GUIDANCE FOR RESPONDING TO THE PSYCHOSOCIAL AND MENTAL HEALTH NEEDS OF PEOPLE AFFECTED BY DISASTERS OR MAJOR INCIDENTS

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Draft Guidance For Responding to the Psychosocial and Mental Health Needs of People who are Affected by Disasters or Major Incidents of All Kinds

1.   THE ORIENTATION AND RATIONALE FOR THIS GUIDANCE

1.1.   This guidance is intended to assist nations to prepare effective responses to the psychosocial and mental health consequences for their populations following emergencies, major incidents and disasters of all kinds and causes. These responses should be led by government policy within each nation that enables the responsible authorities to plan services that are based on a common strategy and which are fully integrated into wider disaster planning and preparedness.

1.2.   This guidance is based on two pieces of work that was conducted for the North Atlantic Treaty Organisation (NATO)[1, 2] and a third for the European Union (EU) – the TENTS programme[3]. The authors perceive that there are many common principles and recommendations. Therefore, they determined to bring them together to provide a consensus of opinion, which is accepted broadly, about the nature of people's psychosocial and mental health needs and the responses that the communities in which they live and work require when they are affected by disasters and major incidents of all kinds.

1.3.   In addition, the authors recognise several other recent sources of guidance. They include the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings[4] and the guidance offered by the European Federation of Psychologists' Associations (EFPA)[5]. This guidance is compatible with and informed by both documents and the authors acknowledge the assistance that they have received from Liz Campbell, President of the British Psychological Society.

1.4.   This guidance proposes a model of care that:

- is empirically based (i.e. based on the best evidence available);
- is flexible across events, cultures and time periods;
- takes account of the potential resilience of people and communities;
- accommodates the needs of vulnerable and at-risk groups of people, including family relatives and other carers and people from professional organisations who provide;
- is realistic in terms of the extent to which it can be implemented in emergencies, given the personnel and resources that are available;
- takes account of population dynamics, including age and cultural differences, that may affect populations that are involved, first responders and staff of services;
- is capable of evaluation;
- acknowledges the importance of anticipated reactions, resilience and the natural healing potential of people, families and communities; and
- endorses the primary principle of, first, do no harm.

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

[2] Williams R, Mikuš Kos A, Ajduković D, van der Veer G, Feldman M. Recommendations on evaluating community-based psychosocial programmes. Intervention 2008; 6(1):12-21.

[3] TENTS Project Partners. The TENTS guidelines for psychosocial care following disasters and major incidents. Downloadable from http://www.tentsproject.eu

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

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

1.5. The *core principles* in this guidance are directly relevant to *national policies and strategies and local operational practices*. Sections in it are aimed at the *national policies and strategies* that are required to underpin the psychosocial and mental health care that is provided by countries for populations that are affected. The *operational practices* summarised in the later sections of this guidance relate to delivering services to meet the needs of populations of 250,000 to 500,000 people. They can be adapted for larger or smaller areas.

1.6. This approach recognises that nations have differing cultural values and expectations as well as different organisational patterns for the services for which they are responsible.

1.7. The principles contained in this document distinguish people's psychosocial reactions to emergencies that are very common, and not necessarily pathological, from reactions that are symptomatic of mental disorders and the care that is appropriate to people's personal needs. Needs for care that arise from the former are termed psychosocial and needs that relate to mental disorder are termed requirements for mental healthcare. It is important to recognise that people who have psychosocial needs may not have needs for mental healthcare, but that the smaller number of people who require mental healthcare are also highly likely to have wider needs for psychosocial care too.

2. KEY FINDINGS FROM THE EVIDENCE

2.1. The factors that influence the philosophy of psychosocial and mental health care in this guidance include:

2.1.1. The substantial resilience of persons and communities; psychosocial resilience[6] is the expected response of communities to disasters and major incidents, but is not inevitable. It can be developed, but it can also be compromised.

2.1.2. Often, the emotional, social, cognitive and somatic experiences of resilient people can be difficult to distinguish from symptoms of stress disorders and later post-traumatic disorders. Therefore, there are the risks of under- and over-estimating the prevalence of disorders unless first and secondary responders and staff in the health and social care, and welfare services are provided with a basic minimum of education and training.

2.1.3. In many cases, there are secondary stressors that follow from the disruption and dislocations in people's lives as a consequence of the primary events. Depending on the circumstances, some of the secondary stressors that emerge as people endeavour to reconstruct their lives, attachments, families, homes, employment, communities, and recreation may be as impactful as the primary event and, as a consequence, some people may require assistance and support over extended periods of time.

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[6] Defined as "*a person's capacity for adapting psychologically, emotionally and physically reasonably well and without lasting detriment to self, relationships or personal development in the face of adversity, threat or challenge*" in Williams R. The psychosocial consequences for children of mass violence, terrorism and disasters. International review of psychiatry, 2007, 19; 3; 263-277.

2.1.4. Disasters and major incidents affect whole communities and populations directly or indirectly and so public psychosocial care is required to reach everyone who is affected. However, the majority of people who develop mental disorders require specific programmed personalised mental health and social care services. Therefore, people who develop disorders are likely to require both psychosocial and mental health care.

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

2.2.1. Distress after disasters and major incidents is very common.

2.2.2. People's psychosocial reactions are shown by their emotional, social, relationship, behavioural, cognitive and physical experiences in anticipation of, during, and after events.

2.2.3. In most cases, distress is transient and not associated with dysfunction.

2.2.4. Some people's distress may last longer and is more incapacitating.

2.2.5. The majority of people do not require access to specialist mental healthcare, though a substantial minority of people may do so.

2.2.6. Screening, surveillance and clinical assessment are required by a proportion of survivors who are thought to be at particular risk.

2.2.7. A small proportion of affected persons may require long-term mental health services in response to their needs.

2.3. The ways in which people respond fall into four main groups. This guidance distinguishes people who are:

2.3.1. Not upset at all (resistant people) or mildly, temporarily, and predictably upset in the immediate aftermath (resilient people);

2.3.2. Proportionately distressed, but who are able to function satisfactorily in the short- and medium-terms (resilient people who have greater distress, but not amounting to a mental disorder, of longer duration than people in the first group);

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

2.3.4. Mentally disordered in the short-, medium- or longer-terms (people who require specialist assessment followed by timely and effective mental healthcare).

2.4. People who are at increased risk of dysfunctional distress and substantial problems following disasters include: women; children and adolescents; older people; people who

have pre-existing health problems and disorders; and socially disadvantaged people. Persons who are at even more risk include people who:

- experience high perceived threat to life (to themselves and/or significant others);
- are physically injured;
- are faced with a circumstance of low controllability and predictability;
- have to live with the possibility that the disaster might recur;
- experience disproportionate distress at the time;
- have experienced multiple losses, losses of relatives and friends to whom they are close, and losses of property that is important to them;
- have been exposed to dead bodies and grotesque scenes;
- have endured higher degrees of community destruction;
- have limited social support; and
- have had a mental disorder previously.

3. CORE PRINCIPLES

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

3.1.1. There is evidence that how people's psychosocial reactions are managed may define the extent and effectiveness of communities' recovery overall.

3.1.2. An important corollary of this principle is that all actions taken after disasters and major incidents must do no further harm.

3.2. Human Rights

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

3.3. Definitions

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

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

3.4. Anticipation, Planning, Preparation and Advice

3.4.1. A core principle arising from work that was conducted for NATO and the EU to construct this guidance is that the services, including the psychosocial and

mental health services that are required following disasters and major incidents, are much more likely to work effectively if the need for them has been anticipated and defined.

3.4.2. This requires understanding of the dynamic shifts that occur with the passage of time and of the clarity about how these services are to collaborate with other services that offer humanitarian aid and responses to people's welfare and psychosocial needs after disasters and major incidents.

3.4.3. Knowledge about how people may react psychosocially to disasters and major incidents is likely to assist responsible people in making effective decisions prior to events and when they are making decisions while under strain during events.

3.5. **Planning for Families and Communities**

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

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

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

3.6. **Developing, Sustaining and Restoring Psychosocial Resilience**

3.6.1. Plans for how societies and services are to respond to the psychosocial and mental health needs of populations should recognise the considerable resilience of people and groups of people including families, communities and groups of strangers who are thrown together by events. Adversity can bond individual people, families and communities.

3.6.2. This principle means that actions taken, including those that determine how services respond to the needs of communities and people for psychosocial and mental health care, should actively maximise participation of local, affected populations whatever the degree of devastation in each area.

3.6.3. Restoring, first, the functioning, and second, the social fabric of communities is highly important in how societies, communities and services respond effectively

to the psychosocial and mental health effects of disasters and major incidents. This means that:

- restoring the social functioning of communities, and protecting vulnerable people and communities from the psychosocial effects of disasters and major incidents are important components of disaster preparedness, responses to major incidents, and facilitating recovery.

- restoring the social fabric of communities is another important component of disaster preparedness, responses to major incidents, and facilitating recovery.

- providing information and activities that normalise reactions, protect social and community relationships, and signpost access to additional services are fundamental to effective psychosocial responses.

- everyone involved is likely to benefit from supporting humanitarian and welfare arrangements in the immediate aftermath according to their needs.

- the effectiveness of the responses made depend on utilising community leaders' prior knowledge of affected communities and the resilience and vulnerabilities of people in affected areas.

3.6.4. Despite adequate preparation before, and actions taken during an event, there is likely to be a sizeable minority of people who are at high risk of developing mental disorders.

3.6.5. If communities are to receive comprehensive responses to their psychosocial and mental health needs after disasters and major incidents, the following types of service are required: (a) humanitarian aid; (b) welfare services; (c) services that are able to assist people and communities to develop and sustain their resilience; and (d) timely and responsive mental health services.

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

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

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

3.7.3. However, this guidance recognises that there is no common pattern across different countries about how aid, welfare, responses to people's psychosocial needs, continuing support, and mental healthcare are provided. Therefore, the focus of this guidance is on the psychosocial and mental health care responses

that people affected by disasters and major incidents require from other people and/or formal services and the common factors that affect service design irrespective of which nations are involved.

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

3.8.1. Achieving comprehensive psychosocial care and mental health services for moderate and large scale emergencies requires that lessons learned through research and experience are translated into integrated, ethical policy and plans at four levels. They are:

- governance policies;
- strategic policies for service design;
- service delivery policies; and
- policies for good clinical practice.

3.8.2. Each of these four aspects of policy should be influenced by the contents of this guidance. This means that there are important roles for practitioners who are skilled in mental health care and experienced and trained in disaster management to provide advice to the authorities as they develop each of these aspects of policy and as they conduct operations in the face of disaster.

3.8.3. Governance policies relate to how countries, regions and counties are governed. Policies at this level are required that set the overall aims and objectives for responses to disasters and major incidents. They should specify the need for services to be designed, developed and delivered that offer psychosocial and mental health care that is integrated into all disaster response plans. Strategic policies are then required that translate political imperatives into the intent and direction of development of specific components of the plans.

3.8.4. Governance policies require the responsible authorities to develop strategic policies. Strategy should be developed by bringing together evidence from research, past experience, knowledge of the nature of areas of the country for which they are responsible and of their populations, and the profile of risks, to design services. Responsible authorities are also responsible for evaluating and managing the performance of those services to meet the identified objectives.

3.8.5. Service delivery policies concern how particular services function and relate to their partner services and how affected populations are guided into and through them according to the evidence and awareness of the preferences of people who are likely to use them. Service delivery policies include evidence-informed and values-based models of care, care pathways and protocols and guidelines for care as well as processes for demand management, audit and review.

3.8.6. Policies for good clinical practice concern how clinical staff take account of the needs and preferences of patients, deploy their clinical skills, and work with patients to agree how guidelines, care pathways and protocols are interpreted in individual cases.

3.8.7. Policy at each of the four levels should be informed by culture and values as well as by evidence and experience gleaned from practice. The Madrid Framework (see Annex A) can be used as a framework for benchmarking how policies deal with the values that are inherent in designing and delivering services.

3.9. **Standards**

3.9.1. All planners, incident commanders as well as practitioners, volunteers, researchers and evaluators should agree to work to a common set of standards.

3.9.2. In certain circumstances, especially those in which there is widespread devastation, high standards may not be achievable until there has been restoration of basic community functioning and resources including clean water and food supplies, shelter and protection, communications, and healthcare. Situations of this kind should be anticipated and covered by planning. Planning should consider what are the minimum standards in a range of different circumstances.

3.9.3. The standards adopted have substantial implications for training, research, evaluation and information-gathering because all of these capabilities should be core parts of all disaster and major incident response plans. This means that the requirement for them is anticipated and standards for research, evaluation and information-gathering should be developed and planned before disasters occur.

3.9.4. Research and evaluation should identify the factors that contribute to either the success or failure of particular types of service, their organisation and delivery, and particular interventions.

3.9.5. Research and evaluation should include follow up studies that are designed to learn about long-term effects that may be associated with psychosocial intervention programmes a substantial time after they have been completed.

4. DEVELOPING GOVERNANCE AND STRATEGIC POLICY

4.1. **General Principles for Policy**

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

- integrating psychosocial and mental health care responses to people's needs within the grand plan for preparing for, and responding to disasters;
- fully integrating psychosocial care and mental health service responses, to people's needs usually sequentially but also simultaneously;
- appointing psychosocial and mental health advisers to commanders of services that respond to needs that are caused by major incidents and disasters during planning and retaining their services to give real-time advice during events and in the, later, recovery phase;
- empowering communities and people;
- ensuring that staff are capable of working with diversity of values and cultures;
- attending first to the basic needs of the populations that are affected;

- developing and enacting effective public risk communication and advisory plans that involve the public and the media and which provide timely and credible information and advice;
- ensuring that the psychosocial care and mental health responses are comprehensive and stepped according to need, are of sufficient duration, and are well co-ordinated;
- allocating and managing roles for mental health professional practitioners;
- ensuring that staff of all organisations that respond to disasters and major incidents are well led, managed, supervised and cared for; and
- promoting learning by planning and managing knowledge acquisition and its transfer, evaluation and performance management.

4.2. A Strategic Stepped Model of Care

4.2.1. The strategic stepped model of care recommended in this guidance links the impact of events with the core components of psychosocial and mental health care that populations of people, communities and particular people require through the modalities of screening, triage, assessment and intervention. It is intended as a conceptual and practical resource for planners.

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

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

- **Public Psychosocial Care**
  - **Families, peers and communities provide responses to people's psychosocial needs that are based on the principles of psychological first aid.**
  - **Assessment, interventions and other responses that are based on the principles of psychological first aid** that is delivered by trained lay persons, who are supervised by the staff of the mental healthcare services, and social care practitioners.

- **Personalised Psychosocial and Mental Health Care**
  - **Access to primary mental health care services** for screening, assessment and intervention services for people who do not recover from immediate and short-term distress.
  - **Access to secondary and tertiary mental health care services** for people who are thought to have mental disorders that require specialist intervention.

4.3. Strategic and Operational Preparedness

4.3.1. Strategic preparedness supports psychosocial resilience and is, thereby, likely to improve responses to people's psychosocial needs and reduce the risks of severe distress and mental disorder.

4.3.2. Effective planning and co-ordination of service responses is likely to maximise the collective resilience of the public and communities and the personal resilience of affected persons and responders.

4.3.3. The building blocks of good planning are:

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

4.3.4. Every jurisdiction requires an integrated disaster and major incident plan. This means that every jurisdiction and area within it should have a disaster and major incident plan that is appropriate to its national, regional and local governance structures which makes provision for responses to people's psychosocial and mental health needs that is fully integrated into wider disaster planning and preparedness. Therefore, a coordinated approach is essential across the emergency response systems and rescue services. Integrated planning is required to support:

- a balance of population-orientated humanitarian aid, welfare, and health services with personalised healthcare services;
- organisations that deliver rescue, humanitarian aid and welfare services;
- social care systems;
- voluntary and non-governmental organisations;
- military systems; and
- military aid to civil powers.

4.3.5. Decision-makers must understand how people respond to disasters and major incidents and the risk factors that affect the likelihood of people coping well with the psychosocial impacts of disasters or of people developing mental disorders. This means that they must understand the:

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

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

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

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

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

4.3.9. Developing and managing the psychosocial and mental health components of disaster and major incident plans should be the responsibility of the agencies and persons who are responsible for all of the planning and preparations for disasters and major incidents. This means that every area should have a multi-agency psychosocial and mental health plan for all emergencies that is incorporated into the overall disaster/major incident plan and regularly updated. Existing psychosocial services should be mapped fully and incorporated into local psychosocial and mental health plans.

4.3.10. There should be explicit arrangements for designing, developing, testing, rehearsing and managing the psychosocial and mental health components of all disaster and major incident plans. Politicians, government officials and senior staff of the agencies that are to be involved should be involved in regular, realistic management training and exercises.

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

4.3.12. The psychosocial and mental health care plans should be developed, managed and monitored by the psychosocial expert advisory subcommittee. The committee should include persons who have been affected by past disasters and major incidents, mental health professional practitioners and managers of mental health services.

4.3.13. Care providers (volunteers and professional practitioners) should be recruited, in advance if possible, and screened for suitability.

4.3.14. First responders are a mix of people with differing capabilities. They face differing profiles of psychosocial risk.

- They include members of the public who are first on the scene as well as frontline rescue and emergency staff.
- They also include staff of humanitarian aid, welfare and healthcare services, and military personnel.
- Evidence shows that some first responders may be vulnerable to the psychosocial and mental health consequences of their involvement in disasters and major incidents while others are hardier.

The planning group should ensure that processes are established to monitor people who deliver care for possible secondary traumatisation and experiences of burnout. The people concerned must include volunteers.

4.3.15. All professional responders, including first responders in the police, ambulance, fire-fighting, humanitarian aid, welfare, social care and health services should work to agreed minimum standards. This requires that they should all have a basic understanding of: the psychosocial and mental health effects of disasters and major incidents on people who are directly or indirectly involved; how to assist people within the first week; awareness of the possible longer-term psychosocial, welfare and mental health consequences; and accurate information about the arrangements that are available for people who require more specialised assessment and care.

4.3.16. A training programme should be in place in every area to ensure that everyone who is involved in planning or delivering the responses to people's needs for psychosocial and mental health care is prepared for their roles and responsibilities. All staff who provide care should have undergone formal

training and receive ongoing training, support and supervision. The content and level of training should correspond with their roles and responsibilities in the stepped model of psychosocial and mental health care.

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

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

This role requires:

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

5. DEVELOPING POLICIES FOR DELIVERING SERVICES AND GOOD CLINICAL PRACTICE

5.1. General Principles

5.1.1. All actions, interventions and other service responses should promote: a sense of safety; self and community efficacy; empowerment; connectedness; calm and hope. They should also deal explicitly with people's human rights, and facilitate appropriate communal, cultural, spiritual and religious healing practices.

5.1.2. Responses should provide general support, access to humanitarian aid, welfare services, financial services and legal advice, social support, physical support and psychological support for all of the people who are involved.

5.1.3. Responses should focus on families. This means enabling people who are involved to contact their families, re-uniting families as soon as possible, and providing humanitarian aid, welfare services and psychosocial support for families.

5.1.4. Local community leaders who are aware of local cultures and particular communities should be involved in local groups for planning psychosocial and mental health care responses.

5.1.5. Efforts should be made to identify the most appropriate supportive resources (e.g. families communities, schools, friends, etcetera).

5.1.6. Specific formal interventions, such as single session individual psychological debriefing for everyone affected should not be provided. They have not been shown to be effective, and may cause harm for some participants.

5.1.7. Formal screening of everyone affected should not be conducted, because there are not, as yet, measures of sufficient sensitivity and specificity. However, responders should be aware of the importance of identifying as early as possible those people who have problems.

5.1.8. Prioritisation and triage should be based on the needs of the people who are involved directly or indirectly.

5.1.9. Responses should include educational services regarding reactions to disasters and major incidents and how to manage them. Furthermore, making arrangement for children to return to school, when it is safe to do so, even if in temporary facilities, is often an extremely important part of recovery plans.

5.1.10. General practitioners and local doctors should be made aware of possible psychosocial experiences and psychopathological sequelae because they should be directly involved in delivering the first level of formal mental health care.

5.1.11. Responding organisations should provide access to specialist psychological and mental health assessments, intervention and management when it is required.

5.1.12. Detailed planning should occur with existing services, local authorities and governments including the funding and provision of appropriate extra provision to augment local services for several years following disasters or major incidents.

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

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

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

5.2.2. Information regarding the situation and people's concerns should be obtained and provided for them in an honest and open manner, and at levels that they can understand.

5.2.3. Written leaflets containing appropriate information and where to seek help, if necessary, should be provided, but they must be tailored to the reading comprehension age of the general community (which is about 9 years of age).

5.2.4. Written materials cannot be relied on or be the main form of communication given the levels of problems with literacy and reading comprehension that are evident in even the most developed societies.

5.2.5. Therefore, telephone helplines should be launched that are staffed by trained personnel, to provide emotional support. Additionally, disaster and major incident plans should include arrangements for preparing websites concerning humanitarian, welfare and psychosocial matters. The latter should be kept

shrouded until they are required when they can be adjusted to the circumstances and made available online rapidly.

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

5.2.7. Psychosocial reactions should be normalised during initial responses to disasters and major incidents.

5.2.8. People should be neither encouraged nor discouraged from giving detailed accounts; they should provide them if and when they feel ready to do so.

5.2.9. Staff who oversee the initial psychosocial care response services should work closely with the media.

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

5.3.1. People who have high levels of distress, and especially people who have dysfunctional levels of distress, or distress of longer duration, during the first month after a disaster or major incident should be identified so that the services are able to maintain contact with them. This means, for example, that further contact should be offered to people and their families who are distressed for more than a fortnight.

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

5.3.3. Treatment with Trauma Focused Cognitive Behavioural Therapy (TF-CBT) should be available for people who have post-traumatic stress disorder.

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

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

5.4.1. People who have high levels of distress (see paragraph 5.3.1) within three months of a disaster or major incident should be identified so that the services are able to maintain contact with them.

5.4.2. Further contact should be offered to people and their families who continue to experience distress at any substantial level that continues for more than a month or who are dysfunctional on account of distress a month or more after events.

5.4.3. Professional practitioners should offer formal assessments to people who have psychosocial problems that continue or develop a month or more after a major

incident or disaster. Assessment should take place before any specific intervention is offered and consider people's emotional, social, physical, and psychological needs.

5.4.4. Treatment with TF-CBT should be available for people who have post-traumatic stress disorder because they are the treatments of choice.

5.4.5. Other treatments for post-traumatic stress disorder with a supporting evidence-base such as Eye Movement Desensitisation and Reprocessing (EMDR) and stress management should be available for people when TF-CBT is not available or is not acceptable to them.

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

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

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

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

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

6. MANAGING THE STEPPED MODEL OF CARE

6.1. Managing the stepped model of care, that forms the core of this guidance, requires the following.

6.1.1. Effective command, control and coordination before, during and following a disaster or major incident.

6.1.2. Appointing psychosocial and mental health trained advisers at the strategic, tactical and operational levels of command to assure full integration of the services that respond to communities' and people's psychosocial and mental health needs within disaster and major incident plans.

6.1.3. The responsible authorities, incident response commanders, service managers and professional practitioners adopt an ethical framework for planning and delivering services.

6.1.4. The responsible authorities, incident response commanders, service managers and professional practitioners adopt a framework for good decision-making.

6.1.5. Commanders should ensure that appropriate services are made available in each phase of response and recovery and this requires services that offer:

- immediate humanitarian aid and welfare services for everyone who needs them;
- service responses that recognise that the intensity and duration of people's exposure to stressors, certain prior experiences, and the availability or otherwise of social support are related to their likelihood of developing more serious psychosocial problems or mental disorders;
- long-term and persistent follow-through; and
- care for responders.

6.1.6. The responsible authorities, incident response commanders, service managers and professional practitioners adopt pre-planned frameworks for:

- corporate governance; and
- clinical governance.

6.2. Execution of psychosocial and mental health care plans depends on effectively managing and caring for staff. Staff and agencies should be provided with:

- clear plans;
- statements of the expectations that are likely to fall on them;
- opportunities for training and rehearsal; and
- increased supervision and social support.

6.3. This means that all rescuers, responders and other staff involved should have:

- clear roles and responsibilities that are agreed in advance;
- professional standards and expectations that are clear, practical and realistic;
- effective leadership; and
- access to the support of colleagues.

7. GENERAL PRINCIPLES FOR INFORMATION-GATHERING, RESEARCH AND EVALUATION

7.1. Information-gathering, research and evaluation are vitally important if lessons are to be learned from clinical practice in disasters and major incidents that will contribute to saving lives, minimising suffering, and reducing risks to staff in other disasters and major incidents.

7.2. There is a particular requirement to agree, internationally, definitions of what constitutes and differentiates information-gathering, research, evaluation and monitoring as applied to psychosocial and mental health intervention programmes.

7.3. Well-designed and well-conducted information-gathering, research and evaluation should:

- clarify the intentions, design, and effective conduct and delivery of specific programmes;

- be beneficial to the communities served by the programmes that are being evaluated;
- promote effective practice by the staff of programmes; and
- reinforce fidelity of programme delivery with what is required by the populations involved and the intentions of the programmes' designers.

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

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

7.6. Well-designed and well-conducted information-gathering, research and evaluation should be conducted according to overt, transparent, acceptable and agreed ethical standards. Ethical procedures and standards should not be compromised.

7.7. Therefore, it is important to:

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

ANNEX A TO: GUIDANCE FOR RESPONDING TO THE PSYCHOSOCIAL AND MENTAL HEALTH NEEDS OF PEOPLE AFFECTED BY DISASTERS OR MAJOR INCIDENTS

THE MADRID FRAMEWORK[7]

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

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[7] this table was created from the text on pages 2-5, and is reproduced with permission, from Marinker M (editor). Constructive conversations in health: about policy and values. Oxford: Radcliffe Publishing; 2006.