UK Psychological Trauma Society Conference
Psychosocial disaster planning
Current best practice

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1.45-5pm
Objectives of the session

• To introduce participants to current best practice in the psycho-social aspects of disaster planning

• On successful completion of the course, attendees will be able to:
  • Describe the principles of developing a multi-agency psychosocial support care plan to be delivered after a disaster
  • Describe the specific roles of multiple agencies in the immediate aftermath of a disaster: the short, medium and longer terms
  • Describe the current evidence base for the effectiveness of approaches to disaster management
Introductions

• Who are we?

• Who are you?
  – What brings you here?
  – What experience do you have with working with disasters?
What is a disaster?

Disasters include:

- natural - flooding; hurricanes; earthquakes;
- human-induced – transport accidents; multiple shootings; terrorist attacks; military conflict; and
- technological - industrial; chemical; radiological and nuclear; biological
What is a disaster?

- World Health Organization (1992):

define disaster as:

“a severe disruption, ecological and psychosocial, which greatly exceeds the coping capacity of the affected community”
Guidelines for Mental Health & Psychosocial Support in Emergency Settings

www.humanitarianinfo.org/iasc
Psychosocial support is defined as any type of local or outside support that aims to protect or promote psychological well-being and/or prevent mental disorder (IASC, 2007)
Core Principles

1. Human rights and equity
2. Participation
3. Do no harm
4. Building on available resources and capacities
5. Integrated support systems
6. Multi-layered supports
Pyramid for Mental Health & Psychosocial Support in Emergencies

Level 1: Basic Services & Security

Level 2: Community & Family supports

Level 3: Focused Non-Specialised Services

Level 4: Specialized Services

Degree of mental health specialisation
Three Types of Response

1. Emergency Preparedness
2. Minimum Response
3. Comprehensive Response
The current context of disaster work – EFPA
The current context of disaster work – NATO

- NATO Joint Medical Committee (2009)
- 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, conflicts, disasters and terrorism
Psychosocial responses to disaster

Distress after disasters and major incidents is very common.
In most cases, distress is transient and not associated with dysfunction.
Some people’s distress may last longer and is more incapacitating.
The majority of people do not require access to specialist mental healthcare, though a substantial minority of people may do so.
Screening, surveillance and clinical assessment are required by a proportion of survivors who are thought to be at particular risk.
A small proportion of affected persons may require long-term mental health services in response to their needs.
Minimum activities/objectives for disaster planning

integrating psychosocial and mental healthcare responses within the plan for preparing for and responding to disasters;
fully integrating psychosocial care and mental health service responses;
appointing psychosocial and mental health advisers to commanders of responses to major incidents and disasters during planning and retaining their services during events;
empowering communities and people;
attending 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 staff are capable of working with diversity of values and cultures;
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 professionals; they should be well led, managed, supervised and cared for; and
promoting learning by planning and managing knowledge acquisition and its transfer, evaluation and performance management.
The Stepped Care Model

**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 untoward events.

**Basic humanitarian and welfare services** that should be made available to everyone and which are centred on families.

**Providing assessment, intervention 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.

**Providing screening, assessment and intervention services** for people who do not recover from immediate and short-term distress.

**Providing access to primary and secondary mental healthcare services**, but only for people who are assessed as requiring them.

Williams, Bisson, Ajdukovic, Kemp, Alexander, Hacker Hughes & Bevan in prep.
The current context of disaster work – TENTS

- TENTS published in November 2008
  - These European guidelines were developed from a ‘delphic’ process involving 106 professionals in 25 different countries.
  - They are recommendations for the delivery of psycho-social care following catastrophe. They are not mandatory.
The recommendations come under six main headings:

- Planning, preparation and management
- General components of the response
- Specific components of the initial response (within the first week)
- Specific components of the early response (within the first month)
- Specific components of the response 3 months after the disaster
- Specific components of the ongoing response (beyond 3 months)
NHS Emergency Planning Guidance
Planning for the psychosocial and mental health care of people affected by major incidents and disasters: Interim national strategic guidance
First published: 30 July 2009
Prepared by Emergency Preparedness Division
NHS Emergency Planning Guidance

– Not at variance with IASC, NATOJMC or TENTS

– Has the foresight not to be prescriptive
DH Psycho-social Emergency Planning Guidance (July 2009)

Overriding principles of psycho-social care following an emergency, major incident or disaster

People may show a broad spectrum of psychosocial responses to major incidents and disasters

- Strategic preparedness supports resilience and reduces risk
- Strategic planning of services should be continuous during an incident

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- Strategic preparedness supports resilience and reduces risk.
- Strategic planning of services should be continuous during an incident.

The social fabric of communities is critical to the extent and impact of psychosocial and mental health effects.

Co-ordination of services is vital to success.

Every area should have a major incident plan within which psychosocial care is integrated.

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Professional responders are also vulnerable to the psychosocial impacts of major incidents and disasters.

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Both rapid, short term responses and long-term services are required in meeting the psychosocial and mental health needs of people who are affected.

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It is important to properly manage the stepped model of care.

- It is important to properly manage.

The cornerstone of responding to people’s psychosocial needs after major incidents and disasters is to support their resources.

- The cornerstone of responding.
- Services should be based on the principles of psychological first aid.

The first responders to people’s psychosocial needs are usually the people involved.

- The first responders.
- A stepped care model of care is required.

It is important to properly manage the stepped model of care.

- It is important to properly manage.

Introduction:
What does the current evidence base tell us?

• Resilience is the expected response of communities to disasters and major incidents. It can be developed and it can also be compromised.

• The responses experienced by resilient people can be difficult to distinguish from symptoms of post-traumatic conditions. There are risks of under and overestimating prevalence of disorders unless responders and staff in the health and social care and welfare services are provided with a basic minimum of education and training.

• Disasters and major incidents affect whole communities and populations directly or indirectly and public psychosocial approaches are required to reach everyone who is affected, while the majority of people who develop mental disorders also require specific programmed personalised mental health and social care services.
Guidance on current best practice

- NICE guidance – what does it mean to us?
- NICE guidelines on PTSD (March 2005)
What is the natural history of PTSD?

- **Usual onset of symptoms**

- **Many recover without treatment within months/years of event (45-80% natural remission at 9 months)**

- **Generally 33% remain symptomatic for 3 years or longer with greater risk of secondary problems**
What is the natural history of PTSD?

How to treat PTSD? (1)

What ISN’T recommended…
• Psychological Debriefing (PD) or Critical Incident Stress Debriefing (CISD)
• Ineffective psychological treatments
• Drug treatments NOT a first line treatment

What IS recommended…
• Watchful waiting
• Trauma-focussed treatments (CBT and EMDR) for adults and children
Implications for practice

• The importance of flexibility in crisis intervention and use of follow-up

• Resources should then be focused on identifying and treating those with abnormal responses e.g. ASD

• Emphasis should increasingly be placed on the early detection of those at risk of developing psychopathology and early interventions aimed at this group, e.g.
  – Free use of the TSQ (2002)
  – Importance of anniversaries
  – Military (and other) use of the TRiM model
Current Good Practice

• Flexibility of approach
• Practical help
• Use of psychological first aid by non-specialists
• Respondent-led support e.g. Support Networks
• Use of screener at >one month
• Signposting & full assessment for those at risk
• Effective treatment for those who develop mental health problems
• Understand the importance of anniversaries
Maslow hierarchy of needs model related to disasters

- **RECOGNITION**
  - e.g. trying to make sense of what happened

- **PSYCHO-SOCIAL NEEDS**
  - e.g. mental reactivity to the event

- **SECONDARY MEDICAL NEEDS**
  - e.g. setting broken limbs

- **SAFETY/SECURITY NEEDS**
  - e.g. freedom from fear

- **PHYSICAL NEEDS**
  - e.g. water, food, shelter, clothing

- **PRIMARY MEDICAL NEEDS**
  - e.g. first aid: resuscitation, dealing with bleeding wounds

- **SURVIVAL NEEDS**
  - e.g. escape, rescue
NHS Developing Practice from the London Bombings

- For the first time using a systematic evidence-based approach!
- Calculation of numbers involved and estimate of those who might develop PTSD (approx 25%, e.g. Green 1992).
- ‘Screen and treat’ programme initiated via the 6 London Trauma Clinics
- Contingency funds of £3 million made available.
- 16 additional clinicians appointed and trained
- Project will be researched and audited – findings from preliminary study (Brewin et al. 2008)
Current signposting to UK services

- Physical health issues via GPs etc
- Psychological issues generally more problematic e.g. a real shortage of specialists in this area
- UK Trauma Group webpage www.uktrauma.org.uk
- Currently 30 specialist PTSD NHS services but patchy provision i.e. 6 in London, none in Birmingham
Longitudinal Exercise (All)

Berkshire Rail Crash 6th November 2004
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On Saturday November 6th at 18.15 the Great Western Service from Paddington to Plymouth Rail Service was derailed after colliding with a car on a level crossing at Ufton Nervet, Nr. Sulhampstead in Berkshire

Emergency Services declare a major incident
Royal Berkshire Hospital declares a major incident

Communications between hospital and paramedics at the scene severely disrupted as ambulance telecommunications become unserviceable after receiving 300 ‘999’ calls in a 45 minute period

5 passengers and the driver died

70 passengers were injured – and all were taken to hospital – 14 were admitted
Berkshire Rail Crash 6 November 2004

At the scene some passengers walked away from the scene.

A local pub opened its doors and acted as an informal rest centre providing shelter, food and drink.

The Red Cross were one of the first on the scene as the fire victim support unit.

A team from First Great Western Rail plus directors were deployed to the hospital for support with logistical arrangements for repatriating discharged and walking wounded casualties with their onward journey.
You are a psychological therapist employed by Berkshire Healthcare Foundation NHS Trust. The Trust has provided a joint author of the Thames Valley NHS guidelines for psycho-social care following a major incident. You are asked for your expertise in this area to provide appropriate care for the survivors and their families following this train crash.

What symptoms might you expect at outset? (use of information around possible symptoms?)

What are you going to do at outset?
Predictive costs at outset (estimate). This estimate is based on PTSD only – clearly other psychopathology may be relevant.

The rate of PTSD from the Paddington rail crash was 34% (interestingly, the rate following the London bombings sample was 20%).
The survivors of the Berkshire train crash is n=200 (an estimate) 34% = 68
The overall audit figures from Berkshire PTSD figures give the mean number of session of 8.2 (range 2-34).
Average cost of each session = £60
8 sessions @ £60 = £480
X 68 = £32,640 + screening outreach administration = £18k

Request at outset at cost = £59k

Other costs involved?
Berkshire Rail Crash 6 November 2004 - the psychosocial response

What will be your tasks during the first week?

Local social workers are insisting on offering critical incident stress debriefing – what are you going to do?

Berkshire radio is asking for an interview to explain possible reactions and to discuss aftercare. What are you going to say (please prepare a short briefing on this)

A local group of church leaders are offering to visit all Berkshire survivors. What do you think about this?

You become aware that there are passengers who walked away from the train crash who are unknown to anyone – how can you deal with this?

Surviving passengers (who are known to the hospital authorities) come from as far afield as Poland and Perth (Scotland). How do you think best to deal with this?
On the 5th anniversary of the Ufton Nervet rail crash, network members realised their wish for a lasting monument at the site of the crash.

This website has been created by people who were involved in the train crash at Ufton Nervet in November 2004. We are all volunteers and part of the Network which came into being after the crash to make sure that everyone had access to information and help. We hope that, in addition to providing practical help and advice concerning the legal and financial aspects of being involved in such a life-changing event; survivors’ personal stories of their experiences; an explanation of trauma and the many different ways of dealing with it; news on related subjects and updates on the progress of the inquest into the deaths at Ufton Nervet level crossing, the 17:35 Paddington to Plymouth High Speed Train operated by First Great Western struck a stationary car obstructing the line. The train was derailed and, unusually, every carriage was overturned to varying degrees. Survivors had to find their way out of the train.

A major rescue operation was activated across the County involving Fire, Ambulance and Police emergency services.

About 200 people (estimates vary) were travelling on the train that night. Five passengers and the train driver died in the accident, as well as the driver of the car. Seventy-one passengers were taken to hospital, 18 were badly injured and many of the remaining passengers suffered from trauma, shock and physical injuries.

This tragic event changed many people’s lives and left a trail of devastation reaching far beyond the route from London to Plymouth.

We want this to be a friendly site that makes you feel welcome. We hope that you find it useful and we would welcome contributions and feedback. You can email our co-ordinator, Liz, at the address given on the Contacts page or email ccme.org@which.net. If you want to hear a human voice, call her on 01635 30644.
What will be your role at a month following the rail crash?

What might be your role in helping/advising other NHS/Social care organisations?

What will be your role a year after the rail crash?
UK Psychological Trauma Society
Conference

Thank you for your attention

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