A co-ordinated response for psychosocial care of survivors of terrorist attacks: Lessons learned from recent programmes run in Wales, Scotland & England

Idit Albert, Neil Kitchiner
Gill Moreton
UKPTS, Cardiff 2017
Emergency Planning Is…

…the development of agreed arrangements to protect the public from the effects of emergencies (whatever their causes)

involves careful risk assessment and planning to aid the response to and recovery from emergencies

description of responsibilities, agreed management structures, pre-planned strategies and available resources
A Major Incident Is...

...any emergency that requires the implementation of special arrangements by one or more of the emergency services, the NHS or the local authority for:

- The initial treatment rescue and transport of a large number of casualties
- The involvement either directly or indirectly of large numbers of people
- The handling of a large number of enquiries likely to be generated both from the public and the news media
- The need for any large scale combined resources of two or more of the emergency services
- The mobilisation and organisation of the emergency services and supporting organisations

Source: *Dealing With Disaster Revised Third Edition.*
Local Response
(Undertake planning duties to deal with disasters)

Regional Response
(Assist in wide area disaster or if local resources are swamped)

National Response
(Plan to coordinate the disaster response & provide further resources)
Emergency + aftermath..

- Often the disruption in people’s lives that follows an emergency can have as big an impact as the emergency itself and some people may therefore require assistance and support due to this and over an extended period of time.

- Arrangements should recognise that people affected by emergencies may be able to function well for some time after the event(s), but they may have psychosocial problems or develop mental disorders several years later.
Steering Group Response

• Coordinate an extraordinary meeting to plan specific response.

• Alert telephone help line volunteers.

• Alert trauma counsellors.

• Liaison with social services and others involved.

• Customise information for leaflets and website.
Effects on Workers

• Ensure workers’ needs prioritised

• Individuals selected for particular roles

• Ensure regular rotation

• Steering group have a key management and supervision role

• Support, guidance, training

• Team meetings

• Team leader ensures coping
Plan Completed
Or
Plan Reviewed

“Living” Document...
Series Of Exercises...
Variety Of Scenarios...

Amendments Made

People Trained

Validated By
Exercise
Understanding wellbeing

- Spending time with family and friends
- Health
- Accommodation
- Financial security (present & future)
- Self-determination (achieving goals, being able to influence life & health)
- Local area / environment
- Involvement in leisure & hobbies
- Feeling part of a community
- Involvement in social activities in local area
Emergencies as a social disease

Lifetime prevalence for Post Traumatic Stress Disorder of 7% following trauma exposure (+ often other mental health problems)

Plus effects of psychosocial stress on physical health:

- Impact of adverse environmental conditions (dust, damp, dirt)
- New physical health problems (e.g. myocardial infarction rate tripled in the week after the earthquake in NZ in 2011)
- Difficulties managing pre-existing chronic health conditions
- Impact of injury, bereavement, dislocation, money worries, unemployment, uncertainty
- Unhelpful coping strategies (restart smoking, drink more)
The European Network for Traumatic Stress

http://www.tentsproject.eu/
What is TENTS?
The European Network for Traumatic Stress

Traumatic events like disasters strike the wellbeing of entire communities. In the aftermath of natural and other disasters victims are in need of adequate psychosocial assistance. The TENTS-project is committed to the dissemination across Europe of evidence based practice for the assistance of victims of natural and other disasters. This project is funded by the European Commission, Directorate General Health and Consumer Protection (DG SANCO).

Learn more here...
Principles for Psychosocial Plans

• Empirically based (i.e. based on the best evidence available)

• Flexible across events, cultures and time periods

• Take account of the potential resilience of people and communities

• Accommodate the needs of vulnerable and at risk groups of people, including family & relatives, other carers, people from professional organisations
Continued

• Realistic in terms of the extent to which it can be implemented in emergencies given the personnel and resources that are available

• Take account of population dynamics, including age and cultural differences, that may affect populations that are involved, first responders and staff of services

• Capable of evaluation
Continued

• Acknowledge the importance of anticipated reactions, resilience and the natural healing potential of people, families and communities

• Endorse the primary principle of, first, do no harm

Preparation 
Scotland
RESPONDING TO THE PSYCHOSOCIAL AND MENTAL HEALTH NEEDS OF PEOPLE AFFECTED BY EMERGENCIES

Supplement to
CARE FOR PEOPLE AFFECTED BY EMERGENCIES
Aims of the Guidance

• To provide a model of care that promotes the resilience and psychological well-being of survivors, the bereaved, indirectly affected persons, the wider community, and staff of all the responding services before, during and after emergencies.

• To enable emergency planners to design and plan a coordinated response and to provide preparatory training for the staff of services required in the event of emergencies. These services will come from the healthcare sector, social care, the emergency services, those involved in humanitarian assistance and the voluntary sector.
The idea of resilience…

• People thrown together in the aftermath of an emergency frequently respond with great fortitude and resilience. Statutory responders should recognise this and should actively promote the fullest participation of local, affected populations.

• There is a broad range of ways in which people react psychologically when they are involved in an emergency. Distress following an emergency is very common, but in most cases is transient and not associated with dysfunction or mental disorder. The majority of people will not require access to specialist mental health care.
Key principles

- Emergency + it’s aftermath
- Need to identify & support the vulnerable
- Understand risk
- Help make sense of reactions
- Stepped approach
- Work together
- Build social capital
- Be ready to learn
- Take care of responders
Psychological First Aid (PFA)

• There are a number of components of effective PFA. There is no particular order to follow, as the order will depend on the individual and the emergency, and the components should be modified to match the needs of the individual, for example, a child will require a different explanation of trauma reactions than an adult.

  – Provide immediate care for physical needs
  – Protect from further threat and distress
  – Provide comfort and console distress
  – Provide practical help and support for real-world-based tasks (e.g. arranging funerals, information gathering)
  – Provide education about normal responses to trauma exposure. This should involve two essential elements:
    • Recognising the range of reactions
    • Respecting and validating the normality of the post trauma reaction
  – Facilitation of reunion with loved ones where possible and/or connection with social supports
  – Provide information on coping and accessing additional support
Welcome to the Scottish Resilience Development Service

ScoRDS (Scottish Resilience Development Service) supports the resilience community by providing learning and development to enhance the knowledge, skills and behaviours required for effective multi-agency emergency planning, response and recovery.
Psychological First Aid

The goal of this e-module is to help you understand when and how to provide Psychological First Aid in the immediate aftermath of an emergency, such as a natural disaster, a terrorist attack or a mass casualty event.

On completion of the e-module you should be able to:

- Define Psychological First Aid
- Describe the 7 key components of effective Psychological First Aid
- Feel reasonably confident in delivering Psychological First Aid to a survivor
- Adapt Psychological First Aid to diverse settings and different populations, and
- Identify ways to look after yourself while providing Psychological First Aid

The e-module is designed for people who may be involved in the response to an emergency, including people from Category 1 responder organisations, third sector organisations, and staff in health and social care services.
Psychological Services in Response to Major Incidents

Dr Idit Albert
Consultant Clinical Psychologist and PTSD Lead
Acknowledgments

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International Terrorist Attacks 2015-2016

**Tunisia:**

- Bardo Museum – 18th March 2015
- Sousse Beach Resort – 26th June 2015

**Paris** - 13th November 2015

**Brussels** - 22nd March 2016

- Zaventem Airport,
- Movenbeek Metro Station

- 33 British were killed
- More than 500 British people were affected by these events
22 people were killed, one British national, Sally Adey was killed in the attack.

50 other people were injured.
A map of the hotel where the attack took place with the route taken by the terrorist from the beach into the hotel complex.
Map showing the locations of the Paris Attacks.
Left: David Dixon escaped the bombs in the airport but was later killed in the Metro bombing.
Rational for Screen & Treat

- 30%-40% of those directly exposed to a terrorist attack are likely to develop PTSD (Whalley & Brewin, 2007).

- Following the London Bombing outreach programme:
  - 596 screened in 18 months
  - 255 referred for treatment by screening team; only 14 by GPs

- NICE Guidelines for PTSD:
  “For individuals at high risk of developing PTSD following a major disaster, consideration should be given (by those responsible for coordination of the disaster plan) to the routine use of a brief screening instrument for PTSD at 1 month after the disaster.”

  - https://www.nice.org.uk/guidance/CG26/chapter/1-Guidance
The Welsh Model

Dr Neil Kitchiner
Week 1 - post attack

• The Welsh Government (WG) contact Veterans’ NHS Wales – one Welsh female killed - Trudy Jones, 51

• Trigger - Police OHU – requested help from WG (re: member of staff who worked in the police control room)

• Consistent with Cardiff & Vale ‘Plan for Psychosocial Care Following a Major Incident’

  – “A dedicated service should be established following a major incident and that funding be identified and protected from the outset” (Bisson et al., 2013)

• Veterans’ NHS Wales funded by WG with National footprint & expertise in treating psychological trauma
Week 2 - post attack

• Following discussions with senior C&V Traumatic Stress Service & Welsh Government civil servants

• Wales launches Tunisia out-patient psychosocial service

• Advertised to key stakeholders – e.g. Primary Care via email bulletins, CMO twitter & dedicated Call Line

• Funding for 6 sessions of band 7 psychological therapist

• Existing VNHSW therapists increased their p/t hours in three LHBs for 6/12 initially = £15K – extended by 12/12

• Dedicated page on VNHSW website for info & online referral
Tunisia Incident

Sousse beach incident, Tunisia, 26 June 2015 / Paris Attacks, 13 November 2015

Following the tragic events of Friday 26 June 2015, in the resort of Sousse, Tunisia and the Paris Attacks, 13 November 2015, The Welsh Government has requested that Cardiff and Vale University Health Board assist them in providing support to victims and families in Wales who may have been affected psychologically. A national helpline has been opened 0800 132737, where trained operating staff from CALL will be available 24/7 to provide advice and guidance about accessing help in your local area.

The Cardiff and Vale Traumatic Stress Service and Veterans’ NHS Wales have joined forces with other agencies to develop an approach of identifying individuals who may have been affected and enabling them to access appropriate support and treatment when this is needed.

How can I access help?

In the first instance we recommend you follow the advice contained in the Sousse beach / Paris Attacks incident leaflet, which can be downloaded here or request a copy is posted to you by using the contact form below or by email or by telephone on 029 20 742 062. If you are concerned about your own symptoms or someone else, then we recommend you contact your GP in the first instance for advice and support.

Your GP may refer you on to other local NHS and other statutory services that can assist you in your recovery. Alternatively, you can self refer to Veterans’ NHS Wales which employs experienced psychological trauma therapists, by completing the on-line contact form below, by email, or telephone: 029 20 742 062.

How affected do I need to be to access help?

If you have been affected by the Sousse beach incident / Paris attacks and you are now having difficulty coping at work, or at home, or socially or having difficulties...
Welsh model

• Individuals referred contacted by telephone & screened
• Provided with advice on coping (use social support) & symptoms normalised
• Leaflet & PHQ-2 & TSQ posted (on website)
• Telephone contact after 7 days & reassessment
• Scores of 3> on PHQ & 6> on TSQ offered an individual assessment
• Individuals with moderate to severe symptoms offered out-patient TFPT (Roberts, Kitchiner, Kenardy, & Bisson, 2010)
• Mild symptoms pts offered follow-up telephone appt
Results

• 14 (40%) individual referred, 12 (34%) screened, 1 declined

• 12 offered individual out-pt TFPT

• 1 offered a follow-up appt & discharged

• 12 provided with TFPT – 10 completed therapy & 2 dropped out early
Demographics

• Average age of the individuals screened = 48 (range 26-61, S.D = 12.3 years)

• 4 male (31.8%) 9 female (68.2%) female

• 12 of 13 individuals assessed (92.3%) indicated that they were directly affected by the shooting or its aftermath
Speed of assessment

• Assessment completed on average 17 weeks after the incident (inc 2 referred from England service 12/12)

• 5 individuals received initial assessment within four weeks of the incident
Main presenting symptoms

• 4 = Acute Stress Disorder (ASD)

• 6 = Post Traumatic Stress Disorder (PTSD)

• 2 = Major Depressive Disorder (MDD)
Co-morbidity

• Individuals PTSD or ASD = 9 had clinically significant symptoms of depression via (PHQ-9)

• 9 also reported clinically significant symptoms of GAD via (GAD-7)
Therapy outcome

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<tr>
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<th>Pre-Rx</th>
<th>Post-Rx</th>
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<tr>
<td>PCL-5 (n10)</td>
<td>55</td>
<td>27</td>
</tr>
<tr>
<td>PHQ-9 (n11)</td>
<td>16</td>
<td>8</td>
</tr>
<tr>
<td>GAD-7 (n9)</td>
<td>17</td>
<td>9</td>
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</table>
Summary 1

- 14 individuals self-referred or were referred by health professionals

- 1 individual declined to be screened

- 1 individual at follow-up assessment was discharged without receiving treatment
Summary 2

• 12 individuals commenced psychological treatment with ASD, PTSD, or MDD
• 10 individuals completed treatment
• 2 dropped out at nine and ten sessions respectively (last measure used as post)
• The majority of individuals obtained a clinically significant recovery from PTSD, MDD and anxiety symptoms
• Patient satisfaction with therapy and the response was high
• Over 90% of individuals who made contact with the service had a mental disorder of some kind (ASD, PTSD or MDD)

• Over 80% had PTSD as their main problem
Summary 4

• Patient satisfaction questionnaire indicated patients were ‘Very Satisfied’ with the service as a whole

• All patients indicated that the subsequent terrorist incidents in Brussels and Paris hindered their recovery ‘massively’

• It is likely that the increased threat of terrorism subsequently to the Sousse incident have impacted on their recovery
Welsh lessons learnt

• Patient satisfaction questionnaire indicated patients were ‘Very Satisfied’ with the service as a whole

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Welsh lessons learnt

- It was possible to react quickly and set-up an out-patient psychosocial service for victims of major disasters.
- Public health messages do NOT always reach all victims.
- The service needs to be regularly promoted to Primary care services.
- The use of social media was helpful in keeping it alive e.g. Twitter.
The Scottish model

Gill Moreton
4 Scots killed in Sousse

# affected?

- 952 Scots flown home from Tunisia
- 562 Brits identified by police as being “directly affected”
- 22 Scots identified as witnesses by police
To screen or not to screen?

September 2015 - DoH approach Scottish Government to ask if they want Scots involved in PHE screening

SG approaches Rivers Centre for advice

Recommend participation to monitor those affected & offer follow-up as required

– How do we identify those most at risk?
– Clinical intervention vs. data collection
– Timing

January 2016 – SG decides to opt-out of PHE register & asks Rivers Centre to run parallel but separate Screen & Assess programme
Scottish model

• Making it personal
  – “Hello”
  – Named contact person
    – Screening the “Mental Health Check” questionnaires
    – Calling people
    – Joining meeting with FCO minister for those affected
    – Doing most of the assessments (in Edinburgh or Glasgow)
    – .. & some of the treatment

• Anticipating resilience
  • “In the months since the attack what has helped you to cope? (Please circle all that apply)
    – Support from family and friends
    – Getting back into a routine (at work or at home)
    – Self care (e.g. exercise, relaxation, hobbies)
    – Support from faith community
    – Support from GP
    – Other (please say what)

• Having an overview
  – One person co-ordinating the scheme
Response

- Met Police sent letter and questionnaires to the 45 people on their list and to the next-of-kin of the 4 Scots who were killed. We also sent some extras (total = 60)
- 26 returned (43%)
- 10 others didn’t return but were in contact (60%)
- Another person was referred by their GP (hadn’t received a Q)
- Majority of responders did so quickly (< 2 weeks)
- We tried to contact all 26 returnees
- Spoke to 23 of them
Most people welcomed the questionnaire and contact from the Rivers Centre, but many expressed dissatisfaction with the support they had received prior to this contact. **Two people reported positive experiences:**

“Happy with support via government / police”
“Self-referred to local charity (sic) and fortunate to have been able to access CBT trauma-focussed counselling from the beginning”

**Others had more negative experiences:**

“I don’t feel like we have been supported at all. People who have been mentally traumatised have been left to fend for ourselves. We have had no information/support from the Government.”
“We feel as if we’ve been forgotten about and as we weren’t physically injured it’s as if we don’t need help. We do. We are the forgotten.”
“It feels like you don’t matter if you weren’t physically hurt”
Wounded

• 9 months after the attack, 18 of the 26 were experiencing clinically significant emotional & psychological (13 scoring 5+ on PTS scale)

• Common difficulties included distressing memories, anxiety + panic, hyperarousal + hypervigilance

• 4 reported thoughts of self-harm or suicide

• Respondents spoke of their lives being “ruined completely”, of feeling “terrified to go out” and of being a “different” or “changed” person.

• Assessments were offered to all 18 (15 accepted)
  • 7 seen face to face / 8 by telephone
  • Advice also given to parents of 5 year old
  • Non-responders were written to & encouraged to contact their GP
• All of those assessed required further psychological treatment:
  – 4 people being seen by ASSIST counsellor through travel company
  – 2 being seen in NHS
  – Others either treated at Rivers or referred to local NHS MH services

• Most of these people believed they should have been more support, more quickly

• The sense of being “ignored” or “forgotten” appeared to have exacerbated some people’s distress
Feedback

• Response rate of 56%
  • 47% very or fairly satisfied
  • 23% neither satisfied / dissatisfied
  • 23% dissatisfied

• just amazing, life-changing
• availability of support & reassurance that I was coping well
• clinician very supportive & discussed with my psychologist what treatment should be offered
• Introduced far too late
Lessons learned

• Support, offered quickly, is highly valued & *vice versa*

• Many people who could benefit from help do not seek or receive it

• People often don’t contact their GPs for mental health issues

• Where treatment is being provided it may not be joined up or evidence-based (+ colleagues may not welcome your assessment and/or offer of supervision)

• Screening programmes work but are challenged by:
  – Ongoing problems with data-sharing
  – Delays setting them up
  – Liaison between incident-specific and generic MH services, and between 3rd sector & NHS

• There needs to be a wider public health response to inform people how to access support
Lessons

Terrorist attacks bring additional challenges for the individual

• Further attacks are likely to maintain and aggravate distress

• People may develop or confirm prejudicial beliefs which maintain anxiety and are challenging for the therapist

• High media and political interest can cause problems
  – Repeated exposure
  – Status + recognition
  – Intrusion vs. invisibility
  – Deserving or not
Centre for Anxiety Disorders & Trauma

NHS England response

Dr Idit Albert
Consultant Clinical Psychologist and PTSD Lead
Rational for Screen & Treat

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- Following the London Bombing outreach programme:
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- NICE Guidelines for PTSD:
  “For individuals at high risk of developing PTSD following a major disaster, consideration should be given (by those responsible for coordination of the disaster plan) to the routine use of a brief screening instrument for PTSD at 1 month after the disaster.”
  - https://www.nice.org.uk/guidance/CG26/chapter/1-Guidance
Roles and Responsibilities:

- Clinical assessment with a specialist psychologist
- Referrals those requiring it to evidence-based treatment with an appropriate local service
- Provide follow-up with all referrals to SLaM
- Ensure that individuals are given support to navigate psychological health services where necessary
- Support local services with training and/or supervision
Numbers Seen (Children in Brackets)

- 178 (7) Positive Screens
  - 17 (1) Unable to Contact
  - 161 (6) Contacted
    - 19 Declined Assessment
  - 22 (3) Assessment not Required
- 15 (0) Negative Screens
  - 161 (6) Contacted
    - 19 Declined Assessment
  - 119 (3) Assessed
    - 38 Referral Not Required
    - 78 (3) Referred
      - 74 PTSD
      - 4 Depression
      - 43 PTSD with Co-Morbid Disorder
  - 3 Declined Referral

- 469 follow-ups
- 16 services provided with supervision
- 1 service provided with training

National Screen and Treat programme April 2016 – March 2017
Geographic Spread
Treatment Outcome

<table>
<thead>
<tr>
<th>Tool</th>
<th>Reliable Improvement</th>
<th>Reliable Recovery</th>
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<tbody>
<tr>
<td>PHQ-9</td>
<td>75%</td>
<td>50%</td>
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<td>GAD-7</td>
<td>73%</td>
<td>53%</td>
</tr>
<tr>
<td>IES-R</td>
<td>79%</td>
<td>71%</td>
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Prior Mental Health difficulties

- % of people who reported previous mental health problems scoring above the clinical threshold
- % of people who reported no previous mental health problems scoring above the clinical threshold

Scores indicating moderate symptoms:
- PHQ-9: 57%
- GAD-7: 57%

Scores indicating significant symptoms:
- IES-R Moderate*: 11%
- IES-R Significant*: 51%
- WSAS*: 41%

Scores suggesting impairment on work, social and leisure activities:
- PHQ-9: 28%
- GAD-7: 29%
- WSAS*: 27%
Very professional approach, just to slow in its set up to peoples needs

“I cannot fault the service I received, once I completed the questionnaire, but for me, this came far too late.”

“I found the psychologists were very understanding of my concerns and they gave me positive ideas as to how I could move forward without making me feel like an 'unusual and therefore difficult to help' case as I felt in the prior counselling I received”

“I feel that if I hadn’t had the treatment I received I wouldn’t be where I am today

89% referrals were very satisfied with the service

What did service users say?
UK Major Incidents 2017 Timeline

- 22/3 Westminster
- 22/5 Manchester Arena Bombing
- 3/6 London Bridge
- 14/6 Grenfell Fire
- 19/6 Finsbury Park
- 15/9 Parson Green
After Westminster and London Bridge incidents

London Attack 3rd June 2017
Brief Tips About Self-Care and Self-Help

How Can Children be helped to cope?
- Let them know that you understand their feelings.
- Give them the opportunity to talk, if and when they want to.
- Respect their pace.
- Measure them that they are safe.
- Keep to usual routines.
- Keep them from seeing too much of the frightening pictures of the event.

Common Reactions to Traumatic Events
The following responses are normal and to be expected in the first few weeks:
- Emotional reactions such as feeling afraid, sad, helpless, depressed, angry, confused, numb or disoriented.
- Disturbing thoughts and images that jar you into your sleep.
- Nightmares.
- Disturbed sleep or nightmares.
- Feeling anxious.
- Care needs.

These responses are a normal part of recovery and are the body's mechanisms of trying to make sense and come to terms with what has happened. They should subside over time.

When Should a Person seek More help?
In the early stages, psychological professional help is not usually necessary or recommended. Many people recover naturally from these events. However, some people may need additional support to help them cope. For example, young children, people who have had other traumatic events happen to them, and people with previous mental health difficulties may be more vulnerable.

If about a month after the event you are still experiencing the following difficulties, it is a good idea to visit your GP or your local NHS service (contact information will be available on the internet) for advice:
- Feeling upset and fearful most of the time.
- Having very difficulty to believe the trauma didn't happen.
- Not being able to work or look after the home and family.
- Having deteriorating relationship difficulties.
- Feeling very jumpiness.
- Having a lot of nightmares.
- Still not being able to enjoy life or all.

What Kind of Help is Available?
Psychological interventions for trauma can vary but generally their aim is to enable people to improve coping and address difficult feelings.

- Support to colleagues in acute health serveries KCH, GSST
- Information to Response planners
- Information to the public; gov website, local health services
- Service for BTP
London Mental Health Response to Major Incidents

• Established to provide a coordinated Mental Health response to the recent terrorist incidents and Grenfell fire.

• The Mental Health Response Group is working with a range of stakeholders across the system to ensure that there is a co-ordinated, pan-London Mental Health response.
The Mental Health Response Group has built on the work that has taken place in Manchester, New York and London previously to define a clinically robust model to provide Mental Health support comprising:

1. **A multi-agency stepped model of care** that is holistic and personalised
2. **Proactive outreach and screen** approach to identify those requiring support
3. **Single point of contact** to support effective referrals and system navigation
4. **Effective Monitoring** of the system response and overall utility of care
Mental Health Response Group has delivered:

1. Approved treatment pathways for adults and CYP

   Adult Pathways: Victims, Bereaved, Witnesses, First Responders

   CYP Pathways: Victims, Bereaved, Witnesses

2. Design of appropriate screen and treat service model


Other Products

NHS coping with stress following a major incident leaflet

Information sheet for Primary Care

Information sheet for IAPTs

Information sheet for CYP
1. To act as a single point of contact
2. Identify witnesses who are most likely to have been impacted by an incident
3. Reach out to those impacted through collaboration with 3rd sector organisations
4. Proactively monitor the at risk population to address issues as they arise
5. Refer those affected by the incident to appropriate evidence based treatments regardless of address
6. Report directly into a Mental Health and Wellbeing Sub-group for incident response
Psychological Trauma Outreach, Screen and Support Service for London Terrorist Incidents
Available details of victims, witnesses and first responders impacted by major incidents

Initial screening

3 months

3 months

Second screening

Final screening

Assessment

Assessment

Requires treatment

Requires treatment

Requires treatment

Outreach and Screen service

Outreach and screen completed

MH services

IAPT

Specialist trauma

Other MH services
Screening
Demographics and contact details

• Name, DOB, Gender
• Personal status
• Address
• Preferred phone number
• Email address:
• GP’s name and address

Screening Questionnaires

• PTSD - 10 Items of the Trauma Screening Questionnaire (Brewin 2002)
• Depression – PHQ2 (two items)
• Anxiety – GAD-2 (two items)
• Alcohol & Drugs consumption
• Increase smoking

Triage Questions

• Have you ever served in the British Armed Forces? (please circle the one that applies to you) Yes / No
• Are you pregnant? (please circle the one that applies to you)
• Yes / No If yes, when is your estimated delivery date (EDD) dd/mm/yyyy: ___ / ___ / ____
• A risk to losing your employment/job Yes / No
• Difficulties looking after your children or others you may be caring for Yes / No
• Previous mental health difficulties

Which, if any, of the following applied to you on the day of the attack?

• Were you injured
• You felt that you might be injured or killed
• A family member or close friend was killed
• A family member or close friend was injured
• You saw someone who had been injured or killed Yes / No
• You only found out about the attack after it was over Yes / No
Clinical Assessment

Standardised questionnaires: (Including IAPT minimum data set)

- **Previous Traumas** - Life Event Check List
- **PTSD** - IES-R
- **Depression** - PHQ9
- **Anxiety** - GAD7
- **Functioning** - Work and Social Adjustment Scale
- **Difficult reactions i.e. shame, guilt, anger** - Visual analogue scales
- **Structured Diagnostic Interview for PTSD** (IPSS – DSM-5, Foa)

- Risk assessment
- Co-morbid mental health difficulties
- Mental Health History
- Physical Health
- Substance misuse
- Expectation and goals
- Agreed care plan
Support for Children and Young People

• A face to face or a remote screen.

• Information and advice for parents and carers

• Provide a choice of assessment by the service or by local CAMHS

• Refer to local multi-agency stepped model of care
Screening for Children

Parents will be asked about their concerns. Children will complete short questionnaires

**PTSD screen**
>8 years: the Revised Impact of Event Scale (CRIES-8), an 8-item questionnaire completed by the child

</=7 years: the Scheeringa questionnaire, a 6-item questionnaire completed by parents or guardians

**Depression screen**
>8 years: the Mood and Feeling Questionnaire (Short Version), a 13-item questionnaire completed by the child
What are the considerations for this clinical group

- Common symptom presentations (hypervigilance, avoidance, travel phobia, mistrust)
- Traumatic bereavement
- Physical injuries
- Affects families and social groups
- Impact of:
  - Reports/ none reports in the media
  - Impact of Public memorials
  - Inquest – Criminal Investigations

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<tr>
<th>For Services:</th>
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<tr>
<td>- Understanding care pathways and providing coordinated care</td>
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<td>- Resources/capacity (unable to prioritise these cases)</td>
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<td>- Need to support responders</td>
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<td>- Numerous referrals within one family or social group – offering coordinated care</td>
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<th>For clinicians</th>
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<td>- Familiarity with the event/s</td>
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<td>- Bereavement counselling or trauma focussed work?</td>
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<td>- Planning treatment that takes into account significant dates (anniversary, memorial, inquest)</td>
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<td>- Therapist’s own estimation for threat of terror</td>
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Lessons learnt

There is a need for an outreach programme implemented quickly

- 40% of those who completed the screen required referral to treatment in England
- Particularly those with previous mental health difficulties
- Need a timely response

Despite significant recent developments in care pathways following major incidents and data sharing further progress is still needed to:

- overcome existing barriers in data sharing
- Coordinate care between statutory and non statutory agencies
Lessons learnt

• Whilst ad-hoc psychological screening services could be helpful the time that is required for their establishment delays treatment and causes frustration to victims and professionals

• Public health messages are not an efficient method to reach all individuals affected – increased use of social media?

• Once assessed and treated service users report high levels of satisfaction with health professionals and therapy

• Psychological therapy providers must be experienced in offering evidenced based trauma focused psychological therapy (Nice approved)

• Physical trauma teams should be targeted with how to refer their patients to the screen and treat services once medically stable
Group Exercise

You are involved in providing psychosocial support following a major incident in your area.

What do you need to consider?

Who needs to be involved?

What would a coordinated response look like?
Our Recommendations to policy makers and Governments

• There are individuals identified with in each country with responsibility for the UK psychosocial disaster responses

• A UK wide psychosocial disaster plan be formulated and agreed which includes service users, health, social services, police, local authority representatives

• Information governance and sharing protocols are developed and signed off by all key stakeholders

• Specific funding in place to activate a national team including expert service users, health, social services, police, local authority to oversee a screen and treat service for the UK

• Annual desk top training exercises used to test the resilience of the UK psychosocial response which include latest academic evidence
Recommendations

• Public health approach based on Psychological First Aid (PFA)
  – Websites / leaflets, use of social media
  – Improve engagement with (and management of) mainstream media

• GPs, NHS Primary Care staff & police family liaison officers to be trained in PFA

• Need for additional collaboration & more exercising between NHS staff working with physical & psychological trauma, e.g. dealing with mental health patients at A&E

• Address data-sharing issues
  – Holiday companies to include clause for data-sharing in emergencies
  – Police to seek consent to share personal details with other support agencies

• Include specific recommendations for emergencies caused by terrorism &/or happening overseas
  – Need for co-ordinated response
  – Need for close working with police & FCO
  – Support during legal proceedings
Recommendations

• Referral of distressed individuals for assessment and treatment when needed as soon as possible

• Consider using “mental health check” 1 – 3 months post-emergency to monitor those at risk
  – Include GP details

• Consideration for people with history of mental health difficulties

• Taking into consideration characteristics of the affected group as well as resources of local services to take additional work *(not sure what this means..)*

• Support should take into account inquests, anniversaries, memorials
A brief summary of the support provided and outcomes achieved by ASSIST Trauma Care

Presented by:
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Lynn Kirk (Senior Specialist Trauma Therapist)
Jag Dhadwal (Director)
The Referral Process

Table 1. Number of most recent terrorism related referrals to ASSIST Trauma Care

<table>
<thead>
<tr>
<th>Incident</th>
<th>Referrals</th>
<th>Completed</th>
<th>Still in therapy to date</th>
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<tbody>
<tr>
<td>London bombings (2005)</td>
<td>10</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Sharm el Sheik (2005)</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Tunisia (2015)</td>
<td>70</td>
<td>36</td>
<td>21</td>
</tr>
<tr>
<td>Paris Bataclan (2015)</td>
<td>4</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Flight MH17 (2014)</td>
<td>7</td>
<td>6</td>
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Evaluation on how therapy has affected victims

- Partnership with Arq Psychotrauma Expert Group
- Analysis of psychometrics gathered from client files pre & post therapy
  - 1) Impact of Events Scale
  - 2) PHQ-9
  - 3) General Anxiety Disorder 7
  - 4) Inventory of Complicated Grief (if needed)
  - 5) Work & Social Adjustment Scale
Results of our model

- Symptoms of PTSD, depression, anxiety & complicated grief all significantly reduced after completing therapy with ASSIST.
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