Responding to the needs of people affected by incidents and emergencies

Guidance for planning, delivering and evaluating psychosocial and mental healthcare

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1. Introduction

Plans for incidents and emergencies must provide psychosocial and mental healthcare for people who are affected. Early intervention for people at risk of developing mental health problems may reduce their severity, chronicity and related costs, including healthcare costs [1, 2]. The actions to be taken by services 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 should be included.

A growing body of research (including that on the Manchester Arena Bombing Incident in 2017) is identifying how long the psychosocial and mental health impacts of incidents and emergencies may persist for people affected; people have reported feeling distressed over the ensuing two to three years. This includes the substantial numbers of people who struggle or are distressed but do not pass the thresholds for diagnosis as well as the much smaller numbers of people who do. While most people affected are unlikely to need services beyond a year, a small minority may require assistance from mental health and social care services over a much longer time. This should be borne in mind when planning service responses and considering the financial consequences.

This guidance develops previous guidance from the Department of Health and NATO/EAPC [3, 4]. It supports providers and commissioners of all NHS-funded services in England, including mental health services and general practice, to plan, deliver and evaluate psychosocial care[1] and mental healthcare[2] for people affected by incidents and emergencies – through all phases of a major incident[3] and across agencies.

Delivering healthcare services can be challenging in communities after incidents because it usually requires co-ordination, co-operation and clear communication across

[1] Psychosocial care offers comfort and improves how people cope with and recover from adverse events. Intervening early in this way can reduce the risk of people who develop psychiatric disorders later. Psychosocial interventions are for people who have short-term distress, persisting distress that may be accompanied by dysfunction or symptoms of a mental health problem but do not reach a diagnosis. Activities offered to the public in the psychological domain are termed interventions to reduce any inference that psychosocial care is synonymous with specialist mental health treatments. They are also required by people who do develop mental health problems as a baseline for their treatment.

[2] Formal biomedical and psychological treatments for people who have mental health problems and disorders that are delivered by trained mental health practitioners. Often, people who require mental healthcare also need continuing psychosocial care.

[3] An event that presents serious threat to the health of the community or causes numbers or types of casualties requiring special arrangements to be implemented. For the NHS, this includes any event defined as an emergency under the Civil Contingencies Act 2004.

health and social care services, schools, community organisations, non-governmental organisations and the media. This complexity emphasises the importance of planning across organisations and sectors.

All accountable emergency officers (AEOs)[4] and emergency preparedness, resilience and response (EPRR) practitioners should 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,[5] and voluntary, community and social enterprise sector (VCSE) organisations.

Our recommended approach is based on World Health Organization (WHO) guidance, research and professional opinion and this guidance has been developed in the context of existing legislation [5-15]. It should be used in conjunction with the NHS EPRR framework.

Accompanying resources are provided by ResilienceDirect: templates and specimen documents such as protocols, letters and leaflets; they are updated regularly.

Disclaimer: Healthcare professionals are expected to take NICE clinical guidelines fully into account when exercising their clinical judgement. This guidance does not override 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.

2. People's reactions in the short, medium and longer terms

Everyone involved in planning for and responding to incidents and emergencies should understand how people may react to emergencies and incidents (summarised in Table 2). They must also understand the factors that affect how well people cope, including the importance of relationships, social support,[6] leadership and care. We encourage you to

[4] A board-level director designated by the chief executive or equivalent who holds the overall responsibility for ensuring EPRR and business continuity management within their organisation. The EPRR framework requires every NHS-funded organisation to have an AEO.
[5] Officials elected to make sure that local police meet the needs of the local community. They fund delivery of support for victims of crime in their area, including with Ministry of Justice grant funding.
[6] Social support is based on people perceiving that they have good social networks that offer them social support. It promotes people's wellbeing and recovery in many settings [16]. Social support "consists of social interactions that provide people with actual assistance, but also embeds them in a

read the Annex describing them, as well as the other considerations informing this guidance.

Table 2: Psychosocial and mental health effects of disasters

Direct effects of incidents and emergencies on people	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 often maintained by secondary stressors b. grief c. mental disorders (NB: they are very frequently co-morbid with other disorders): • substance use disorders • adjustment disorders • post-traumatic stress disorder • depression. 3. Impacts on personality.
Direct effects of complex, sustained or repeated disasters on people who are at higher risk	1. 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: • increased poverty • changed social and societal relations • threats to human rights • domestic and community violence.

web of relationships that they perceive to be caring and readily available in times of need" [8, 16, 17]. It includes informational, operational and emotional components.

While people involved in emergencies or incidents, either directly or indirectly and including first responders and other staff, may experience a broad spectrum of interrelated reactions, there are four recognised patterns or trajectories of response in the ensuing weeks, months and years:

1. **Short-term distress** (around 50% of people) in the days and weeks after an incident or emergency. This may be accompanied by brief impairment of functioning, but people shortly return to their usual activities.
2. **More persistent distress and slower recovery** (around 30-40%). This may be accompanied by social impairment and is often sustained or made worse by secondary stressors, eg health, housing, legal, work and financial difficulties. People may increase their use of alcohol and drugs as a means of coping. They require assessment and advice.
3. **Deteriorating responses** that often mean people suffer prolonged stress (around 10%). Those in this group are at much greater risk of developing mental health problems and may require assessment by specialist mental health practitioners.
4. **High stress responses** (around 10%). People in this group are at much greater risk of developing mental health problems and may require assessment by specialist mental health practitioners.

People may be described as 'resilient'[7] if the psychosocial impacts on them are brief or minimal. Resilience does not indicate the absence of adverse psychosocial experiences after exposure to very stressful events. Social relationships are important in recovery. Very often people affected seek out family members and friends. Usually, families and communities come together in the aftermath and the social support that people gain from this is a vital contributor to their effective recovery.

Children and older people may experience particular problems if the adults who usually support them are unavailable or preoccupied with their own distress.

2.1 In the immediate aftermath

Contrary to popular belief, people rarely panic after an incident or before the emergency services arrive. Usually, they remain goal directed and purposeful. They are often the

[7] 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 ability to cope, tend to recover in days and weeks with the support and care of their families, friends and colleagues.

first to act – the first responders – and are remarkably altruistic in putting themselves at risk to care for strangers. They may make their own assessment of risk and act against emergency services advice, eg re-enter a burning building to rescue a pet or retrieve property. But, these behaviours do not indicate panic. Rather, people make their own assessments of the hazards that are not in line with professional advice.

Many people go through one or more cycles of **delay** and **deliberation** before they **decide** (the 'three Ds') to act, and again contrary to popular belief, may not rush to action. Only occasionally, but particularly when affected by large-scale events that destroy infrastructure, are people immobilised by fear and helplessness.

2.2 In the short and medium term

Many people affected by incidents and emergencies suffer distress[8] in the two to eight weeks after single incidents. These responses may be sustained and complicated by threats of repeated events and ineffective responses. Distress may also be generated and sustained by secondary stressors that may have exaggerated effects in the context of emergencies.[9]

Mental health problems may emerge within months of an incident. Distressed people must be offered support but also monitored for the emergence of symptoms and signs that they could be developing a mental disorder.

2.3 In the longer term

People's distress may persist for a considerable time at levels below the threshold for diagnosis of a mental health problem. Also, they may seek assistance with their distress

[8] People are likely to experience stress in major incidents because these events may undermine their positive perceptions of the environment and themselves, their sense of control and feelings of worth. These experiences are described as distressing. Recent research shows that common experiences that people describe as distress include: feeling upset; fear; anxiety; fear of recurrence of the event; vigilance at social gatherings and in public places; avoiding uncomfortable feelings; and social withdrawal. Despite the contents of many public-facing leaflets, re-experiencing, anger, shock and numbness are rarer experiences. The main differences between distress and the symptoms of common mental health problems lies in the trajectory of people's recovery, the severity of their experiences and the impacts of those experiences on their social functioning. Until recently, the literature has tended to underestimate the number of people who take a long time to recover from distress.

[9] In the context of emergencies, primary stressors are the sources of worry, anxiety or stress that stem directly from the events and the consequential tasks that the staff of services face. Secondary stressors are generated by circumstances, events, practices, social, organisational, and financial matters that have their origins in society, employers' policies and people's personal life circumstances prior to an emergency or incident. They are not inherent in incidents and emergencies; but may be provoked or brought out by them (eg stressors related to people losing their homes and personal memorabilia, livelihoods and financial stability, infrastructure recovery, problems with insurance).

at varying intervals after the incident. People may develop mental health problems over a number of years because of their direct or indirect involvement.

2.4 Risk factors for developing mental disorders

The intensity of people's exposure to events and the death of loved ones are risk factors for their developing mental health problems. 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 associated with people developing mental health problems after incidents.

Examples of pre-incident risk factors are:

- pre-existing social problems (eg poverty and discrimination)
- female gender
- younger age
- prior exposure to traumatic events
- past mental health problems.
- past psychiatric disorders.

Research points to bi-directional associations between COVID-19 and psychiatric disorder. A large study indicates a psychiatric diagnosis in the previous year is associated with higher incidence of COVID-19, independent of known physical health risk factors. Possible residual confounding by socioeconomic factors could not be excluded [18].

2.5 Physical symptoms

A substantial proportion of people affected by a major incident, including responders, may seek assistance from primary care services for somatic symptoms. Common symptoms (3-78%) are headache, fatigue, abdominal pain and 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.

3. Planning principles and key approaches

Psychosocial care is intended to sustain people in the aftermath of an incident or emergency, and reduce their distress, suffering and risk of developing a mental disorder. It should be available to anyone who is affected by an incident, including those people who are distressed or have mild mental health needs.

It can be delivered by non-specialist health practitioners, including staff who work in community services, and the VCSE sector, education and social care professionals. Practitioners who deliver it should be supervised by people who have experience of and are trained in mental healthcare.

Mental healthcare should be available to anyone who has moderate to severe mental health needs, including people who have a diagnosed mental health problem or disorder. These interventions are usually delivered by specialists who work in mental health services for children and young people (CAMHS), Improving Access to Psychological Therapies (IAPT) services and mental health services for adults (AMHS). It is important that there are locally agreed care pathways that ensure that people can be referred for mental healthcare after incidents.

3.1 Principles

The psychosocial care and mental healthcare responses to the direct and indirect impacts of incidents and emergencies must be well co-ordinated so that people can obtain the right help at the right time. They must therefore be planned, tested through exercises and delivered to:

- ensure psychological safety
- provide information for the public about people's distressed reactions to incidents
- distinguish people who are distressed and require psychosocial care from those who also require mental healthcare[8]
- offer early intervention and active outreach to minimise distress and reduce the numbers of people at risk of developing longer-term mental health problems[8]
- provide lower-intensity psychosocial interventions to the substantial numbers who are likely to be distressed[8]

- provide more specific interventions (eg evidence-based psychological interventions) in a timely and effective manner for people assessed as needing them
- recognise the important role that GPs have in identifying people in need (including the public and professional practitioners), monitoring and supporting people affected and recognising when and how to refer them to specialist services.

These responses 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.

3.2 Key approaches

Planning should ensure that the NHS:

- Provides services for adults, children, young people and families that enable them to develop and maintain their abilities to cope. In this, they should consider the important role of parents and carers, families, work colleagues, other trusted adults and community resources, including schools and colleges. 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.
- Establishes the initial support (roles and actions) to be delivered by primary care, community and specialist services; and monitors people whose symptoms persist and screens those people thought to be at risk of developing a mental health problem.
- Provides 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 any anticipated major incidents and emergencies.

- Ensures that approaches are evidence-based and proportionate, flexible and timely.
- Ensures that all psychosocial and mental healthcare responses are provided:
  - as part of a local multi-agency response
  - within a clear governance framework
  - to support co-ordinated delivery of care that manages key interfaces and transitions seamlessly.
- Includes a review of current capacity within local services for delivering:
  - psychosocial care, with steps taken to address projected resource gaps
  - specialist mental healthcare, including assessment and evidence-based treatments that are appropriate for the projected impacts and needs, with steps taken to address any projected resource gaps.
- Ensures 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.
- Social support is a natural and powerful intervention.
- 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 preventing or treating PTSD [13].

4. Planning for post-incident psychosocial and mental healthcare

This section describes the roles and responsibilities of those people who should be involved in planning psychosocial and mental health responses to an incident or emergency.

4.1 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 healthcare 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 follow each of the four major trajectories of reaction to incidents (see Section 2 above).

They should also be aware of how long affected people may need continuing psychosocial and mental healthcare.

Plans for effective responses require commissioners and providers of NHS-funded services to assess the risks faced by people, families, communities and staff of both primary and secondary stressors arising generically from incidents. The likely impacts on local populations from the range of risks outlined in the community risk register must be identified and used to identify common consequences that form the basis of planning assumptions.

Top-down approaches to delivering services are essential where there is significant and/or rapid devastation and continuing threat; but, where possible, commissioners and providers should plan interventions in conjunction with leaders of affected communities because co-production is more effective.

Services should be reviewed to ensure that there is a common understanding and agreement on the models of care to use 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 any roles and responsibilities for partner organisations, including VCSEs, as well as the occupational health arrangements for staff who are affected (see Section 10).

Organisations that deliver psychosocial care and mental healthcare should support the principles of choice, collaboration and trust by planning interventions with leaders of local communities. This should include considering people's social environments and cultures, and the needs of their families and communities.

Currently, there is a paucity of trained practitioners to provide either psychosocial care or mental health services in the aftermath of incidents or emergencies. Instead, learning

has tended to be ad hoc following events. To remedy this, comprehensive training and exercises across all services that may be involved in the response must be in place, including but not limited to:

- **Responders**:
  - recognising and responding to distress
  - how to differentiate reactions that are anticipated (such as distress) from pathological reactions that may be shown by adults, children, young people, themselves and colleagues
  - understanding and using the established local care pathways for incidents.
- **Service managers and practitioners**: including how to support staff exposed to incidents and emergencies and recognise their distress.
- **Planners and service managers**: understanding that an incident affecting populations local to an identified site (concentrated incidents) requires a different response from one affecting people who come from across the country (dispersed incidents) or one that happens overseas. Dispersed and overseas incidents are likely to require liaison with services in other areas of England and the devolved administrations.

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

4.2 Communication

Provider communications managers should work closely with communications teams in NHS England and NHS Improvement to develop a consistent and co-ordinated strategy. They should also work with VCSE services, Public Health England and other partner organisations to identify sources of advice and guidance. Bish et al [19] provide advice on communicating with the public about risks.

Where possible, messages – including information leaflets – should be pre-prepared and use language that is relatable and accessible to the general population, including by providing alternative formats and translations. The information should reinforce choice, collaboration and the availability of any care that might be required to enhance psychological safety – eg see the NHS leaflet for the public *Coping with stress following a major incident* – as well as providing practical advice, eg acknowledging distress, strategies to support recovery and how to contact services for additional support.

4.3 Care pathways, resources, training and facilities

Services and organisations that deliver psychosocial and mental healthcare should be co-ordinated through local care pathways and integrated within the wider response and recovery plan and with primary and acute healthcare services. This means that the following matters should be considered in local planning for incidents and emergencies:

- Local and regional commissioners should agree a pathway and process for escalating people to most specialist mental healthcare. The response and model of service delivery adopted will depend on the capacity and capability in current services, numbers of people affected, nature of the event and geographical coverage, and needs of complex or diverse populations.
- Local integrated care pathways for psychosocial care and mental healthcare should be developed and agreed by organisations during planning and then tested, so that practitioners are clear about their own and other organisations' roles following an incident. These pathways must recognise the needs of responders and healthcare staff.
- Plans should provide psychosocial care and mental healthcare for NHS staff (see Section 10) as well as the public.
- Commissioners should model several high-possibility scenarios so that they can respond rapidly and then adjust their approach as more information about an incident becomes available. Scenarios should range from business as usual – for responses to small scale events that can be accommodated by existing services – through to arrangements for resource sharing across multiple commissioners (local and national) and providers for large-scale events.
- Local planning should appraise the resources required (including staff, estates and IT support) to deliver accessible and effective psychosocial and mental health services for people of all ages. This appraisal should assess requirements to deliver a programme for assessing and screening the mental health needs of people affected.
- Local commissioners should audit community resources, including the capacity and skills of staff and availability of self-help information.
- Commissioners and providers should be ready to provide the planned psychosocial and mental healthcare, including specialist mental health services for adults and children and young people, after an incident. This means that they should assess the training needs of the workforce by considering how well

psychosocial and mental healthcare can be provided after an incident, including specialist mental health services for adults and children and young people.

- Local and regional commissioners should identify potential services, such as major trauma centres, that can deliver large-scale outreach programmes if required, along with the associated resources.

4.4 Leadership

Each organisation should appoint a designated lead for planning and delivering psychosocial care and mental health services in response to incidents and emergencies, and engage mental health trusts in designing and planning the mental healthcare responses.

The commissioners and providers of NHS-funded services in each area should agree, through the LHRP, which of the designated leads should be the overall leader of psychosocial and mental healthcare for the area. That person should ensure during planning that the design of responses and delivery of psychosocial care and mental healthcare for people affected and their families and for staff during and after incidents are adequate and appropriate.

They should ensure all organisations are aware of the equal importance of providing ongoing physical, psychosocial and mental healthcare.

4.5 Information and data sharing

All agencies should be aware of the extended timescale of the response phase in meeting people's psychosocial and mental health needs. Maintaining collection of information about group, family and community demographics (eg age, needs of the population affected, including special needs) is vital in providing appropriate support and interventions for the duration of the psychosocial and mental health responses.

The Civil Contingencies Act 2004 gives responders the explicit duty to share information that supports the response to an incident. They must do this across health organisations and appropriate partner organisations during the planning, response and recovery phases of incidents and emergencies. This means that local organisations should agree how data should be collected on the ways in which the public and professionals are affected, including those injured and those who died (to ensure appropriate support to families), as well as how a list of first responders should be compiled.

During the response and recovery phases, personal data may need to be shared; the public interest of sharing such information must be balanced against the potential damage to individual people and, where appropriate, the public interest of keeping information confidential. In relation to legitimate interests, a UK survey reported that most people consider sharing their details acceptable when this facilitates a mental health response to a major incident [20].

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 [21].

The General Data Protection Regulation (GDPR) must be followed when preparing information sharing agreements. Where possible, a statement that personal data may be shared should be included, to inform people 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 state what information can be shared, and how it will be stored securely and disposed of afterwards.

4.6 Health responders

NHS-funded organisations and services should identify staff who are likely to be involved in the response to 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 (see Section 10).

4.7 Developing psychosocial care and mental healthcare

Pre-hospital specialist services, hospital-based health services, ambulance services, primary care, local, regional and national public health services and mental health services should work together during the planning phase to create and agree designed care pathways.

Mental health services should work with partner organisations, including primary care, hospital-based acute health services, local authorities, local authority public health departments [22, 23], VCSEs and the police, to develop appropriate local care pathways for delivering psychosocial care and mental healthcare. They should include referral pathways for people and staff affected.

Response pathways should be graduated or stepped – from initiating psychosocial care, through to specialist mental health services for people identified as facing significant risk factors, existing mental health needs, and/or symptoms and signs suggestive of a mental health problem.

Mental health services should be represented in LHRPs and ensure that co-ordinated local psychosocial care and mental healthcare responses are developed and tested in advance of incidents.

4.7.1 Psychosocial care

Providers and trainers should have regard for the general principles of designing and delivering psychosocial interventions in the immediate aftermath of events. The objectives are listed in Table 3.

Table 1: Objectives of psychosocial care

1. Provide early intervention for everyone who is involved Early psychosocial interventions in communities after emergencies aim 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). This means ensuring that everyone affected has access to early social support from their natural social networks, volunteers and/or professional practitioners.
2. Ensure that people are provided with practical interventions that offer: • emotional social support • informational social support • operational social support.

3. Ensure that people are provided with interventions that are available:

- close to where people are (proximity)
- as soon as possible (immediacy)
- with the expectation that people will recover (expectancy)
- as simply as possible (simplicity).

This approach gives rise to the acronym PIES. Research has shown that frontline intervention in the military based on PIES improves outcomes even two decades after its application. This intervention may also be effective for non-military precursors of PTSD [24].

4. Base interventions on core actions:

- provide comfort and support 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 place their experiences in context by understanding what reactions can be anticipated while being aware that they could develop a mental health problem (in the past this may have been called 'normalisation' though it is no longer a preferred term)
- advice that enables people to seek further help.

5. Deliver community support for people by enabling them to sustain their social identities and restore their agency through:

- effective and visible community leadership
- restoring and reuniting families and community groups
- reopening schools
- restoring work opportunities.

4.7.2 Mental health services

Service managers should assess existing staff capacity and skills for delivering NICE-compliant treatment for children and young people (CYP) 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 local providers of emergency and trauma care to train first professional responders in initial psychosocial care. VCSEs, 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 distress, physical symptoms that might suggest distress, psychosocial needs and mild mental health needs.

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

5. Psychosocial and mental health actions required when an incident occurs

5.1 Immediate actions relating to psychosocial and mental healthcare

It is important that everyone 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. Survivors of the Manchester Arena incident of 2017 say that they were keen to have, soon after the incident, the name and contact details of someone to whom they could turn later for advice about how to manage their feelings.

As soon as a major incident is declared all commissioners and providers of relevant NHS-funded services should implement their planned immediate psychosocial response to ensure psychological safety and social support for everyone, including staff, who is distressed.

They should:

- activate the agreed local data-sharing agreements within and across relevant organisations
- activate plans to provide universal practical support and psychosocial care, and co-ordinate them effectively with the plans to provide acute medical assessments and treatments
- activate plans to co-ordinate arrangements for psychosocial care with the plans to deliver psychological screening, assessment and mental healthcare

- activate and publicise care pathways immediately after an incident so that people at risk can access:
  - early assessment in primary care
  - assessment and monitoring by services created to offer tailored responses after the major incident
  - onward referral to specialist services.

5.2 Leadership

The leaders of psychosocial and mental healthcare should respond by:

- activating the agreed local psychosocial and mental healthcare plans
- ensuring delivery of psychosocial care and mental health services, including support for staff, and ensuring that standards and practice are evidence-based and pragmatic
- ensuring that data-sharing agreements within and across relevant organisations are activated and the effectiveness monitored of data sharing between the organisations responsible for commissioning and delivering psychosocial and mental healthcare.

5.3 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 about activation of the services delivering psychosocial care and mental healthcare.

5.4 Communication

A variety of platforms should be used to communicate information to ensure 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.

All services need to be made 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.

5.5 Psychological first aid

Psychological first aid (PFA) is a framework for delivering psychosocial care during and in the aftermath of incidents; it can reduce survivors' and relatives' initial distress and foster their adaptive functioning. It is not a single intervention or treatment, but an evidence-informed modular approach designed to respond to people's psychosocial needs after emergencies [5, 25, 26].

The core components are:

- initiating contact and engaging with affected people in a non-intrusive, 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 their families and communities
- gathering information to determine the immediate needs and concerns of people affected to tailor interventions
- providing practical assistance to help survivors 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.

The CALMER approach (Table 3) to initiating and delivering PFA has been developed and tested by the British Red Cross [27]. The headings are helpful prompts when speaking to very distressed people.

Table 2: 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; signpost people to services they require
R	Resources	Know where to get support for the people affected and for yourself

5.6 Mental health services

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

6. Psychosocial and mental health actions immediately after, and up to four weeks following an incident

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

The principle of making evidence-informed and appropriate care available at the right time must be followed at all stages of the clinical pathway. Provision of lower-intensity psychosocial interventions for the substantial numbers of people who become distressed must be distinguished from that for mental health treatments for the minority who develop mental health problems.

The assessment in the planning phase of the risks to people, families, communities and staff arising from primary and secondary stressors should be revisited in the aftermath, and then adjusted to the particular event so that service provision can be adjusted in the light of better-informed estimates. This revision may require adjustment of the general

plan to ensure effective, responsive and timely psychosocial care and mental healthcare.

GPs and other primary care practitioners have an important role in recognising people who require psychosocial care as well as those people who may be at greater risk of developing mental health problems. They should offer to monitor people at risk and access support for them. GPs should be advised on plans for assisting people affected and given details of how to access local care pathways for the psychosocial and mental healthcare of their patients.

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

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

People who may be at greater risk of developing mental health problems and who require active monitoring or screening should be identified and offered opportunities to contribute to co-producing a care plan that ensures that they can stay in contact with services of their preference.

6.1 Communication

Communications about each incident must be co-ordinated between responding organisations, and consistent at local, regional and national levels.

The messages should ensure the public's physical and psychological safety by offering information about possible risks and their mitigation, and where to find further information and assistance.

A very important part of psychosocial care for the public is listening to what people say about their experiences and what they want to assist them. This is a process that is described as acknowledging and validating people's feelings and reactions. Recent research after the Manchester Arena Incident shows how important the process of validation is to people's recovery. It has also shown that the word 'normalising', which has been used to describe this process, is best avoided because some people may experience it as invalidating their feelings. Sending public messages to let people know

what to expect in terms of how they may react to an incident and providing information are other important components of good communications. People affected by incidents should be given information on distress and coping mechanisms, and using social networks (families, friends and colleagues) to support their recovery.

These messages should also identify where people should turn for further support and assessment if their distress does not improve within two to four weeks.

Communications should ensure that people who have persisting distress or other symptoms know they can get help through their GP, and that mental health problems develop in a minority of people exposed to incidents and emergencies – including depression, anxiety disorders (including generalised anxiety disorder and panic attacks) and PTSD – and are treatable.

It is important to recognise the vital role that parents and carers have in supporting CYP who are affected. Adults need to listen to children, give them information and re-establish routines.

6.2 Collecting information and community support

Information about the demographics (eg age, needs of the population affected, including special needs) of groups, families and communities must be collected throughout the response and recovery phases. This informs how the response should be adjusted, if necessary.

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

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

- identifying formal and informal leaders and assessing what they may need to support their communities (eg information, guidance, resources)
- making use of community leaders' knowledge of affected communities, their strengths and the risks they face in addition to those arising from 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 offer emotional support
- ensuring that responses to people's practical needs are adequate and social and community relationships protected
- signposting people to services that can respond to their psychosocial and mental health needs.

Working with multi-agency partners is essential to help communities by, for example, reopening schools and community facilities, and restoring working opportunities as soon as reasonably practicable. Local authorities should be advised that, usually, education services – schools, colleges and universities – should remain open, reopen early or be relocated to interim premises.

6.3 Leadership

The leader with overall responsibility for local delivery of NHS-funded psychosocial care and mental healthcare should work with the psychosocial and mental health leaders in each organisation involved, to ensure the continued co-ordination of services through local care pathways and integration with the wider response and recovery plan, including with primary and acute healthcare services.

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

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

- monitor the effectiveness of the agreed local psychosocial care and mental healthcare plans and care pathways
- ensure delivery of psychosocial and mental health services – including support and care for staff – and ensure that standards and practice are evidence-based and pragmatic
- ensure that data-sharing agreements are effective within and across the organisations responsible for commissioning and delivering psychosocial and mental healthcare

- review and monitor information collection and sharing, to ensure services can 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 the psychosocial care and mental healthcare outlined in local pathways
- monitor the agreed organisational governance response for incidents and emergencies, including notifying key operational and clinical leaders across the system.

6.4 Psychosocial care

People should continue to be offered psychosocial care for as long as they feel it is beneficial, and especially for 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 their risk of being affected by 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 as problems and needs can emerge at varying intervals after incidents and emergencies. The principles of PFA lie 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.

Mental health services should work with VCSEs and other partners to ensure that people can obtain practical and social support and agreed information about emotional reactions and potential mental health problems following an incident. Written information should be provided but also opportunities for telephone and face-to-face conversations.

6.5 Mental health services

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

People who have experienced mental health problems or traumatic events before the incident should be advised to contact the specialist mental health services for an assessment. This is to ascertain any increased levels of need, and the possible risks to the continuity of their care due to increased demand on, or dislocation of, services and/or their displacement from their homes.

In particular, the mental health services should offer trauma-focused cognitive behaviour therapy to people who have serious clinical symptoms or acute stress disorder.[10]

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

Monitoring and assessment can be made available at facilities offering support to people who report distress, and screening for possible serious disorders should be activated in preparation for the subsequent response phases. Such 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.

7. Psychosocial and mental health responses in the short term (one to three months)

Services should be flexible and use, or expand as necessary, existing resources available in the health system and local communities. They should collaborate with VCSEs and other partner organisations. Everyone affected should continue to be able to access psychosocial care – especially those people who do not meet the criteria for referral to specialist mental health services.

Services should understand that some survivors may have unrecognised or hidden 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, a variety of approaches needs to be employed to identify people affected, with the intention of signposting them to the care they require. All approaches should be co-ordinated with local authorities, community leaders and groups, VCSEs, schools and religious institutions to allow everyone, including CYP and families, confidential access to services. Social media can be used to inform the public about availability of services.

[10] A persistent syndrome similar to PTSD but which can be diagnosed earlier than PTSD, which is a diagnosis that is not available until one month after an incident.

In the first three months after an incident, it may be unclear whether people who continue to be distressed are taking longer to recover because they are affected by secondary stressors, and/or because they have a mental health problem. Early recognition and appropriate referral are particularly important for people who have sustained problems and high levels of stress.

The population affected, and particularly those people at risk of developing mental health problems or who have a mental health history, should be monitored and screened to ascertain who needs specialist assessment.

Routine use of a validated, brief screening tool should be considered for people at high risk of developing depression, anxiety disorders or PTSD one month after the incident, and then at intervals in line with local screening programme practices. Assessment, monitoring and screening programmes should be available to everyone affected, including staff.

Information about the people affected must continue to be collected, to inform any adjustments to the care pathways required, as well as changes to the assessments and interventions required to ensure that services continue to reflect the impacts and circumstances of particular incidents and the populations they affect.

7.1 Communication, information and data sharing

Organisations must continue to share information about how and where people can access psychosocial care services. Monitoring services and screening programmes should be promoted along with information on how to access mental health screening.

It will start to become clearer two to three months after an incident who has symptoms of a mental health problem, rather than persistent distress, but this can take several years for some people. So efforts to attract people at risk to monitoring, screening and psychosocial care must be sustained.

7.2 Resources

The period after an incident is likely to be when it is particularly important to review resources for any gaps, and ensure adequate planning to deliver psychosocial care and mental health treatments for people affected in the short- to long-terms.

Returning to 'business as usual' for the services that deliver psychosocial care and mental healthcare may take much longer than for the other components of the healthcare response, and longer than the commissioning agencies estimate.

7.3 Leadership

The leader with overall responsibility for local delivery of NHS-funded psychosocial care and mental healthcare should work with the psychosocial and mental health leaders in each organisation involved, to ensure the continued co-ordination of services through local care pathways and integration within the wider response and recovery plan, including with primary and acute healthcare and social care services.

The leaders of psychosocial and mental healthcare should continue to:

- monitor the effectiveness of the agreed local psychosocial and mental healthcare plans
- ensure delivery of psychosocial and mental health services, including support for staff, and ensure that standards and practice are evidence-informed and pragmatic
- ensure that data-sharing agreements are effective within and across the organisations responsible for delivering psychosocial and mental healthcare
- review and monitor information collection and sharing, to ensure services can 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 healthcare 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
- report relevant information to local resilience forums regarding sustaining services to meet the needs of people affected and the system's capacity.

7.4 Psychosocial care

People should continue to be offered psychosocial care for as long as they feel it is beneficial, and especially for 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 and psychosocial care over time.

Services based on the principles of PFA are likely continue to be required throughout the response and recovery phases, because people are likely to 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 giving people opportunities to explore their wider social, educational, employment and recreational needs, and enabling people affected to seek further help, if appropriate. Suitable non-healthcare interventions are likely to be required.

7.5 Mental health services

Mental health services should provide early specialist interventions that involve 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 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
- making access to the range of specialist mental health services available to the affected population as close to home as possible
- ensuring that staff who have specific training, expertise and experience are able to conduct screening and assessments
- enabling fast-track referral to specialist mental healthcare services within the care pathways for people who require it
- multi-agency collaboration and appropriate information sharing
- offering a co-ordinated, family-based approach for CYP who may be affected and their families or carers. This is important because parents' mental health needs and responses to an incident influence their children's or young people's reactions to the incident and their responses to treatment [26]. This collaborative approach should include ensuring that practitioners are trained and experienced in working with CYP as well as 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 facility designed and established for this specific purpose or by several services working together.

Screening for impaired functioning, increased substance use, symptoms of depression, anxiety and PTSD, and risk to self or others, followed by specialist assessment for people who require it, should be available to those people for whom distress and dysfunction persist at substantial levels for four weeks after an event, or earlier if they worsen over time [15].

Parents and carers of CYP may not always be able to provide accurate accounts of their children's mental health because of their own distress or stigma. This is why each child or young person who is considered to be at greater risk should be screened and assessed directly [28].

Monitoring, screening and specialised assessment may need to run for up to five years after an event. During the first year, screening and/or assessment should take place every three months, then 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 not added to the bottom of the receiving provider's priority list.

7.6 Training and workforce development

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

8. Psychosocial and mental health responses in the medium term (three months to one year)

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

- are taking longer to recover (eg experience after the Manchester Arena incident in 2017 indicates that substantial numbers of people suffered distress for longer than was initially anticipated)
- are experiencing secondary stressors that are maintaining their distress
- have a mental health problem.

Access to psychosocial care must continue to be available through the first year after incidents because early recognition and effective responses to their needs are important. Also, people who may have a mental disorder require an appropriate referral; this is particularly important for people who have sustained problems and high levels of stress.

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

- early assessment in primary care
- continued access to psychosocial care
- assessment and screening by appropriate services
- onward referral to specialist services.

As before, people 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. Plans for these events as well as inquests should be made with community leaders, the

police (eg 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 set up in the early stages, in collaboration with NHS England and NHS Improvement.

8.1 Communication

People still affected by the incident and those whose problems come to light or develop beyond three months continue to require information.

Information regarding any commemorative events or inquests, as well as available psychosocial care, should be provided across a range of media and in a variety of formats. Survivors and their families involved in or affected by inquests, inquiries and court trials should be offered support.

8.2 Mental health services

Mental health services should continue to offer monitoring and screening to everyone who has been exposed directly or indirectly to an incident or emergency and those close to them (eg families), including people whose initial results did not show the need for referral to more specialist assessment. Co-ordinated clinical assessments and treatments for family members should be offered.

People in whom mental health problems are identified should be referred to appropriate services for NICE-recommended interventions.

People who have complex mental health needs (ie co-morbidity and/or co-occurring significant social difficulties) should be given a choice of appropriate, co-ordinated care to address their needs.

The care plans for affected people should be reviewed with them at the end of their treatment. These should include personalised plans for how commemoration, anniversaries and future reminders can best be managed, and they should be co-ordinated with all organisations involved in delivering services.

9. Psychosocial and mental health responses in the long term (from one year onwards)

People may come forward for help a long time after an incident. Professional practitioners and staff of services often present later than the public.

Leaders of services that deliver psychosocial care 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.

Services should make resources available for at least five years following an incident to offer continuing psychosocial care, monitoring, screening and clinical assessment of people affected, and for the mental health treatments that some may require. Findings from information gathering and evaluation of responses should inform resource decisions, including those about meeting future training needs for staff of responding services.

It is important to be aware that some people may still be receiving mental healthcare at the end of the planned duration of services. Therefore, deciding when to scale down services and return to 'business as usual' is a sensitive matter. Good information is required to estimate the scale of requirements beyond the ordinary capacities of local services.

The graduated scaling down of psychosocial, monitoring, screening and mental health services specific to major incidents must be co-ordinated. In parallel, arrangements should be made to redirect people seeking help to services commissioned to provide this as 'business as usual', as well as other appropriate organisations.

Long-term planning should include assisting people affected by incidents and professionals by informing them how they may react to anniversaries and any further inquests or other legal proceedings.

9.1 Communication

People affected are likely to require continuing access to information, including on where they can access support.

Targeted communications should be considered on anniversaries and other events, to explain to people that these circumstances may trigger reactions and to provide information about where people can seek help, including from primary care services.

10. Psychosocial and mental healthcare for responders and all staff involved in responses

Public expectations are that healthcare staff consistently deliver effective, evidence-based care and interventions sensitively and compassionately, even in difficult environments. To do so, they need to be appropriately trained and supported by their employers, especially when implicitly or explicitly asked to take greater than usual risks. Thus, the approach taken in this guidance is to consider the needs of staff who work in business as usual environments, and to suggest that the services required to meet their needs for psychosocial care and mental healthcare are scaled up when major incidents and severe emergencies occur.

10.1 Exposure of healthcare staff to stress in business as usual environments

The Stevenson Farmer review [29] identifies three main groups of people in all working environments: people who are thriving at work; people who are struggling at work; and people who are ill and possibly off work. The review sets employers three main tasks:

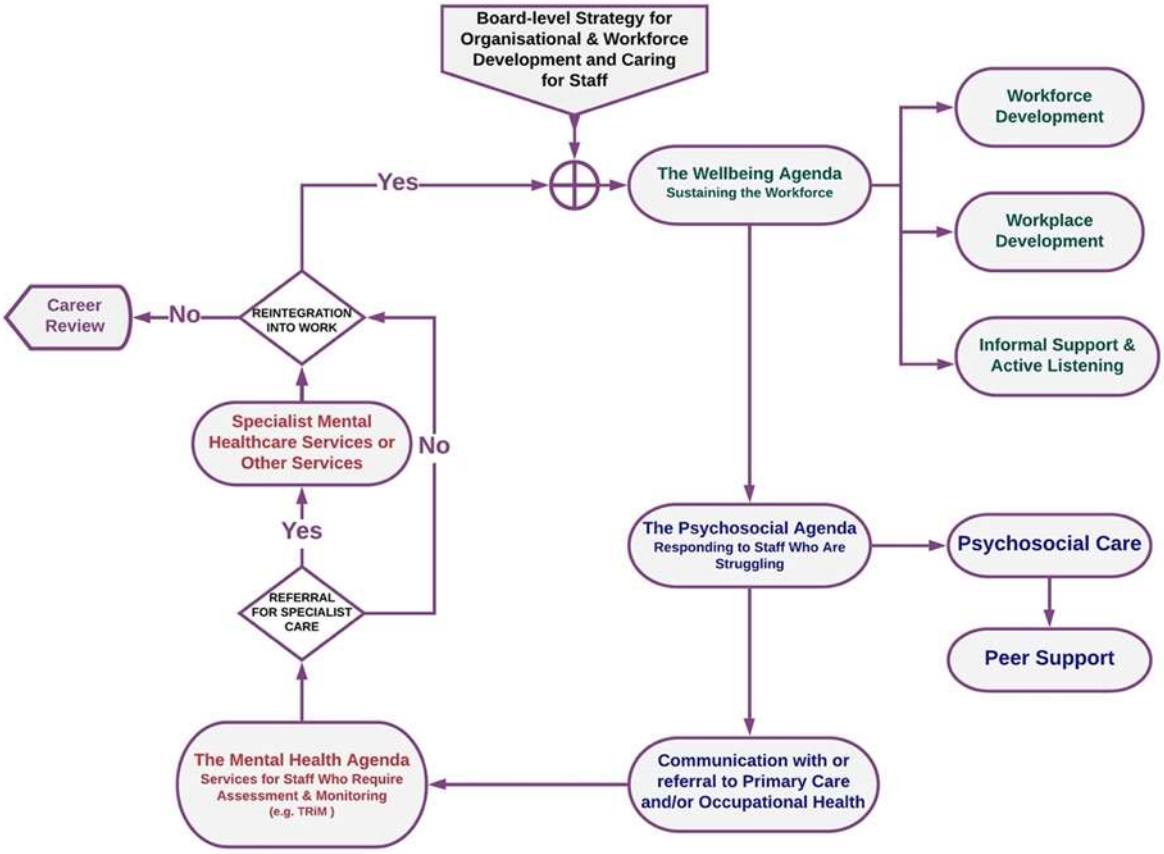
1. assisting employees to continue to thrive and flourish at work
2. supporting staff who are struggling
3. enabling people who are ill to recover and return to work.

This means that ordinarily health service employers should routinely promote the wellbeing of their staff to help them thrive. They should be able to respond to the needs of staff who are struggling and resource care for staff who suffer mental health problems. Service leaders and managers should be aware that all staff including people in clinical, administrative, managerial and facilities management jobs may be affected. Staff in frontline clinical roles are at risk but so too are staff who work in jobs away from the frontline.

The approach requires effective, skilled leadership, continuing appraisal, supervision and mentoring. This means, for example, that leaders and managers should be visible to staff and available to listen, support and guide as necessary.

Figure 1 summarises what might be done for all staff routinely and how this 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 care for staff after a major incident in the clinical guidelines for major incidents and mass casualty events.

Figure 1: A model of care for staff wellbeing [developed from Williams & Kemp, 30] © R Williams and V Kemp 2020. All rights reserved.



This approach creates three agendas for care of staff that mirror the tasks indetified by Stevenson and Farmer All. The Wellbeing Agenda focuses on sustaining the health of all staff. Staff require places and time to talk through their work. The Psychosocial Agenda is similar to the approach described in this document for people who are distressed. Staff who are struggling because they are distressed require active listening

and some whose distress is more persistent require peer support. Peer support is not a form of counselling, treatment or therapy. Peer supporters should [31]:

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:
   - do not limit their activities to high-risk incidents
   - maintain confidentiality.
4. be selected according to the following principles – ie they are:
   - 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 staff on the operational and medical aspects of the support they have given to people 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" [13]. It also states that support should "be delivered in a way that reduces the risk of exacerbating symptoms, "to reduce the risk of secondary traumatisation, staff must not be encouraged to relive their experiences until they are ready to do so" [32].

The Mental Health Agenda concerns staff who require specialist assessment and possibly mental healthcare. They may feel stigmatised about being referred to a mental health service, particularly if this could affect their employment or qualifications / competencies. Having a comprehensive stepped care pathway in place can help reduce such concerns. This pathway should address how people who hold sensitive positions can access effective care confidentially.

Employers should augment this approach following incidents by offering extra support to deal with the immediate stress arising from an incident, as well as access to services

that can identify those who may need more substantial assessment and potentially referral for mental healthcare.

10.2 Exposure of staff to emergencies and major incidents

Just like the public, those people involved indirectly or directly in responding to incidents and emergencies are at risk of becoming distressed and/or developing mental health problems. The principles and approaches outlined in Chapters 3, 4 and 6 in this guidance apply in full measure to staff of NHS-funded services.

However, a more common scenario for healthcare staff is that they are already stressed and exhausted by the pressure of their 'ordinary' work and responding to incidents and emergencies is an additional source of stress that may push them into distress and mental health problems. Responding to COVID-19, for example, has illustrated how many staff are affected by secondary stressors in the ordinary course of their work and how the impact of those stressors is increased when they face emergencies and incidents.

Organisations, including NHS trusts, should monitor staff for distress, continuing distress, fatigue and secondary traumatisation; monitor the nature and volume of caseloads and staff exposure to distressing circumstances; and ensure that staff take appropriate rest breaks and feel supported.

Staff from a wide range of services are likely be involved either directly or indirectly in the response to an incident, both immediately and in the aftermath. They are likely to have differing psychosocial risk profiles and education, training, social and peer support needs. All of them require access to assessment and treatment: frontline rescue and emergency staff, but also other clinical staff, staff who deliver psychosocial care, staff of mental health services and volunteers, as well as non-clinical staff (eg call takers, dispatchers, co-ordinators and service managers, commissioners, administrators, board members). This access should be available for staff for at least five years following an incident.

Healthcare staff tend to be reluctant to attend services designed for members of the public. Dedicated services, including monitoring and screening programmes, 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.

Staff returning to work after treatment need ongoing assessment and supportive care as they reintegrate into active jobs. Also, staff who give evidence in legal investigations (court trials and inquests) in relation to the event need to be supported, as well as those whose families are affected by their experience.

Section 4 in the Annex summarises the constructs and evidence that support the approach to caring for staff outlined above.

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