years that follow.

Prioritisation should be based on clinical needs and risk. Protocols should be in place to ensure that people who require immediate referral from one service to another are prioritised appropriately and do not go to the bottom of the priorities of receiving providers.

11.6 Training and workforce development

Mental health providers should liaise with local or regional trainers (e.g. IAPT learning collaboratives or trauma centres) to organise additional training events if unmet training needs are identified.

12 Responses in the medium term (three months to one year)

It may be unclear in the period three months to one year after incidents if people who continue to be distressed:

- Are taking longer to recover
- Are experiencing secondary stressors that are maintaining their distress or
- Have a mental health problem

Early recognition and an appropriate referral are particularly important for people who have sustained problems and high levels of stress. Therefore, it is important for access to psychosocial care to continue to be available throughout the first year after incidents.

The affected population should be monitored and screened to ascertain people who need specialist clinical assessment, including those who are at risk of mental health problems or those who have had a problem previously. Sustainable evidence-based pathways should be created by the mental health services in association with primary healthcare so that people at risk can access:

- Early assessment in primary care
- Continued psychosocial care
- Assessment and screening by appropriate services
- Onward referral to specialist services

As before, people who are thought to be experiencing secondary stressors should be offered opportunities to explore their wider social, educational, employment and recreational needs. Suitable non-healthcare interventions may be required. In particular, previously unrecognised or unresolved secondary stressors should be mitigated and interventions put in place to help people avoid secondary stressors.

Plans for memorials and commemoration should be discussed with bereaved families. Planning for commemorative events and inquests should be made in collaboration with community leaders, the police (e.g. with involvement from police family liaison officers) and other partner organisations. The events should be culturally sensitive.

Research and evaluation should continue to be an integral part of the response to major incidents and should be set up from the early stages of the process and in collaboration with NHS England and NHS Improvement.

12.1 Communication

Information is required by people who continue to be affected by the incident and those whose problems come to light or develop beyond three months.

Information regarding any commemorative events or inquests, including psychosocial care available should be made available across a range of media and in a variety of

formats. Support should be provided for survivors and their families if they are involved in or affected by inquests and court trials.

12.2 Mental health services

Mental health services should continue to offer monitoring and screening to everyone who has been exposed and people who are close to them (e.g. families and friends) even if the initial results do not show requirements for people to be referred for more specialist assessment. Coordinated assessments and treatments for family members should be offered, while maintaining a focus on addressing the needs of the people who were directly affected.

People who have mental health problems identified should be referred to appropriate services for interventions that are recommended by NICE.

People who have complex mental health needs (i.e. comorbidity and/or co-occurring significant social difficulties) should receive a choice of appropriate, coordinated care to address their needs.

Care plans for survivors' treatment should be reviewed with each person at the end of their treatment and include personalised plans about how best to manage commemoration, anniversaries and future reminders. These plans should be coordinated with all organisations that are involved in delivering services.

13 Responses in the long term

Resources are required to ensure that services are available for at least five years following an incident to offer continuing psychosocial care, monitoring, screening and clinical assessment of people who are affected, and for the mental health treatments that some people may require. Professionals are likely to present later.

Planning assumptions should include matters such as assisting survivors and professionals by informing them about their possible reactions at anniversaries and at, and after, any further inquests or other legal proceedings.

Leaders of services that deliver psychosocial and mental healthcare should:

- Ensure managers and commissioners consider what resources are required to support continuing access to services
- Continue to monitor waiting times for access to mental health treatments

Deciding when to scale down services that deliver psychosocial care and mental healthcare and return to 'business as usual' is a sensive matter that requires good information from which to estimate the scale of likely continuing requirements and the ordinary capacities of local services. It is important to be aware that some people may still be receiving mental healthcare at the end of this period. There should be a coordinated and graduated approach to stepping-down psychosocial, monitoring and screening and mental health services. Arrangements should be made to redirect people who seek help thereafter to routes of access to services and appropriate organisations that provide help and support based on commissioning facilities that offer 'business as usual'.

Findings from information-gathering and evaluation of responses should be used to inform decisions about making available resources, including meeting training needs in the future.

13.1 Communication

Continued access to information to assist people affected and to let them know where they can access support should continue to be available.

Consideration should be given to targeted communications at times of anniversaries, and other events that may trigger reactions, to ensure that their responses may be explained and information for service providers, including primary care services, is available to remind people of the incident. This is because there can often be a long period of time in which survivors of incidents come forward and their experiences at the time of and after incidents may be reflected in their current difficulties (e.g. alcohol use or depression).

14 Psychosocial and mental health care for responders and other staff

Staff from a wide range of services are likely be involved either directly or indirectly during the incident itself and in the aftermath. They face differing profiles of psychosocial risk and needs for education, training, social support and peer support. Responders are a mix of people with differing roles and all of them require access to psychosocial and mental healthcare services. They may include:

- Members of the public who are first on the scene as well as frontline rescue and emergency staff
- Staff of humanitarian aid, welfare and healthcare services, and military personnel

Psychosocial and mental health services should be available for all responders, including members o fht epublic, who are involved in the response and people who work as call-takers, dispatchers, coordinators and service managers.

Public expectations are that staff consistently deliver effective, evidence-based care and interventions sensitively and compassionately, even if the environments in which they work are not optimal. But it is difficult for healthcare staff to continue to provide compassionate, evidence- and values-based care for their patients unless they are supported by their employers or if there is dissonance between the quality of support and training for staff and the quality of care that they are expected to deliver. This is especially so when employers implicitly or explicitly ask staff to take more than minor risks.

The summary of the potential impacts of incidents and emergencies (Section 5) on survivors also applies to staff who deal directly and indirectly with the public in response to their psychosocial and mental health needs. The principles and approaches outlined in Section 7 of this guidance apply in full measure to staff of NHS funded services. Organisations, including NHS trusts, should ensure that there are ways of monitoring staff for continuing distress, compassion fatigue, burnout and secondary traumatisation.

The report on the Stevenson Farmer Review identifies three main groups of people in all working environments[28]. They are: people who are thriving at work, people who are struggling at work and people who are ill and, possibly, off work. There are continuing dynamic exchanges of people between these groups. That review advises employers to establish programmes to respond effectively to the needs of staff. Those who are involved in responding to incidents and emergencies are at risk of becoming distressed and developing mental health problems.

Frontline staff of health services report that some of them may develop mental health problems after incidents in much the way as do members of the public who are affected directly or indirectly. But, a much more common scenario arises for the many staff who work in high pressure jobs and environments. It is that they become stressed and exhausted by their ‘ordinary’ work and the continuing impacts of working under pressure. Responding to incidents and emergencies is an additional source of stress that may push them into distress and mental health problems.

In effect, the Stevenson Farmer Review sets three main tasks for staff and employers and they are:

1. Assisting employees to continue to thrive and flourish at work
2. Supporting staff who are struggling
3. Enabling people who are ill to recover and return to work

This means that the care that healthcare staff are offered after incidents should be based on augmenting a continuing dynamic approach that offers staff routine assistance with all three tasks.

Health service employers should promote the wellbeing of their staff in order to raise the chances of them thriving. Their staff should be offered additional support to assist them to deal with the immediate stress arising from an incident and also offered ease of access to services to identify the needs of some people for more substantial assessment and potentially referral for mental health care.

The approach should be based on effective, skilled leadership continuing appraisal, supervision and mentoring. This means, for example, that staff should have visible leadership, leaders and managers should be available for staff present on the ground and in control rooms to listen, support and guide as necessary. Sustaining the wellbeing of staff in the context of their work with the public who are affected by an incident requires that leaders monitor the nature and volume of the caseloads of their staff and their exposure to unpleasant circumstances. They should ensure that staff take appropriate rest breaks and feel supported.

Figure one: A model of care for staff[29]

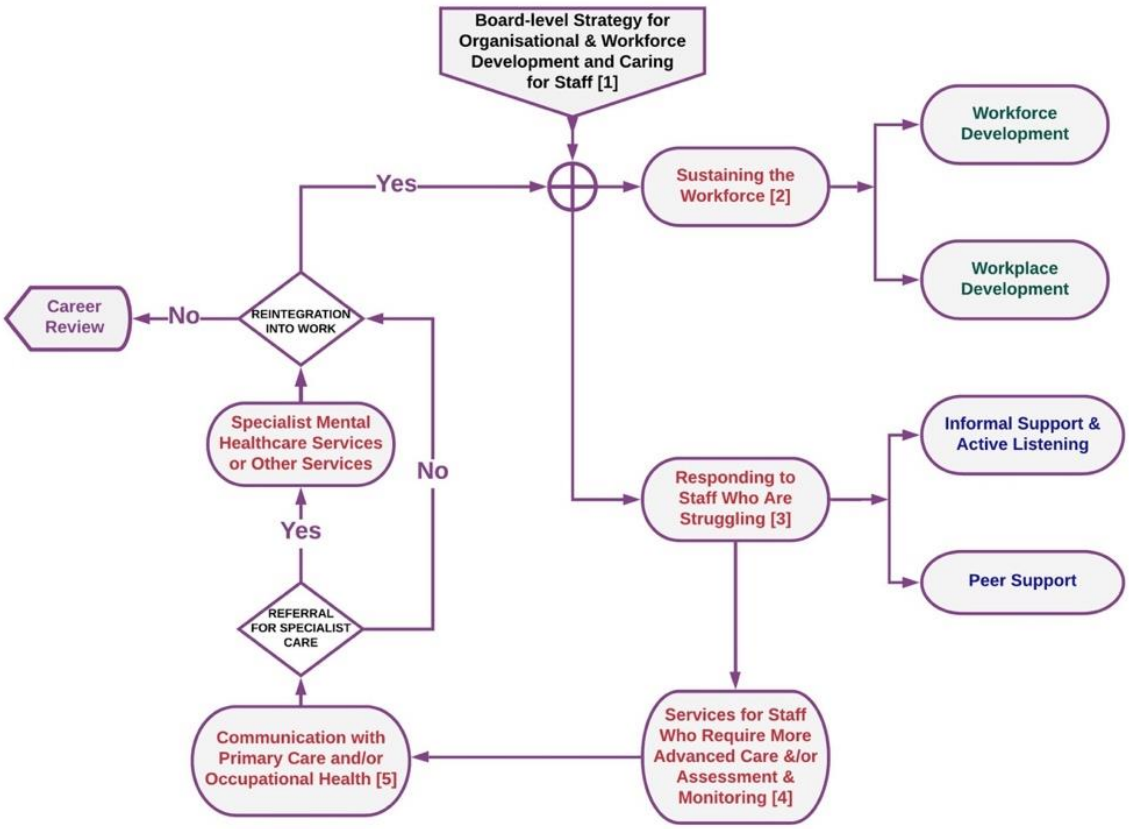

Figure one summarises what might be done for all staff at all times. It provides an integrated care pathway that can be expanded in the planning phase before, during and after staff are engaged in caring for people affected by an incident or emergency. It develops Guideline 12: Psychosocial Support for Staff after a Major Incident in the Clinical Guidelines for Major Incidents and Mass Casualty Events (NHS Engalnd).

Leaders should not focus solely on staff who are directly exposed to events but ensure that such a network of care is available to all staff who are involved in caring for people who are affected by an incident including non-clinical staff (e.g. managers, dispatchers, staff who deliver psychosocial care, staff of mental health services, commissioners, administrators, board members) and volunteers.

All staff require places and time to talk through their work. Staff who are struggling because they are distressed require active listening and some whose distress is more persistent require access to peer support. Peer support demands clarity of the scope and limitations of approach because it is not a form of counselling, treatment or therapy. Peer supporters should[30]:

1. Be empathic listeners

2. Have clear goals to:
   - Identify colleagues who may be at risk
   - Facilitate pathways to professional help

3. Have definite roles
   - Not limit their activities to high-risk incidents
   - Maintain confidentiality

4. Be selected according to the following principles:
   - Members of the target population
   - Considered to have substantial experience in that field of work
   - Respected by their peers
   - Trained
   - Provided with access to support, including supervision from a mental health practitioner
   - Evaluated in their work

Debriefing on the operational and medical aspects of the interventions staff have offered to the public affected by the incident is good practice. However, NICE states that psychologically focused debriefing should not be offered 'for the prevention or treatment of PTSD'[15]. It also states that support should 'be delivered in a way that reduces the risk of exacerbating symptoms'. This approach is intended to reduce the risks of secondary traumatisation by not encouraging staff to relive their experiences until they are ready to do so[31].

Staff who may require specialist assessment and, possibly, mental health care may experience stigma about being referred to a mental health service. This applies particularly to those in jobs or with qualifications/competencies that may be affected. However, the risks of stigma affecting the willingness of responders to accept help may be diminished where employers have a comprehensive stepped care pathway already in place.

A task for leaders in designing appropriate care pathways for staff during the planning phase is including in the pathway how people who hold sensitive positions access effective care confidentially.

In addition healthcare staff tend to be reluctant to attend services designed for members of the public and so dedicated services for staff should be available and staff encouraged to use them. This means that the occupational health services of employing organisations should be prepared to play important roles in the augmented services after a major incident. These services should be sources of psychosocial care for staff by providing:

- Emotional, practical and welfare support
- Honest, accurate and timely information
- Active, reflective listening
- Support for bereaved families
- Support for and access to monitoring and screening programmes to ensure staff have access to support, appropriate screening and the specialist services that they require

The plans made for staff should include plans for their assessment and supportive care as they return to work after treatment and are reintegrated into active roles. Also, support should be made available for staff who give evidence in legal investigations (court trials and inquests) in relation to the event or whose families are affected by what the staff have experienced.

Staff should be provided with ongoing access to assessment and treatment as required through a period of at least two years. This is because experience shows that the responses of staff who develop mental health problems may peak in prevalence later than they do for survivors.

Section 4 in Annex A to this guidance provides a summary of the constructs and evidence that support the approach to caring for staff that is outlined here.

15 References

1. Williams R, Bisson J, Kemp V. Health care planning for community disaster care. In: Ursano RJ, Fullerton CS, Weisaeth L, Raphael B, eds. Textbook of Disaster Psychiatry. 2nd edn: Cambridge University Press; 2017. p. 244–60.
2. North Atlantic Treaty Organisation. 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. Annex 1. In: EAPC, editor. Brussels: NATO; 2009.
3. Department of Health. NHS Emergency Planning Guidance. Planning for the Psychosocial and Mental Health Care of People Affected by Major Incidents and Disasters: Interim National Strategic Guidance. London: Department of Health; 2009.
4. Williams R, Bisson J, Kemp V. Principles for Responding to People's Psychosocial and Mental Health Needs after Disasters (Occasional Paper OP94). London: Royal College of Psychiatrists; 2014.
5. Forbes D, O'Donnell M, Bryant RA. Psychosocial recovery following community disasters: an international collaboration. Australian & New Zealand Journal of Psychiatry. 2016; 51: 660–2.
6. Schoenbaum M, Butler B, Kataoka S, Norquist G, Springgate B, Sullivan G, et al. Promoting mental health recovery after hurricanes Katrina and Rita: What can be done at what cost. Archives of General Psychiatry. 2009; 66(8): 906–14.
7. Deloitte Access Economics. The Economic Cost of the Social Impact of Natural Disasters. Sydney: Deloitte Access Economics; 2016.
8. Patel V. Rethinking mental health care: bridging the credibility gap. Intervention. 2014;12:15–20.
9. Williams R, Kemp V. Psychosocial and mental health before, during and after emergencies, disasters and major incidents. In: Sellwood C, Wapling A, eds. Health Emergency Preparedness and Response. Wallingford: CABI; 2016. pp. 83–9.
10. Williams R, Kemp VJ, Alexander DA. The psychosocial and mental health of people who are affected by conflict, catastrophes, terrorism, adversity and displacement. In: Ryan J, Hopperus BA, Beadling C, Mozumder A, Nott DM, eds. Conflict and Catastrophe Medicine: A Practical Guide. 3rd edn. London: Springer; 2014. p. 805–49.
11. Williams R, Greenberg N. Psychosocial and mental health care for the deployed staff of rescue, professional first response and aid agencies, NGOs and military organisations. In: Ryan J, Hopperus BA, Beadling C, Mozumder A, Nott DM, eds. Conflict and Catastrophe Medicine: A Practical Guide. 3rd edn. London: Springer; 2014. p. 395-432.
12. Lee A, Challen k, Gardois P, Mackway-Jones K, Carley S, Phillips W, Booth A, Walter D, Goodacre S. Emergency Planning in Health: Scoping study of the international literature, local information resources and key stakeholders. HMSO, 2012
13. Inter-Agency Standing Committee. IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva; 2007.
14. United Nations Office for Disaster Risk Reduction. Sendai Framework for Disaster Risk Reduction 2015-2030. Geneva, 2015

15. National Institute for Health and Care Excellence. Post-Traumatic Stress Disorder (NICE guideline NG116). London: NICE; 2018 (https://www.nice.org.uk/guidance/ng116).
16. Lewis SJ, Arseneault L, Caspi A, Fisher HL, Matthews T, Moffitt TE, et al. The epidemiology of trauma and post-traumatic stress disorder in a representative cohort of young people. Lancet Psychiatry. 2019; 6: 247–56.
17. Smith P, Dalgleish T, Meiser-Stedman R. Practitioner review: Posttraumatic stress disorder and its treatment in children and adolescents. Journal of Child Psychology and Psychiatry. 2018; Oct 23. doi: 10.1111/jcpp.12983. [Epub ahead of print]
18. Lewis SJ, Arseneault L, Caspi A, Fisher HL, Matthews T, Moffitt TE, et al. The epidemiology of trauma and post-traumatic stress disorder in a representative cohort of young people in England and Wales. Lancet Psychiatry. 2019; 6(3):247-56.
19. Wang PS, Berglund P, Olfson M, Pincus HA, Wells KB, Kessler RC. Failure and Delay in Initial Treatment Contact After First Onset of Mental Disorders in the National Comorbidity Survey Replication. Arch Gen Psychiatry. 2005; 62(6):603–613.
20. McFarlane AC, Williams R. Mental health services required after disasters: Learning from the lasting effects of disasters. Depression Research and Treatment. 2012;2012.
21. Haslam SA, Reicher SD, Levine M. When other people are heaven, when other people are hell: How social identity determines the nature and impact of social support. In J. Jetten, C. Haslam and S.A. In J. Jetten, C. Haslam and S.A. Haslam (eds) The Social Cure. Hove: Psychology Press, 2012, pp. 157–74.
22. Rubin GJ, Webster R, Rubin AN, et al. Public attitudes in England towards the sharing of personal data following a mass casualty incident: a cross-sectional study. BMJ Open. 2018; 8: e022852
23. Association of Directors of Public Health. Major Incident Checklist for Directors of Public Health. London: ADPH; 2018.
24. Association of Directors of Public Health. Mutual Aid Guidance for Directors of Public Health. London: ADPH; 2018.
25. Davidson S. The development of the British Red Cross psychosocial framework: CALMER. J. Soc. Work Prac. 2010;24:1:29-42.
26. Hiller RM, Meiser-Stedman R, Lobo S, Creswell C, Fearon P, Ehlers A, et al. A longitudinal investigation of the role of parental responses in predicting children's post-traumatic distress. Journal of Child Psychology and Psychiatry. 2018; 59: 781–9.
27. Gobin M, Rubin GJ, Albert I, Beck A, Danese A, Greenberg N, et al. Outcomes of a mental health screening programme for UK Nationals affected by the 2015 and 2016 terrorist attacks in Tunisia, Paris and Brussels. Journal of Traumatic Stress. 2018; 31: 471–9.
28. Stevenson D, Farmer P. Thriving at work: The Independent Review of Mental Health and Employers. London: HM Government; 2017
29. Williams R, Kemp. Caring for professional carers. BJPsych Advances. 2019 doi: 10.1192/bja.2019.66.
30. Varker T, Creamer M. Development of Guidelines on Peer Support Using the Delphi Methodology: Final Report. Melbourne: Australian Centre for Posttraumatic Mental Health, University of Melbourne; 2011.

31. Rose S, Bisson J, Churchill R, Wessely S. Psychological debriefing for preventing post traumatic stress disorder (PTSD). Cochrane Database of Systematic Reviews. 2002;2:CD000560.
32. Bish A, Michie S, Yardley L. Principles of effective communication: scientific evidence base review. London, Department of Health; 2011.
33. HM Government: Data Sharing in Emergency Preparedness, Response and Recovery. Live consultation document. London; 2019.

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Disclaimer

Healthcare professionals are expected to take NICE clinical guidelines fully into account when exercising their clinical judgement. However, this guidance does not overrise the responsibility of healthcare professionals to make decisions appropriate to the circumstances of each patient, in consultation with the patient and/or their guardian or carer